Population Trends and Policy Options in Selected Developing Countries

Population Policy Series **Editor: Joe Thomas**

Partners in Population and Development (PPD)
An Inter-Governmental Organization
for Promoting South-South Cooperation

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DISCLAIMER

The views expressed in this compendium of population stabilisation reports from 9 Partners in Population and Development (PPD) member countries funded by Population Communication are those of the author(s) and do not necessarily reflect the official policy, position, or opinions of Partners in Population and Development.

The country stabilisation reports were compiled by the authors from nine PPD member countries. These reports were prepared mainly based on the secondary data from Government sectoral-ministry data and reports, demographic and health surveys, and development partner reports. The authors also utilised contents of various published and unpublished documents, including information gathered from websites.

Any references/quotations used in the reports, which may not have been demonstrated and credited properly is not an intentional omission on behalf of the authors.

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GRAPHS

ACRONYMS

A	
AHDP	Adolescent Health Development Programme
AIDS	Acquired Immune Deficiency Syndrome
AMTSL	Active Management of the Third Stage of Labour
ANC	Ante-natal Care
ASHAs	Accredited Social Health Activists
ASRH	Adolescent Sexual and Reproductive Health
B	
BCC	Behaviour Change Communication
BDHS	Bangladesh Demographic & Health Survey
BEAM	Basic Education Assistance Module
BUDFOM	Business Development Fund for Women
C	
CBO(s)	Community Based Organisation(s)
CCs	Community Clinics
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CHAG	Christian Health Association of Ghana
CHC	Community Health Centre
CHCP	Community Health Care Provider
CHPS	Community Based Health and Planning Services
CITC	Client Initiated Testing and Counselling
CMEIAST	Community Empowerment and Mobilisation for Improved Access to Care, Support and Treatment
CPR	Contraceptive Prevalence Rate
CSCRP	Cadre Strategique pour la Croissance et la Reduction de la Pauvrete
CSO(s)	Civil Society Organisation(s)
D	
DFID	UK Aid from the Department for International Development
DLHS	District Level Health Survey
DRH	Division of Reproductive Health
E	
EC	Emergency Contraceptive
ECD	Early Childhood Development
ECOWAS	Economic Community of West African States
EDIF	Export Development & Investment Fund
EFA	Education for All

EmOC	Emergency Obstetric Care
ERS&WEC	Economic Recovery Strategy for Wealth and Employment Creation
ESAP	Economic Structural Adjustment Programme
F	
FCT	Federal Capital Territory
FCUBE	Free Compulsory Universal Basic Education
FGN	Federal Government of Nigeria
FMOH	Federal Ministry of Health
FP	Family Planning
FPL	Food Poverty Line
FRU	First Referral Unit
G	
GBV	Gender based Violence.
GDHS	Ghana Demographic and Health Survey
GDP	Gross Domestic Product
GES	Ghana Education Service
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
GHS	Ghana Health Service
GNI PPP	Gross National Income at Purchasing Power Parity
GNFP	Ghana National Family Planning Programme
GOB	Government of Bangladesh
GOK	Government of Kenya
GOU	Government of Uganda
GSGDA	Ghana Shared Growth and Development Agenda (2010–2013)
GVB	Gender Based Violence
H	
HCP	Healthcare Providers
HDI	Human Development Index
HIV/AIDS	Human Immuno Deficiency Virus/Acquired Immune Deficiency System
HIPC	Heavily Indebted Poor Countries
HIV	Human Immunodeficiency Virus
HPI	Human Poverty Index
HPNSDP	Health, Population & Nutrition Sector Development Project
HPSP	Health Professionals Services Program
HSSP	Health Sector Strategic Plan
I	
ICPD	International Conference on Population and Development
ICPD PoA	International Conference on Population and Development Program of Action
IEC	Information, Education and Communication
IGA	Income Generation Activities
IIPS	International Institute of Population Sciences
ILO	International Labour Organization
IMCI	Intergrated Management of Childhood Illnesses
IMR	Infant Mortality Rate

INGOs	International Non-Governmental Organisations
IOM	International Organization for Migration
IPCR	Institute for Peace and Conflict Resolutions
IUD	Intra-uterine Devices
J	
JHS	Junior High School
JPP	Joint Population Programme
JSK	Janasankhya Sthirata Kosh
JSY	Janani Suraksha Yojana
K	
KAIS	Kenya AIDS Indicator Survey
KDHS	Kenya Demographic Health Survey
KFS	Kenya Fertility Survey
KIHBS	Kenya Integrated Household Budget Survey
KNBS	Kenya National Bureau of Statistics
KNUST	Kwame Nkrumah University of Science and Technology
L	
LAPM	Long-term and permanent methods
LGAs	Local Government Areas
M	
MCH	Maternal and Child Health Care
MDAs	Ministries, Departments and Agencies
MDG(s)	Millennium Development Goal(s)
MMR	Maternal Mortality Rate
MMU	Mobile Medical Unit
MOE	Ministry of Education
MOFPED	Ministry of Finance, Planning and Economic Development
MOGLSD	Ministry of Gender, Labour and Social Development
MOH	Ministry of Health
MOSPND	Ministry of State for Planning, National Development and Vision 2030
MOWAC	Ministry of Women and Children's Affairs
MR	Menstrual Regulation
MTP	Mid-term Plan
N	
NACA	National Agency for Control of AIDS
NAN	News Agency of Nigeria
NAPEP	National Poverty Eradication Programme
NAPTIP	National Agency for Prohibition of Traffic in Persons and other related matters
NASSWI	National Association of Small Scale Women Industrialists
NAWE	National Association of Women Entrepreneurs
NBS	National Bureau of Statistics
NCAPD	National Coordinating Agency for Population and Development
NCPD	National Council for Population and Development
NCWS	National Council of Women's Societies

NDE	National Directorate of Empoyment
NDHS	National Demographic and Health Survey
NDP	National Development Plan
NDPC	National Development Planning Commission
NEEDS	National Economic, Empowerment and Development Strategies
NEPAD	New Partnership for Africa's Development
NERP	National Economic Revival Programme
NFED	Non Formal Education Department
NFHS	National Family Health Survey
NGO(s)	Non Government Organisation(s)
NHIS	National Health Insurance Scheme
NHP	National Health Policy
NLC	National Leaders' Conference
NMR	Neonatal Mortality Rate
NPC	National Population Commission
NPHP	National Population & Health Policy
NPP	National Population Policy
NPPAP	National Population Policy Action Plan
NPPSD	National Population Policy for Sustainable Development
NRHM	National Rural Health Mission
NSV	No-scalpel vasectomy
NTF	National Task Force
NV	Nigeria Vision
NYEP	National Youth Employment Programme
O	
ODA	Official development assistance
P	
PAAP	Poverty Alleviation Action Plan
PAC	Post Abortion Care
PATH	Postpartum Haemorrhage
PEAP	Poverty Eradication Action Plan
PFA	Platform for Action
PHC	Population and Housing Census
PHC	Primary Health Care
PID	Pelvic Inflammatory Dieseases
PITC	Provider Initiated Testing and Counselling
PMTCT	Preventing Mother to Child Transmission
PoA	Plan of Action
PPAG	Planned Parenthood Association of Ghana
PPD	Partners on Population and Development
PPP	Public Private Partnership
PPPHI	Perspective on Postpartum Haemorrhage Initiative
R	
RAPID	Resource for Awareness in Population and Development
RCH	Reproductive & Child Health

RH	Reproductive Health
RHCS	Reproductive Health Commodity Supplies
RIDS	Rural Infrastructure Development Scheme
RTI(s)	Reproductive Tract Infection(s)
S	
SACA	State Agency for Control of AIDS
SAC	Satisfied Acceptor Couple
SHS	Senior High School
SME(s)	Small & Medium Enterprise(s)
SOWESS	Social Welfare Services Scheme
SRS	Sample Registration System
SSC	South-South Cooperation
STEP	Short term Emergency Plan
STERP	Short-term Economic Revival Plan
STIs	Sexually Transmitted Infections
STME	Sciences Technology Mathematics Education
SURE-P	Subsidy Reinvestment Programme
T	
TFR	Total Fertility Rate
TBA	Traditional Birth Assistants
TWFR	Total Wanted Fertility Rate
U	
U5MR	Under 5 Mortality Rate
UDHS	Uganda Demographic Health Survey
UN	United Nations
UNAIDS	United Nations Joint Programme on AIDS
UNDP	United Nations Development Program
UNFPA	United Nations Fund for Population and Development
UN-HABITAT	United Nations Human Settlements Programme
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children Fund
UN WOMEN	United Nations Women
USA	United States of America
USAID	United States Agency for International Development
W	
WILDAF	Women in Law & Development in Africa
WFP	United Nations World Food Programme
WHO	World Health Organization
WOFEE	Women Fund for Economic Empowerment
Y	
YES	Youth Empowerment Scheme
Z	
ZNASP	Zimbabwe National HIV and AIDS Strategic Plan

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We are extremely indebted to Population Communication, USA for partnering with PPD to produce these reports. In particular we are grateful to Dr Bob Gillespie, the President of Population Communication for his kind support, technical and collegial guidance from the inception period to the finalisation of the reports.

PPD is appreciative of the following authors for their contribution to the nine country reports. They worked under extreme pressure to complete the work in the shortest possible time. We especially would like to express our gratitude to Dr Betty Kyaddondo, Head of Family Health Department, Population Secretariat, Uganda; Mrs F N Abdulraheem, National Planning Commission, Nigeria; Dr Munyaradzi Murwira, National Family Planning Council, Zimbabwe; Dr Atiqur Rahman Khan, former Director of MCH-FP Services and Chief of Population in the Planning Commission and Ms Mufaweza Khan, Executive Director of Concerned Women for Family Development, Bangladesh; Dr Boubacar Samba Dankoko, Medical Public Health Specialist, Technical Adviser No. 1 of the Minister of Health, Senegal; Mr Charles Oisebe, National Council for Population and Development, Kenya; Mr Mountaga Toure, Executive Director of AMPPF (Malian Association for the Protection and Promotion of the Family), Mali; Dr Anant Kumar, Assistant Professor in Department of Rural Development at Xavier Institute of Social Service, and Prof. Jay Satia, Advisor (Public Health Foundation of India) and Director-in-Charge of Indian Institute of Public Health, India (Bihar); and the National Population Council, Ghana.

The compilation of this report was made possible with the invaluable technical support of PPD staff members in particular Dr Lorna Tumwebaze, Deputy Executive Director, and PPD Programme staff: Ms Therese Maye Diouf, International Program Officer, Dr Nazrul Islam, Senior Programme Officer and Dr Mahbubur Rashid, Programme Officer.

Behind all PPD activities, there is always the unstinting support, cooperation and commitment of the PPD member countries and Board Members for the realisation of

the South-South cooperation towards advancing reproductive health, population and development in developing countries. We express our hearty thanks to all our Board Members and Partner Country Coordinators.

We deeply appreciate Dr Ritu Mahendru, Head of Policy and Research, Spatial and Social Development Perspectives Ltd, UK who provided the editorial support, overall analysis of the nine country chapters and for her contribution towards the introductory chapter.

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Joe Thomas, PhD
Executive Director

FOREWORD

Partners in Population and Development (PPD) is the only international organisation focused on South-South collaboration with the mission of achieving the principals and practices of the International Conference on Population and Development. The 25 member countries meet annually to determine how best to strengthen the networks and partnerships that deliver family planning and reproductive health services.

The authors who have prepared the population stabilisation reports focus on the demographic realities that take into consideration the age structure, sex ratios, migrations, population projections as well as adolescent pregnancy, fertility and mortality. The historical, religious, cultural, political, resource and environmental considerations are reviewed in the reports.

The underlying principals of poverty eradication, sustainable growth, universal education, with a focus on girls, gender equality and empowerment, food security, access to primary health services and a rights-based approach to sexual and reproductive health, are fundamental to the principals and practices that are prescribed within the framework of the reports.

Populations will stabilise by lowering birth rates to replacement levels or an increase in the death rate. Satisfying the existing demand to prevent unwanted pregnancies requires contraceptive methods stressed according to the needs of the individuals and the family. Providing primary healthcare to prevent maternal and child deaths, increasing age at marriage to twenty, spacing of births by two to three years and achieving the two-child family is fundamental to achieving population stabilisation.

Many of the PPD countries that have achieved replacement size families have had strong commitments from the heads of government, cabinet members, parliamentarians, judiciary, religious leaders, entertainment community, mass media and more recently, increase use of cell phones, the internet and computer applications specifically geared towards improving access to health and education.

Bangladesh has a total fertility rate (TFR) of 2.3. PPD countries such as Indonesia have total fertility rates of 2.3, Vietnam 2.0, Thailand 1.6, Morocco 2.3, Mexico 2.3, and Tunisia 2.1. In addition to reports in this compendium, Dr Usha Ram, Associate Professor, Department of Public Health & Mortality Studies, International Institute for Population Sciences has authored, "Population Stabilization in Uttar Pradesh, India: Past, Present and

Future Directions", Dr Osama Refaat, Deputy Director of Regional Center for Training in Family Planning and Reproductive Health, OB/GY Hospital, Faculty of Medicine, Ain Shams University, "Population Stabilization Policies and Programs in Egypt", and Tomas Osias, Lolito Tacardon and Luis Pedroso, Commission on Population, "People Beyond Numbers: the Road to Population Stabilization in the Philippines". From each of these countries and the state of Uttar Pradesh, annual progress reports have revealed a commitment to the principals of the ICPD.

At the ICPD in Cairo, Dr Nafis Sadik, Executive Director of the UNFPA, accepted the Statement signed by 75 heads of government from Haryono Suyono, chairman of the BKKBN. In Dr Sadik's comments, she emphasised, "The importance of population and development issues and the urgency of population stabilization must be recognized." The Statement refers to human rights three times and how women should participate in formulating policies and programmes.

World Leaders Statement On Population Stabilisation

Humankind has many challenges:

- obtain lasting peace between nations;
- preserve the quality of the environment;
- conserve natural resources at a sustainable level;
- advance the economic and social progress of the less developed nations;
- assure basic human rights and at the same time accept responsibility for the planet Earth and future generations of children;
- stabilize population growth.

Degradation of the world's environment, income inequality, and the potential for conflict exist today because of rapid population growth, among other factors. If this unprecedented population growth continues, future generations of children will not have adequate food, housing, health services, education, earth resources, and employment opportunities.

We believe that the time has come now to recognise the worldwide necessity to achieve population stabilisation and for each country to adopt the necessary policies and programmes to do so, consistent with its own culture and aspirations. To enhance the integrity of the individual and the quality of life for all, we believe that all nations should participate in setting goals and programmes for population stabilisation. Measures for this purpose should be voluntary and should maintain individual human rights and beliefs.

We urge national leaders to take an active personal role in promoting effective policies and programmes. Emphasis should be given to improving the status of women, respecting human rights and beliefs, and achieving the active participation of women in formulating policies and programmes. Attention should be given to realistic goals and timetables and developing appropriate economic and social policies.

Recognising that early population stabilisation is in the interest of all nations, we earnestly hope that leaders around the world will share our views and join with us in this great undertaking for the well-being and happiness of people everywhere.

The Statement has been signed by the heads of government of the following countries:

Austria	Jordan	Rwanda
Bangladesh	Kenya	Saint Kitts and Nevis
Barbados	Korea, DPR	Saint Lucia
Bhutan	Korea, Republic of	Saint Vincent and the Grenadines
Botswana	Laos	Saõ Tomé and Príncipe
Cape Verde	Liberia	Senegal
China, People's Republic of	Libya	Seychelles
Colombia	Macedonia	Singapore
Cyprus	Malawi	Slovak Republic
Dominica	Malaysia	South Africa
Dominican Republic	Maldives	Sri Lanka
Egypt	Malta	Sudan
Fiji	Mauritius	Suriname
Gambia	Moldova	Swaziland
Ghana	Morocco	Tanzania
Grenada	Myanmar	Thailand
Guinea-Bissau	Namibia	Tonga, Kingdom of
Guyana	Nepal	Trinidad and Tobago
Haiti	Nigeria	Tunisia
Iceland	Pakistan	Turkey
India	Palau	Uganda
Indonesia	Panama	United Arab Emirates
Israel	Peru	Uzbekistan
Jamaica	Philippines	Vanuatu
Japan	Romania	Zimbabwe

"Zimbabwe Population Stabilisation Report", by Dr Munyaradzi Murwira reveals that the early pioneering support for family planning has resulted in one of the highest contraceptive prevalence rates in sub-Saharan Africa. "Uganda's Population Stabilisation Report", by Dr Betty Kyaddando has been described by Charles Zirarema, Acting Director, Population Secretariat, as the blueprint for "the strategic interventions that will help Uganda achieve social and economic development and transformation". On 10 December 2011, Human Rights Day, Dr Kyaddando presented her report at the Uganda National Population Conference. A total of 200 participants drawn from policy makers, such as Ministers and Members of Parliament, representatives from sector Ministries of Finance, Health, Education and Sports, Environment, Urbanisation and Housing, Gender, Labour and Social Development, local government, partners implementing population and development initiatives, development agencies and donor partners, representatives from selected districts, the private sector, universities and state cooperation (parastatals) attended the conference.

The report by Mountaga Toure, "Demography in Mali: Situation and Implications", reveals a level of urgency in focusing on the underlying demographic, ecological, economic, social, health and education transformations that include gender equality, achieving the principals of the ICPD, the Millennium Development Goals and ultimately population stabilisation. Mr Charles Oisebe's report, "Population Stabilization: Kenya Case", highlights a longtime commitment to family planning and reveals the current obstacles as well as opportunities required to achieve population stabilisation in Kenya.

The report by Jay Satia and Anant Kumar, "Population Stabilization in Bihar, India: Situational Analysis and Future Directions," is structured within the framework of "Health Strengthening under the National Rural Health Mission (NRHM) in India", reported by Anuradha Gupta, Joint Secretary, Government of India. India is mobilising over 750,000 ASHAs (Accredited Social Health Activists), training 46,000 auxiliary nurse midwives, 17,500 paramedics, 25,000 staff nurses, 8,600 doctors with over 1,000 mobile medical units. Maternal and child health and family planning are being delivered and promoted to the doorstep of every village and the urban centre. The emphasis has been on community-based distribution and improved management and quality of services in both the public and private sector. Each of the 146,000 sub-centres reach between 3,000 to 5,000 population. An active decentralisation programme with flexible financing has mobilised community participation. Progress has been made in Kerala with a TFR of 1.8, Andhra Pradesh 1.8, West Bengal 1.8, Maharashtra 1.9, and Tamil Nadu 1.7. The major challenges are in Uttar Pradesh, which now has a TFR of 3.5, Uttarakhand 2.6, Bihar 3.7, and Rajasthan 3.1.

In 1962 the Nigerian population was 36,000,000. Today the population is 170 million. With the existing TFR of 5.7, the population will reach 554 million in 2060. Nigeria could have over

1 billion people before the turn of the century. Even with a focus on a two-child family today, the population will double, because half the population is under the age of 17. The Nigerian report by Faillat Abdulraheem, "Nigeria's Progress in Achieving Population Stabilization: 2011", reveals the cultural, religious, economic, social and gender challenges, and the obstacles to expanding access to contraceptive services.

Dr Boubacar Samba Dankoko's report, "The Evolution of the population in Senegal" notes that Senegal was the first French-speaking sub-Sahara African country to initiate a population policy. Family Planning is being expanded in health centres through midwives, social marketing and now includes inter-uterine devices and implants. Support is being gained from Imams and Ulemas and is focusing on comprehensive integration of contraceptive services with reproductive health.

According to the Ghanaian National Population Council's, "Population Stabilisation Report: Ghana, 2011", Ghana has been blessed with new oil production and has a 14.5 per cent economic growth rate. The report incorporates the latest data from the 2010 Population and Housing Census and reveals a declining of TFR from 6.4 in 1988 to 4.0. The current fertility projections are for a TFR of 3.8 by 2015, 3.5 by 2020 and a replacement level of 2.1 by 2050.

The authors Atiqur Rahman Khan and Mufaweza Khan's report, "Population Stabilization in Bangladesh: Problems, Prospects and Policy Issues", reveal a new policy has been formulated this year which proposes to achieve replacement level by 2015. In contrast to past policies on "Two children is enough", the new "Bangladesh Population Policy 2011", proposes to promote family sizes lower than two, with a new slogan, "Not more than two, it is better to have one". In Bangladesh, conventional methods were delivered by full-time family planning field workers and a social marketing programme focused on delivering contraceptives in retail outlines. The first priority was establishing 2,350 family welfare centres consisting of a medical assistant, a family welfare visitor and a pharmacist. In addition, there were 48 health sub centres and 1,275 rural dispensaries. Sterilisation services were provided by physicians with fee-for-service contracts. A coupon system was used to measure and monitor the performance of the programme and to arrange appropriate payments. There was an active information, education and motivation programme using both the mass media and a multi-sectoral approach in the school system. Twelve welfare training sites were designated, and the 6,700 traditional birth attendants (TBAs), 13,500 Dais (village midwives), 13,500 family welfare attendants, 2,722 family welfare visitors and 18,000 family welfare workers were trained and mobilized from 1975 to 1978. All of these efforts were complemented by extensive research and evaluation. All cabinet members and at the district level, the district councils, Thana (councils), union parishads and village leadership structures were mobilised. Specific reforms were institutionalised to raise the age at marriage to 21.

I wish to thank each of the authors who has contributed to the compendium of reports on population stabilisation. Collaborating with the authors has been an honour and privilege. I look forward to active participation with the leadership of the PPD, Joe Thomas, Lorna Tumbewaze, and Nazrul Islam in utilising these reports to expand access to family planning services and achieve the principals of the ICPD.

Bob Gillespie
Pasadena

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NATIONAL POPULATION COUNCIL (NPC), GHANA was established by an Act of Parliament (Act 485, 1994) with responsibility to H.E. The President. The core function of the Council is to advise the Government on all matters relating to population. The Council is also mandated to coordinate, monitor and evaluate the development and implementation of all population programmes in the country. The vision of NPC – "a better quality of life for the people of Ghana through effective population management" – is a reflection of Article 37, Clause 4 of the 1992 Fourth Republican Constitution of Ghana which "enjoins Government

to maintain a population policy that is consistent with the aspirations and development needs of the country". The NPC sets population targets for development planning and mobilises resources for population programmes in the country.

Dr RITU MAHENDRU is a sociologist specialising in ethnographic research focusing on gender, equity, health policy and social inequalities. Her research interests lie in gender, gender based violence, sexual health, HIV, ethnicity, migration, displacement, health and human rights. She is currently teaching Health Policy at the University of East London and has been working on development issues for over 11 years. She has country knowledge and experience of working in the UK, South Asia, South Africa and Serbia. In her capacity of working as a Senior Researcher, she has worked with the World Health Organization, United Nations, South Asian Association for Regional Cooperation (SAARC), Ministry of Public Health Afghanistan, provincial government of South Africa, and various national and international agencies. She is currently writing a chapter on Gender and Healthcare and has authored a book titled: Gender, Risk and AIDS: Young People's Perceptions of Gender, Risk and AIDS: A Comparative Analysis of India and the UK.

Dr ROBERT W GILLESPIE is the President of Population Communication and authored the Statement on Population Stabilisation by World Leaders, which has been signed by 74 heads of the Governments. He worked as Director of Special Projects for Population Crisis Committee (now Population Action International) in India, Mexico, Bangladesh, Pakistan, Sri Lanka, Thailand, Philippines, Nigeria and Egypt on innovative family planning programmes. With Ford Foundation support, he provided assistance to the Bangladesh government to design a national sterilisation plan of action. He worked on the training methodologies, curriculum and evaluation of a programme to mobilise 18,000 field workers. With the Director of Research, he outlined proposals to link fertility to the development process. He also provided short-term technical assistance focusing on mass media campaigns, the use of field personnel and designing research projects in the Philippines, Bangladesh, Sri Lanka and Indonesia. He has authored several books, reports and articles. He has been associated with different organisations, including research and academic, as board of directors and member of advisory committees namely Population Institute, WHO Task Force Member on Contraceptive Acceptability in Expanded Programmes of Research and Development in Human Reproduction, UNESCO Family Planning Communication Research Committee, International Committee on Applied Research in Population, Pasadena Planned Parenthood, Advisory Committee to the Dean of the School of Public Health, University of California at Los Angeles, the Advisory Committee to the Population Research Laboratory at the University of Southern California, Population Education Committee and Earth Communications Office.

CHAPTER 1

INTRODUCTORY CHAPTER
POPULATION STABILISATION AND DEVELOPMENT

Ritu Mahendru, Joe Thomas & Lorna Tumwebaze

INTRODUCTION

The Population of the World is growing at an unprecedented rate. The current population of the world has already reached 7 billion and is likely to reach over 9 billion by 2050 (UNFPA, 2012a). It is reported that even if the fertility rate decreases "continued population growth is inevitable". Future population growth would mean increase in social, economical and environmental disparities, inequities and impacts. Increasingly, most developing countries have witnessed growth in population and it is further projected that future human population growth will remain concentrated in the poor countries (Grundy, 2002), especially those in the most vulnerable parts of the countries.

The highest infant mortality rates are currently found in sub-Saharan African countries and in certain regions of South Asia where population growth is expected to be highest, and larger impacts are on infant and maternal mortality rates with poor social and gender development indicators. Of the nine countries included in this publication, currently, Uganda has the highest fertility rate (6.7) after Mali (6.6), and Mali has the highest infant mortality rate (95.8 per 1000) in the world. While some progress has been made across the countries, the scenarios presented in this edited volume do not project a satisfactory population stabilisation picture. Even if the wanted/required fertility rate is achieved, the population will continue to grow in many developing countries.

There are several reasons behind rapid population growth – historic, social, political and economic conditions. However, one of the key determinants of rapid population growth is the socio-economic status of women and women's inability to exercise their sexual and reproductive health rights.

The experiences of nine country (Bangladesh, India (Bihar), Ghana, Kenya, Mali, Nigeria, Senegal, Uganda and Zimbabwe) reports included in this edited volume have moderate to rapid patterns of growth. The countries selected for this compendium can be categorised into fragile, low-income and developing countries – countries that have gained Independence in the last few decades and conflict affected settings such as Uganda and Mali.

While the country chapters presented in this book have similar social and economic challenges, they arise at different stages both economically and politically. The socio-cultural, political and economic transitions of these countries are set out in a different space and time that separates them from one another. However, the thematic areas outlined

and discussed in this chapter are where the reader will begin to see an interesting coalesce between all these countries that present a similar story, occurring in different settings.

The authors of the nine reports borrowed from various published/unpublished sources including website sources, some of which may not be adequately referenced. There may also be variations in the individual country report formats. There was no uniform format and rigorous methodological process and investigations followed as may be entailed for an academic publication and for journals. The reports were originally written for sharing information on population stabilisation policies and programmes in southern countries. However, Partners in Population and Development (PPD) found the country reports worth compiling into a book to communicate a compelling story at the global level in the wake of review of achievements towards the International Conference on Population and Development (ICPD) Programme of Action (PoA) and Millennium Development Goals (MDGs). This publication is first in the series of analytical work we are planning to bring out which we expect to contribute to the on-going policy dialogue on challenges of population policy in the context of post ICPD & MDG initiatives.

In the introductory chapter, we present and discuss the experiences from nine countries to contribute to knowledge based on population stabilisation. Where information was lacking, the editors consulted the UNFPA, World Bank and MDG indicator websites that present and discuss specific region-based MDG indicators' progress.

As 'insiders', who have firsthand experience of working with those who are vulnerable and marginalised as well as the government machinery. We believe the authors of the nine country reports present the realities of their countries in their own ways by embracing the lived grounded realities of disadvantaged communities. In essence, the chapters give an overall picture of the population transition and provide a useful qualitative historic background to the situation of women, religion, culture and the overall socio-political transition itself.

The chapters incorporate cultural, political, faith based and social elements in order to reach a better understanding of the population of their countries. Authors of country chapters report Government policies and commitments as the main determinants to stabilise population through programme achievements, programme approaches, and sustainability.

The particular strength of this edited book is a more integrated approach to changing population stabilisation strategies. This includes attention to sustainable development and gender equity. Another innovative feature of the book is the use of case studies from African and Asian countries. And yet another advance is its focus on the intersection between gender and a wide range of social inequalities, for instance migration status, geographical location, history and social space. In this chapter, we begin by identifying themes commonly presented in all the chapters and current debates on population development that recur across the various chapters and topics of this handbook. Population stabilisation is explored through a lens of sustainable development. This book is designed to enable sharing of reflective information, respective country experiences and population policies that contributed to the nine countries population stabilisation programmes.

The editors allowed the expression of frustration and left insights from lived experiences unchanged. These insights would not have been possible if the opportunities were not created. As insiders, the editors feel, the authors are aware of the disappointments of grounded realities which are better understood by the authors. By adopting this approach, PPD is creating opportunities for South-South Partnerships in analysing the experiences of population transition in developing countries. This book provides developing country perspective on population stabilisation and related policy challenge. The first chapter aims to present comprehensive analysis of the current country situations with regard to its demographic trends, social, economic, political and policy analysis.

Each country chapter follows a historic trail and patterns of population transition affecting the fertility rate of their urban and rural population. The chapters look at successes and challenges towards population stabilisation – what worked, what did not work and possibilities of introducing improved family planning strategies with particular attention to social protection, economic growth, gender equity, sexual and reproductive health, prevention of HIV/STIs and improving the rates of maternal and child mortality.

In this introductory chapter, we make attempts to excavate and present population stabilisation country scenarios and present a comparative analysis. The chapter addresses these questions by uncovering the policies, programmes and intervention strategies and mechanisms that worked. It also analyses the trends within and across the nine counties in order to determine whether or not population in these countries is stabilising. Subsequently, we present and discuss the key population and demographic indicators, compliance with international agreements and goals, and finally conclusion and recommendations are presented.

Due to the rapid demographic transition during the past five decades, the world is now more diverse in birth, death and population growth and countries can be divided into groups such as; Rapid growth (>2% per year), Moderate growth (1–2% per year) and Low or no growth (<1% per year) (Ezeh, Bongaarts and Mberu 2012).

Though the Population Growth Rates (PGR) and Total Fertility Rates (TFR) are closely linked, they are two different population phenomenon. According to the World Bank, Population Growth Rate (PGR) is defined as the increase in a country's population during a period of time, usually one year, expressed as a percentage of the population at the start of that period. It reflects the number of births and deaths during a period and the number of people migrating to and from a country. Whereas, TFR is the number of children that would be born to a woman if she were to live to the end of her childbearing years and bear children in accordance with age-specific fertility rates.

The relation between PGR and TFR is complex. In high mortality settings, it is possible to have high fertility rates accompanied by low population growth. Likewise, even when fertility rates are declining, high population growth rates can continue due to population momentum. The complex relationship between PGR and TFR is manifested in many ways. Rapid PGR and high fertility rates correlate closely with high rates of infant and maternal mortality.

Table 1.1: Population Growth and Policy Implications in Selected 9 Countries					
No.	**Country**	**Population Growth Rate (Data from country reports)**	**Population Growth rate (World Health Statistics 2012)**	**TFR***	**Policy Implications**
A	Pattern of growth: Moderate growth: ≤ 1-2% population growth per year				
1	Zimbabwe	1.1*	1.4 ****	3.8	Promoting investment for the human resources to benefit demographic dividend Promoting women empowerment and employment, Child care support
2	Bangladesh	1.2**	1.4	2.3	Sustaining current gains in FP programmes while mitigating for impact of rapid urbanisation
B	Pattern of growth: Rapid growth: ≥2% population growth per year				
1	Bihar (India)	2.2 (India 1.6)***	- (India1.5)	3.7	Policies mitigating adverse social, economic, and environmental pressures.
2	Kenya	3.0 *	2.6	4.6	Policies mitigating adverse social, economic, and environmental pressures. Continuing the implementation of voluntary Family Planning programmes. Policy option to reduce the high unmet need for contraception, unwanted pregnancies and addressing reproductive health rights, particularly of adolescent and young girls. Promoting right based reproductive norms. Ensuring reproductive health commodity security Policies emphasising gender, equity and rights
3	Ghana	2.7*	2.4	4.0	
4	Mali	3.0**	3.1	6.6	
5	Nigeria	3.2*	2.5	5.7	
6	Senegal	2.5**	2.7	4.8	
7	Uganda	3.2*	3.2	6.7	
*Sources: * Country Reports, ** World Bank 2012, *** Provisional Population Totals, 2011 (India), **** the World Fact Book 2012.*					

Country Scenarios of Population trends and policy options

Bangladesh

Bangladesh has a TFR of 2.3 and the population growth rate is 1–2 to 1.4. The country has noticed increase in contraceptive methods and decline of fertility due to addressing two forms of equity – gender and geographical. The constant efforts on family planning services provided opportunity to expand access to a wide range of modern contraceptive methods geographically – to both men and women. Given the existing complex social, political, religious and economical settings, decline was noticed due to widespread acceptance of contraceptive practice resulting from a strong family planning programme. The contraceptive methods were promoted through joint efforts between the public sector and civil society organisations, including faith based organisations and NGOs as well as advocacy at the local level. Moreover, a policy of financial compensation to service providers, acceptors and referrer played an important role in promoting methods' acceptance. The acceptance of methods helped in building user confidence. The major method utilised was the permanent family planning method for women (tubal ligation) and an increase in male vasectomy was also promoted. However, challenges in the country remain to reach the replacement fertility level such as elimination of all unwanted birth rates, early child marriage, socio-economic factors, involvement of private and public sector. The additional questions Bangladesh need to address are sustainability of the financial compensation system and also female and male user experience and access to counselling for informed choice and voluntary family planning uptake, increasing method mix and sustaining client's contraceptive use.

Bihar, India

Fertility transition in the rural state of Bihar, India is much slower. The state has a high fertility rate of 3.7 in comparison with the other states and urban areas in the country where the TFR is 2.5. The country authors report social, economic and governance, as well as intervention methodological issues, as the key problems creating obstacles to stabilise the population. Social issues involve high number of marriages under the age of 18 years, preference for male child, low rate of female literacy and low female status, and modest level of infant mortality. Other social issues are desire for large families and the male child, but more importantly because women are unable to use contraception necessary to achieve their wanted fertility. This is due to weak family planning intervention strategies resulting in lack of information, choices for safe family planning services and low level of contraceptive use. The intervention and governance issues include accessibility, availability and quality of care for family planning as well as non comprehensive policies policies. In the past, the focus has been in achieving the stipulated target by any one method rather than provision of multiple contraceptive methods. For instance, it was IUDs in the 1960s, vasectomy in the 1970s and tubectomy in the 1980s. Moreover, the state decisions have been dependent on the Central government. Critical review of this analysis reported that deep rooted gender inequality,

lack of holistic approach, top-down approach, targeting only women for contraception rather than seeking and increasing male involvement, poor counselling, poor follow-up services and lack of needs based programmes are some of the reasons for high fertility. However, the National Rural Health Mission (NRHM) Programme provides a window of opportunity, bringing all programmes including Reproductive and Child Health (RCH) and population stabilisation under one umbrella. The NRHM seeks to provide universal access to equitable, affordable and quality health care. The authors are optimistic about the NRHM, they express concerns around the time, infrastructure and human power shortages in the State. There is an opportunity to work in partnership with local NGOs, women and civil society organisations to shift the TFR pattern to a wanted or a desired fertility rate.

Ghana

The Total Fertility Rate (TFR) in Ghana declined from 6.4 in 1988 to 4.0 in 2008 and is one of the lowest in Sub-Saharan Africa. The population growth is 2.4 to 2.6. The country has achieved almost universal knowledge in family planning (over 90 per cent) with its ongoing political commitment towards stabilising population. Despite the recorded declines in fertility in Ghana, the author reports that population will continue to grow. The population growth rates have not shown much change, and have remained between 2.4 and 2.7 per cent from the period of 1984–2010. Even though increased knowledge in family planning has been reported, practice of contraception in the country remains low. This is due to low educational status, demographic momentum and population increase concentrated in specific geographical areas and social disparities leading to marginalisation – geographical and gender – of some population groups. The difficulties in reaching the replacement level are the unavailability of resources and capacity issues in rural areas. The authors suggest that to achieve population policy goals and objectives successfully, a large body of trained human resource needs to be in place, particularly district planning officers. Furthermore, socio-cultural and demographic factors continue to pose challenges in addressing the reproductive health needs of Ghana's young people. These challenges include early age at first marriage, early age at first (unprotected) sex, increasing indulgence in premarital (unprotected) sex and low use of contraception. Governance issues could also present challenges to achieve the replacement rate – such as lack of political commitment, issues with policy planning and implementation, social disparities and burgeoning of the youth population at reproductive age. Despite the growth in economy being between 7 per cent and 14 per cent per annum, literacy rate in the country remains low (50%). The country needs to address challenges it is currently facing, i.e., inequalities, low literacy level, lack of political commitment, regular demographic information and regular commitment to the ICPD principles.

Kenya

With a population that has doubled over the past 25 years, the authors highlight a number of relevant policies in an effort to stabilise population and remain committed to the ICPD

principles. The chapter on Kenya presents an interesting fertility transition. The current TFR of the country is 4.7. The population in the country has continued to grow (PGR is 2.6 to 2.7). The population growth is attributed towards increase in fertility levels and decline in maternal mortality, and also improvement in health, especially child nutrition and socio-economic status. However, a sharp decline between 1979 and 1999 was noticed due to Kenya entering the demographic transition as well as promotion and use of contraceptive method mix; substantial national and international support of the National Family Planning (FP) Programme, including reinvigoration of the Population Policy. Human and financial resources were invested in the National FP Programme. However, the authors report that family size in some parts of the country have been reduced due to migration to other regions, modern agricultural technologies, intensification of agriculture activities, and more importantly, investment in their children's education. The National FP Programme was launched in 1967. Knowledge on FP methods has increased steadily and currently it is almost universal for both men and women. The authors are optimistic that the fertility rate in the country will decline with ongoing education reforms and gender empowerment activities. However, there is concern that the population momentum could cause the population to increase even after fertility rates decline to the replacement level. The country also has social, economic and demographic challenges. The major challenges are contraceptive commodity insecurity; social, cultural and religious beliefs and practices; coupled with over dependency on erratic donor funding for modern contraceptives. The authors also report there might be variations in the data attributed to the large sampling errors, and socio-cultural myths, beliefs and practices associated with death, where family members rarely report deaths. The author suggests collecting data regularly on all demographic information, addressing unmet family planning need, and sustained client's contraceptive use as the key to stabilise the population in Kenya.

Mali

The TFR of Mali is 6.6 and has remained invariable since 1987. The population growth rate is 3 to 3.1. The government of Mali has made numerous efforts towards population stabilisation. Since 1991, a National Population Policy (NPP) exists and its implementation takes place through the Priority Program of Action and Investments. Policies in Mali took recommendations from ICPD and have focused on improving the health of women and children. However, it has been unsuccessful in achieving its targets in population and development. There is lack of integration of policies into other areas and lack of political commitment. Following numerous interventions in outreach and advocacy, a law (No. 02-044) on Reproductive Health and an Action Plan to ensure Secure Contraception were adopted respectively in 2002 by the National Assembly and the Government of Mali. The country, already in a conflict setting, is facing a number of challenges including low contraceptive prevalence rate, high TFR, high maternal and infant mortality rates. The major factors are governance issues, internal conflict, poverty, low economic growth and national development. The Government of Mali seems to have realised the urgency to act! It has developed a National Development Strategy Cadre Stratégique pour la

Croissance et la Réduction de la Pauvreté (CSCRP) that aims at accelerating growth, reducing poverty and improving the well-being of the population. However, the CSCRP strategy is being executed under weak technical capacity of national structures in charge of the formulation and implementation. A strong commitment to achieving development goals such as the MDGs and ICPD as well as focus on underlying social development determinants such as health, economy, education, equity, women empowerment, conducting needs assessments and recoding regular demographic information are some of the possibilities to stabilise its population.

Nigeria

The current TFR of Nigeria is 5.7 Nigeria has one of the fastest growing populations in the world at an annual growth of 3.2 per cent. Its the most populated nation in Africa and one of the ten most populous countries in the world. Nigeria has experienced rapid population growth over the years.

The population growth rate over the years has not been stable, varying from 6.04 per cent in 1963 to 4.82 per cent in 1973, further declining to 2.82 per cent in 1991 and then rising to 3.18 per cent in 2006. This growth rate raises concern on the possibility of achieving the fertility replacement level of the targeted 2 per cent or lower by 2015. Population growth rate is determined by three main factors: fertility, mortality and migration. Of all the three factors, fertility and mortality trends have resulted in a very high rate of population growth. Nigeria, has a youthful population with 44 per cent of the population in the reproductive age bracket. A National Policy on Population for Sustainable Development has been developed which is aligned with the ICPD principles. However, the authors report that to meet population stabilisation and development objectives, there needs to be much focus on the economy and the provision of social services. The major challenges are management of decentralised powers, including the customary laws as well as deep-rooted social and gender inequalities, low private sector involvement and high cost of services that present obstacles to expanding access to contraceptive services.

Senegal

The TFR in Senegal is 4.8. Senegal was the first French-speaking sub-Sahara African country to initiate a population policy. The population growth rate of Senegal is 2.5–2.7. The country, through its Policy initiative and implementation programmes, focused on the maternal and child health. It is the first country in Africa that offered free antiretroviral drugs (ARVs) and thereby placing clients on antiretroviral therapy (ART). However, the author reports that the efforts of the state are subject to numerous challenges in terms of availability of trained and skilled human resources. One of the major constraints in promoting family planning are deep-rooted gender inequalities. Less than 50 per cent of the population in Senegal is literate and only 1 in 5 women are literate. Girls often have less chance of accessing school education due to socio-cultural reasons. Despite the countries progress to stabilise HIV epidemic, especially amongst the drivers of the epidemic (sex workers and men who have sex with men) in the last ten years, the author

reports that modern contraceptive prevalence is still low while the unmet need remains high (32%). This is because of low male involvement in the family planning process. However, progress is under way. The country, with its focus on health, is expanding family planning through social marketing and increased availability of midwives. The health centres now provide long term family planning methods (intra-uterine devices and implants. Support is being gained from opinion and religious leaders such as Imams and Ulemas to focus on provision of comprehensive and integrated family planning and reproductive health services. Senegal, has a youthful population structure with a higher female proportion compared to males, which could result in high level of fertility. The demographic transition and dividends provide a window of opportunity to consolidate the gains from the existing population and RH programmes to strengthen policies and service delivery of a muti-sectoral integrated HIV/AIDS/RH/FP programme.

Uganda

Uganda has a TFR of 6.7 followed by Mali (6.6), of the nine countries reported in the book. After decades of instability and civil conflict, Uganda has enjoyed relative stability, sustained economic growth, and great improvements in health over the last 20 years. Notable among these have been decreases in infant and child mortality, increased life expectancy, and great strides to reduce the prevalence and spread of HIV/AIDS. The primary driver of the high population growth rate is the persistently high fertility rate. Censuses in the past three decades estimate that fertility levels have remained fairly constant. The key determinants contributing towards this demographic transition are gender inequalities, a pro-natalist culture that places high value on children (for security to continue the family lineage and to contribute economically to the parents during their old age), and sex preference by some families but also due to insufficient access to family planning services and poverty. The sexual and reproductive behaviour of adolescents and young people (that lack accurate information, life skills youth friendly service and faced with a host of vulnerabilities), compounded by a very high unmet need for family planning at 41 per cent, are some of the additional determinants of high fertility.

Despite Uganda's efforts towards increasing the amount of resources for health interventions, funding for reproductive health services and the health sector in general remains inadequate.

The author expresses concerns that with this pace, it is unlikely that the country will achieve the MDGs relating to maternal health and the population will continue growing at alarming rates. Therefore, lifting girls and women's agenda, focusing on both their equity and equality, provision of education and health services as well as economic opportunities could provide an opportunity to shift the current TFR rate towards a more progressive society. The country has significant population and development policy and strategic documents that provide opportunities for key partners (government, NGO, civil society organisations) to strategically plan and deliver family planning services.

Zimbabwe

Zimbabwe has the lowest TFR of 3.3 amongst all the sub-Saharan countries reported in the book. The population of Zimbabwe has grown more than tenfold since 1901. The first doubling of the 1901 population occurred in 1931 (within 30 years). A steep rise in the population was observed between 1969 and 1992. This was largely due to the attainment of Independence in April 1980 from Britain, which saw an influx of people into the country. A decline then was noticed in population between 1997 and 2002. This demographic change is attributed to brain drain and mass departure of people from the country to seek greener pastures due to prevailing economic hardships. Further decline in population growth was then observed between 1992 and 2002 to 1.1 per cent. This change can be explained due to many factors, including HIV/AIDS related mortality, success of the family planning programme, improvements in female education, decline in fertility, and additional population groups who migrated to different countries. Zimbabwe has the highest Contraceptive Prevalence Rate (CPR) in Sub-Saharan Africa. CPR has increased significantly from 35 per cent in 1984 to 65 per cent in 2009. The author suggests that increase in contractive knowledge (99% universal) does not proportionately lead to an increase in the CPR. Other factors such as social and Gender Based Violence (GBV), economic (cost of services), religious and cultural factors may be some of the inhibitors to accessing services. Another challenge that remains for the country is the age structure. The age group 15–64 constituted about 53 per cent of the population between 1982 and 2002 and is critical for economic development. While it is a challenge, the author sees it is a 'generation for change' opportunity where differences can be made before young people reach the reproductive age group. The other issues that remain to strengthen the population stabilisation agenda are maintaining the economic recovery momentum, improving access to comprehensive RH Services, constitutional amendments, research and advocacy to promote gender equality and equity, addressing negative socio-cultural beliefs and practices and mechanisms for timely and accurate data for monitoring implementation of the ICPD-Plan of Action and MDGs.

Critical aspects of population transition

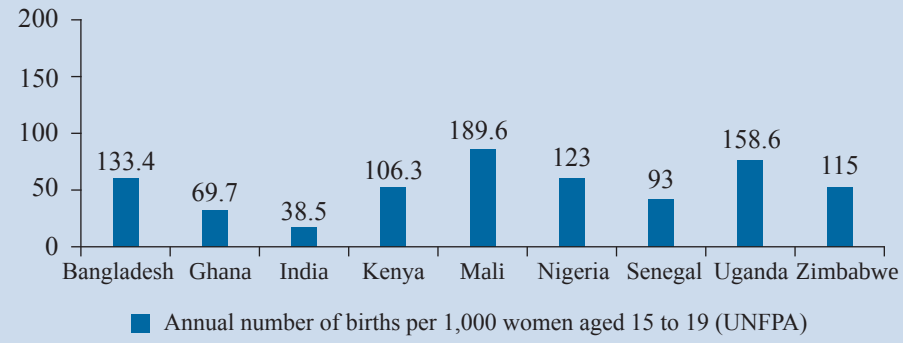
While the authors do make the link between 'demographic transition' and TFR, they recognise that fertility and mortality decline (life expectancy) are the two key features of demographic transition (UNFPA, 2012b). The chapters present mixed trends in all countries associated with natural disasters, conflict/post-conflict situations, prevalence of communicable diseases and illnesses such as malaria and HIV/AIDS. While the crude death rate, infant, child and under-five mortality rates have declined significantly in these countries in the past two decades, birth rate has either remained constant, slightly increased or decreased. Other factors contributing to the TFR are lower mortality rates, longer life expectancy and large youth populations in the nine countries affecting the age and sex structures. The population in these countries predominantly remain youthful. This situation is the direct consequence of high fertility and declining mortality of past years. This population and demographic change is also associated to poor living conditions

and uneven distribution of the population due to internal (rural to urban) and external migration, social and economic conditions and lack of resources. These countries have the potential for further high population growth despite the decline in fertility. Authors consider these to be the major indicators that affect the birth and death rate of the countries presented and discussed as follows.

Birth rate amongst adolescent and teenage women

The comparative birth rate analysis chart that follows demonstrates that Mali has the highest number of birth rates among teenage women aged 15–19 years. Teenage pregnancy, which has negative repercussions, has been associated with increase in infant and maternal mortality rate due to a range of social and economic factors. For instance, in Ghana in 2009, one in ten teenagers has already had a child and 3 per cent are pregnant with their first child. It is reported by author from Ghana that 15 per cent of all maternal deaths in Ghana are adolescents. They attribute this trend to social and demographic factors that precipitate challenges to address reproductive health needs of the young. There is also an increase in age at first sex whereby women may have little control over their sexuality in casual or steady heterosexual encounters (Mahendru, 2010).

Graph: 1.1 Annual Number of Births per 1000 Women Aged 15 to 19

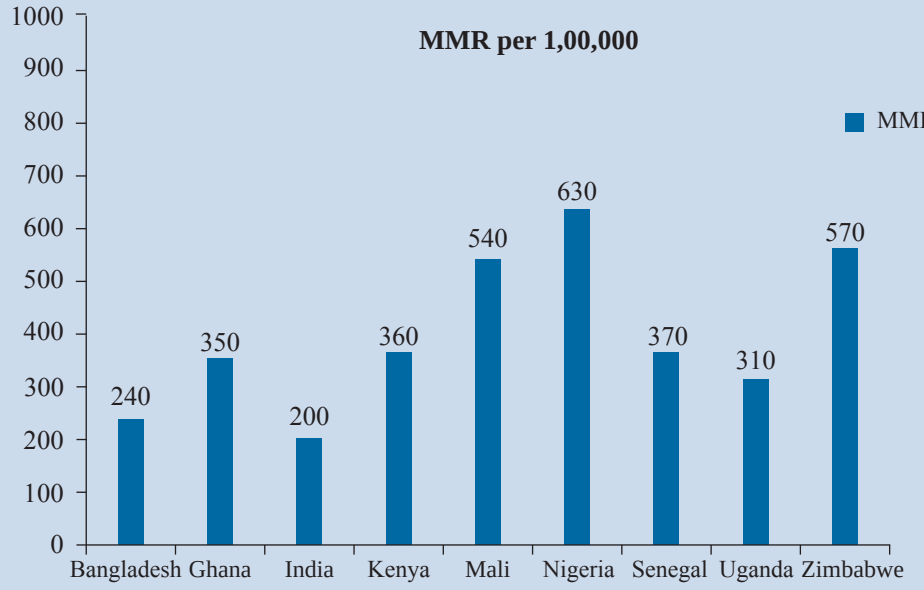


(UNFPA, 2012c)

Maternal Mortality Rate (MMR)

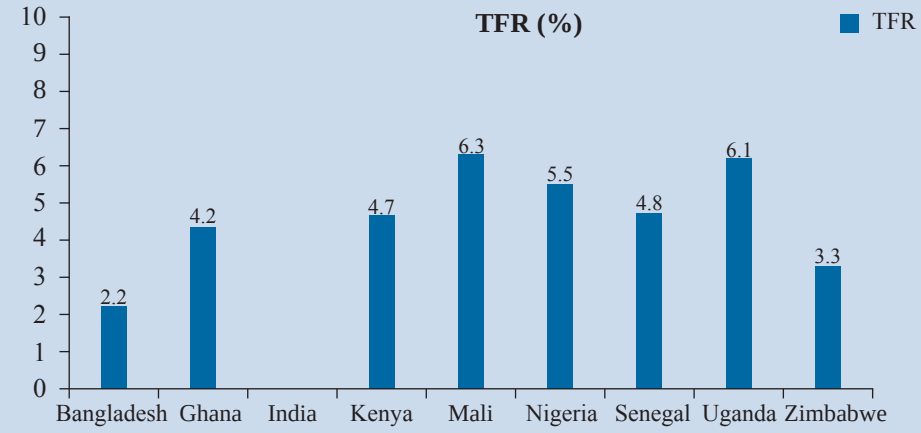
The overall MMR trend in Graph 1.2 demonstrates that Nigeria has the highest maternal mortality rate but is also the most populous country in Sub-Saharan Africa. Interestingly, according to the World Bank data, Nigeria also has the highest female infant mortality rate. This data further exhibits inequalities that may very well be posed due to gender and other social power structures in the country. While women are at a disadvantaged position due to social and structural power relationships, little is being done at the national and international level to promote gender equity. For instance, Payne and Doyal (2010) present a convincing argument that authorities at the international policy level are still failing to address equity; rather the focus is still on equality.

Graph: 1.2 **Maternal Mortality Ratio (Modeled Estimate, per 100,000 Live Births)**



The World Bank Data (2012a)

Graph: 1.3 **Total Fertility Rate Total (Births per Woman)**



The World Bank (2012b)

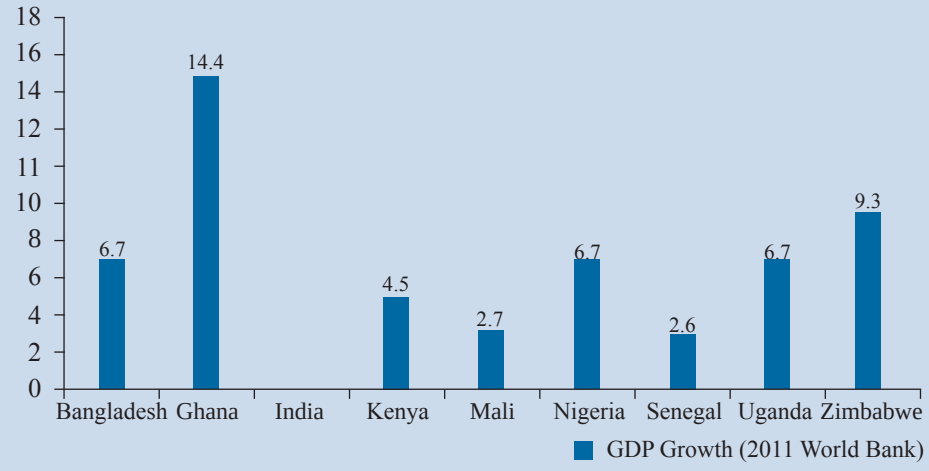
The data for India is missing from the World Bank data. However, the authors from Bihar report that the TFR in the state is 3.7 (lower than Senegal and higher than Zimbabwe). The main focus of the countries is to reduce the unmet need and increase the CPR and mainly focus on the young people, and individuals and couples in the reproductive age group.

Economic Indicators

Birth rates have also been linked to the TFR. Therefore, the editor felt it necessary to make conceptual linkages between the country's Gross Domestic Product (GDP) when establishing an overall argument around the fertility rise and decline. The World Bank

data reports that Ghana has the highest GDP growth in comparison to all the other countries in this book. The data for India is still missing on the World Bank database. However, the authors provide a fiscal year picture of Bihar. They indicate that Bihar's per capita income is less than 40 per cent of the national average and the rural poverty ratio is as high as 43.1 per cent compared to a national average of 27.1 per cent. Bihar is one of the worst states with negative social and economic indicators presenting challenges to deal with population health and development issues in India.

Graph: 1.4 **Gross Domestic Product (GDP) Growth**



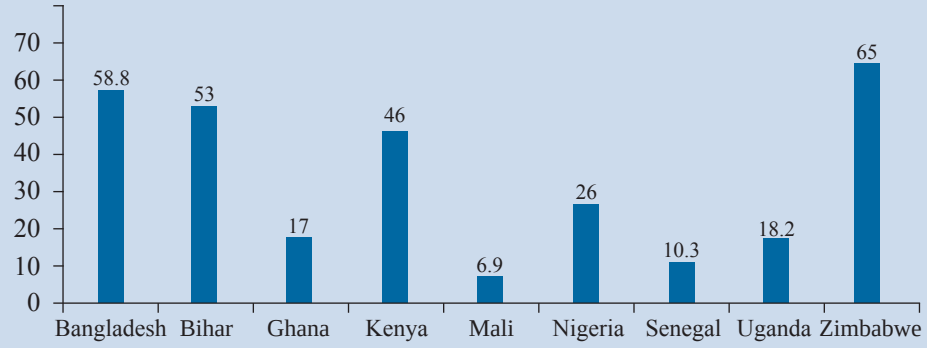
World Bank, 2012c

CONTRACEPTIVE PREVALENCE RATE (CPR)

Contraceptive prevalence rate "is the proportion of women of reproductive age who are using (or whose partner is using) a contraceptive method at a given point in time" (WHO, 2006). It is one of the crucial indicators that measures the status of health, population and women in any given society. It also serves to measure the level of access to reproductive health services that are essential for meeting many of the Millennium Development Goals (MDGs), especially child mortality, maternal health, HIV/AIDS, and gender related goals.

There are some other conceptual issues associated to CPR for instance even when couples do not want larger families; CPR is decreasing in some countries. What are the reasons for that and what should be done to tackle it? The authors of individual chapters in this book demonstrate that high fertility is not just because families want larger families but due to barriers (social-cultural, access, choice) to informed and voluntary family planning use to plan for when to have children and the desired family size. According to Graph 1.5, Mali has the lowest CPR (6.9%) in comparison to all the other eight countries. This seems to imply that increasing CPR is not the only factor that leads to low TFR since Uganda that has the highest TFR does not have the lowest CPR.

Graph: 1.5 **CPR %**



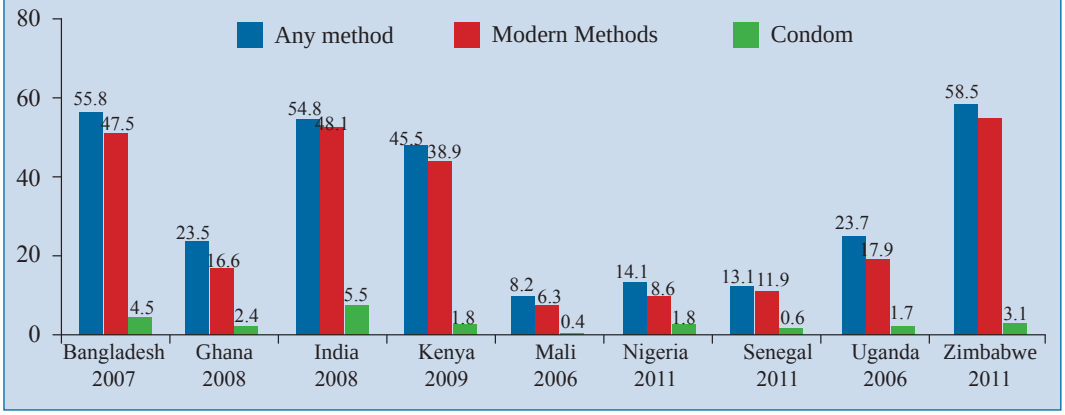
Data from country chapters

It is important to note that the data above is based on the country reports submitted for the purpose of this book and may not be in line with World Bank data. The data the authors present in the chapters is based on the country DHS reports 2006, 2008 and 2009. The chart above reflects the CPR levels of each country. CPR is lowest in Mali and highest in Zimbabwe.

The total CPR in Mali was 6.9 per cent in 2006 out of which 7 per cent are using modern contraceptive methods and 1 per cent were using traditional contraceptive methods. A slow and gradual increase in the CPR in Mali was observed since 1987 from 4.7 per cent to 7.7 per cent in 2006. However, huge differences were noted in the use of contraceptives based on women's wealth and educational background. The data demonstrates that the more educated and wealthy the women were, the higher the CPR was.

On the other hand, in Zimbabwe the increase in CPR was due to successful family planning programmes designed to prevent unwanted pregnancies and encourage child spacing. The women in the country reported using more modern family planning methods than traditional methods. The most common family planning method used was the pill (43%), followed by injectables at 10 per cent. The percentage of women using at least one

Graph: 1.6 **Percentage of Women Using at least One Method of Contraception among those Aged 15 –49 Who are Married or in Union**



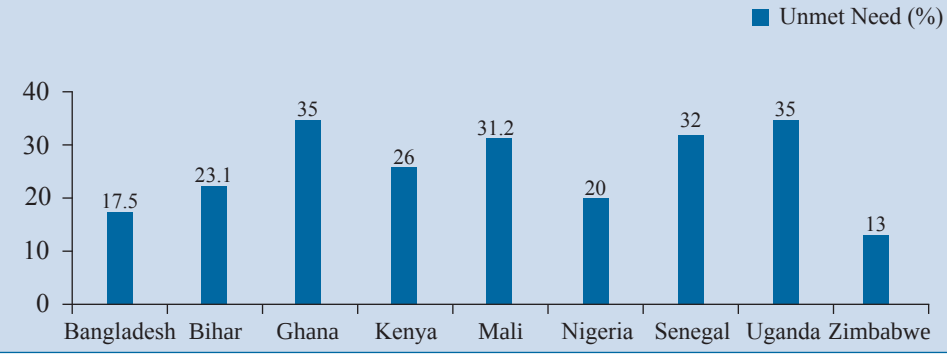
Contraceptive Prevalence: (UNFPA, 2012c)

method of contraception in Graph 1.6 presents data on contraceptive prevalence for nine countries for the period of 2011. It also shows that the majority of women used a method of contraception. Use of FP potentially contributes to improvements in maternal and infant health by serving to prevent unintended or closely spaced pregnancies. The authors of each country chapter discuss what major efforts were made at policy and programme levels to expand access to family planning services and widen the choice of methods. These measures greatly contributed to increase in contraceptive prevalence. Having said this, there are variations in CPR between rural and urban areas (Chapter 3 on Bihar, India).

UNMET NEED FOR FAMILY PLANNING

The World Health Organization defines women with unmet need as those who are fecund and sexually active but are not using any method of contraception, and report not wanting any more children or wanting to delay the birth of their next child.. The analysis of the reports shows which of the nine countries has the highest and lowest level of unmet need (Graph 1.7). Some of the countries provide data on varied issues that determine the access, availability, quality of services, client user satisfaction, options of contraceptive methods, and social economic factors like ethnic status, location (urban or rural), literacy level, marital status (married and unmarried) and level of income .

Graph: 1.7 **Unmet Need (%)**



Data from Country chapters

Uganda and Ghana have the highest unmet need of 35 per cent amongst married women whereas Zimbabwe has the lowest unmet need for family planning. Unmet need and demands for family planning will inevitably result in high fertility rates and contribute to population growth until the age structure stabilises.

Some of the data in graph 1.7 demonstrate perplexities, as normally the rise of CPR should conversely signify decrease in the unmet need. However, data from Ghana, Mali and Uganda present a different story. The achievement of replacement level fertility, and eventual stabilisation of the population, is possible by meeting the unmet need and demands. The authors however do not explicitly emphasise the policy needs in other sectors such as social, economic and legal sectors. Gender mainstreaming often receives little or no attention at local level and social justice is rarely high on the list of priorities in the health sector and other sectors.

SOCIAL DEVELOPMENT INDICATORS

There are a range of significant social development factors that different population groups face based on their age, gender, and social status. This includes migrants, ethnic minorities and other disadvantaged population groups.. This section of the chapter deems age, gender,, social status, literacy levels, income, marital status and geographical location as some of the key indicators that need to be taken into consideration for equitable access to social services.

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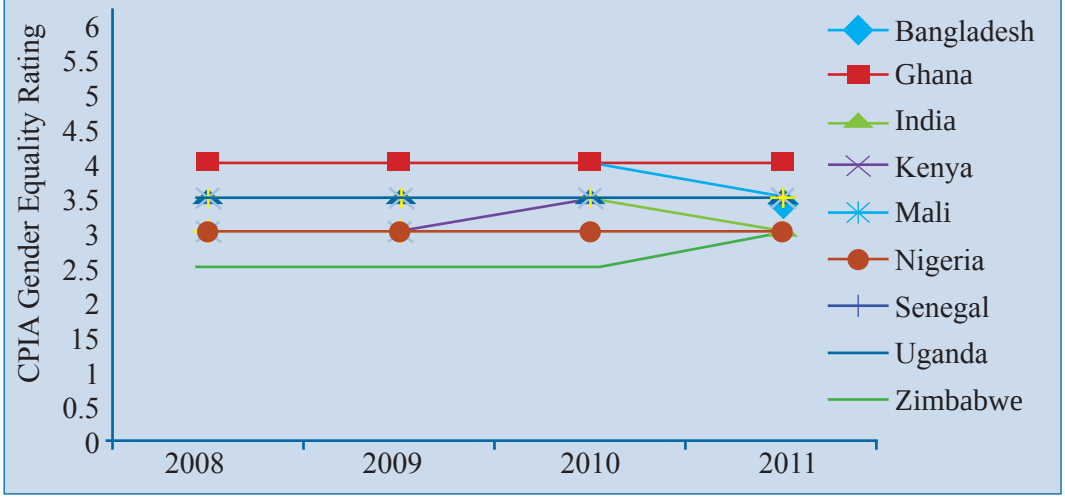
Gender Equity

Graph: 1.8 **Gender Equality Rating CPIA Gender Equality Rating (1=low to 6=high)**



World Bank (2012b)

Gender Equality Rating (CPIA gender equality rating (1=low to 6=high)				
Country	2008	2009	2010	2011
Bangladesh	4	4	4	3.5
Ghana	4	4	4	4
India	3.5	3.5	3.5	3
Kenya	3	3	3.5	3.5
Mali	3.5	3.5	3.5	3.5
Nigeria	3	3	3	3
Senegal	3.5	3.5	3.5	3.5
Uganda	3.5	3.5	3.5	3.5
Zimbabwe	2.5	2.5	2.5	3

As mentioned above, CPR is one of the key indicators that measures access to and utilisation of family planning services. This has direct linkage to rights based reproductive and sexual health policies and programmes. However, there is also a correlation between these and other determinants such as literacy, income, geographic location (urban and rural), enforcement of laws and, empowerment of women . Therefore, is important to look at Gender Equality Rating in relation to population stabilisation. The World Bank data shows that India, Nigeria and Zimbabwe have the lowest gender equality rating as compared to Bangladesh and Ghana that stands at the rating of 4.

Migration and Urbanisation

The world has seen different migration trends over the past five decades. The changing nature of urban cities in developing countries presents new challenges. It has been estimated that more than half of the world's population is classified as living in urban areas, as opposed to rural. These shifting patterns have impacted significantly on the geographical distribution of the population and will continue to transform the social fabric in various settings in the coming decades (UN – United Nations Department of Economic and Social Affairs Population Division, 2011).

It is projected that in the years to come, the urban population in the developing world, especially in parts of Asia and Africa, will continue to grow. The trajectories of migrant populations are now spatially defined with its relevance to urban/rural dichotomous relationship. The countries have seen rapid internal migration affecting the linkages and disparities between urban and rural development. The growth in city population in some countries has increased at a breakneck pace due to increasing economic opportunities. Yet the concerns are that many urban cities are expanding without attending to the economic and social needs of its habitants (Earle, 2011). The pace and scale of urbanisation present challenges for urban planning, management and governance to meet the needs of a population that is diverse socially, culturally and potentially poor. The rapid population growth in the cities translate to urban poverty as many still lack basic access to social services such as housing, health, water and hygiene. Patterns and degrees of vulnerability differ across scales and levels of analysis. Amongst the vulnerable populations in the cities, the urban poor, often migrants from rural or remote parts of the country, are at risk of and more vulnerable to marginalisation. This leads to intersectional inequalities based on individual social, geographic and economic identities such as age, gender, class, geographical location, etc. Despite this reality, many hundreds of millions of these urban dwellers lack access to basic services.

POLICY INDICATORS: GOVERNANCE, RULE OF LAW AND INSTITUTIONAL CAPACITY

The capacities of government officials to address complex population policy challenges are still weak in these countries. Many countries lack governance and institutional capacity to handle the impact of population growth and change. The population of developing countries continues to suffer from income and social inequalities as well as lack of resources such as clinical and other human resources (Chapter 2; "Bangladesh

- Shrinking role of public sector"; p. 61). The chapters in this volume show that the countries are moving or have moved from a centralised to a decentralised system whereby decision making powers are being dispersed to local level. This is seen as a fundamental shift if the countries are to have population stabilisation and reduce maternal and child mortality rates. Giving power to the local people is seen as a self-organising empowerment process whereby individual states/districts provide services and governance based on their local needs.

Authors suggest that poor populations in remote areas can be empowered through a decentralisation system. Payne and Doyal (2010) indicate some disadvantages of the decentralisation system. They argue that the decentralised system can go wrong "if resources are scarce and when efficiency gains are not immediately obvious to those holding the power" (Payne and Doyal, 2010: 32). They suggest there are potential implications of gender sensitive programmes and policies that can put women at even more disadvantaged positions, resulting in increased gender inequity. The decentralised system can potentially reinforce traditional and patriarchal values.

While all the nine countries have a decentralised system, the devolution of power faces tremendous challenges. Lessons learned indicate that delegating responsibility to the local and district levels alone is not working. The authors clearly state that the process is bureaucratic and complex in nature. Similarly, at the district and local levels the customary laws are rooted in the different customs of many different ethnic tribes that make up the district or state as highlighted by the author from India and some from the Sub-Saharan Africa. Therefore, the law is enforced according to the cultural demands of each 'ethnic nationality'. These nations that are in favour of the socially-constructed system tend to position men before women in many areas of life. For instance in Nigeria, the Islamic Sharia law which took its root from the customary law of the "Muslim north" of the country was put into practice by other States in the country, a few years ago. This law does not support the right of women to exercise their reproductive health choices.

Therefore, even though power has been devolved at the local level, for instance in Bihar – India at the "Panchayat" level, and in Uganda and Nigeria, the customary laws still get practised. These laws are often created by revered opinion leaders such as faith based and cultural leaders, whereby opposition to modern methods such as condoms (Chapter 9; Uganda) is expressed. These customary laws can potentially undermine the rights of the poor and women. Customary laws and the "Panchayat Raj" system in India are often organised by elderly men. In Zimbabwe for instance, power was handed over to men who use Customary Laws which exist despite the General Law. In the case of Zimbabwe, section 23 of the Constitution allows discrimination against women in the application of Customary Law in matters relating to adoption, marriage, divorce, inheritance of property, etc. Similarly, in Nigeria, customary law gets practised undermining the rights of women. They might be working towards the policy but with a different set of principles and standards. Across the nine countries, the reader will notice there is preference for

the boy child over the girl child that perpetuates to inequalities compounded by neonatal and under five mortalities. The important question is how development plans for women empowerment would best be formulated and implemented under the Panchayati Raj institutions and Customary Laws. What is also being questioned is the insufficient technical and financial support and resources. In both central and local governments, assigning the function to individuals without adequate training, support, supervision and resources is unlikely to change the fertility rate. It is important to monitor the process in which decisions about family planning at the local level come into effect.

For instance, Uganda clearly highlights the need for equity and inclusion to stabilise population. Improving representation of women in leadership is one of the key areas to address deep-rooted social inequalities. Women's presence and their personal/collective contribution would inevitably remove the biases against them that are structurally generated and determined. Women have remained largely invisible from the structures of governance, i.e., often little or no input is sought from women in terms of the ways resources get allocated. The lived realities of women could potentially provide different dimensions and perspectives, highlighting the grounded needs of those who are different from the powerful groups.

RESEARCH AND DEMOGRAPHIC LEVEL INDICATORS

Data on demographic events on population characteristics are deficient in almost all countries. Demography tends to excavate the reasons population changes in a given society and the ways these changes can be measured and how this could potentially impact the new society. Assessments of reports have indicated a range of additional data needs. Additional micro level data is needed on historical, structural factors contributing to disempowerment of youth and women; location specific population burden; barriers to universal access to health care and family planning knowledge, and in addition to this, demographic data is needed for binary analyses. Consistent specific data is required on demographic transition.

Authors do make the link between 'demographic transition' and TFR, they recognise that fertility and mortality decline (life expectancy) are the two key features of demographic transition (UNFPA, 2012b) whereby demographic transition refers from high birth and death rates to low birth and death rates. This demographic transition observes changes in birth and death rates in a given society.

PROGRESS IN COMPLYING WITH INTERNATIONAL AGREEMENTS AND GOALS

Alongside other countries in the world, nine countries have signed the MDGs and are party to other international commitments and conferences such as (Cairo 1994, Beijing 1995), as well as the binding international human rights agreements rooted in countries agreed for implementation through policies, programmes, and actions.

MDG PROGRESS

The data presented in this chapter are those available from the World Bank and UNFPA website for the years 2011 and 2012. They serve as a basis for the estimation of country trends to assess progress made in the achievement of the Millennium Development Goal 5 and Indicator 5.3 (Contraceptive Prevalence Rate). These data are an input for the database on the Millennium Development Goals 2012 reports maintained by country representatives. Many countries are still struggling to stabilise their population. Amongst the country authors, there is a broad consensus that fertility transitions are unlikely to be completed in the next few decades and that MDGs are unlikely to be achieved.

MDG 3: Promote Gender Equality: The authors reported that gender inequality persists in many parts of the nine countries and women continue to remain marginalised and vulnerable to non enabling customary practices whether it is in access to social services, economic strengthening activities, and participation at governance level. Moreover, the "MDG 2012 Report" highlights this as an area of concern and states that "Violence against women continues to undermine efforts to reach all goals. Further progress to 2015 and beyond will largely depend on successs on these interrelated challenges" (MDG Report 2012).

MDG 5.3: Contraceptive Prevalence: improvement in contraceptive use and reduction in mortality rates have been reported by the countries. However, the progress is at a slow pace or has remained stagnant.

MDG Goal 1: Eradicate extreme poverty and hunger

Target	Sub Saharan Africa	Southern Asia
Reduce extreme poverty by half	Very high poverty	Very high poverty
Productive and decent employment	Very large deficit in decent work	Very large deficit in decent work
Reduce hunger by half	Very high hunger	High hunger (no progress or deterioration)

MDG Goal 2: Achieve universal primary education

Target	Sub Saharan Africa	Southern Asia
Universal primary Schooling	Moderate enrolment	High enrolment

MDG Goal 3: Promote gender equality and empower women

Target	Sub Saharan Africa	Southern Asia
Equal girls' enrolment in primary school	Close to parity	Parity
Women's share of paid employment	Medium share	Low share
Women's equal representation in national parliaments	Moderate representation	Low representation

MDG Goal 4: Reduce child mortality

Target	Sub Saharan Africa	Southern Asia
Reduce mortality of under five- year-olds by two thirds	High mortality	Moderate mortality

MDG Goal 5: Improve maternal health

Target	Sub Saharan Africa	Southern Asia
Reduce maternal mortality by three quarters*	Very high mortality (no progress or deterioration)	Moderate mortality
Access to reproductive health	Low access	Moderate access

MDG Goal 6: Combat HIV/AIDS, malaria and other diseases

Target	Sub Saharan Africa	Southern Asia
Halt and begin to reverse the spread of HIV/AIDS	High incidence	Low incidence
Halt and reverse spread of tuberculosis	High mortality	Moderate mortality

MDG Goal 7: Ensure environmental sustainability

Target	Sub Saharan Africa	Southern Asia
Reverse loss of forests	Medium forest cover	Medium forest cover (no progress or deterioration)
Halve proportion of population without improved drinking water	Low coverage	Moderate coverage
Halve proportion of population awithout sanitation	Very low coverage	Very low coverage
Improve the lives of slum-dwellers	Very high proportion of slum-dwellers	High proportion of slum-dwellers

MDG Goal 8: Develop a global partnership for development

Target	Sub Saharan Africa	Southern Asia
Internet users	Low usage	Low usage

ICPD PROGRESS

The contributors in this edited volume reported that their countries carefully considered the needs of population strategies and policies within the broader principles of human rights and the United Nations International Conference on Population and Development (ICPD) September 1994, Cairo, Egypt commitments. The countries' population policies relate to the principles of the ICPD that include lifting the status of women and girls

through empowerment in the economic, political, and social areas, eliminating gender disparities and inequalities in education, integration of family planning services with related efforts to improve maternal and child health; and removal of 'target' family sizes.

Since ICPD, the governments have initiated many programmes to reduce population growth. A number of policies were developed to guide implementation of programmes such as the National Reproductive Health Service, achieving the vision of improving health status and reducing inequalities in health outcomes. In addition, the Safe Motherhood Programme was initiated in some countries such as Bangladesh, Uganda and Ghana as a component of the larger reproductive health programme. For successful implementation of sexual health programmes, challenges associated with financial, human and clinical resources are highlighted by the authors as well as social factors such as gender equity, contraceptives acceptance and choice and access.

It is now nearly two decades since the ICPD and there is a need to review population stabilisation efforts that countries have made and any challenges they may have experienced. This review is likely to be conducted during ICPD, beyond the 2014 review which will identify progress and achievements towards the goals set out in the original ICPD. It will provide evidence and information on the gaps, lessons learnt and the challenges collected from the governments, civil society organisations and partners using the ICPD Global Survey, civil society consultations and a series of thematic conferences. It is clear from the chapters in this book that ICPD worked as a landmark for many countries to continue the commitment towards stabilising population and promoting gender equality. Countries seem to have made some efforts towards population development. For instance, the countries now have a national policy on population stabilisation and introduced many population stabilisation programmes.

CONCLUSION, PROGRAMME AND POLICY RECOMMENDATIONS

What has worked in these countries is the continuous commitment of the government to fulfil international obligations and national health issues as well partnerships between the public sector, development partners, and other key players (faith based and cultural institutions, NGOs etc) . By prioritising social issues to some extent and taking a holistic approach to stabilising population, the countries have attempted to stabilise the TFR and population growth. However, it is important that to tackle population development issues, the governments take a multi-dimensional approach to address deep-rooted social-cultural norms and inequalities, rights and gender based programming for access to voluntary and informed choice FP and other RH services uptake, and meaningful participation in decision making processes at all levels.

Tackling inequalities would require an equitable approach and understanding that the needs of those disadvantaged are prioritised at the national and local level. An in-depth analysis of social realities of individuals, such as adolescents and women could be fruitful

in identifying the reasons for the increased rate of TFR, high unmet need and low CPR. There is compelling evidence from the reports that calls for immediate investments in training and capacity building for ensuring adequate human resources for quality service delivery as well as commodity security at all levels. Longer term investments include education, women empowerment, urban development and other multi-sectoral poverty eradication and sustainable development plans.

Research and Data Needs

In the countries there is lack of social research data and demographic information. This information is needed to assess and understand different layers and dimensions in which certain communities get marginalised further and so also their impact on individuals based on their gender, socio-economic status, geographical location, religion, etc. Moreover, there is little information available about the effectiveness and appropriateness of existing interventions.

Progress in implementing a response to population stabilisation should be assessed with indicators on accessibility, availability, coverage outcome (knowledge of contraceptive methods, CPR and unmet need) and impact, taking into consideration commitments articulated in national and international declarations such as MDGs and ICPD.

All the indicators presented in this chapter should get disaggregated based on class (education, employment status), caste (as appropriate), age, gender, ethnic background, geographical location (urban/rural). This is to determine whether the population stabilisation policy response is inclusive of the needs of those who are vulnerable and if it appropriately addresses the key social issues impacting the vulnerable population groups, and takes the necessary steps to achieve equitable access to services. Working towards and achieving equity involves using intersectional approaches and analyses, highlighting differences within and between groups, within and across countries, using a series of variables and indicators. The following key interconnected, inter alia, core elements have been identified in the book to ensure, address and promote equity and reproductive health rights specifically to the vulnerable, and marginalised:

- Gender.
- Inclusive right based approach.
- Social inclusion.
- Social protection.
- Stigma and discrimination.
- Cross border migration, particularly of adolescent and young women.
- Measurement and evidence.
- Resource and knowledge management.

South-South Partnership

PPD will leverage its position as an Inter-Governmental organisation mandated to promote South-South Cooperation for promoting inter-country sharing of best practices in population stabilisation. PPD will advocate with the member countries to invest more and monitor progress towards the achievement of international commitments to achieve the targets set out in the MDGs and ICPD PoA. This will also include comparative analysis between and within countries to assess performance of activities and its impact on the region.

South-South partnership also means regular mechanisms for sharing best models and practices within the countries and regions including costing for expansion, scaling up and replication of programmes. This places emphasis on evidence-based practice and decision-making to underpin the recommendations stated here. Evidenced-based decisions are often required to ensure that policies and programmes focus on the rights based approaches and issues, take actions efficiently and produce evidence based results for best practice. Evidence based programming requires research and systematic studying of population related issues (such as MDG 2, i.e., education and MDGs 4, 5 6, i.e., health issues) and underlying factors, the impact being both through planned and unintended actions. It then requires collecting and documenting relevant data, information and sharing amongst country partners and members states.

Through this, trends can be documented and analysed using country TFR transitional history to identify emerging issues, since population issues are always changing and imperceptible. Evidence-based decision-making along with empirically derived knowledge can play a crucial role in planning and implementing activities for the vulnerable, marginalised and women. PPD will ensure that this mechanism commences with the consensus of all the member states.

Priority Policy Options

The 1994, International Conference on Population and Development (ICPD) observed that the key to lower fertility and slower population growth are: Strengthening women's sexual and reproductive rights and social status; improving maternal and child health, nutrition and education; and increasing access to and the use of modern family planning. The link between high fertility and maternal and child mortality is particularly strong in an environment which promotes women's sexual and reproductive rights and appropriate services, empowers women to choose to have fewer children and space their pregnancies. This has positive effects on the health of mothers and children alike. Where women lack rights, they are married at an early age; where they lack the knowledge, means, status or the power to insist that their partners use contraception, or where modern family planning is simply not available, closely-spaced children and high fertility rates are very common, which subsequently impact negatively on the health and well-being of women, adolescents and children and contribute to poor national development.

Any policy discussion on population issues should be based on the understanding that population growth is not a construct blaming the poor for having too many children. The poor in developing (or developed countries) countries are not responsible for their poverty. Often the poor in developing countries demonstrate extraordinary levels of resilience. Despite their best efforts, the poor remain in a vicious cycle of poverty due to the social structures that deny them their rights and the opportunities to improve their circumstances. Lack of reproductive health choices exasperates the situation.

More than two decades of our experience in implementing ICPD plan of action indicates that to help support population transition in developing countries, and to slow down and stabilise population growth, a range of policy options are available for the donors, international development agencies and developing country governments.

Investing for 'demographic dividend'

The case studies of all the countries presented in this edited volume are about to experience or are experiencing a window of opportunity 'demographic dividend' that opens up as fertility rates decline when faster rates of economic growth and human development are possible, combined with effective policies. The drop in fertility rates often follows significant reductions in child, infant and maternal mortality rates.

Policies to spur social and economic development are shaped by the age structure of a country's population. Declining fertility and population growth, accelerated by investments in better health, voluntary family planning services, and gender equality results in a smaller population at young dependent ages and a larger population of adults in the labour force. Subsequently this produces large and positive economic and social returns, referred to as the "Demographic Dividend".

However, most developing countries have only a short window of opportunity to enact policies that promote investments to raise the social and human capital of young people to position them for greater social and economic productivity when they enter their working years.

Focus on the rights of women and young girls

Higher fertility rates in any given society should be taken as a sign of women's lack of opportunities, or the means to control their own fertility. Particularly, women in resource scare settings, especially with low or no literacy, often lack power in their communities and families, and have limited capacity to challenge coercive sex or to make choices about family size or child spacing. This is particularly the case for teenage girls, who are often forced into early marriage and this most tragically puts an end to opportunities for their individual advancement.

Fertility decline is associated to reproductive health rights of the young and women. Evidence suggests that the methods that work the best towards reducing population growth are the methods established by the ICPD focusing on gender equality, and maternal and

child health. The ICPD recommends that focusing on the reproductive health rights of young people and women are vital to attain stability in population (Chapter 9).

Amongst young people, knowledge, skills and confidence to learn about their reproductive health choices (methods and tailored made interventions) as well as accessing them can help achieve replacement or the desired fertility rate. Addressing the needs of young people and addressing youth as a 'target' group for prevention messages is the key to reduce population growth.

Similarly, it is also as important to focus on the reproductive health needs of women through rights and gender based family planning interventions. The interventions should focus on improving contraceptive services in terms of accessibility, choice and availability, access to a range of family planning methods (unbiased), increase in safe abortions (where not against the law) and post abortion care reducing maternal, infant and child mortality rates and allowing birth spacing. The intervention to promote gender equity and equality should focus on lifting the status of the women by providing economical and social opportunities to give them confidence to access family planning services confidently. Efforts made to promote and ensure reproductive health rights of young people and women will directly contribute towards MDGs 3, 4, 5 and 6.

A commitment to the rights of women and girls, and to tackling a range of structural inequities that prevent the realisation of their rights, should be central to health and the broader development policy. This calls for a policy which promotes gender equity and rights in all national policies and short- and long-term poverty eradication plans .

Obviously, promotion of gender equity and rights should be part of early childhood socialisation of boys and these issues also should be addressed through male participation, to help them change their views that may be damaging to the health, well-being and broader opportunities of women and girls.

Family planning, as part of a comprehensive package of services

There is need to prioritise reproductive health in maternal and child survival strategies and improve access to and use of family planning as part of a comprehensive package of services. All the case studies listed here, report significant levels of unmet need for family planning services. Due to some strange prioritisation, the MDGs originally made no reference to population growth, family planning and development. However, a new sub-target was subsequently added addressing universal access to reproductive healthcare by 2015. Based on the current estimates, this target is unlikely to be met.

It seems, in the context of 'economic crisis', financing for reproductive healthcare support and resources for family planning have fallen in recent years. This must change. Investment in these services must become a high priority for development spending. It is now time to reinvigorate implementation of rights and gender based policies as reflected in the ICPD PoA (Chapter VII) that states "Reproductive rights

rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. They also include the right of all to make decisions concerning reproduction free of discrimination, coercion and violence. Full attention should be given to promoting mutually respectful and equitable gender relations and particularly to meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality".

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CHAPTER 2

POPULATION PROGRAMMES IN BANGLADESH: PROBLEMS, PROSPECTS AND POLICY ISSUES

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BACKGROUND SCENARIO

With an estimated population of 150.5 million in 2011, Bangladesh is the seventh most populous country in the world (UN, 2011).[1] A total land area of mere 147,500 sq. kms accommodating the above population size makes it by far the most densely populated among the populous countries. The per capita Gross National Income Purchasing Power Parity (GNI PPP) is around US$1700 which is still among the lowest in the world (World Economic Outlook, IMF, 2011).[2] Even after a considerable rise in adult literacy in recent years reaching 56.9 per cent of male and 51.4 per cent of female population 7 years and above, a sizeable fraction of the population still cannot write for communication (BBS 2011). Majority of the people are employed in agrarian occupation, facing an ever shrinking agricultural land; one-quarter of the population are in the service sector and only about one-tenth in industry. A large scale unplanned rural-to-urban migration which is mainly driven by increasing landlessness and poor sustainability in agricultural occupation, has been a significant strain on urban infrastructure resulting in constant unintended growth of the slum population, road congestion, environmental degradation and air pollution. Even after a significant decline in fertility during the past decades, the already very high population density, together with the prospect of continued growth in size resulting from population momentum effect, the population related problems pose serious concern. Rapid unplanned urban growth, widespread illiteracy and conservative socio-cultural environment, together with poor reproductive health status – characterised by, as yet, high maternal and infant mortality and morbidity, high incidence of communicable diseases, widespread malnutrition and a very high teenage fertility rate with limited access to services for adolescents – also compound the problems. On a longer term perspective, another unwelcome, but inevitable prospect of the rising sea level caused by greenhouse gas effect of climate change would lead to large scale displacement of populations from low lying coastal areas. With very little absorption capacity in the rural areas of the already crowded country, a large proportion of the excess population would gravitate most likely to urban centres, resulting in further growth of slum population. The above situation depicts the challenging scenario for policy makers.

[1] 2011 Census preliminary report estimates population size at 142.3 million

[2] GNI PPP is gross national income in purchasing power parity

Population Policies in the Past

Soon after liberation in 1971, development policies in Bangladesh took into cognisance the pressing need to reduce population growth rate in order to ease mounting pressure on its finite resources. The sense of urgency was amply expressed in the First 5-Year Plan statement, "No civilised measure would be too drastic to keep the population of Bangladesh on the smaller side of 15 crores for the sheer ecological viability of the nation" (Planning Commission, 1974). Since mid-1970s, though the enunciated policies encompassed a broad range of multi-sectoral activities, major efforts were devoted mainly to family planning services. Consequently, the family planning programmes succeeded in vastly expanding access to a wide range of modern contraceptive methods. These measures greatly contributed to rise in contraceptive prevalence and decline of fertility. All subsequent governments maintained a strong emphasis on population programmes, though commitment to and implementation of the service programme began to slacken from around late-1980s. The current population policy, formulated in October 2004, laid down a target of reaching replacement-level fertility by 2010 and stabilising the population at 210 million around the year 2060 (MOHFW, 2004). Though in terms of expressed intent and broad objectives, the stated policies, as well as programme approaches were reasonably justifiable. They lacked in strategic details and adequate operationally viable issue-specific strategies to achieve the stated goals. More recent policy goals expressed in the Health, Population and Nutrition Sector Development Project (HPNSDP), 2011–16, propose to achieve replacement level by 2016.

Population stabilisation, replacement fertility, zero growth – conceptual issues

During the 1980s and early 1990s, when fertility levels showed a steady decline from a TFR of 6.3 in 1975 to 3.4 in 1993–94, the goal of reaching replacement fertility appeared well within reach and planners were looking at policy odds to attain population stabilisation. However, attainment of "zero" growth rate remained elusive for several reasons. Firstly, the fertility decline process became stagnant during the 1990s making it uncertain when the replacement level would be reached. Secondly, most important, even after the replacement level is reached, the population momentum effect – an inevitable consequence of high fertility in the past – would continue to add to population growth till the age structure stabilises. Thirdly, on an immediate term, prospects of further mortality decline would partly offset the impact of fertility decline on population growth rate. Theoretically speaking, the future impact of population momentum can be minimised if fertility could be reduced more sharply to below replacement level, which should not be rejected as an unlikely prospect if recent trends in programme performance can be further stimulated and effective policies on social and legal fronts are adopted, to increase age at marriage, delay child bearing within marriage and increase child spacing (birth interval) which should receive priority attention.

FERTILITY LEVELS AND TRENDS IN BANGLADESH

In spite of a seemingly unfavourable socio-economic environment, as depicted above, family planning programmes in Bangladesh achieved a remarkable success in promoting family planning practice and lowering fertility, with total fertility rate (TFR) declining

from 6.3 in 1975 to 3.4 in 1993–94 and contraceptive prevalence rising from 7.7 per cent to 44.6 per cent during the same time (Table 2.1). However, during the following ten years, contraceptive prevalence rose further from 44.6 per cent to 58.1 per cent though fertility decline was minimum or static. Subsequently, contraceptive prevalence also stagnated between 2004 and 2007. In the recent past, decline in fertility accelerated to reach 2.3 in 2011 with an increase in contraceptive prevalence to 61.2 per cent.

Table 2.1: TFR and Contraceptive Prevalence, 1971– 2011

Data source	TFR	Any method	Modern method	Traditional method
BFS 1975	6.3	7.7	5.0	2.7
CPS 1983	--	19.1	13.8	5.4
CPS 1985	--	25.3	18.4	6.9
BFS 1989	5.1	30.8	23.2	7.6
CPS 1991	4.3	39.9	31.2	8.7
BDHS 1993–94	3.4	44.6	36.2	8.4
BDHS 1996–97	3.3	49.2	41.6	7.7
BDHS 1999–2000	3.3	53.8	43.4	10.3
BDHS 2004	3.0	58.1	47.3	10.8
BDHS 2007	2.7	55.8	47.5	8.3
BDHS 2011	2.3	61.2	52.1	9.2

Source: NIPORT et al, 2009 & NIPORT, 2012

The initial fertility decline in Bangladesh was not preceded by any significant degree of socio-economic development, which would have been expected by demographers and specialists. In fact, fertility decline came as a surprise to many demographers who never thought it possible under the existing social settings in 1970s. Widespread acceptance of contraceptive practice resulting from a strong family planning programme, even in the absence of any noteworthy socio-economic change, was regarded as the major cause of the fertility decline (Cleland, 1994).

The major success in family planning programmes came from the introduction of a broader range of modern and effective methods in the 1970s which created an expanded access to contraceptive services. For example, soon after liberation, introduction of the oral pill, high-quality lubricated condoms in place of old dry condoms, newer generation more effective and safer intrauterine devices (IUDs such as Copper-T IUD 380A), long acting injectable contraceptives, menstrual regulation and minilaparotomy procedure for female sterilisation, performed on an outpatient basis without general anesthesia – all contributed to increased acceptability of contraceptive services. Mohammadpur Model Clinic, established in 1975, in addition to offering a broad range of modern methods, acted as a base for research on the newer methods which facilitated later introduction of newer, effective methods along with service strategies that would make

them acceptable on wider scales. Many of these methods, initially introduced under NGO efforts, were later replicated in the nationwide programme in 1979–80. A policy of financial compensation to service providers, acceptors and referrer played an important role in promoting method acceptance. A technical supervision and monitoring system, instituted to oversee quality of care of permanent methods assisted in complication crisis management, helped in building user confidence. The scope of this system was later extended to other clinical methods, These measures resulted in a significant rise in new acceptance of contraceptives, especially that of more effective methods (Annex Table 2.3).

The rate of decline in fertility created optimism in late 1980s with replacement fertility appearing within easy reach. The observed parallel relationship between contraceptive prevalence and fertility was used as a basis to project that replacement fertility would be attained by raising the contraceptive prevalence to around 70 per cent. This success, unfortunately developed a sense of complacence, resulting in declining performance from late 1980s, with a slip of grip on the programme as noted below.

Mid-transition fertility stagnation in 1990s

Disappointingly, as noted earlier, the process of fertility decline came to a stall in early 1990s with TFR remaining at around 3.3 in two subsequent inter-survey periods between 1993 and 2000. During this period, contraceptive prevalence rose for the first few years, though with a shift in method mix, later stagnated at around 58 per cent in 2004.

A demographic study documenting this process in 2002 concluded:

"The actual level of fertility in Bangladesh in 1999–2000, after adjusting for tempo effect, would be close to 4, more precisely 3.9, as compared to that of 3.8 in 1996–97. In other words, there is a slight increase in the level of fertility during the recent past. The conventional TFR appears to be lower due to an upward shifting in the parity specific birth intervals. An increase in the parity specific birth intervals causes a decline in the level of conventional TFR" (Islam, 2002).

Concern raised from this trend led to a renewed emphasis on programme implementation. Fertility decline process gradually picked up, with TFR decreasing to 3.0 (BDHS, 2004) and to 2.7 (BDHS, 2007), though overall contraceptive prevalence showed a small decline to 55.8 in 2007, with use of modern methods remaining static. More recently, as shown from 2011 BDHS data, there was a greater decline in fertility from 2.7 in 2007 to 2.3 in 2011 and a rise in overall contraceptive prevalence to 61.2 per cent. Notably, use of modern methods which previously remained stagnant for several years rose significantly to 52.1 per cent.

Fertility stagnation: dynamics and implications

Even though the fertility decline process has again accelerated, mid-transition fertility stagnation during 1990s noted earlier delayed the timeframe for achieving demographic goals including population stabilisation. It therefore seems sensible to review the dynamics involved and future implications. As noted by Bongaarts, such phenomenon of

stall or near-stall in mid-transition was also observed in several other countries mainly in sub-Saharan Africa, where two factors played major roles:

- Socio-economic variables, including "poorly performing economy and rising mortality" were among plausible causes in many sub-Saharan Africa.
- "Lower priority assigned to family planning programs in recent years" was cited as relevant in sub-Saharan areas (Bongaarts, 2008), appears distinctly relevant to and consistent with concomitant programme performance in Bangladesh.

Several programme trends in Bangladesh which provide consistent clues to this hypothesis were:

- Shift in 'contraceptive method mix' toward less effective method.
- Significant decline in new acceptance of effective methods.
- Shrinking role of public sector in contraceptive service delivery.
- Simultaneous increase in unmet needs during the period of fertility stagnation.
- De-emphasis of outreach services in the programme.

Contraceptive method mix and its implication on fertility

Contraceptive method mix, its pattern from mid-1970s to 2011 is reviewed (Annex Table 2.1). Since mid-1970s, there was a distinct proportionate rise in the use of permanent methods, with female sterilisation becoming the most widely used method. Regrettably, however, during the decade of 1990s and thereafter, contraceptive practice trends took a turn towards use of less effective methods. For example, use of sterilisation was 9.7 per cent in 1989 representative of 41 per cent of all modern methods, which declined to 6.2 per cent in 2011 representative of only 11.9 per cent of all modern methods.

This decline in female sterilisation at a time when there was an increase in the proportion of women who would like to permanently limit their child bearing but were not using any contraception, clearly implied insufficient access to these methods. Since sterilisation is mainly offered in the public sector, these changes reflect on the diminishing role of public sector in family planning service provision. The contraceptive method mix pattern in selected countries in the region (Annex Table 2.2) shows that use of long term and permanent methods (LAPM) in Bangladesh was lower as compared to China, India, Iran, Nepal, Sri Lanka and Thailand. Even Pakistan, with a very low overall contraceptive prevalence, had a higher use of sterilisation.

Because of early marriage and early childbearing in Bangladesh, women on average have to spend a longer span of their reproductive life protecting themselves from unwanted pregnancy. As per the 2007 Survey, the median age at first birth was around 18 years; by around 25 years women have 2 children, with still another 25 years of their reproductive life remaining to be protected. Obviously, in this situation, methods with higher failure rates would disproportionately increase unwanted births. A comparative review of failure rates should make the contention clearer. For example, in theoretical terms, with perfect use, the oral pill would be the most effective method with a failure rate of only

0.3 per cent (Table 2.2). However, in typical use, taking into account forgetfulness, incorrect and inconsistent use, the failure rate of the pill would reach as high as 8.0 per cent (Hatcher et al, 2007).[3]

Table 2.2: Incidence of unintended pregnancy per year in typical use as compared to perfect use

Method	Typical use	Perfect use	Continuation at one year
Oral pills	8.0	0.3	68
Condoms	15	2	53
IUD (Copper T)	0.8	0.6	78
Injectable	3	0.3	56
Implanon	0.05	0.05	64
Male sterilization	0.15	0.10	100
Female sterilization	0.5	0.5	100

Source: Hatcher et al 2007

Thus if a 25-year-old woman who already has two children plans contraceptive protection using the oral pill, at the above failure rate, she would end up with two additional unwanted pregnancies.

Decline in new acceptance of contraceptives

Overall contraceptive acceptance rates also explain for the fertility patterns as well as for change in method mix. As shown in Table 2.3 (ref. Annex Table 2.3), new acceptance of effective methods rose steadily from 1973 until mid-1980s, number of sterilization rising from 1,462 in 1973–74 to 552,424 in 1983–84 and thereafter dropping to only 30,397 in 2000–2001.

Table 2.3: Year-wise acceptance of selected contraceptive methods for selected years, from 1973–74 to 2000–01

Year	Voluntary sterilization			IUD	Implant
	Female VS	Male VS	Total VS		
1973–1974	1,016	446	1,462	27,590	--
1978–1979	81,719	24,705	106,424	22,631	--
1983–1984	336,502	215,665	552,162	303,338	--
1988–1989	130,946	13,027	143,973	361,698	--
1993–1994	71225	49,134	120,359	335,840	40,359
1998–1999	45,220	16,500	61,720	176,514	50,183
2000–2001	19,205	11,192	30,397	101,160	34,127

Note: Years represent from July to June; source: Program statistics compiled by 'Engender Health', Bangladesh

[3] These data were based on large studies conducted in USA under National Surveys of Family Growth (NSFG) in 1995.

Similarly, new acceptors of IUDs rose from 27,590 in 1973–1974 to 303,338 in 1993–1994 and, thereafter, numbers steadily declined to 101,160 in 2000–01. These declining trends are reflected in reduced use rates of these methods as per subsequent survey findings as (Annex Table 2.1).

Shrinking role of public sector in service provision

Currently with a growing number of users obtaining contraceptive services from private sector outlets rather than from the public sector also explains the change in method mix. Official policy shift from outreach domiciliary services to clinic based services also accounts for a decline in the number of field workers' home visit. For example, users who obtained pills from the Government of Bangaladesh (GOB) sources dropped from 61.4 per cent in 1996–97 to only 29.6 per cent in 2007 (Al-Sabir, 2008). An aide memoire jointly prepared by the World Bank and its development partners remarked: "Between 1997 and 2004, the share of public sources in contraceptive provision declined from 74 per cent to 57 per cent largely due to the diminishing role of the government's outreach programme" (Haq, 2005). As the Bangladesh Demographic and Health Survey (BDHS) 2004 Reported, "One of the major controversial aspects of Health Professionals Services Program (HPSP) was the proposed transition from outreach or domiciliary family planning services to static community clinics (CCs). In the confusion surrounding this issue, the public sector lost a substantial share of family planning service provision, very little of which was picked up by the CCs. Household visits for family planning by GOB fieldworkers have fallen dramatically since the mid-1990s" (NIPORT et al, 2004). Regarding the community clinics, the above World Bank aide memoire noted: "the intention to increase the delivery of services through the CCs failed" (Haq, 2005). The World Bank Country Director Christine Wallich, in a letter to the Health Secretary also noted: "We are concerned at the decline in share of the public health services delivery and insufficient level of transfers of public health subsidies to the poor."

Proposed as an alternative to outreach services, the community clinics did not actively replace the vacuum created by stopping of the outreach system. Possible reasons for failure of the community clinic strategy were lack of accountability in the administrative system, no viable mechanism to oversee its implementation and to ensure physical presence of clinical staff. In retrospect, it now appears that outreach services were discontinued prematurely without gaining sufficient prior experience in the community clinical system. These factors explain, at least partly, for low programme effectiveness during 1990s and early 2000s.

Demand factors, unmet needs

Unmet needs for fertility regulation is defined as: "fecund women who are currently married and say that they either do not want any more children or that they want to wait two or more years before having another child, but are not using contraception". As Table 2.4 shows, unmet need fell steadily from 18.2 per cent in 1993–94 to 11.3 in 2004 implying that unmet needs were partially met by services offered by the programme.

Subsequently, as found in BDHS 2007, unmet needs increased considerably from 11.3 per cent in 2004 to 17.5 per cent in 2007 before declining again to 11.7 per cent.

Table 2.4: Unmet need for contraceptive services, 1993–2007

	BDHS 1993–94	BDHS 1996–97	BDHS 1999–00	BDHS 2004	BDHS 2007	BDHS 2011
Unmet needs, non-users (A)	18.2	15.7	15.3	11.3	17.5	11.7
Expressed limiters	9.0	7.9	7.3	6.2	10.8	7.3
Expressed spacers	9.2	7.8	8.0	5.1	6.7	4.4
Met need, users of modern methods (B)	36.2	41.5	43.4	47.3	47.5	52.1
Total needs, users + non-users (A+B)	54.4	57.2	58.7	58.6	65.0	63.8

Source: NIPORT et al, 2009 reporting various surveys and NIPORT et al, 2012

Most interestingly, the proportion of "expressed limiters" who wanted to terminate childbearing altogether, which earlier declined from 9.0 per cent in 1993–94 to 6.2 per cent in 2004, thereafter rose to 10.8 per cent in 2007 before declining again to 7.3 per cent. Trends in unmet needs are important indicators of the programme's access to contraceptive services and, on the other hand, of scopes and opportunities that exist for future policy options. These trends appear to show a mid-term shrink in access to contraceptive services, especially for permanent methods, as indicated by a greater proportionate increase in the expressed "limiters" as compared to "spacers", 74 per cent as compared to 54 per cent in 2007. Based on a finding of BDHS 1996–97: "about one third of births in the three years prior to the survey were reported to be unplanned, including 20 per cent mistimed and 11 per cent unwanted", it was concluded: "If unwanted births could be eliminated altogether, the total fertility rate in Bangladesh would reach replacement level of 2.1 births per woman instead of actual level of 3.3" (Mitra et al, 1997).

Regarding intended future use, 70 per cent of non-users expressed intention to use contraception in future which also reflects on the extent of unmet needs (BDHS, 2007). Conventional measures of unmet needs often does not take into account use of inappropriate and less effective methods or cases of pregnancies arising from method failure, which further emphasises the use of long acting and permanent methods. As past experience suggests, demand for fertility regulation is likely to grow with improved access to services.

Wanted fertility measure, based on questions if births during the preceding 5 years were planned (wanted then), mistimed (wanted, but at a later time) or unwanted (wanted no more children), shows that the total wanted fertility rate (TWFR) was 2.0 in 2004 and 1.9 in 2007 as compared to conventional total fertility rates (TFR) of 3.0 and 2.7 respectively (Table 2.5).

Table 2.5: Total wanted fertility rate and total fertility rates for Bangladesh and its divisions, 2004–2007				
	BDHS 2004		BDHS 2007	
	TWFR	TFR	TWFR	TFR
Khulna	1.9	2.8	1.5	2.0
Rajshahi	1.7	2.6	1.7	2.4
Barisal	1.7	2.9	1.8	2.8
Dhaka	1.9	2.9	1.9	2.8
Chittagong	2.3	3.7	2.1	3.2
Sylhet	2.9	4.2	2.4	3.7
Total	2.0	3.0	1.9	2.7
Source: BDHS, 2004 and BDHS, 2007				

Based on these findings, it has been concluded in the BDHS 2007 Report: "This means that if all unwanted births could be eliminated, the TFR would drop below replacement level of fertility (2.1 children per woman)".

Early child bearing, teenage fertility

A major constraint in fertility control effort in Bangladesh is early child bearing practices, which showed only small change during the past decades. For example, number of births per 1,000 women aged 15–19 years is 72 in Bangladesh, compared to only 13 in Malaysia, 18 in Iran, 30 in Sri Lanka, 40 in Indonesia, 46 in Pakistan and 68 in India (UNFPA, 2009). The high teenage fertility partly arises from early and universal marriage practised in Bangladesh. Age at marriage in Bangladesh is lowest in the region, with around half the women being 15–19 years of age ever married, compared to only 6.9 per cent in Sri Lanka, 8.5 per cent in the Philippines, 17.4 per cent in Thailand, 24.9 per cent in Pakistan and 34.5 per cent in India. The age at marriage in the Asian countries, where replacement fertility was achieved, is much higher. Because of the young age structure of the Bangladesh population, teenage mothers share 30 per cent of all births. Even though there was some postponement of 2nd and 3rd births in recent decades when many couples adopted family planning after the first birth, there was no significant rise in age at marriage for women, or for that matter, in age at first birth. Consequently, the need to protect a longer reproductive life span, arising from low age at marriage and early child bearing practices, underscores the importance of use of more effective methods.

Probable role of other proximate determinants of fertility, such as postpartum infecundity, age at marriage and pregnancy termination, in the recent fertility trend has not been precisely defined yet. As shown in Table 2.6, for example, median duration of postpartum amenorrhea steadily decreased from an average of 10.3 months in 1993–1994 to 5.8 months in 2007 (NIPORT, 2009).

Table 2.6: Median duration of postpartum amenorrhea (PPA) in months	
Year	PPA
1993–1994	10.3
1996–1997	8.4
1999–2000	7.9
2004	6.1
2007	5.8
Source: NIPORT ,2009	

The declining practice of breastfeeding, with reduced fertility impact of postpartum infecundity, partly offset the programme's impact. Notably, the duration and intensity of breastfeeding practices had all along been the most dominant factor in determining the fertility level until 1990s when contraceptive practice overtook as the most dominant factor (Islam et al, 2002). Pregnancy termination by menstrual regulation has presumably played an important role in the fertility decline process. In fact, its role as a back up to deal with contraceptive failures has been significant.

Regional variation

An important policy issue emerges from the wide variation in the level and trend of fertility change, as well as contraceptive practice, between different regions (Table 2.7). As per BDHS 2007, the fertility level varies from a TFR of only 2.0 in Khulna to 3.7 in Sylhet and contraceptive prevalence varies from a low of 32 per cent in Sylhet to 65 per cent in Rajshahi. With nation-wide decline in fertility between 2007 and 2011, region-specific fertility should also have declined further.[4] Wide differential is also seen in family size desire. More than half the women in Sylhet and Chittagong regions desire three or more children compared to only 22 per cent and 26 per cent in Khulna and Rajshahi respectively.

Table 2.7: Fertility (TFR) and contraceptive practice in the regions			
Regions	TFR	Contraceptive practice	% desire 3 or more children
Khulna	2.0	63.1	22
Rajshahi	2.4	65.9	26
Barisal	2.8	56.3	38
Dhaka	2.8	56.4	34
Chittagong	3.2	43.9	51
Sylhet	3.7	31.5	56
Bangladesh	2.7	55.8	
Source: BDHS, 2007			

[4] Regional fertility data of BDHS 2012 were not readily available and could not be presented in Table 1.7.

The two high fertility regions of Sylhet and Chittagong are also widely known as socially conservative and culturally orthodox. They also show greater gap between their desired family size and actual family size, possibly reflecting on socio-cultural barriers to contraceptive practice.

Current programme performance and prospect for change

After about a decade of low performance, more recently there appears a turnaround in the number of new acceptors of long term and permanent methods. As noted earlier (Table 2.8 and Annex Table 2.1) new acceptor of selected effective methods, which was lowest in the year 2000–2001, rose steadily, with total sterilisation rising from only 30,397 in 2000–01 to 289,637 in 2011–12 and IUDs rising from 30,397 to 244,266 during the same time.

Table 2.8: Year-wise acceptance of selected contraceptive methods, 2000–2009

Year	Voluntary sterilization			IUD	Implanon
	Female VS	Male VS	Total VS		
2000–2001	19,205	11,192	30,397	101,160	34,127
2001–2002	28,974	22,364	51338	161,679	57,876
2002–2003	32,761	43,203	75,964	181,762	66,163
2003–2004	52,132	41,839	93,971	195,018	68,307
2004–2005	83,627	60,645	144,272	208,769	105,958
2005–2006	71,133	52,658	123,791	257,915	74,871
2006–2007	100,571	91,486	192,057	222,259	13,812
2007–2008	105,787	92,890	198,677	236,960	177,351
2008–2009	115,754	100,646	216,400	330,709	86,720
2009–2010	128,605	162,297	290,902	226,220	40,278
2010–2011	138,381	150,920	289,301	307,271	273,677
2011–2012	131,324	158,313	289,637	244,266	200,796

Note: Years are July–June, Program statistics compiled by Engender Health, Bangladesh

This performance trend may also explain for the recent decline in fertility between 2004 and 2011. The recent rise in use of permanent methods seems to also explain for the corresponding decline in "expressed limiters" from 10.8 per cent in 2007 to 7.3 in 2011. Since permanent methods do have a cumulative effect, further impact would be expected in future, especially if this trend continues.

A Proposed Path to Population Stabilisation

In view of an earlier conclusion: "if all unwanted births could be eliminated, the total fertility rate in Bangladesh would reach replacement level or below replacement level", it appears feasible to achieve population stabilisation. The existing unmet needs justify making family planning services as the most priority focus in population policies. Policies should aim at:

- Expanding access to safe, effective and affordable contraceptive services.
- Improving reproductive health.
- Implementing social and economic measures that would generate further demand for fertility regulation.

SCOPE FOR EXPANDING FAMILY PLANNING SERVICES

Opportunities exist to improve programme performance by expanding access, improving quality of care and creating awareness of benefits of newer generation of methods, through communication support and making special efforts in low performing areas.

Method specific actions

Within the broader principle of equal choice, in Bangladesh, a special emphasis on more effective methods is legitimate. The ICPD-POA recommended policies that ensure: "...informed choices and make available a full range of safe and effective methods..." (UN, 1995). In the Bangladesh context, experts emphasised that "programs for sterilization need to be given renewed priority to improve the effectiveness of the method-mix" (Islam et al, 2002). It was also noted that "the wide availability of effective methods through the public or private sector is required to achieve high levels of effectiveness" (Bongaarts, 2008). Method-specific strategies are therefore recommended to reach an effective and desirable method mix.

Promote use of IUDs

Modern IUDs, such as Copper T 380A and hormonal IUDs, are more effective and safer as compared to the older generations such as Lippe's loop. "Misperceptions about safety of the IUD help explain low rates of use in many countries" (Salem et al, 2006). This interpretation is fully relevant in Bangladesh. Misperception about IUDs originated from old unpopular IUDs in the 1960s and 1970s, delivered under poor and inadequate service conditions. Notably, IUDs are popular in Muslim countries. For example, as shown in Annex Table 2.2, rate of IUD use in eligible couples is 49.7 per cent in Uzbekistan, 36.5 per cent in Egypt, 27.6 per cent in Tunisia, 25.7 per cent in Syria, 24.8 per cent in Palestinian territory and 23.6 per cent in Jordan and only 0.9 per cent in Bangladesh (PRB, 2008). The new IUDs are almost as good as sterilisation with an added advantage of being reversible. WHO-sponsored multi-centred studies have found failure rate of copper T 380A at 0.4 per cent which is comparable to that of sterilisation (UNDP et al, 1997). Many experts believe that IUDs are the most underutilised potential in the contraceptive field and, if promotional actions are taken, IUDs can play a major role in attaining replacement fertility. IUDs would be more acceptable if only facts are known widely. Notably, recent changes to WHO guidelines now allow women with STIs (sexually transmitted infections) other than gonorrhoea, Chlamydia or purulent cervicitis to have IUDs inserted (WHO 2004). Minor reproductive tract infections (RTIs) such as bacterial vaginosis, trichomoniasis, moniliasis and non-specific cervicitis, do not constitute a contraindication for IUD insertion. Long-term studies showed that risk of pelvic inflammatory diseases (PID) was comparable to that in population at large (Salem 2006).

To popularise IUDs it is essential to:

- Implement well-designed, innovative strategies to communicate these facts and to create a new image of IUDs.
- Strengthen counselling efforts to dispel doubts and remove misperceptions about IUDs.
- Improve quality of clinical services, especially for aseptic precaution, proper screening for contraindications and use of correct insertion techniques.
- Revise clinical indication to IUD use in conformity with recent WHO's eligibility criteria (see explanations below).
- Create a cadre of satisfied users to act as peers to inform others.

Concern has been expressed regarding a high incidence of reproductive tract infections (RTIs) which may constitute contraindications for IUD use. A review of the pattern of RTIs defines that clinical measures are necessary. In fact, IUD acceptance offers a clinical screening opportunity for detection and treatment of RTIs among potential users who otherwise would remain undiagnosed. Moreover, as noted above, not all RTIs are contraindications for IUD use. It should however be useful to undertake further research to define the current incidence and pattern of RTIs as a basis to formulate a simpler standard syndromic management regime for RTIs.

Expand sterilisation services

New acceptance of sterilisation is already on the rise in recent years. A positive note is that there is a proportionately greater rise in male sterilisation which may be attributed to a wider use of no-scalpel vasectomy (NSV). In view of high unmet needs, especially that for limiters, easy access to quality services should increase acceptance of sterilisation further. Wider involvement of doctors, in both private and public sector, in sterilisation services is necessary, by making it financially competitive with their medical practice earnings. Further expansion of NSV, together with communication materials designed to dispel doubts about its safety and possible effect on masculinity, can promote acceptance of male sterilisation further. To make it more user-friendly, with easy accessibility, names of centres providing sterilisation should be listed and publicised, with hours of service availability.

Expand access to emergency contraception

A recent study shows that only 23 per cent of wives and 26 per cent of husbands knew about emergency contraception, while only 14 per cent of wives and only 12 per cent of husbands had specific knowledge of emergency contraceptive (EC) pills (Khan et al 2009). Only 1.3 per cent had ever used EC pills. Use of emergency contraceptives (ECs) after unprotected sexual exposure can prevent unwanted pregnancy. However, since it must be used within a short window period of 3–5 days after an unprotected sexual exposure, without prior knowledge of the method, its use would not even be thought of. To promote use, its knowledge must be widely disseminated, its availability, sources for supplies and use instructions expanded. An innovative idea can be to display informative posters on walls of all reproductive health clinical facilities. Several commercial brands

of emergency pills are available in the market which should be known to family planning service providers. Family planning service providers training should include how standard dose oral pills can be used as ECs. Method-specific communication strategies are needed to disseminate the relevant knowledge. Another possible option to widen access to EC would be to offer it through social marketing channels. Knowledge of copper bearing IUDs as an effective emergency contraception should also be promoted.

Introduce newer generations of implants

Recent introduction of Implanon which has only one rod as compared to six in Norplant, appears to have made implantable devices more popular. Consideration should also be given to introduction of Sinoimplant (II) which, with four years of protection, would be more convenient and, with less than half the cost as compared to any comparable western product, be more affordable for longer term use. It may be noted that Sinoimplant (II) is gaining increasing popularity in recent years in several countries including China and Indonesia (Ringheim and Gribble, 2009).

Promote effective use of injectables

An uneven erratic trend in Injectable use rate, from 9.7 per cent in 2004 to 7.0 per cent in 2007 and to 11.2 per cent in 2011, has been attributed to irregular supplies. BDHS 2007 data on intended future use showing 15 per cent of non-users expressing interest to use injectables may, on the one hand, imply that many of them were unable to obtain services and, on the other hand, suggest that improved access to services should raise Injectable use significantly. To meet the needs of expressed future users, services should be expanded, supplies should be regular and counselling should be strengthened. Besides the above actions, introduction of simpler techniques can allow wider use of the method. Recently developed Depo-SubQ Provera (DepoSQ), which has been specially reformulated for administration by subcutaneous route, can be provided by community based workers (Landey and Richey, 2009). The new device is already available in USA and several European countries. A still newer innovation is awaiting introduction soon which will provide DepoSQ in pre-filled uniject single syringe.

Improve menstrual regulation services

Demand for menstrual regulation (MR) has all along been very high in Bangladesh since liberation and, in fact, MR has played an important role in preventing many abortion related maternal mortality as well as unwanted births. Importance of MR services in policy pursuit towards population stabilisation can be underscored by findings of an analysis of 170 countries. None had achieved replacement level fertility without access to safe services for pregnancy termination (Campbell and Adams, 2001). Besides its impact on fertility, greater access to safer MR services can prevent clandestine abortion and health complications arising out of that, thereby eventually improving maternal health and saving hospital resources (Khan et al, 1984). In the Bangladesh context, in view of high use rate of less effective methods involving risk of method failures, MR represents an important back-up to minimise unwanted births. Unfortunately, there are no clear strategies to improve MR services.

Even though MR is offered free in public sector clinics, majority of the people are known to pay for this. As per one study, only 11 per cent received free services and all others had to pay even in public sector facilities, with around 40 per cent paying more than 500 Takas per service (Akhter 1998). Such an amount would pose a financial constraint for many poor women and thereby would limit its affordability. On the other hand, providers receiving forbidden payments for MR services are inclined not to report the cases, leaving most cases unreported (Khan, 2000). There are also an unknown number of MR cases performed by untrained providers in unsafe environment on a clandestine basis, many of which may in fact end up with complications representing an important health problem. Wider access to safe and quality services should prevent this health problem.

It seems therefore urgently necessary to document the current status of MR services, including its quality of care, accessibility and affordability, and formulate strategies to improve MR services. Possible scopes for action are expanded availability, improved quality of care and improved provider skill and technical competence through training and monitoring. An institutional mechanism is needed to monitor and also assure quality of its services.

The existing restriction imposed on USAID funded NGOs to offer MR grossly limits access to MR in the country. This requires that the Government assume a greater role and responsibility in MR programmes. Government may organise a non-AID NGOs consortium supported by donors who have a liberal policy on MR services to coordinate and promote its services.

Ensure continuity of commodity supplies

The high method discontinuation is known to be at least partly due to inadequate or irregular supplies and temporary stock-outs. Therefore, regular supplies of commodities must be ensured at every service point. To ensure regular supplies at all service points and to avoid small pockets of temporary unavailability, it may be useful to establish a reproductive health commodity supply (RHCS) monitoring cell under the logistics system that will keep a watch on stock levels at peripheral points.

Define problems through research

Besides the actions proposed, scientific efforts, including operations research on quality care, and acceptability studies are needed to identify method-specific issues and problems. Clinical studies are needed to define the incidence and pattern of contraindications and gaps in clinical practices and technical competence. A useful study can be undertaken by using interdisciplinary approach in methodology to define existing incidence and pattern of RTIs, current practices in clinical procedures in IUD insertion, MR procedure and antenatal care, which would greatly contribute to improved reproductive health as well as increased method use.

Strengthening of community level services including community clinics

Importance of bringing services closer to people is underscored by a finding in Bangladesh that couples were two and a half times less likely to use contraception if obtaining a

method would require a travel time of 30 minutes or more from home (Levin et al, 2000). Priority attention is therefore needed to make the existing community clinics function at an optimum level of their projected capacity. Creation of a new cadre community health care provider (CHCP) has been announced to manage and run the community clinics (Rahman 2010). Accordingly, plans are underway to recruit 13,500 married women with higher secondary education and computer literacy in this new cadre (Ujjal, 2010). Besides bringing services closer to the doorstep, the community clinics are likely to increase public sector involvement in contraceptive services.

Success of the clinics however depends on the appropriate training and supervision of this cadre. Several propositions in this regard are to:

- Strengthen supervision and guidance.
- Design and institute a system of accountability for the clinical service providers.
- Contract out some selected clinics to some reputed NGOs for operational management and supervision, especially those located within operational reach.
- Make community leadership responsible to oversee a few selected clinics on experimental basis. In reference to premature stoppage of outreach services by field workers, as indicated from BDHS 2007, likelihood of using modern contraceptives was found to be 1.6 times higher for those who were visited by a field worker. Therefore consideration should be given to restore domiciliary level outreach services at least until community clinics replace their needs and in selected low performing conservative areas.

Strengthening of private service outlets

The growing use of private sources for contraceptive services calls for strategic efforts to strengthen the technical capacity of these sources. Because of privacy and convenience in obtaining supplies, expectedly, private sources' role is likely to further increase. The reported high discontinuation from health problems (20.8% for pills and 33.6% for injectables) can be partly attributed to inadequate or lack of counselling for supplies received from pharmacies and retail stores. New acceptors are especially vulnerable to insufficient information and therefore remain unprepared to deal with side effects. For this purpose, provision should be made for better, updated information and advice on use instruction in case of methods. These efforts should be in conformity and coordinated with the technical support system in the mainstream programme. Adequate provision is needed for instructional materials and technical manuals to pharmacies and retailers. Pharmacist curricula in the universities should be reviewed and updated to include newer generation of contraceptives and new scientific evidences influencing user instructions. Such policy updates should be undertaken periodically on a regular basis and as warranted by new developments.

Managing an appropriate system for financial compensation

Even though compensation for providers and acceptors were used and abused in the past, and the payments were also seen to conflict with 'informed choice', there is sufficient justification

for keeping a suitably balanced compensation structure to promote acceptance of more effective, longer term and permanent methods. Payments to clinical providers is particularly important because the existing health system, by default, allows the health care providers in government facilities to practise privately and earn extra money which necessitates that compensation amounts are financially competitive with what they would otherwise earn. However, the amount of compensation payments is critically important because, on one hand, unnecessary high amount can invite abuse and fraud or allure insufficiently motivated acceptors just for money, which is the main argument in its conflict with 'informed choice'. On the other hand, a lower amount may be insufficient to compensate for loss of wage and transportation of acceptors and also not financially competitive for the clinical providers.

Possibility of abuse and fraud can be minimised if the amounts paid to acceptors and providers are just enough to compensate for their lost time and travel for service, not too high or too low. A scientific monitoring system should be instituted for periodic review of amounts of compensation. Recently, the compensation/payment amounts, including that for providers and acceptors, have been reviewed and revised. Possible impact of this change on programme performance and possible abuse remains to be seen.

Improving quality of care

Improvement of quality of care is essential to reduce method discontinuation, frequent switching of methods, promote acceptance and, thereby, promote effective use. Improvement of quality of care remains as the major frontline for the programme to focus on if further gains in contraceptive prevalence are to be achieved (Khan, 2000). Two strategies are important:

- improved provider skills in counselling can effectively address issues such as appropriate choice of methods, knowledge to deal with side effects and encourage continuity, and facilitate cross referrals as and when necessary (Bruce 1989).
- improved technical skills, especially for aseptic precaution, screening for contraindication and clinical procedures can reduce side effects and complications and, thereby, promote acceptor satisfaction, method continuation and effectiveness. Given the method mix trend, efforts should focus on "raising the awareness and availability of under-used methods, overcoming provider biases for and against certain methods, and strengthening provider's counselling skills" (UNFPA/PATH, 2008). An often neglected aspect of quality of care is the provision of unbiased information, including those on expected side effects and possible complications. Effective implementation of quality of care strategies necessitates institutions of a technically competent support system to monitor on a regular basis, clinical procedures, aseptic precautions, counselling practices, follow-up arrangements, and availability of equipment and supplies.

Focussing communication strategies

Communication efforts in support of family planning programmes and services have been grossly inadequate or unfocused in recent years. It is a misnomer to say that knowledge of family planning is universal because, in many instances, knowledge of

a method is incorrect, unsupported by sources of availability, and often shrouded by doubts, confusion and misperceptions. There is also widespread ignorance regarding safe motherhood and child care needs. Connection between education and fertility behaviour is well understood. However, as shown in Table 2.9, educational attainment is related to TFR, but unrelated to total wanted fertility, meaning it does not influence the fertility motive, but influence fertility by creating better access to and effective use of fertility control means.

Table 2.9: Wanted and total fertility and the difference by educational attainment

	TWFR	TFR	Difference (%)
No education	1.9	3.0	59
Primary incomplete	2.0	2.9	45
Primary complete	1.9	2.9	53
Secondary incomplete	1.9	2.5	32
Secondary complete or higher	1.8	2.3	28
Total	1.9	2.7	42

Source: BDHS, 2007

This would imply that, in theoretical term, the gap between wanted fertility and total fertility can be eliminated by innovative communication approaches and education programmes. Therefore, properly planned strategies for behaviour change communication (BCC) can be an essential tool to translate policy intents into public acceptance. However, for effective BCC strategy, it is necessary to identify the extent and pattern of ignorance, misinformation, doubts, rumours, confusion and, accordingly, design problem-specific communication materials. A few suggested areas of communication support are to:

- Improve knowledge of methods, including their benefits, side effects, use instructions, especially those for more effective methods such as IUDs and sterilisation.
- Dispel existing doubts, misinformation and rumours about contraceptives.
- Popularise the community clinic system.
- Create awareness about health and social implications of early marriage and early child bearing.
- Promote social equity for and participation of women in all walks of life.
- Create social awareness about maternal and child health issues.

To reinforce a message, BCC strategy should use both mass media (TV, radio, newspaper, posters, bill boards) as well as inter-personal communication, at outreach and in clinical settings (Shane, 2006).

Implement region-specific strategies

Wide regional variation in fertility decline and programme performance calls for special attention to diverse regional issues. As noted earlier, some of the low performing areas are also widely known as socially conservative and culturally orthodox. Socio-cultural

factors that affect family size norm or act as a barrier to contraceptive practice are uniquely different in magnitude and nature between regions, and call for formulation of region-specific micro-strategies. In this respect, the basic principles underlying policy proposition: "Decentralize population activities and ensure the people's participation in population, nutrition and health activities, decentralisation of services through devolution of power to the upazila level and further below" appears sound and should be acted upon (GOB, 2004).

Unequal fertility decline between regions calls for region-specific population goals with targets to achieve below replacement for regions which are already around that level which would have an averaging effect in reaching nation-wide overall replacement fertility. Decentralised service strategies should also be planned carefully taking into account regional norms, values and cultures. While decentralisation is appropriate to address the local issues and problems, there must be back-up support for technical oversight and quality assurance to be applied uniformly without compromise. In addition, centrally or regionally instituted technical expertise should be maintained to assist in micro-level problem solving. For example, conservative, religious issues – mostly arising from ignorance about religious teachings – may be an important factor in Sylhet. Accordingly, communication strategies, both at mass level and inter-personal level in that region should be appropriately designed in the regions. Recent surveys and selected research findings provide regional data on social, economic and cultural factors that should be useful in identifying region-specific issues. The findings of surveys that the poorer sections of population obtain contraceptive services mainly from public sector imply the need for emphasising the role of field workers in selected areas inhabited by poorer population such as urban slums.

REPRODUCTIVE HEALTH

Even though the primary focus of the paper is population and family planning, reproductive health issues are so closely linked and interactive with family planning and population that effective population policies cannot be conceived in isolation of relevant reproductive health issues. Necessarily, these are briefly reviewed with due attention to the prospect for mutual integration of services that would make family planning more widely acceptable and effective.

Safe motherhood

Significant progress – 18.0 per cent in 2007 to 31.7 in 2011 – has been made in recent years in proportion of childbirths attended by medically trained personnel (Table 2.10).

Table 2.10: Per cent deliveries attended by a medically trained person and per cent delivered by caesarean section

Wealth quintile	Delivered by medically trained personnel (%)		Delivered by caesarean section (%)	
	2007	2012	2007	2012
Lowest	4.8	11.5	1.8	5.0
Second	6.7	18.6	1.9	10.3
Middle	12.1	28.2	3.3	18.9
Fourth	22.5	43.2	8.5	18.9
Highest	50.9	63.8	25.7	34.7
Total	18.0	31.7	7.5	17.1

Source: BDHS, 2007 & 2012

In spite of this progress, as yet more than two-thirds of child births still occur without a skilled attendant. Continued efforts are therefore needed to train midwives and other medical personnel and equip facilities to improve safe motherhood. Since pregnancy complications can occur unpredictably, it is also essential to create access to emergency obstetric care (EOC) for all pregnant women as and when necessary (Starr, 1997). Safe motherhood programmes in Bangladesh have adopted these strategies to offer EOC at two levels – basic and comprehensive – available and accessible at several tiers of service points, including hospitals and health centres. Because caesarean section is the single most important intervention that prevents long term maternal morbidity, it is often used as a proxy indicator of access to EOC. By this token, there has also been a noteworthy progress with proportion of births conducted by caesarean section rising from 7.5 per cent in 2007 to 17.1 in 2011 (Table 2.10). However, distribution by income shows unequal access to both deliveries attended by medically trained personnel and caesarean section. As also shown in Table 2.10, poorer sections of population have much less access to both types of services. This lack of equity in access to safe motherhood services poses as an important challenge requiring policy options to establish more equitable access to services. The role of antenatal care would focus on management of pregnancy and planning and preparing for child birth.

The incidence of postpartum haemorrhage in Bangladesh is high at 17.5 per cent (Akhter, 1996). This calls for implementation of a recent WHO proposed intervention on Perspectives on Postpartum Haemorrhage Initiative (PPPHI) designed to reduce postpartum haemorrhage (PATH, 2007). This involves:

- Active management of the third stage of labour (AMTSL) by a skilled attendant or, when that is not an option.
- Administration of an uterotonic drug (oxytocin or misoprostol) by a trained health worker (WHO, 2007).

Infant and child survival

Notably, child survival was found as an important barrier to further decline in fertility (M Islam et al, 2002). In this respect, improved child survival in recent years is seen as a positive aspect for population policies. Recent studies have also shown that son-preference has diminished in recent decades. Expectedly, parental perception of the chance of survival of their existing children will continue to improve, further reducing their family size desire. Innovative communication strategies may help to enhance parental confidence in this regard, while continued efforts are needed for further improvement in infant and child health.

Integrated approach

The expanding access to reproductive health services provides an excellent opportunity to integrate family planning messages and referral mechanisms with them. An integrated service system allows clients to reach more services in one visit making them more acceptable, with mutually reinforcing health impact. During the last three decades there have been administrative and structural changes several times on grounds of integration and separation, and it is undesirable to make any further structural changes. Integrated approaches have already been clearly adopted though most service components even when these are not under one roof. There exist opportunities to promote the principles of integration through better coordination and cross referral between different components of reproductive health.

POLICY INTERVENTIONS ON SOCIAL FACTORS

Socio-economic development was seen as a "key driver of fertility decline" during the early demographic transition in the developed world in the past centuries (Bongaarts, 2008). More recent experience with fertility transition in many developing countries has showed that certain social indicators, such as education, women's development, organised community efforts and legal reforms, can be advanced independent of broader economic progress, which in turn can influence fertility without any significant economic development. Notwithstanding the need for economic progress, selective policy actions in social sectors – many such issues seen as important on their own merit – should therefore be pursued more vigorously. Most important among them in the population context are:

Women's development

Improved status of women in the family and society is an important determinant in the fertility decline process. Women's economic and social roles – especially those requiring out-of-home activities – provide the motive, knowledge and power to prevent unwanted pregnancy and also positively contribute to economic progress. The UN Forum acknowledges that: *"ensuring gender equity and equality and empowerment of women depends in part on overcoming cultural, social and economic constraints that limit women's access to education, as well as providing universal access to reproductive health services that allow them to control their fertility"* (UN, 2002).

Recognising this interrelationship, Government has shown commitment to women's development as reflected in its development policies and programme actions in all relevant sectors. Most importantly, a number of legal measures have also been taken, including Dowry Prohibition Act (1980), Cruelty to Women Act (1983), Family Court Ordinance (1985), Women and Children Repression Prevention Act (1995) and Acid Offenses Prevention Act (2002). More recently, legal reforms are being considered for equal rights of women to inherit property. The increased political role of women has been noticeable. The above actions and reforms have heavily contributed to women's participation in social and economic activities with visible transformation in women's status, especially in urban areas. However, rural women living in a conservative social environment, still remain subjected to discrimination. Orthodox rural society, together with widespread ignorance, shrouded by deep-rooted religious misconceptions, has been a limiting factor for women to participate in the rural societies.

Efforts should continue to:

- Create social support in favour of women's education, enhanced role in social, political and economic activities.
- Adopt further social and legal measures to prevent violence against women.
- Dispel social and religious misconceptions (such as the one that leads to so-called "fatwas").
- Enforce legal provisions to prevent discrimination against women.

Education

Education, especially for women, is the single most important factor which can remove superstition, ignorance and misgivings, create aspirations and opportunities in life, generate further demand for and promote family planning. In recent years, there has been significant increase in school enrolment, especially that for girls, though socio-cultural and economic barriers still pose as a major hindrance in retention of girl children in school. Innovative policies, such as provision of lunch, books and supplies, stipends, parental education and community mobilisation are needed to improve retention in schools. It is particularly important to retain girl children in schools until they gain physical and emotional maturity to understand the implications of early marriage and early child bearing. Suitably designed population subjects need to be integrated in education curricula, including that for the existing madrasha education system, and reviewed on a regular basis to ensure that these are in conformity with correct knowledge.

Age at marriage, early child bearing and adolescent health

Age at marriage in Bangladesh, as noted earlier, has remained very low with teenage pregnancy rate at one of the highest in the world. Both these factors have been relatively unresponsive to programme and policy actions and pose as major obstacles for fertility decline. As per BDHS 2007, 66 per cent of women are married before 18 years, the legal age of marriage for women. Low age at marriage with early child bearing also

carries important health and economic implications for the mothers as well their children. Recommended options are:

- Innovative measures to enforce legal age at marriage. With new birth certification systems it should be easier to enforce legal provision now than ever before.
- Communication activities and public campaign to create social awareness on the importance of allowing girls to become physically and emotionally mature before they are married.
- Education of girls as a means to keep them busy.
- Community based activities designed to encourage delayed marriage, delay in first birth as well as child spacing.
- Adolescents health programmes designed to enhance and create access to reproductive health and sexuality knowledge, counselling, services and supplies.
- Exploring possible options of increasing current marriage age from 18 years to 20 years for girls.

Development of community institution

Sector-wide policies and programmes may benefit from a structure of community organisation that would generate community consensus in favour of policies and programmes. For such purposes, community facilities should be in place to hold meetings, promote exposure to media through provision of newspapers, books, radios and television and cultural events. Once instituted, communities can be involved in vetting policies and programmes, including those on population. Such organised community efforts can be a powerful legitimising force for raising literacy and education, girl's education, women's role in society, addressing maternal health needs, access to adolescent knowledge and services, awareness about health and social implications of early marriage and early child bearing.

POLICIES TO MINIMISE IMPACT OF "POPULATION MOMENTUM"

As noted earlier, even after fertility declines to replacement level, the population will continue to grow due to effects of "population momentum" – which is an inevitable consequence of the young age structure caused by high fertility in the past – until the age structure of population stabilises. On a longer term perspective, it is therefore critically important to seek policy options that would minimise the impact of "population momentum" and reduce the lag period between achievement of replacement level and stabilisation of population growth. Possible options are:

- Adoption of one-child family norm.
- Postponement of births by increasing age at child bearing and child spacing. Recent program slogan: *"Dutir beshy noi, ekti hole bhalo hoi"* ("not more than two, better if one") is already in conformity with this proposition. This also underscores the importance of policy actions to enforce the existing legal age at marriage, and further

raise the legal age of female marriage and thereby delay child bearing. Notably, these propositions were earlier made under HNPSP 2003–2010 (MOHFW, 2005). It is necessary to designate a focal point to carry these policy intents forward and, because of multi-disciplinary nature of possible activities, such policy options may be best addressed under an inter-ministerial consortium.

AUTHORS' NOTES

This chapter was originally prepared for and with support from Robert Gillespie, President, Population Communication Inc., California, USA in January 2009. Recently when advised to disseminate the paper, since more than a year had passed from its first write-up, it was felt necessary to update and revise the paper taking into account more recent developments. The title of the paper, and a clear focus on selective approach in fertility regulation, were deliberately chosen. Even though the seriousness of population problems in Bangladesh deserve an overriding consideration to focus on fertility regulation in its population policies, the authors carefully considered the needs of population policies within the broader principles of human rights and the ICPD commitments. Given the convincing evidences indicating that achievement of replacement level fertility, and eventual stabilisation of population, is possible by meeting unmet need and demands, the paper focuses on programme efforts in the fertility regulation sector. The authors however do not de-emphasise the policy needs on other sectors such as social, economic and legal sectors. The authors gratefully acknowledge the support and encouragement from Robert Gillespie, President, Population Communication Inc.

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Annex Table 2.1: Contraceptive method mix trend from 1975–2011 as per cent women age 15–49 using different methods, different sources											
Method	**1975 BFS**	**1983 CPS**	**1985 CPS**	**1989vBFS**	**1991 CPS**	**1993–1994 BDHS**	**1996–1997 BDHS**	**1999–2000 BDHS**	**2004 BDHS**	**2007 BDHS**	**2011 BDHS**
Any method	7.7	19.1	25.3	30.8	39.9	44.6	49.2	53.8	58.1	55.8	61.2
Modern method	5.0	13.8	18.4	23.2	31.2	36.2	41.5	43.4	47.3	47.5	52.1
Pill	2.7	3.3	5.1	9.6	13.9	17.4	20.8	23.0	26.2	28.5	27.2
IUD	0.5	1.0	1.4	1.4	1.8	2.2	1.8	1.2	0.6	0.9	0.7
Injectable	--	0.2	0.5	0.6	2.6	4.5	6.2	7.2	9.7	7.0	11.2
Implant	--	--	--	--	--	--	0.1	0.5	0.8	0.7	1.1
Condom	0.7	1.5	1.8	1.8	2.5	3.0	3.9	4.3	4.2	4.5	5.5
Female Sterilization	0.6	6.2	7.9	8.5	9.1	8.1	7.6	6.7	5.2	5.0	5.0
Male sterilization	0.5	1.2	1.5	1.2	1.2	1.1	1.1	0.5	0.6	0.7	1.2
Traditional meth	2.7	5.4	6.9	7.6	8.7	8.4	7.7	10.3	10.8	8.3	9.2
Periodic abstinence	0.9	2.4	3.8	4.0	4.7	4.8	5.0	5.4	6.5	4.9	6.9
Withdrawal	0.5	1.3	0.9	1.8	2.0	2.5	1.9	4.0	3.6	2.9	1.9
Other traditional	1.3	1.8	2.2	1.8	2.0	1.1	0.8	0.9	0.6	0.6	0.4
Source: NIPORT et al 2009 reporting from various surveys from 1975 to 2007 & NIPORT 2012											

Annex Table 2.2: Contraceptive method mix for selected countries										
	Any method					Voluntary sterilization			Source of supply	
		Pill	IUD	Inject	Condom	Male	Female	Tradi	Public	Private
Bangladesh	55.8	28.5	0.9	7.0	4.5	0.7	5.0	8.3	57	38
China	86.9	1.7	39.6	0.1	4.3	6.9	33.0	0.7	-	-
India	56.3	3.1	1.7	0.1	5.2	1.0	37.3	7.8	71	24
Indonesia	60.3	13.2	6.2	27.8	0.9	0.4	3.7	3.6	28	67
Iran	73.8	18.4	8.5	2.8	5.9	2.7	17.1	17.8	76	25
Nepal	48.0	3.5	0.7	10.1	4.8	6.3	18.0	3.7	77	20
Pakistan	29.6	2.1	2.3	2.3	6.8	0.1	8.2	7.9	57	18
Sri Lanka	70.0	6.7	5.1	10.8	3.7	-	23.1	20.5	-	-
Thailand	71.5	30.9	1.2	10.4	1.4	1.0	24.5	1.4	-	-
Viet Nam	75.7	9.0	35.9	1.2	7.6	0.5	5.8	14.8	86	14
Source: Population Reference Bureau, 2008 Data Sheet, Washington DC										

Annex Table 2.3: Numbers of new acceptors of selected methods, 1972–73 to 2009–10						
Year	Permanent methods			IUD	Implant	Injectables
	Female	Male	Total			
1972–73	129	240	369	15,600		-
1973–74	1,016	446	1,462	27,590		-
1974–75	4,707	14,469	19,176	50,391		58
1975–76	11,078	37,839	48,917	77,840		1,908
1976–77	41,248	75,066	116,314	59,421		2,548
1977–78	44,722	32,643	77,365	40,464		4,527
1978–79	81,719	24,705	106,424	22,631		11,280
1979–80	171,248	27,534	198,782	21,801		26,028
1980–81	232,497	26,296	258,793	41,601		112,010
1981–82	235,084	67,824	302,908	83,668		81,065
1982–83	274,842	88,315	363,157	117,743		72,697
1983–84	336,502	215,665	552,167	303,338		122,457
1984–85	232,389	259,210	491,599	432,465		165,933
1985–86	116,418	151,125	267,543	367,668		216,489
1986–87	140,625	209,935	350,560	420,338		314,748
1987–88	96,169	99,846	196,015	379,128		389,299
1988–89	130,946	13,027	143,973	361,698		598,702
1989–90	141,953	83,109	225,062	365,623		1,257,581
1990–91	97,404	67,896	165,300	274,231		1,689,114
1991–92	92,133	69,142	161,275	269,565		2,254,778
1992–93	63,200	50,416	113,616	261,770		2,561,166
1993–94	71,225	49,134	120,359	335,840	40,359	3,533,643
1994–95	53,821	16,821	70,642	244,891	49,448	4,333,234
1995–96	39,074	10,266	49,340	195,111	23,925	5,454,159
1996–97	43,286	7,603	50,889	175,487	40,359	6,305,035
1997–98	55,955	13,117	69,072	194,535	99,448	6,552,054
1998–99	45,220	16,500	61,720	176,514	50,183	7,193,788
1999–00	33,839	21,617	55,456	146,270	50,565	6,926,575
2000–01	19,205	11,192	30,397	101,160	34,127	
2001–02	28,974	22,364	51,338	161,679	57,876	
2002–03	32,761	43,203	75,964	181,762	66,163	
2003–04	52,132	41,839	93,971	195,018	68,307	
2004–05	83,627	60,645	144,272	208,769	105,958	

2005–06	71,133	52,658	123,791	257,915	74,871	
2006–07	100,571	91,486	192,057	222,259	13,812	
2007–08	105,787	92,890	198,677	236,960	177,351	
2008–09	115,754	100,646	216,400	330,709	86,720	
2009–10	128,605	162,297	290,902	226,220	40,278	
2010–11	138,381	150,920	289,301	307,271	273,677	
2011–12	131,324	158,313	289,637	244,266	200,796	
Source: data from service statistics compiled by Engender Bangladesh						

Annex Table 2.4: Per cent married women using any FP method and IUDs in selected countries

Countries	Any method	IUDs
Selected Muslim countries		
Uzbekistan	64.9	49.7
Egypt	59.2	36.5
Tunisia	62.6	27.6
Syria	58.3	25.7
Palestinian territory	50.2	24.8
Jordan	55.8	23.6
Turkey	71.0	20.2
Lebanon	58.0	13.8
Iraq	49.8	12.2
Libya	45.2	11.2
Qatar	43.2	9.0
Iran	73.8	8.5
Indonesia	60.3	6.2
Pakistan	29.6	2.3
Bangladesh	55.8	0.9
Other countries		
North Korea		42.8
China		39.6
Source: PRB Family Planning Worldwide Data Sheet 2008		

CHAPTER 3

POPULATION STABILISATION IN BIHAR, INDIA: SITUATIONAL ANALYSIS AND FUTURE DIRECTIONS

Anant Kumar and Jay Satia

INTRODUCTION

The purpose of this chapter is to carry out situational analysis and identify future directions for population stabilisation in Bihar, India through examining the programmes and policies that would help achieve this.

The chapter describes the status of the population policies and family planning programmes in Bihar that would accelerate progress towards population stabilisation. It has largely relied upon the various secondary sources including government reports, policy papers related to health, population policy and programmes; literature review and desk research. However, information was also gathered about health, population and the reproductive health scenario in Bihar through discussions with different stakeholders like Government officials, Bihar State Health Society, Public Health Resource Network, Donor agencies, Non Governmental Organisations (NGOs) and individuals.

The chapter provides a population and development profile of Bihar. It then reviews family planning status in terms of current use and unmet need in section three. This is followed by a discussion of evolution of population policies and programmes. The strategies to accelerate progress towards achieving replacement fertility and subsequent population stabilisation and their implementation requirements are what follow. In conclusion, based upon recent improvement trends in socio-economic development and family planning programme performance, we can be cautiously optimistic that replacement fertility could be reached in 20–25 years although the technical group on population projection, Registrar General of India (2006) had estimated that Bihar will achieve replacement level of fertility by the year 2021.

POPULATION AND DEVELOPMENT PROFILE OF BIHAR

The state of Bihar is situated in the eastern part of India (Graph 3.1). About 2.97 per cent of India, it covers an area of 94,163 sq. km. As per the provisional population Census of India (2011),[5] the State had a population of 103.8 million (males: 54.18 million and females: 49.62 million). The rural and urban population comprises 88.70 per cent and 11.30 per cent respectively implying a high population density at 1102 persons per sq. km compared to a national figure of 382 persons per sq. km (Provisional Census, 2011). In

[5] As per the Provisional Population Totals of Census of India 2011.

population, Bihar is the third largest state (having 8.58% population of India) next to Uttar Pradesh and Maharashtra (Census of India, 2011). The Sex Ratio in the State is 916[6] as compared to 940 for the country, and the child sex ratio is 933 as compared to the national average of 944.

Map of Bihar

No. of Districts: 38

Population of Bihar: 103,804, 637 m

% of total Population of India: 8.58

Literacy Rate: 63.82%

- Male: 73.39%
- Female: 53.33%

Bihar state is situated in north-eastern India, bordered by Nepal on the north, West Bengal state on the east, Jharkhand state on the south, Chhattisgarh state on the south west, and Uttar Pradesh state on the west.

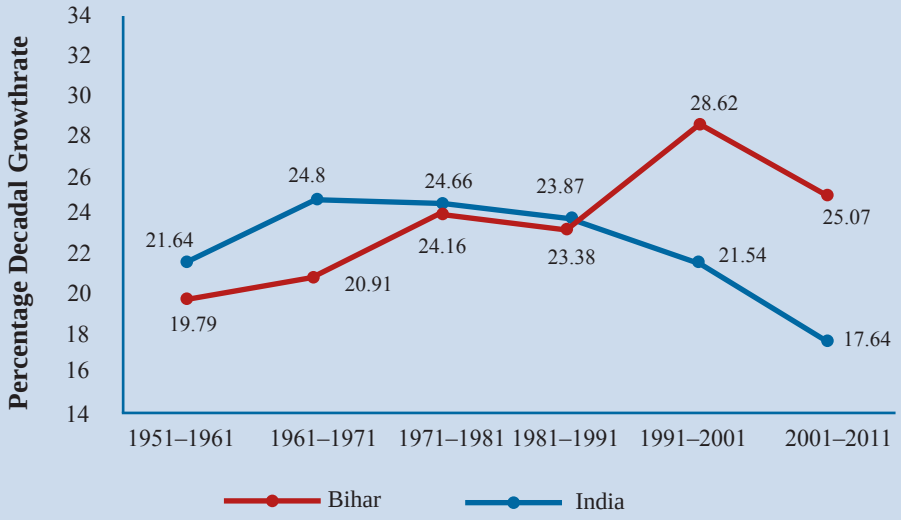
The population in Bihar has been growing rapidly during the decade 2001–2011 at 25.07 per cent compared to India as a whole at 17.64 per cent (Table 2.1). The population nearly doubled in thirty years from 1981 to 2011 (Graph 3.3).

Table 3.1: Decadal Population Growth Rate

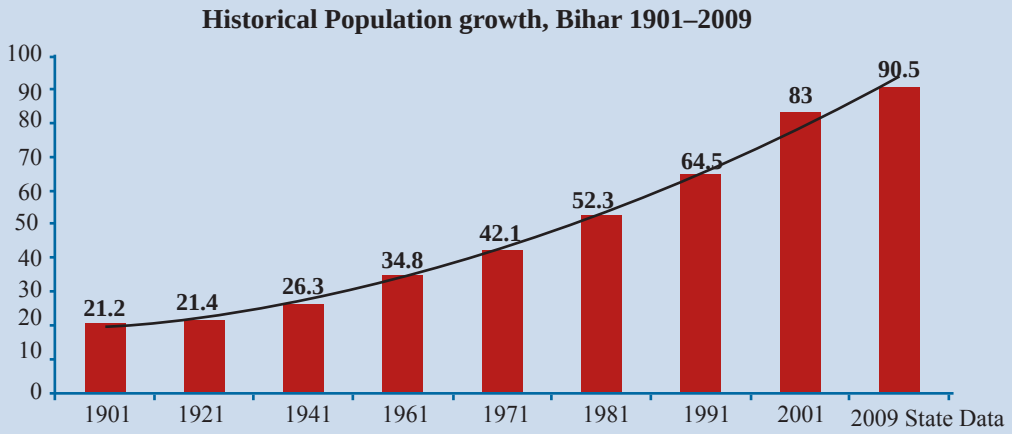
SL	India/ State	Percentage Decadal Growth Rate			Sex-Ratio (Females/1000 Males)			Population Density per sq. km.		
		1981–91	1991–01	2001–11	1991	2001	2001	1991	2001*	2011
1.	India	23.87	21.54	17.64	927	933	940	267	324	368
2.	Bihar	23.38	28.62	25.07	907	921	916	685	881	1102

[6] The overall sex ratio of Bihar which was 919 in 2001 has fallen by 3 points to 916 in 2011. In rural areas, the decline has been by 7 point from 926 to 919 while in urban areas it has gone up by 23 points from 868 to 891. There has been a decline in overall sex ratio in 20 districts as compared to Census 2001.

Graph: 3.2 **Percentage decadal growth rate in Bihar**



Graph: 3.3 **Historical population growth in Bihar**



Demographic Diversity in India

According to a Report of the Technical Group on Population Projections for India and States 2001–2026, Census of India, 2001,[7] the population of India is expected to increase from 1029 million to 1400 million during the period 2001–2026. This will be an increase of 36 per cent in 25 years at the rate of 1.2 per cent annually, while India's population growth rate has been declining over the years. The overall population will continue to grow as 51 per cent of the population is in the reproductive age group (15–49 years). Millions more will join this cohort each year.

[7] Report of the working group on population stabilisation for the eleventh five year plan (2007–2012). Planning Commission. Government of India. New Delhi.

The Group also estimated that under the current trends, it would take at least 25 years for the use of contraception, female age at marriage, unmet need for contraception, ideal family size and regular exposure to mass media to reach respective levels required to attain replacement-level fertility in Bihar (Table 3.2). At current levels, it may take several more decades to stabilise the population. Considering the age structure and population distribution (according to Census 2011) where 0–6 years constitutes the highest proportion (17.9 per cent) of the state's total population, concentration of population in this age group also implies that the fertility transition in Bihar is much slower.

Table 3.2: Population Projection for Bihar, 2001–2026

State	Projected growth rate 2008–11 (%)	Projected population growth			Total fertility rate	
		% growth	(millions)	% share	2011	2021
Bihar	1.5	37.2	30.85	8.3	3.0	2.2
India	1.4	36.1	371.23	100.0	2.5	2.1

Out of the estimated total population increase of 371 million between 2001 and 2026 in India, 187 million are likely to be added in the seven States of Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Rajasthan, Uttar Pradesh and Uttaranchal,[8] i.e., nearly 50 per cent of India's demographic growth although they currently account for 40 per cent of the total population. Of the total population growth during the period 2001–26, it is estimated that Bihar would continue to contribute to the current 8 per cent of its current share even then.

There is considerable demographic diversity in India (Table 3.3). While some states accounting for 61 per cent of the total population have achieved or are close to achieving replacement level fertility, others with 39 per cent of the population will still take many more years.

Table 3.3 Estimated Dates for Reaching Replacement Fertility Level in Different States

States have already or nearly achieved replacement fertility	States that are expected to achieve replacement fertility by 2020	States that are expected to achieve replacement fertility after 2020
Kerala (1988)	Assam (2019)	Uttar Pradesh (2027)
Tamil Nadu (2000))	Jharkhand (2018)	Madhya Pradesh (2025)
Andhra Pradesh (2002)	Haryana (2012)	Chhattisgarh (2022)
Himachal Pradesh (2002)	Orissa (2010)	Uttarakhand (2022)
Delhi (2001)	Gujarat (2012)	Bihar (2021)
NE States (2005)	Maharashtra (2009)	Rajasthan (2021)
West Bengal (2003)	Punjab (2006)	Accounting for 39% of India's population in 2001
Accounting for 28% of India's population in 2001	Karnataka (2005)	
	Accounting for 33% of India's population in 2001	

Source: The Technical group on Population Projection, RGI. 2006.

[8] A. Singh (2010). Population Stabilization: the Way Ahead. viewed 23 August, 2010, <www.jsk.gov.in>.

Socio-cultural Context of High Fertility

Bihar has a very high total fertility rate (3.7 children per woman according to SRS, 2010 estimates) in comparison to other states and country fertility rate (2.5 children per woman) (Graph 3.4). Except for the Infant Mortality Rate (IMR) which is only marginally higher in Bihar than in India, the demographic situation of Bihar is extremely difficult. On the socio-economic front too, Bihar lags far behind the other states due to its high fertility, educational backwardness, and unemployment. Figures of major health and demographic indicators are given in Table 3.4. The IMR is 48 per 1000 live births (SRS, 2010) and Maternal Mortality Ratio (MMR) is 312 per 100,000 live births (SRS, 2004–06) which are higher than the National average.

Table 3.4: Demographic, Socio-economic and Health profile of Bihar as compared to India

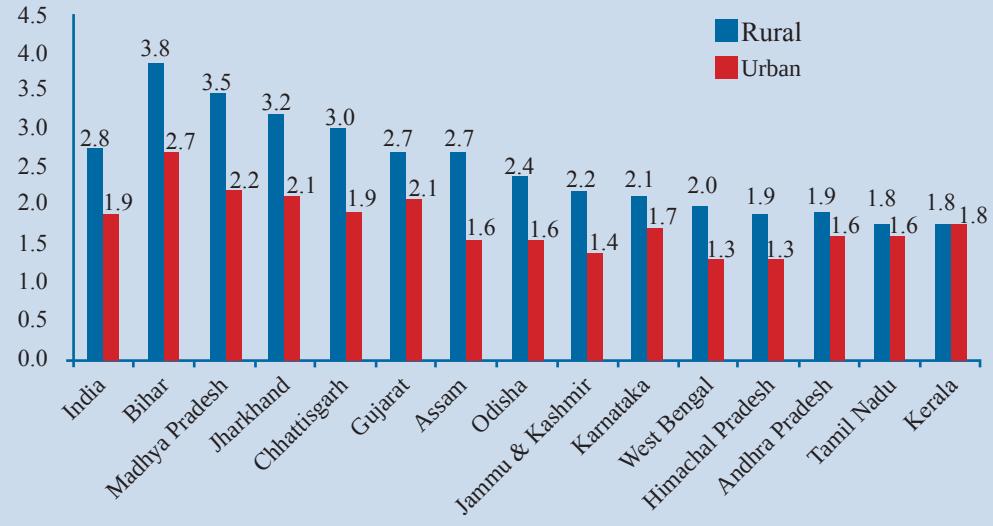
S. No.	Item	Bihar	India
1	Total population (Census 2011) (in millions)	103.8	1210.19
2	Decadal Growth (Census 2011) (%)	25.07	17.64
3	Crude Birth Rate (SRS 2010)	28.1	22.1
4	Crude Death Rate (SRS 2010)	6.8	7.2
5	Total Fertility Rate (SRS 2010)	3.7	2.5
6	Infant Mortality Rate (SRS 2010)	48	47
7	Maternal Mortality Ratio (SRS 2004–2006)	312	254
8	Sex Ratio (Census 2011)	916	940
9	Population below Poverty line (%)	42.60	26.10
10	Schedule Caste population (in millions)	15.07	166.64
11	Schedule Tribe population (in millions)	0.9	84.33
12	Female Literacy Rate (Census 2011) (%)	53.33	65.46

Graph: 3.4 **Total Fertility Rate, India and major States, 2010**

Source: Sample Registration System

The state is predominantly rural with 88.70 per cent people living in rural areas (Provisional Census, 2011). It comprises 38 districts with 9 divisions, 101 sub divisions, 534 blocks, 199 towns and 44874 villages. All the districts have a rural population of over 80 per cent with 7 districts having a rural population of over 95 per cent. Rural areas are socio-economically much less developed. In the rural areas of Bihar, fertility (3.7 children per woman) is higher in comparison to urban areas (2.7 children per woman) and is the highest in the country (Graph 3.5).

Graph: 3.5 **Total Fertility Rate, India and major States, Rural and Urban, 2010**



Source: Sample Registration System

The data and indicators associated with high fertility in the State can be attributed to various factors. Prominent among them are:

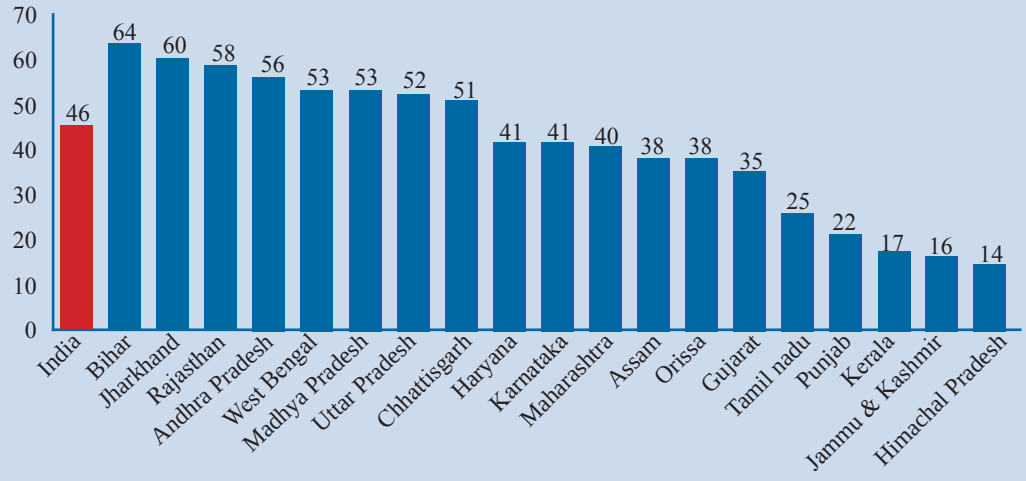
- Economic backwardness.
- High percentage of marriages under the age of 18 years.
- Preference for male child.
- Low rate of female literacy and low female status.
- Modest level of infant mortality.

In addition, the family programme is weak resulting in lack of information and choices for safe family planning services and low level of contraceptive use.

Economic backwardness of the State can be judged from the fact that its per capita income is less than 40 per cent of the national average and the rural poverty ratio is as high as 43.1 per cent compared to a national average of 27.1 per cent. The state is facing desperate challenges in improving its growth and health of its population, particularly that of women and children.

In Bihar, where female mean age at marriage is lower than the legal age, marriages are mostly early and arranged. Percentage of girls married below the legal age of 18 is 64 per cent (Graph 3.6) with the mean age of marriage for boys and girls being 21.6 and 17.6 years respectively (DLHS-III). This survey also shows that in Bihar out of total births, 8 per cent of births are to women aged 15–19 years.

Graph: 3.6 **Per cent of Women, Ages 18–29, Married by Age 18, Major States of India, 2005–06**



Source: NFHS-3

The society places high emphasis on fertility with enormous social pressures, particularly on the youth, to bear children immediately after marriage. This is a serious concern in the state that needs to be immediately addressed (Table 3.5). In such a society and with such social pressure, many young people do not consider the possibility of delaying first child. However, some young people want to delay child bearing, but do not know how to do so. It is difficult for newly wed couples to translate intent into practice because of various barriers in Bihar such as:

- Conventional thinking that women have no right to decide.
- No confidence to fight against societal norms.
- Lack of spousal communication.
- Inadequate knowledge of contraceptives and Reproductive Health (RH) services.
- Fear that contraceptive use can cause infertility.

Table 3.5: Fertility among youth	
Fertility among youth	
Fertility in women under 25	55%
15–19 married	19%
15–24 want no more children	34%
Married 15–19 experienced pregnancy	58%
Median birth interval 15–29 months	25 to 29
Unmet need for spacing 15–24	35.1 to 26.7%
Spacing contraceptive use 15–24	3% to 16.7%
Source: NFHS 3 (2003–2005)	

NFHS-3 results indicate that son preference in Bihar is strong. Thirty-nine per cent of women and men want more sons than daughters in Bihar. On the other hand, only 1–2 per cent want more daughters than sons. The vast majority of 88 per cent of women want at least one son and 85 per cent want at least one daughter. The desire for more children is strongly affected by the number of sons a woman has. Among women with two children, 68 per cent of women with one son and 77 per cent of women with two sons want no more children, compared with only 20 per cent of women with two daughters and no sons. In India, among women with two living children, 62 per cent of women with two daughters and no sons do not want any more children.

More than half of the young boys and nearly three-fourth of the young girls are not enrolled in primary schools even today. The overall literacy rate in Bihar is only 63.82 per cent (male: 73.39, female: 53.33)[9] as compared to 74.04 per cent for India and the disparity is even wider for female literacy with 53.33 per cent and 65.46 per cent for Bihar and India respectively.

The State indicators demonstrate substantially lower status of women in India. Only 22 per cent of the women reported making autonomous decisions about their own health care and 30 per cent reported having made decisions about the purchase of daily household needs (NFHS-3). Less than one in 10 women said that they could make the decision to visit their family or relatives.

Family Planning Status: Current Use and Unmet Need

The percentage of married women using contraception in India has increased from a level of just over 10 per cent in the early 1970s to 48 per cent in 1998–99, and to 53 per cent by 2004 (all India). Considering the logistical problems of supplying information and services to more than 250 million women of reproductive age, this increase is a remarkable achievement. Surveys have repeatedly shown that women's knowledge about

[9] Bihar ranks last in the country preceded by Arunachal Pradesh (66.95 per cent) and Rajasthan (67.06 per cent).

contraception is nearly universal. Female sterilisation remains the most common method of family planning. As mentioned earlier, for the first time in recent decades, the 2001 Census has registered a fall in the growth rate of population below two per cent, indicating that the decline in the birth rate has begun to overtake the decline in the death rate. In the early 1970s, less than 15 per cent of the deliveries were occurring in institutions. It has increased from 12.1 per cent (1992–93) to 22 per cent (2005–06) to 27.7 per cent (2007–08) to 47.9 per cent (CES, 2008). This increase in institutional delivery since 2005–06 is largely due to the conditional cash transfer scheme (Janani Suraksha Yojana).

National Family Health Surveys (NFHS) surveys show that there was little change in contraceptive use for all methods between NFHS-1 (1992–93) and NFHS-2 (1998–99) in Bihar. However, contraceptive use for all methods increased from 23.5 per cent to 34.1 per cent by 2005–06 (Table 3.6). The unmet need declined from 25.7 per cent to 23.1 per cent showing that total demand for family planning had increased from 49.2 per cent to 57.2 per cent.

Nevertheless, contraceptive use in the state is characterised by the predominance of non-reversible methods, limited use of currently male/couple-dependent methods, substantial levels of discontinuation, negligible use of contraceptives among both married and unmarried adolescents and wide district level variations. Even per cent of currently married women (15–44 years) using female sterilisation is lower in Bihar in comparison to other states (Graph 3.9).

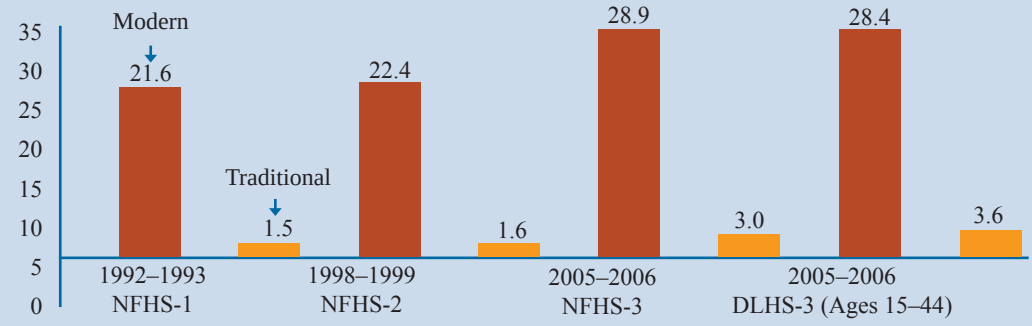
Table 3.6: Use of Family Planning Methods in Bihar

Key Indicators for Bihar from NFHS II and III	NFHS-3 (2005–06)			NFHS-2
	Total	Urban	Rural	(1998–99)[3]
Marriage and Fertility				
1. Women age 20–24 married by age 18(%)	60.3	37.3	65.2	71.9
2. Men age 25–29 married by age 21(%)	43.0	23.2	48.8	na
3. Total fertility rate (children per woman)	4.00	2.87	4.22	3.70
5. Median age at first birth for women age 25–49	18.7	19.6	18.6	18.9
Family Planning (currently married women, age 15–49)				
Current use				
7. Any method (%)	34.1	50.6	31.4	23.5
8. Any modern method (%)	28.8	41.2	26.8	21.6
8a. Female sterilisation (%)	23.8	31.2	22.6	18.5
8b. Male sterilization (%)	0.6	0.7	0.5	1.0
8c. IUD (%)	0.6	1.1	0.5	0.6
8d. Pill (%)	1.3	3.1	1.0	0.8
8e. Condom (%)	2.3	4.8	1.9	0.6
Unmet need for family planning				
9. Total unmet need (%)	23.1	17.4	24.0	25.7
9a. For spacing (%)	10.7	5.9	11.5	13.1
9b. For limiting (%)	12.4	11.5	12.5	12.5

na: not available, 3. NFHS-2 estimates recalculated to exclude Jharkhand.

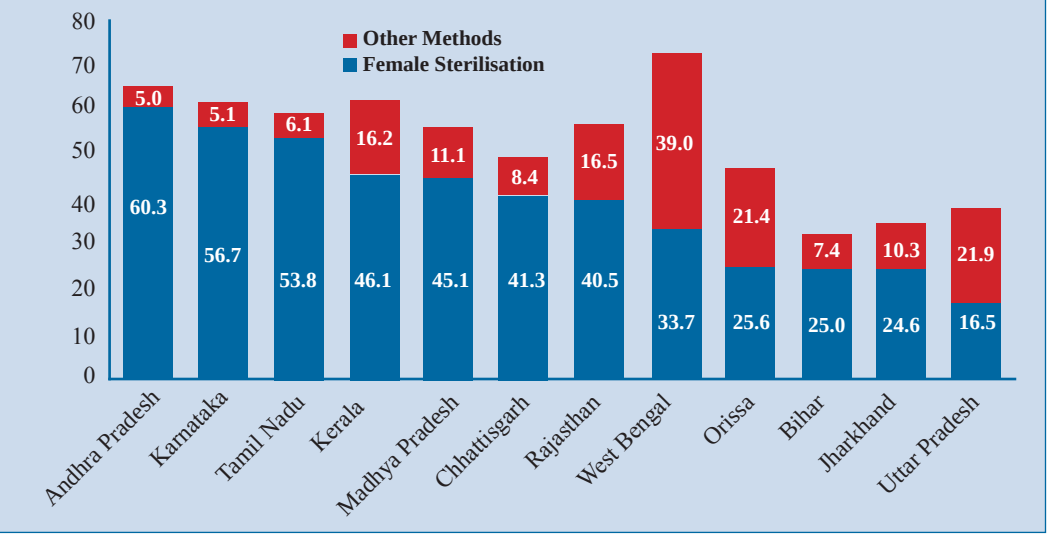
The four surveys, NFHS 1–3 and District Level Health Surveys (DLHS) show that there is improvement in acceptance of modern methods of contraception. Family planning, particularly sterilisation acceptance has increased in the state (Graph 3.7 and 3.8).

Graph: 3.7 **Contraceptive use by Currently Married Women, Ages 15–49 (Modern and Traditional Methods, Bihar, Four Surveys)**



Source: NFHS-1, 2, 3, and DLHS-3

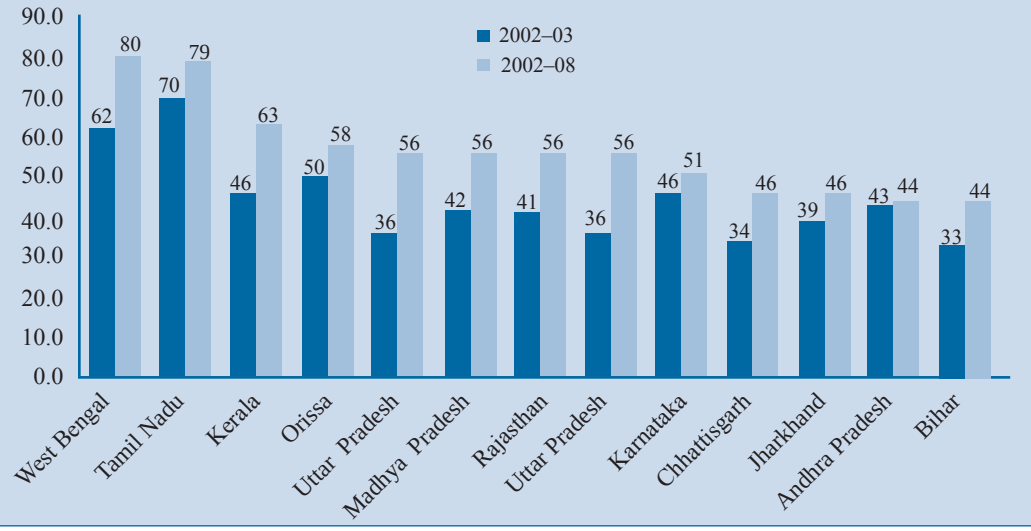
Graph: 3.8 **Per cent of Currently Married Women, Ages 15–44, Using Female Sterilisation and using other methods, Selected States of India, 2007–2008**



Source: DLHS-3

Demand for children is higher in Bihar compared to India: percentage of married women with two children in the reproductive age group wanting no more children in Bihar was 44 per cent, lower than all states (Graph 3.9).

Graph: 3.9 **Per cent of married women, ages 15–49, with two children who want no more**

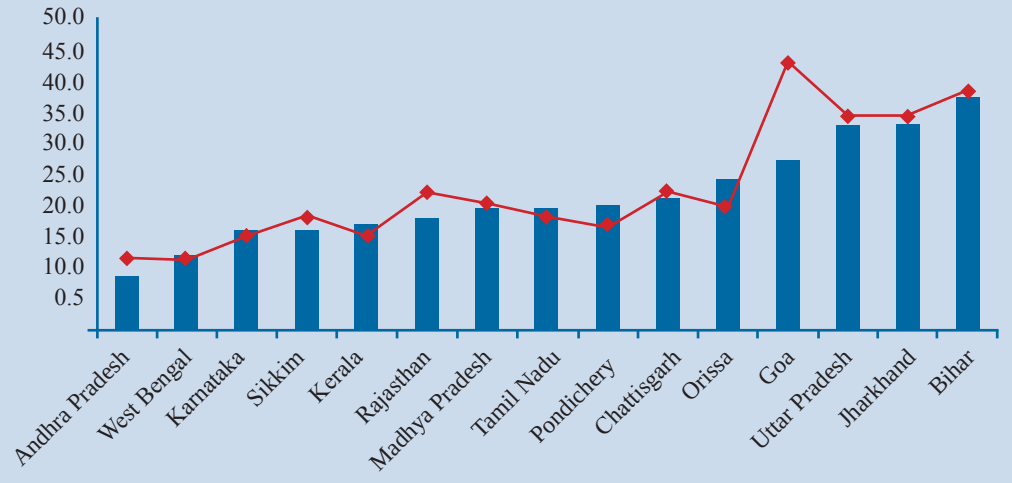


Source: DLHS 1 and 3 (District Level Health Surveys, Selected States of India)

Meeting the unmet need for contraception

The National Population Policy document lays great stress on meeting the unmet need for contraception as an instrument to achieve population stabilisation. The presence of high level of unmet need for contraception for limiting of the family size and spacing between childbirths in Bihar state is validated by data from both NFHS and DLHS. It would be a mistake to assume that inadequate access to services should be the dominant, or even a major, explanatory factor for its presence. Total unmet need for family planning according to NFHS-3 (2005–06) was 23.1 and DLHS-3 (2007–08), using a different methodology estimated it to be 37.2 per cent (Graph 3.10). One in three to four women in the state had unmet need for family planning. Unmet need for limiting has increased in the state, which is a poor reflection of availability of services and service provisions, especially when majority of clients depend on public health services in the state. Total unmet need is highest among the younger women and women of lower parity, particularly for spacing. It is important to address the unmet need for contraception, particularly for spacing by providing access to safe, effective and reversible methods. To do so it may be necessary to expand the basket of contraceptive choices. Social marketing of contraceptives and availability of the range of methods would help to meet the needs of couples who are not ready to accept sterilisation. Peripheral health workers, auxiliary nurse-midwives (ANMs) and Accredited Social Health Activists (ASHAs) should identify women with unmet need for contraception and address their concerns so that unwanted pregnancies could be avoided.

Graph: 3.10 **Unmet Need for Family Planning-Total**



The increase in Contraceptive Prevalence Rate (CPR) in Bihar was nearly negligible during the period 1992–93 (NFHS-1) and 1997–98 (NFHS-2) as compared to 7.4 per cent increase in India (Table 3.7). However, increase in CPR was higher in Bihar compared to India during the period 1997–98 and 2005–06 with programme interventions discussed later.

Unmet need declined in India over time but not so in Bihar. Total demand for Family Planning (FP) is much higher in India compared to Bihar but it increased significantly between NFHS 2 and 3. Only 59.6 per cent demand is satisfied in Bihar compared to 81 per cent for India as a whole. Later in this section, reasons for high unmet need in Bihar are discussed.

Table 3.7: Contraceptive Prevalence and Unmet Need in India and Bihar

	Bihar			India		
NFHS	I*	II	III	I	II	III
Contraceptive prevalence rate	23.1	23.5	34.1	40.8	48.2	56.3
Unmet need	25.1	25.7	23.1	19.5	15.8	13.2
Total demand	48.2	49.2	57.2	60.3	64.0	69.5
% demand met	47.9	47.8	59.6	67.6	75.3	81.0

**For Bihar and Jharkhand together*

Bihar is much poorer than India on the whole as can be seen by the proportion of households in different wealth quintiles (Table 3.8). As expected, Total Fertility Rate (TFR) decreases, CPR increases, unmet need decreases and per cent demand met increases as households become wealthier. However, it is very difficult to disentangle the effect of the socio-economic development and family planning programme on fertility. Bihar's CPR is lower than India's and TFR is higher than India's for each wealth quintile. The total demand for FP in Bihar for each wealth quintile is also lower than India. If the contraceptive use and fertility of persons in each wealth quintile household in Bihar was same as in India then wealth adjusted CPR and TFR for Bihar would be 52.8 and 3.07. If for each wealth quintile,

the same proportion of FP demand was met in Bihar as in India, then the CPR would be 44.9; 10.8 per cent more than current CPR of 34.1 which is nearly half the difference between India's and Bihar's CPR. Similar is the situation with respect to education levels of women.

Table 3.8: TFR and CPR by Wealth Quintiles in India and Bihar

	Wealth quintiles					Total
	I	II	III	IV	V	
India (%)	20	20	20	20	20	100
Bihar (%)	31	30	18	13	9	100
Bihar CPR	21.5	28.4	38.1	48.0	60.4	34.1
India CPR	42.2	51.1	56.8	62.5	67.5	56.3
Bihar TFR	5.1	4.5	(3.6)	3.0	2.1	4.0
India TFR	3.89	3.17	2.5	2.24	1.78	2.68
Bihar unmet need	27.3	24.4	23.3	17.6	11.0	22.8
Bihar Total demand	48.8	52.9	61.4	65.6	71.4	56.9
India Unmet need	18.2	14.8	12.8	10.6	8.1	12.8
India Total demand	60.4	65.9	69.6	73.1	75.6	69.1
Bihar per cent demand satisfied	44.0	53.7	62.0	73.2	84.6	59.6
India per cent demand satisfied	69.9	77.6	81.6	85.4	89.3	81.5
Education levels of household population above 6 years of age						
	No education	< 5 years	5–7	8–9	10–11	12+
Bihar TFR	4.6	NA	3.2	3.2	2.4	2.4
India TFR	3.6	2.5	2.5	2.2	2.1	1.8
Bihar CPR %	29	40	41	41	53	53
India CPR %	52	63	59	59	60	62

High fertility is not just because women want much larger families (wanted TFR 2.8) but also because they are not able to use appropriate contraception essential to achieve their wanted fertility (Table 3.9).

Table 3.9: Wanted fertility Rates by Wealth Quintiles in India and Bihar

	Wealth quintiles					Total
	I	II	III	IV	V	
Bihar TFR	5.1	4.5	3.6	3.0	2.1	4.0
India TFR	3.9	3.2	2.6	2.2	1.8	2.7
Bihar wanted TFR	2.8	2.7	2.1	2.1	1.7	2.4
India wanted TFR	2.4	2.1	1.8	1.7	1.5	1.9

This demonstrates that the wanted fertility is lower than current fertility and higher than replacement fertility, while the unmet need for contraception is high. Reasons for non-use of contraception in future for those with unmet need are related to fertility, opposition to use and FP method-related. It is both a supply problem in terms of access, availability and quality of care for family planning services and a demand problem because of opposition to use of contraception and gender inequalities which require behavioural change communication and changes in socio-economic correlates of fertility (Table 3.10).

Table 3.10: Reasons for Non-use of Contraception

Reason for non-use	Bihar	India
Fertility related (infecund, breastfeeding, menopausal, etc.)	32	67
Opposition to use (self, husband, religious, social, etc.)	30	15
Method related (fear of side effects, cost and access, etc.)	27	12
Other	11	6
Total	100*	100*

**More than one reason was mentioned by respondents. Their responses have been adjusted to a total 100 per cent*

EVOLUTION OF POPULATION POLICIES AND PROGRAMMES

Population stabilisation has been a challenge for the Government since Independence. More than 60 years ago, India became the first developing country to initiate a state-sponsored family planning programme in 1951 to control its high population growth rate. As Bihar state did not have a policy, it was mostly dependent on the Central government for the direction and population control initiative. Nevertheless, the State specific initiatives were not supportive and played a crucial role in poor performance of the state in terms of demographic achievements because of various reasons. This resulted in the FP programme not appealing to the people.

Other reasons behind these were a number of well-intended but miscalculated policies. Largely the programmes had been characterised by an ad-hoc nature offering a one-shot solution to the problem of the high rate of fertility. It was intrauterine devices (IUDs) in the 1960s, vasectomy in the 1970s and tubectomy in the 1980s, where administrators, family planning workers and politicians put all their efforts in achieving the stipulated target by any one method. Thus, these programmes which needed a delicate touch of social nurturing became a game of sheer numbers (Govt. of India, 1978,[10] 1982:[11] Wadia, 1984[12]) with too much focus on numbers rather than focusing on deep-rooted gender inequality.

[10] Government of India, 1978, Central Calling, March 1978, Department of Family Welfare.

[11] Government of India, 1982, Yearbook 1980-81, Ministry of Health and Family Welfare.

[12] Wadia, A. B., 1984, "The Family Planning Programme in India: The Non-governmental Sector", The Journal of Family Welfare, Vol. 30, No. 4.

The passive, clinic-based approach of the 1950s gave way to a more proactive, extension approach in the early 1960s. A number of clinics were opened during the first two plan periods (1951–56 & 1956–61) to provide contraceptive services, especially for women at clinics through socially trained female workers. Moreover, during the third plan (1961–66), the "clinic approach" was shifted to an "extension approach" to provide information to all eligible couples about every contraceptive method offered by the programme. The late 1960s saw the emergence of a "time-bound", "target-oriented" approach with a massive effort to promote the use of IUDs and condoms followed by a more forceful "camp approach" to promote male sterilisation in the 1970s. However, from the early 1960s until the 1990s, the family planning management programme of the state was hindered by government determined targets for contraceptive acceptance. Such an approach to achieve the targeted demographic goals received several criticisms. Some of the reasons for the criticism were lack of holistic approach; totally government based programme with little involvement of local people; targeting only women for contraception; poor counselling; excessive focus on target achievement as an end in itself rather than as a guide; poor follow up services; and lack of need based programmes.

Following the International Conference on Population and Development (ICPD) held at Cairo in 1994, a major review was undertaken with the support of the World Bank and other agencies in 1994–95. As an outcome, method-specific contraceptive targets were abolished and the emphasis shifted to decentralised planning at the district level based on community need assessment, and implementation of programmes aimed at fulfilling unmet needs. This approach eliminated nationwide mandated targets for contraceptive acceptance, but continues to allow for locally determined targets at the community level, where grassroots workers were assigned targets for their service areas after assessing the clients' needs (Ashord, 2001).[13]

> For promoting sustainable development with more equitable distribution Stabilising population is an essential requirement. However, it is as much a function of making reproductive health care accessible and affordable for all, as of increasing the provision and outreach of primary and secondary education, extending basic amenities including sanitation, safe drinking water and housing, besides empowering women and enhancing their employment opportunities and providing transport and communications (NPP, 2000)

Since the International Conference on Population Development (ICPD), the central and state governments have initiated many programmes to slow the population growth. National Population Policy (NPP), 2000 is one such initiative in this direction. NPP articulated the new broad-based approach towards population stabilisation, and set long-term policy goals. The two important demographic goals of the (NPP, 2000 are achieving the replacement fertility level (TFR 2.1) by 2010 and a stable population

[13] Ashford, L. S., 2001, "New Population Policies: Advancing Women's Health and Rights". *Population Bulletin*, PRB, Vol. 56, No. l.

by 2045. The states were also directed to prepare state-specific population policies. Despite these initiatives, Bihar state does not have a state-specific population policy and most of the programme and policies are still guided by the Central government and National Population and Health Policy (NPHP).

The National Commission on Population (NCP)[14] (constituted in May 2000 under the Chairperson, the Prime Minister of India) is another attempt by the government to provide overall guidance for population stabilisation by promoting synergy between demographic, educational, environmental and developmental programmes. Recently, Government of India has constituted five Expert Groups for studying the population profile of the states of Bihar, Uttar Pradesh, Rajasthan, Madhya Pradesh, and Orissa to identify weaknesses in the health delivery systems and to suggest measures to improve the health and demographic status of these States.[15] Another important initiative for population stabilisation is the constitution of the Janasankhya Sthirata Kosh (JSK) (Population Stabilisation Fund – a public-private-partnership model) to provide proper guidance and information about the reproductive health care including of adolescents, with a corpus fund of Rupees 1 billion.

In April 2005, the government of India launched the National Rural Health Mission (NRHM) Programme bringing all programmes including Reproductive and Child Health (RCH) and population stabilisation under one umbrella. The NRHM seeks to provide universal access to equitable, affordable and quality health care, which is accountable at the same time responsive to the needs of the people. Although things are improving under the NRHM Program, it will take time to show its results considering the poor infrastructure and human power shortage in the State. There is an increase in outpatients and institutional deliveries nd several public-private-partnership (PPP) interventions have been implemented to increase the family planning services and contraceptive use. Although the Janani Suraksha Yojana (JSY) assistance is received by lower percentage of women (only 73.6% villages have any beneficiary of JSY), District Level Household Survey-2 (DLHS) and DLHS-3 show that there is 8.9 percent increase in institutional deliveries in the State. The NRHM Bihar State report shows increase in institutional delivery[16] in the State with total 1.05 million JSY beneficiaries (institutional delivery increased to 28% from 19%).

Health Services

Although the health infrastructure in the state is improving, it needs further improvement considering the wide variations in coverage at the district level. There are 10,793 health centres in Bihar, of which 533 are rural Primary Health Centres (PHCs), 69 urban PHCs, 8858 sub-centres, 1243 additional PHCs, and 70 Community Health Centres (CHCs) or

[14] The National Commission on Population has been re-located from Planning Commission to the Ministry of Health and Family Welfare for ensuring comprehensive and multi-sectoral coordination of Planning and implementation between health and family welfare on the one hand and the schemes of the related Departments on the other.

[15] India. 2009. Publication Division. Ministry of Information and Broadcasting, Government of India.

[16] Nevertheless, only 11% beneficiaries stayed for at least 2 days in health facility after delivery.

referral hospitals (Annex 1). In total, 105 PHCs have been strengthened with three staff nurses to make them functional for 24x7 work, and 70 CHCs are functioning on 24x7. A total of 76 facilities has been made operational as first referral units (FRUs) at district and sub-district levels. No districts have a functional Mobile Medical Unit (MMU).

One of the major reasons for inadequate family planning service is the weak health infrastructure (Table 3.11). The shortfall in facilities compared to those required according to population norms was 41 per cent for sub-centres, 32 per cent for primary health centres and 79 per cent for community health centres.

Table 3.11: Health Infrastructure of Bihar

Health Institution	Required	In Position	Shortfall
Sub-centre	14959	8858	6101 (41%)
Primary Health Centre	2489	1641	848
	2489*	533*	1956 (79%)*
Community Health Centre	622	70	552 (89%)
Multipurpose Worker (Female)/ANM	10499	9127	1372
Health Worker (Male)/MPW(M)	8858	1074	7784
Health Assistants (Female)/LHV	1641	479	1162
Health Assistants (Male)	1641	634	1007
Doctor at PHCs	1641	1565	76
Surgeons	70	28	42
Obstetricians & Gynaecologists	70	21	49
Physicians	70	38	32
Pediatricians	70	17	53
Total specialists at CHCs	280	104	176
Radiographers	70	15	55
Pharmacist	1711	439	1272
Laboratory Technicians	1711	135	1576
Nurse Midwife	2131	1425	706

*Source: RHS Bulletin, March 2008, M/O Health & F.W., GOI, *NRHM*

Trained health human resource is another important concern for the State. At present, for every 100,000 population there are on an average 5 doctors in position in the state. However, there are district-wise differences in availability of doctors. While 49 doctors are available per 100,000 population in Khagaria and 38 in Gopalganj, there is only one doctor available per 100,000 population in Arwal district. Except Khagaria and Gopalganj, no district has more than 18 doctors per 100,000 population. The situation is even more acute for staff nurses. There are only two Grade A staff nurses in position for every 100,000 population. The same pattern repeats in the availability of Auxiliary-Nurse Midwives (ANMs) in sub-centres. The appointment of community-based volunteer workers has been much closer to target but their training, efficiency and involvement is a matter of concern.

Family Planning Performance

Because of these initiatives and the state government's increased interest, number of family planning sterilisations has increased considerably during the period 2007–08 to 2009–10. Nevertheless, despite the improvements in certain indicators, policies, programmes, investments by the government, and donor agencies, the population stabilisation initiatives in Bihar state is a serious demographic challenge and a cause of concern for the social and economic well-being of the state. One of the several root causes of the delay in population stabilisation and fertility reduction in the state has been the changing NPPs towards FP programmes. On several occasions, goals were established but not met, resulting in subsequent revisions.

Recently the Government of Bihar identified the following steps to improve performance of the family planning programme:[17]

- Need for more skilled human power.
- Infrastructure needs strengthening: moreso in rural areas.
- Improvement in counselling and expanding informed choice of methods.
- Regular contraceptive supply.
- Improve quality of services.
- Reduce seasonality in work as operations are mostly conducted in specific months/seasons.

Several actions have been taken including preparation of district FP action plans, training of service providers for IUD insertion and Non-Scalpel Vasectomies (NSVs), population education in school textbooks and steps to strengthen Information, Education and Communication (IEC) for FP. The state has also formed the population council at state level and coordination committees at various levels. To activate the service delivery system, there are performance-based awards for district magistrates and civil surgeons, block levels and village level health volunteers (ASHAs) which are top performers. There are proposals to increase incentives to ANMs for IUD services as well as improve community-based distribution. The plans are for public-private-partnership for FP service delivery.

In partnership with UNFPA, programmes for adolescent sexual and reproductive health services in school as well as out-of-school settings are being implemented. The David and Lucile Packard Foundation has supported an NGO, Janani, to promote private sector service delivery through social franchising as well as expanding clinical network for FP services.

There are incentives to eligible poor couples from backward districts who fulfill the Responsible Parenthood Practices: to promote delayed marriage, spacing of children

[17] C. K., .Misra (2010). Family Planning Strategies for Population Stabilization and Sustainable Development: Bihar 2010. Presented at the National Consultation on "Repositioning Family Planning". New Delhi 5th May 2010. www.mohfw.nic.in accessed on August 20, 2010.

and celebration of the birth of a girl child. There are also several government schemes to empower women, including reservation for women at the local government level. Population Stabilisation Fund of India held motivational meetings for the field level staff to promote IUD and sterilisations in low performing districts. More than 95 per cent of staff have attended these meetings. Therefore, IUD users increased from 40,000 IUDs annually to 214,000 IUDs in the year 2009–10. However, this detracts from informed choices of contraceptive methods.

The David and Lucile Packard Foundation has implemented the leadership development programme in Bihar and a large number of government and NGO leaders have been developed (http://iieldm.org/where-we-work/india/index.shtml). This can serve as an important resource for the state. The recent initiative by the Bill and Melinda Gates Foundation to improve family health in collaboration with CARE is another opportunity. Presently, the programme focuses on the eight selected districts (Patna, Begusarai, East Champaran, West Champaran, Samastipur, Khagaria, Gopalganj, and Saharasa) and is likely to be extended to all districts.

Despite these initiatives by different agencies and donors, much remains to be done. Financially, the state was able to spend only about 50 per cent of its NRHM allocations in 2009 –10. However, this has improved compared to 2006–07 when only 27 per cent was spent (Table 3.12).

Table 3.12: Financial Progress – Expenditure pattern

Financial Year	GoI Approved Envelop (in millions)	Expenditure (in millions)	Expenditure as % of approved budget
2006–07	3464	921	26.55%
2007–08	7970	2377	29.83%
2008–09	7666	3397	44.31%
2009–10	10406	5625	54.05%

STRATEGIES TO ACHIEVE POPULATION STABILISATION

High fertility in Bihar is the result of low socio-economic development as well as the poor performance of the government-sponsored family planning programme. Low levels of education, low age at marriage, poverty, gender disparity, and modest declines in infant and child mortality have all contributed to maintaining high fertility. These factors, along with poor health infrastructure and the non-focused family planning programme are likely to lead to a persistently high fertility regime. Even at the national level, the views regarding the ideal number of children are fast approaching the two-child norm. However, preference for sons is clearly evident in the State. Given this context, the chapter reviews the strategies that can be adopted to achieve the population stabilisation within a reasonable time period.

More recent data supports the main arguments made in this chapter. A recent survey in Bihar by the Population Council[18] found that among currently non-pregnant women aged 15 to 34, who had given birth in the three years preceding the survey, only 31 per cent were using a contraceptive method. This is much below the national average of 43 per cent. There was a skewed choice of methods with use of modern spacing method at 6 per cent (condom use 2.9%, oral contraceptive pills 2.4%, IUD and injectables together about 0.7%) followed by safe period and withdrawal at 3 per cent each. The most used method was female sterilisation (18%). Post-partum contraception remained low. Contraceptive use among women who had given birth within one year preceding the survey was 20 per cent, with skewed method-mix as half had adopted sterilisation. The survey found that there is considerable unmet need for family planning. Among these women, nearly half reported that they did not want any more children and more than half of them (55%) were not resorting to any contraceptive method.

Both demand and supply side factors worked as barriers. In general, delaying first pregnancy did not appear as a very accepted norm in the community; although this social context may be changing. There is a norm of a large family size; median desired family size being with 3 children. The desired family size is also affected by strong son preference. Although birth spacing was generally preferred, most were not aware of the dangers of closely spaced pregnancies (pregnancy within 15 months of delivery). Nearly one-third of women reported that with their husband living elsewhere there were increasing chances of unplanned pregnancy for non-contraceptive users.

On the supply side, poor access to methods, cost of contraception, limited advice on family planning and fear of side effects of contraception acted as barriers. Private sector appeared to be a more popular source for condoms or pills. However, cost is one major factor hindering many adults to buy and use them. Only a half of the community level volunteers – ASHAs and AWWs – had ever been supplied condoms; while only one-third had been supplied oral contraceptive pills.

Thus, factors affecting demand and supply barriers need to be addressed including exposure to mass media, advice received from community health worker, spousal communication, improved quality of care and access to and availability of contraceptives. These cannot be addressed by campaigns alone. A comprehensive programme is essential to bring about sustained reduction in the unmet need for contraception as well as changed social norms about gender and fertility, eventually leading to population stabilisation.

Although the government has recently taken several steps to strengthen the family planning programme, our discussions with key stakeholders project that the poor performance of Bihar state in population stabilisation initiatives is primarily due to of lack of political

[18] Population Council (2012). Shaping Demand and Practices to Improve Family Health Outcomes in Bihar: Final Survey Report. Edited by M.E. Khan, France Donnay, Usha Kiran Tarigopula and Kumudha Aruldas

commitment and shared vision, and weak leadership of programme. In the past and in the present, the state, its leadership including NGOs and civil society, have not ascribed the importance to population stabilisation. Most of the initiatives taken in this direction in the state are because of the private donors and central government initiatives and largely because of pressure to spend the budget allocated by the central government, which is very much evident from the performance of Reproductive and Child Health (RCH) I and II programmes in the state. It is also evident that just increasing the budgetary provision and investment will not yield the desired results unless it is accompanied by strategic reforms and programmes to involve local communities in population stabilisation. Based on discussions with various stakeholders such as government, NGOs, donors, and through a review of available literature and reports, this paper recommends the following which may help in improving the family planning programme and population stabilisation initiatives in the state of Bihar.

Launch a Comprehensive Family Planning Programme

Typically the measures to achieve replacement fertility are of three types:

- Meet the unmet need which is quite high in Bihar.
- Reduce desired family size by influencing correlates of fertility.
- Reduce population momentum by family planning for youth.

Clearly gender affects all the three and measures to improve women's status cannot be over emphasised. As wanted, the fertility rate is only 2.4 compared to the current TFR of 3.7, the immediate focus has to be on addressing unmet need and family planning services for youth. Continued improvements in female education and empowerment as well as decline in infant mortality will lead to further reduction in wanted fertility rate. Therefore, there is a need to urgently launch a comprehensive family planning programme addressing factors at government/private service delivery, individual/ household and community levels for both supply and demand.

Government/private service delivery

Informed choice and improve quality of care

There is an urgent need to improve quality of care and offer informed choice. For instance, only 11 per cent women were told about side effects of their method in Bihar compared to 32 per cent in India, which itself is low (NFHS-3). Only 9 per cent were advised on what to do in case side effects occur and 27 per cent women were told about other methods. Consequently, only half the acceptors of modern methods of contraception opted to use the public sector for services. Focus on counselling and quality of care in the programme needs emphasis in terms of training, supervision, monitoring and reward systems.

Expanding the basket of contraceptive choices

Female sterilisation has been the mainstay of the Indian FP programme. The users of reversible methods form less than 15 per cent of the users of all methods. A high level of

infant and child mortality, and strong preference for sons, deter women from accepting a terminal method of contraception early. The data from the NFHS show that about half of the unmet need for contraception is for spacing. There is an urgent need to expand the basket of reversible methods of contraception offered under the programme. Research indicates that addition of a method to the basket of choices has an independent effect on the overall use.[19] Injectables which are not currently offered under the programme should be introduced as early as possible by taking necessary safe guards. Female condoms would also be a welcome addition to the programme.

Increasing male involvement

Male contraceptive methods account for only 6 per cent of the current contraceptive use. Vasectomy, a very popular method, went out of favour after the excesses committed in the 1970s. Vasectomy is safer and easier to perform in primary health centres than tubectomy. In recent years, the introduction of NSV has shown some signs of success in some states. Vigorous efforts should be made to promote this method, and train more doctors in performing this task. As males are the main decision makers in most households, IEC activities also need to focus on men for imparting knowledge on reproductive health of both men and women and about the advantages of a small family.

Social marketing

In spite of longstanding social marketing programmes by the government and various organisations such as Janani[20] in the State for the promotion of condoms, IUDs and oral pills, the use of these methods continue to remain low. The social marketing programme has suffered from:

- strong urban bias in the distribution network;
- low incentive to commercial participants;
- limited product range; and
- simultaneous presence of wasteful, free distribution system.

Surveys have disclosed large unmet need for contraceptives in the State. Apparently, the government delivery system is not reaching to the most in need. As per the NFHS data, less than 10 per cent of rural women report that they are visited by the ANMs during a year. This implies that ANMs are able to visit less than 100 households in a whole year. On the other hand, there is a large pool of formally or informally qualified Rural Health Practitioners (RHPs) who manage to meet the day-to-day health care needs of the rural population. It is proposed to use them in the delivery of non-clinical methods of contraception and referring the clinical cases to the PHCs or FRUs, for a nominal fee. The successful experimentation of this approach in Bihar by Janani gives hope for future replication and scaling up.

[19] Population Stabilization for the Eleventh Five Year Plan (2007-2012). Planning Commission, Government of India.

[20] www.janani.org accessed on August 20, 2010.

Involvement of private sector

There is an urgent need to increase the involvement of private sector in the delivery of family planning services, especially in areas where the public sector is weak with assurance of quality of care. It is estimated that private practitioners provide more than two-thirds of all healthcare in India. In rural areas, they are more respected and accessible than government grassroots heath workers. As experience of Janani in Bihar has shown rural registered medical practitioners could be recruited for social marketing of non-clinical methods and for referring clinical methods to public/private health institutions.

Strengthening family welfare infrastructure

The sub-centre, operated by an ANM, is the most peripheral health institution available to the rural population. The primary health centre (PHC) is a first referral unit for sub-centres to provide outpatient services. However, in many remote areas of the state, there are no functional PHCs. Community Health Centres (CHC) are planned as First Referral Units (FRUs) for four PHCs for offering specialised care. Moreover, majority of CHCs do not function as FRUs, as they either do not have the required number of specialists or adequate and appropriate facilities. The facility survey undertaken as a part of the RCH project has brought out the serious shortfalls in physical infrastructure, staff and supplies at the pubic heath institutions.

Individual/household level

Diffusion through satisfied users

Strong spatial patterns in fertility decline, and systematic changes in fertility differentials by socio-economic status, support the innovation-diffusion hypothesis. The satisfied adopters of the method play a key role in this ideational change. By recruiting such couples for working in liaison with grassroots health workers, it may be possible to increase the rate of diffusion. Research has shown that contraceptive use increases in closely-knit communities through diffusion of information and the idea of a small family norm.[21] Thereby satisfied users can serve as active agents in this process. Janani[22] also uses "Women Health Partners" for IEC. As the family planning programme has been there for half a century, there are already some users of contraception in every community. The scheme intends to use to identify 'satisfied' acceptor couple (SAC) of each method from different castes and communities among whom the acceptance of the method is low. The SAC are requested to spread the information about the methods, and motivate others as Peer Workers in their community. They should work in coordination with health workers at grassroots such ASHA, ANM and Village Child Development Center (Anganwadi) worker. For their services, a fixed honorarium could be provided. The performance of these SACs should be reviewed each year by the ANM to decide whether they could be retained for this work in the following year.

[21] ibid.

[22] Janani is a non-profit Indian NGO that implements a large service delivery programme in three of the poorest states of India, including Bihar. It has active social franchising, social marketing and a network of clinics providing family planning services.

The role of mass media

The role of mass media has become increasingly useful to promote the small family norm and provide information on family planning. The rapidly increasing exposure to electronic media has made this an important channel of behavioural change communication. The analysis of NFHS data has shown that the exposure to mass media, and family planning messages through these sources have strong independent effects on the current use of contraception, and future intention to use among non-users. Nevertheless, surveys show that in Bihar, regular exposure to mass media has not yet reached desirable levels to have a wider impact. It is therefore required to raise exposure to mass media in the state by using different media and mechanisms such as radio programmes, providing DVD/CD players and introducing television sets in PHCs and FRUs.

Community level

Involvement of local self-government institutions

The 73rd and 74th Constitutional Amendments made health and family welfare a responsibility of local bodies. Being closer to the people, a decentralised institution is expected to meet their needs and preferences. The whole idea of decentralised governance is based on some key factors like people's participation, accountability, transparency and fiscal transfers. Experiences from across the country indicate that community participation in decision-making and programme implementation is a precondition for enhancing the effectiveness in delivery of public health services. This can be facilitated through the intervention of the Local Government Institutions (Panchayati Raj Institutions [PRIs]) by making health services responsive to local needs, more accountable to the local population, focusing on local problems, prioritising the requirements, generating public demand for the services, and efficient use of available resources. The NPP-2000 reiterates the crucial role of panchayats in planning and implementation of health and family welfare programmes. Decentralisation is expected to bridge the existing gap between the service providers and the clients to a great extent. However, for the PRIs to be effective in health service delivery, more responsibilities need to be given in the sector-specific budget allocations, revenue-raising powers, and training. Since one-third of elected members at the local bodies are women, it is an opportunity to promote a gender sensitive, multi-sectoral agenda for population stabilisation with the help of village level health committees. Nevertheless, in Bihar only 1.7 per cent Villages had Village Health and Sanitation Committees by 2007–08 (DLHS-3).

Meeting the Family Planning Needs of the Youth

About one-third of the total population is in the age group of 10–24 years and it they who contribute significantly to the population momentum. Meeting family planning needs of the youth is another important area which requires to be addressed adequately. Although many policies and programmes (RCH II) over the last decade have articulated commitment to promoting the sexual and reproductive health and rights of adolescents and youth, insights from the Youth in India: Situation and Needs 2006–2007 study by

Population Council and IIPS[23] shows that the state has not addressed their specific needs for family planning information and services.

Three major initiatives are needed:

- There is need to have comprehensive programmes for family life education.
- Awareness of even basic pregnancy related issues remain limited. 47 per cent of young women said they did not receive information about pregnancy from any source.
- In-depth contraceptive awareness is limited even though there is a general awareness on contraception. While the married are better informed than the unmarried, no more than 40 per cent were aware that a woman can get pregnant after having sex the first time. Only 26 per cent young men and 48 per cent young women know how frequently oral pills are taken. 30 per cent of young women and 62 per cent of young men are aware that the male condom should not be used more than once.

Sources for information are limited. Communication with father and/or mother on growing up issues and reproductive processes was rare for young men. A large proportion of young women communicated with their mother about growing up issues, such as, menstruation. However, few young women discussed reproductive processes with their mother. There is also limited access to information from teachers on family life or sex education. Only 7 per cent of young men and 3 per cent young women had received sex education in or outside the school setting. Peers and media are the leading sources of information for young people. 62 per cent young men and 30 per cent young women cited a friend or neighbour as the leading source of information about sexual matters, 41 per cent young men and 6 per cent young women cited the media as a source of information. However, evidence is clear that neither the friends nor the media are necessarily reliable sources of information.

There are several advantages of family life education. Youth who have had sex education are more likely than others to:

- Be correctly aware that a woman can become pregnant at first sex.
- Have in-depth awareness of contraceptive methods.
- Have practised contraception consistently (in pre-marital relations).
- Become more gender-sensitive.

According to the study recommendations, in-school and out-of-school youth should be provided:

1. Life skills education comprising:

   - Information on biological growth and changes in the body targeting both young men and women before they reach puberty, description of what is potentially risky

[23] A major portion of this section is derived from "Meeting the family planning needs of youth: Insights from the Youth in India: Situation and Needs 2006–2007 study". Shireen Jejeebhoy, K.G. Santhya, Rajib Acharya . Population Council, New Delhi

and protective actions in sexual encounters, and where information, counseling and services can be accessed.

- Enable youth to acquire the communication and negotiation skills that facilitate the adoption of safe practices.

Through all this, there is also an urgent need to develop the capacity of trainers.

2. Comprehensive, youth friendly family planning services. The ARSH Strategy's Implementation Guide for State and District Programme Managers notes that "friendly services are to be made available for all adolescents, married and unmarried, girls and boys" (MOHFW, 2006). Less than 4 per cent obtained information on contraception from a health care provider (IIPS and Population Council, 2008). Female sterilisation is the leading method used, even among young women: nearly half of all women practising modern methods of contraception were sterilised.

   Non-terminal methods which are considered to be far more appropriate for the young are practised by just half: 37 per cent used condoms, 12 per cent used OCs and 1 per cent IUDs. Large proportions of young men and women reported that they would hesitate to procure contraceptives from healthcare providers or pharmacies. Even among the married, one-fourth of young men and half of young women reported shyness to approach healthcare providers (HCPs) or a medical shop.

   Of the sexually experienced who practised contraception, involvement of the female partner in decision making regarding contraceptive use is limited in a large proportion of sexually experienced unmarried youth. The unmet need in the state is high and a large proportion of married youth (24% married men 15–29 years, and 33% married women 15–24 years) reports that their last pregnancy was mistimed, unintended or unwanted.

   Therefore, counselling and sexual and reproductive health (SRH) services to married and unmarried young people in a non-threatening, non-judgmental and confidential environment need to be made available. As health care providers often have biases about providing such services to young people, they need to be oriented to:

   - Overcome biases about SRH service provision to the unmarried.
   - About the special needs, heterogeneity and vulnerability of unmarried and married young people.
   - Develop appropriate strategies to reach diverse groups of youth.
   - Reposition the condom as a suitable method for youth.

3. Age of marriage and services to newly married couples require serious attention. The study findings show that child marriage continues among young women (one in 5 married before 15 and half married before age 18), minorities of young men transitioned

to marriage in adolescence; and nearly one-quarter before the legal minimum age of marriage. Seventy-seven per cent of women in the age group 21–24 married before 18 years of age and 43 per cent of the men in the age group 21–24 married before 21 years of age in Bihar. Pressure to prove fertility immediately after marriage is enormous and more common in Bihar where 68 per cent women report first pregnancy before 18 years of age (Youth in India: situations and Needs Study). Half of young women and one-third of wives of young men initiated childbearing before the age of 18 years (44% of men and 68% of women in Bihar 15–24 years of age). Childbearing is too closely spaced – despite their young age, 11 per cent of women aged 15–24 years already had 3 children.

Among the unmarried, few sexually active youth practice contraception. Although almost all sexually experienced unmarried youth wish to avoid pregnancy, few have practised contraception. Just 28 per cent of young men and 12 per cent of young women had practised any form of contraception at first sex, and 21 per cent and 9 per cent had done so consistently in all sexual encounters. Just 13 per cent sexually experienced young men and hardly any young women had used condoms consistently.

Since 2001, the Pathfinder's Promoting Change in Reproductive Behavior (PRACHAR) Project has been transforming attitudes and behaviours to accelerate the use of and demand for contraception to delay and space pregnancies among youth and newlywed couples in Bihar.[24] Working with NGO partners across five districts, Pathfinder disseminated powerful lifecycle-specific family planning and reproductive health behaviour change communication messages in 700 villages. By working with local NGOs as implementing partners, it has succeeded in changing beliefs, attitudes, and practices in areas where women and girls have traditionally been married young, faced extreme social and economic inequality, and been pressed by parents, in-laws, and the wider community to prove their fertility by bearing children immediately. Pathfinder's approach has contributed to a four-fold increase in contraceptive use among young married couples in project areas, a 1.5-year increase in the age of marriage, and a two-year increase in the age of mothers at first birth in intervention areas. Now in the third phase of the project, Pathfinder is working with the Government of Bihar and civil society to integrate the PRACHAR model into the state's healthcare system.

It is therefore extremely necessary to impart early knowledge on the responsibilities of parenthood to newlyweds, information about contraception, and maternal and child health care. ASHAs under the NRHM could be visualised as an opportunity in this initiative for communication strategies with specific focus on providing information on the virtues of small family size, interval between births, methods of contraception and abortion. Campaigns around increasing female age at marriage could be undertaken in the state.

[24] www.pathfinder.org accessed on August 20,2010

4. There is a need to invest more in youth. The demographic dividend will only be realised if young people have education and livelihood. Therefore, state needs to implement right to education through achieving universal school enrolment and promote youth employment.

DATA AND RESEARCH NEEDS

The absence of a health research institute in the state is a major hindrance. The state has the State Institute of Health and Family Welfare (SIHFW) and Population Research Centre (PRC), but its needs to be capacitated for research and innovation. Most of the research studies on family planning and population stabilisation are being undertaken by various NGOs and private agencies. For demographic information, the state is dependent on the Census, Sample Registration System, National Family Health Surveys (NFHS), and the District level Household Surveys (DLHS-RCH) conducted by the International Institute of Population Sciences. The survey provides information on issues related to antenatal care, immunisation, safe delivery, contraceptive prevalence, unmet need for family planning, awareness about Reproductive Tract Infections (RTIs) and Sexually Transmitted Infections (STIs), and utilisation of government health services and user's satisfaction. The state needs more focused research to address the population stabilisation issue and dimensions of demographic, epidemiological, and health transitions in the state. These findings could highlight the reasons behind fertility change, mortality, and the changing attitudes towards contraception. The state should promote research with focus on the relationship between acceptance of family planning and socio-economic conditions of population; documentation and analyses of successful family planning interventions for their success. The research studies should focus on demographic changes, migration, ageing, factors responsible for changing value of children, gender preferences, attitude towards small family norms, and imbalances in sex ratio. With the introduction of new contraceptive methods and RCH services, it is necessary to find out the acceptability of contraceptive methods for men and women belonging to various socio-economic strata. This will help in understanding the misconceptions as well as side effects of various birth control methods. Based on the findings of these studies, the programme can be fine-tuned to meet the requirements.[25] Demographic and behavioural surveys should also address issues related to reproductive rights, male involvement in family planning, adolescent reproductive health, and women's health status and autonomy.

IMPLEMENTATION RECOMMENDATIONS

In summary, implementation of the comprehensive programme would need the following policy, programme and organisational actions.

[25] Report of the working group on population stabilisation for the eleventh five-year plan (2007–2012). Planning Commission. Government of India. New Delhi

Policy measures

Political commitment

The state should be oriented and sensitised to identify population as an important issue towards overall growth and development of the state. It should work towards having its own population policy with focus on (a) compulsory population/family life education with special focus on girls' education; (b) unmet need for contraception, family planning, and abortion for population stabilisation; and (c) strengthening human resources, training, and infrastructure (restructuring of the Primary Health Centers and Sub-centres).

Vital registration

State should focus and develop a mechanism to ensure the coverage and quality of registration of births, deaths, marriages, and pregnancies. Child marriages law should be strictly implemented which prevents marriage of girls and boys below the legal age of 18 and 21 years.

Financial resources

Government must utilise resources allocated towards the NRHM and appropriate a higher proportion of these funds targeted at family planning programs and interventions as well as include family planning as key programs in its own budget to comply with its own commitment.

Programme actions

Informed choice

The focus should be on limiting family size, and meeting the unmet need for family planning services. The state should focus on increasing the scope of informed choice in context of family planning and abortion services. An outreach effort needs to be made to help young women and men to understand how the available spacing methods would help in meeting their desired fertility level. Specific efforts need to be made to involve the private sector for the promotion of spacing methods, in general, and condom use, in particular.

Flexible locally responsive programme

In the state there is inter-district variation in family planning performance. The state should have flexible approach and focus on poor performing districts based on the data available from the DLHS and facility surveys.

Maternal health programme

There should be focus on antenatal and institutional delivery care to reduce infant and maternal mortality to accelerate the process of fertility transition and population stabilization.

Organisational mechanisms

Community involvement

Local self government and institutions such as Panchayati Raj Institutions (PRI) and Gram Sabha should be involved and strengthened in realising the goal of population stabilisation.

Unless and until there is realization among people at grassroots and community level, it is not possible to achieve population stabilisation in the state. There is also a need to develop better co-ordination mechanism between local self-governments and health care institutions. Community leaders, Self-help groups (SHGs) members, ANMs, Anganwadi worker, and ASHA can play pivotal role in identifying and addressing the adolescents' and couples unmet need of contraception.

Research

State should strengthen its own institution for research, development and innovations for effective policy and programme action discussed earlier.

Role of private sector

NGOs and donors intervention should be in partnership and coordination with the government. Their role should be as strengthening partners rather than a duplicating role with appropriate regulatory framework.

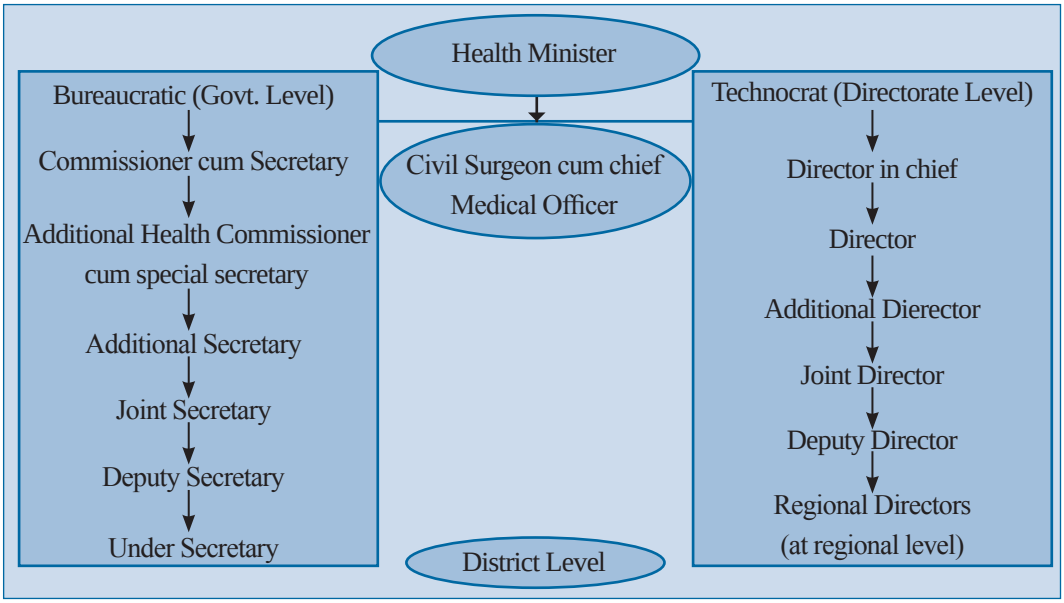
THE FUTURE

Earlier it was estimated that replacement fertility will be reached by 2021, barely 11 years away. This seems most unlikely, as fertility did not decline during the period 1997–98 and 2005–06. Some have estimated that replacement fertility will be reached 20–25 years hence. The most conservative estimate is that of Population Reference Bureau which presumes that fertility will follow the same path as that of Karnataka state and estimates that replacement fertility will be reached later than 2060 and Bihar's population will be about 10 per cent of India's population at that stage.

Recent trends are promising – both for the socio-economic and family planning programme. The socio-economic correlates of fertility are accelerating in their progress. The Right to Education Act has been passed. Its implementation will require enormous investments and 220,000 new teachers would have to be recruited. This will lead to much higher levels of education, particularly that of females. Although income levels are known not to be strongly correlated with fertility decline, recent estimate of the state domestic product suggests that it grew by about 11 per cent compound annual growth rate in the last 5 years compared to a negligible increase during the previous 5 years. While this may impact fertility only indirectly, it will provide more resources for overall socio-economic development. The Infant Mortality Rate (IMR) has been steadily declining. Health infrastructure should also improve under the NRHM.

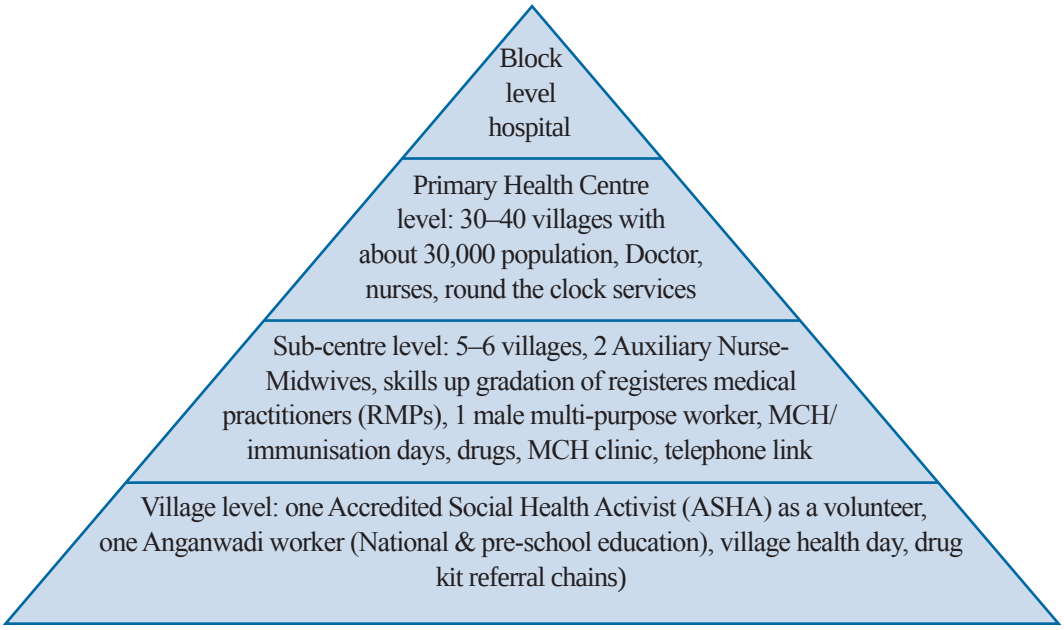
Annex 3.1. Health Administration in Bihar

The department of Health, Medical Education and Family Welfare functions through a two-tier system, first the governmental tier and the second the directorate tier. Both the tiers are primarily headed by the Health Minister, followed by the bureaucratic and technical tier:



Further, the hierarchy is diluted in the field i. e. regional level and primary health centre (PHC) level, to facilitate the health care at door step the primary health centre is further divided in to many Additional PHC's and sub-centres depending upon the workload and density of population. Under the primary health care delivery system multipurpose scheme is followed in the Bihar and the health workers, whether male or female are assigned an area of fixed population i.e. sub-centre, where he/she is supposed to look after overall health facilities. In case of need, he/she is supposed to refer the matter further ahead to APHC/PHC. At the PHC level, Medical Officer in charge is solely responsible for the health activities within the jurisdiction that in turn assisted by 3–4 medical officer, para-medical staffs and lower level functionaries.

The service delivery system as envisaged in NRHM is as follows:



AUTHORS' NOTES

We are thankful to Population Communication for taking the initiative to prepare a report on population stabilisation for future programmatic interventions and direction in Bihar, India. The report examines the programmes and policies that would accelerate progress towards population stabilisation in Bihar and proposes recommendations that will help in achieving the replacement level fertility. We would especially like to thank Bob Gillespie for his support, guidance and inputs.

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CHAPTER 4

NATIONAL POPULATION COUNCIL: GHANA POPULATION STABILISATION REPORT

By National Population Council

GENERAL INTRODUCTION

Ghana is situated on the West Coast of Africa off the Gulf of Guinea. It occupies a land area of 238,589 sq. km and is bordered on the west by Cote d'Ivoire, east by Togo and the north by Burkina Faso. The country consists of ten administrative regions, subdivided into 170 districts to ensure efficient and effective administration at the local levels. Ghana's economy is mainly agricultural with crops produced for both local consumption and exports. Minerals including gold, bauxite and manganese as well as timber also contribute to the country's earnings. In 2009, Ghana attained lower middle-income status and in 2010, became an oil producing country.

As in many developing countries, Ghana's population has increased rapidly over the years from 6.7 million in 1960 to 12.4 million in 1984 and then doubled to 24.6 million in 2010 with all regions of the country experiencing growth. With a current growth rate of 2.5 per cent, the population is expected to double in 28 years. The age and sex structure of the population reflects a youthful population with 38 per cent of the population under 15 years of age for both sexes. With such a youthful population, there is an in-built momentum for further growth. Ghana is experiencing a demographic transition with both fertility and mortality levels declining. The population is also rapidly urbanising with 50 per cent of the population currently living in urban areas.

Since Ghana attained Independence, a number of policies and programmes have been put in place to accelerate the growth of the economy and to raise the living standards of the people with varying degrees of success. These include Ghana Vision 2020 (1996–2020); the First Medium-Term Plan (1997–2000); Ghana Poverty Reduction Strategy (2003–2005); Growth and Poverty Reduction Strategy (2006–2009) and the Ghana Shared Growth and Development Agenda (2010–2013).

These pragmatic policies and programmes have resulted in significant economic gains. According to the World Bank, in 2011, Ghana's economy grew at 14.4 per cent boosted by new oil production and a rebounded construction sector. In recent times, the country has also witnessed a reduction in its poverty indicators with the proportion of Ghana's population defined as poor falling from 51.7 per cent in 1991/92 to 39.5 per cent in 1998/99 and further to 28.5 per cent in 2005/06. Despite these strides, poverty still

remains an important challenge. This challenge means that Ghana must optimally harness the necessary resources, including reducing its rapid population growth in order to gain from investments made. The correlation between population growth and economic development has long been established. A number of studies have proven that high birth rates reduce economic growth while declines in birth rates have shown positive impacts on per capita income yielding positive dependency effects.

The determination of the Government of Ghana to effectively manage the population for development is reflected in its commitment to global and regional agreements and conventions on population and development. These include the International Conference on Population and Development (ICPD), the Millennium Development Goals (MDGs), Beijing Platform for Action, the World Summit on Sustainable Development and NEPAD. Furthermore Article 37, Clause 4 of the 1992 Constitution of Ghana enjoins the Government to maintain a population policy that is consistent with the aspirations and development needs of the country. Ghana first adopted a Population Policy in 1969 and was the third African country to do so. The Policy was later revised in 1994 to incorporate new and emerging issues such as HIV and AIDS, the environment and gender. The revised policy provides a framework to guide the development, implementation, monitoring and evaluation of several reproductive health and population related policies, plans and programmes in the country.

The chapter provides a situation analysis of the implementation of reproductive health and population and development policies and programmes in Ghana, achievements, challenges as well as recommendations to inform future interventions to effectively manage Ghana's population for development.

It is significant that this report is being prepared just after the 2010 Population and Housing Census in Ghana as well as the attainment of a global population of 7 billion in October 2011. These two events both point to the growing population at both the local and global levels and its implications for development at different levels, thus emphasising the centrality of population and its strong linkage with sustained socio-economic development.

This chapter is therefore a clarion call for accelerated action by all stakeholders to strengthen the development, implementation, monitoring and evaluation of reproductive health and population and development policies, plans and programmes. It is also expected to contribute to strengthen policy and programme interventions to improve the quality of life of the people of Ghana.

POPULATION SITUATION ANALYSIS

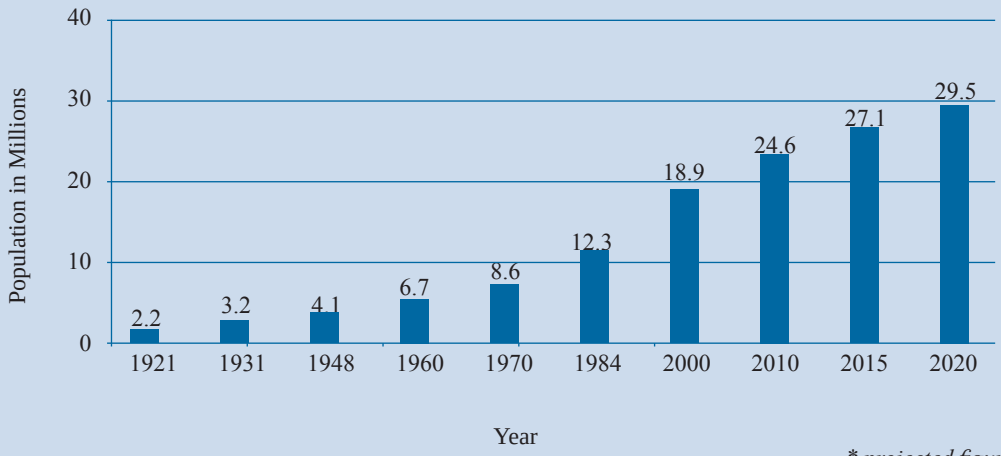
Ghana has one of the fastest growing populations in the world despite the desire of many Ghanaian women and men for better spaced and smaller families (GDHS, 2008). The rapid growth of the population has created a youthful age cohort whose numbers are

still expanding and which has an in-built momentum for rapid population growth. This has profound implications for development and the quality of life for the people of the country. As in countries all over the world, Ghana's demographic processes play a vital role in her development. Changes in population growth, age structure and composition have direct and indirect impact on national development and poverty reduction, as well as the general well-being of the population.

Population Growth

In 1921, Ghana's population of just over 2 million increased to 6.7 in 1960 and 8.6 million in 1970, thus more than tripling in nearly fifty years. Although data for the early part of the 20th century are not that reliable, they are indicative of a rapid increase in the country's population.

Graph: 4.1 **Trends in Population Growth (1921–2020)**



Source: 2000 Population and Housing Census, GSS

In 2010, Ghana recorded a population of 24.6 million people, of which 51.2 per cent were females. With a growth rate of 2.5 per cent, the population in Ghana is expected to double in 28 years. Graph 4.1 presents a picture of the changes in the population size since 1921. In view of the declining mortality and constant fertility levels until the 1980s, an average annual growth rate of 2.4 per cent was recorded for the decade of 1960–1970. Despite the recorded declines in fertility, the population growth rate has not shown much signs of change hovering between 2.4 and 2.7 per cent for the period 1984–2010. Due to the demographic momentum, these increases in population are expected to continue for at least the next decade.

The variation in the spatial distribution of the population by region clearly shows an increasing percentage share of Greater Accra region from 8.1 per cent in 1960 to 15.4 per cent in 2000 to 16.3 per cent in 2010. Over the years Ashanti region has also

shown tremendous increase in the relative share of population. In 1960, the population in Ashanti region was 16.4 per cent, this increased to 19.1 per cent in the year 2000 and then to 19.4 per cent in 2010. Upper East and Upper West regions have shown significant dwindling of the percentage share of the population. In 1960, 7.0 per cent and 4.3 per cent of the total population resided in the two regions respectively. This reduced further to 4.9 and 3.0 in 2000 and at 2010 their percentage share of the population had reduced to 4.2 and 2.8 per cent respectively (Table 4.1).

Table 4.1: Relative Share of Population in Ghana, by Region, 1960–2010 (%)

Region	1960	1970	1984	2000	2010
All Regions	100.0	100.0	100.0	100.0	100.0
Western	9.3	9.0	9.4	10.2	9.6
Central	11.2	10.4	9.3	8.4	8.9
Greater Accra	8.1	10.6	11.6	15.4	16.3
Volta	11.6	11.1	9.8	8.6	8.6
Eastern	15.5	14.1	13.7	11.1	10.7
Ashanti	16.4	17.3	17.0	19.1	19.4
Brong Ahafo	8.7	9.0	9.8	9.6	9.4
Northern	7.9	8.5	9.5	9.6	10.1
Upper East	7.0	6.3	6.3	4.9	4.2
Upper West	4.3	3.7	3.6	3.0	2.8
Total population	6,726,815	8,559,313	12,296,018	18,912,079	24,658,823

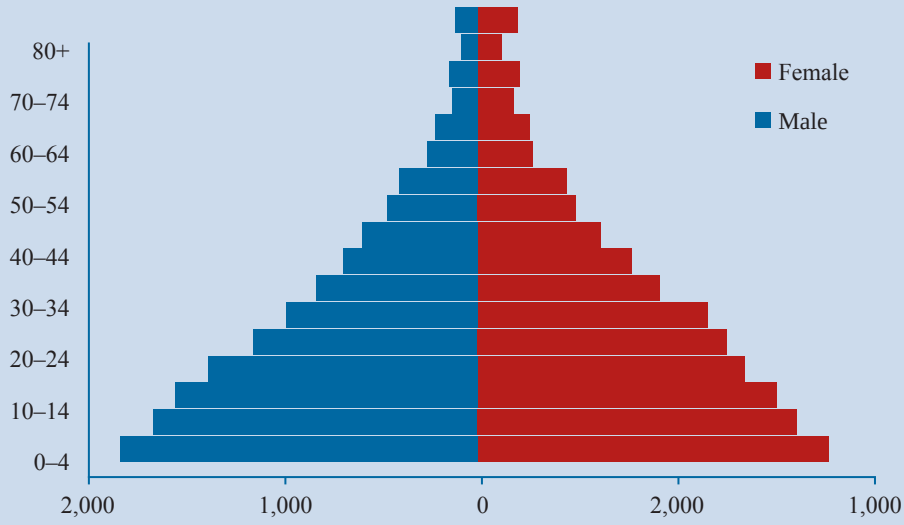
Source: NPC Population Distribution and Urbanisation Papers & Census Results, 2010

Population Age-Sex Structure

Since 1960, the population aged 10–24 years has increased steadily both in terms of proportion and in absolute numbers from 1,813,279 in 1960 to 3,806,500 in 1984 to 5,656,258 in 2000 and is estimated to reach 8,010,957 by 2015. This situation is the direct consequence of high fertility and declining mortality of past years. At a current total fertility rate (TFR) of 4.0, coupled with a low contraceptive usage of 16.6 per cent for modern methods and low educational attainment among women in particular, Ghana has the potential for further high population growth despite the decline in fertility.

The population pyramid of Ghana in Graph 4.2 has a broad base which clearly indicates the heavy concentration of Ghana's population in the younger ages (below 15 years). Those in the age range from 15–64 years carry the burden of working for themselves and the non-working age group. This often results in high dependency ratio and subsequently leads to low savings and poor living standards. Ghana recorded a high dependency ratio of 75.6 per cent in 2010.

Graph: 4.2 **Age-Sex Structure of Population (Population Pyramid)**



Source: Ghana Population and Housing Census, 2010

Table 2 shows that, the proportion of the population aged below 15 has decreased consistently from 46.9 per cent in 1970 to 38.3 per cent in 2010, and is expected to decrease further to 35 per cent by 2020. Correspondingly, the proportions aged 15–64 years and 65 years and above have increased from 49.4 per cent and 3.6 per cent respectively in 1970 to 56.9 per cent and 4.7 per cent in 2010. The gradual transformation of the youthful population age structure is attributed to falling fertility levels and improvement in life expectancy. This depicts a country that is moving from the first stage of the demographic transition where both birth and death rates are high to the second stage of low fertility and low mortality.

Table 4.2: Proportion of Population within the Various Age Groups 1960–2020

Age Group	1960	1970	1984	2000	2010	2015*	2020*
0–14	44.6	46.9	45.0	41.3	38.3	37.0	35.0
15–64	52.3	49.4	51.0	53.4	56.9	59.0	61.4
65+	3.2	3.6	4.0	5.3	4.7	4.0	3.6

**Projected figures*

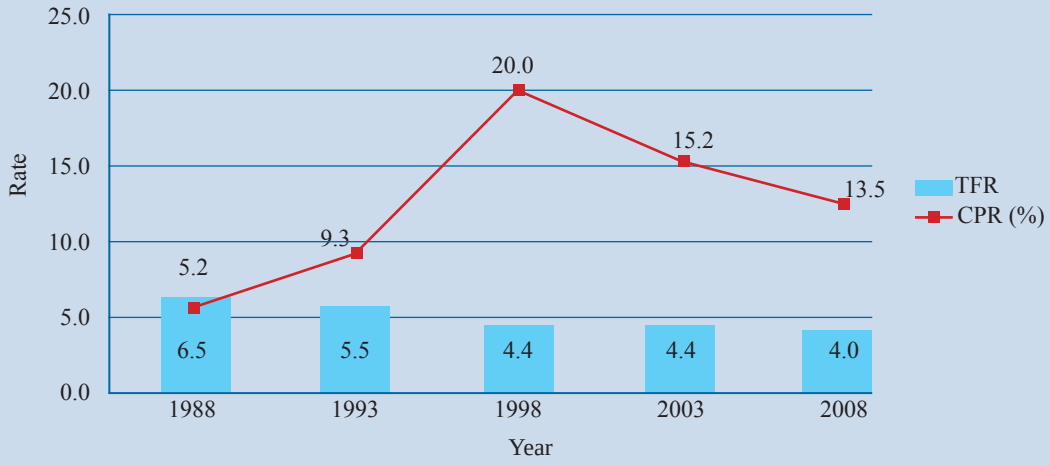
Source: Population Censuses 1960, 1970, 1984, 2000, 2010

This means there is roughly one dependent person (under 15 or over 64 years old) for every economically active adult compared to about 2 adults per dependent in more developed countries. The need to provide for economically dependent persons puts pressure on the resources of the government and individual households. The ability to care for the dependent population depends on the structure and stability of the economy and the income levels and organisational abilities of the population. It is important therefore that interventions are put in place to enable the country reap the full benefits of her demographic transition.

Fertility

Available evidence from the various Ghana Demographic and Health Surveys (GDHS) indicate clearly that the fertility behaviour of Ghana's population is changing. The average Ghanaian woman marries at the age of 19 years, has her first child a year later and has an average of 4 children in her lifetime. The Total Fertility Rate (TFR) in Ghana declined from 6.4 in 1988 to 4.0 in 2008 and is one of the lowest in Sub-Saharan Africa. However, there are variations in TFR depending on a number of factors including educational status and place of residence. In Ghana, urban fertility between 2003 and 2008 was 3.1 compared to 5.6 for the rural area in 2003 and 4.9 in 2008. Furthermore, fertility among women with higher education (secondary school and above) was 2.5 compared to an average of 6.0 children for those with no education in 2008. Despite the almost universal knowledge in family planning (98 per cent for women and 99 per cent for men), practice of contraception remains low. In 2008, the country's contraceptive prevalence rate was 13.5 per cent for modern methods for all women. The use of modern contraceptives among women almost quadrupled between 1988 (5.2 per cent) and 1998 (20 per cent) but then dropped to 15.3 per cent in 2003 and further to 13.5 per cent in 2008, while TFR continued to decrease. Overall, the use of contraception has remained steady over the past five years (Graph 4.3). Despite the declines in fertility recorded, various socio-cultural practices and beliefs tend to sustain the high levels of fertility. Further declines in TFR can be achieved if the right programmatic interventions are put in place.

Graph: 4.3 **Total Fertility Rate and Contraceptive Prevalence Rate (1988–2008)**



Source: GDHS 1988, 1993, 1998, 2003, 2008

Mortality

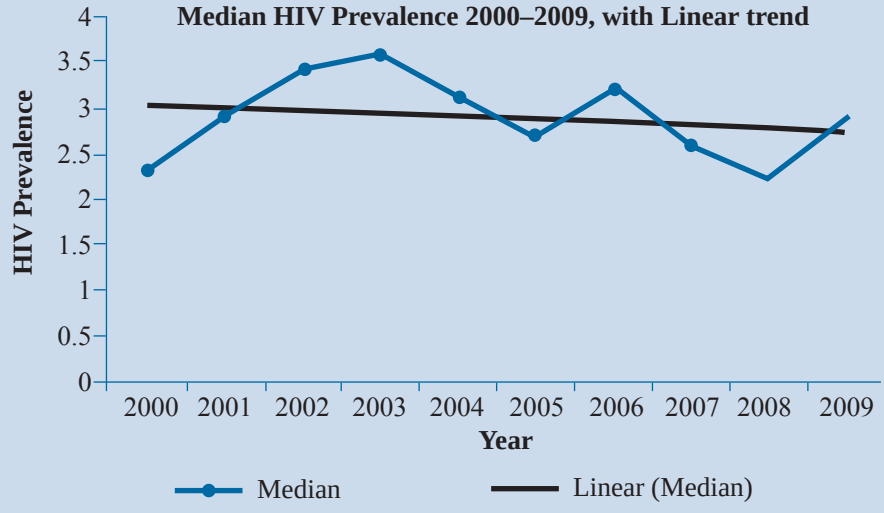
Death rates in Ghana have been declining steadily over the years as a result of a combination of factors, including improvements in health conditions, increasing education and modernisation. In 2007, Life expectancy was estimated at an average of

59 years (57 years for males and 60 for females). Life expectancy in Ghana has also improved from about 58 years in 2003 to 59 years in 2007 to 60.71 years for males and 61.81 for females in 2010 as people live longer. According to the World Factbook 2011, the life expectancy at birth for the total population stands at 61 years.

Maternal and childhood mortality rates in general are often used as broad indicators of social development and as specific indicators of a population's health status. In Ghana, maternal mortality has been high at a national average of 451 deaths per 100,000 live births (Ghana Maternal Health Survey, 2007), although a maternal mortality rate (MMR) of more than 700 has been recorded in studies carried out in some districts, particularly in Northern Ghana in the early 1980s. According to revised UN estimates in 2008, Ghana has a MMR of 350 deaths per 100,000 live births.

Even though maternal mortality has recorded gradual declines, the slow pace of decline is not adequate enough for Ghana to achieve the Millennium Development Goal (MDG) 5 target of reducing maternal mortality by 75 per cent by 2015. To achieve this, Ghana's maternal mortality has to reduce to 185 or less by 2015. Socio-economic and cultural factors are mainly responsible for the low utilisation of available maternal health services.

Graph: 4.4 **Trends in Maternal Mortality Ratio in Ghana (1990–2015)**

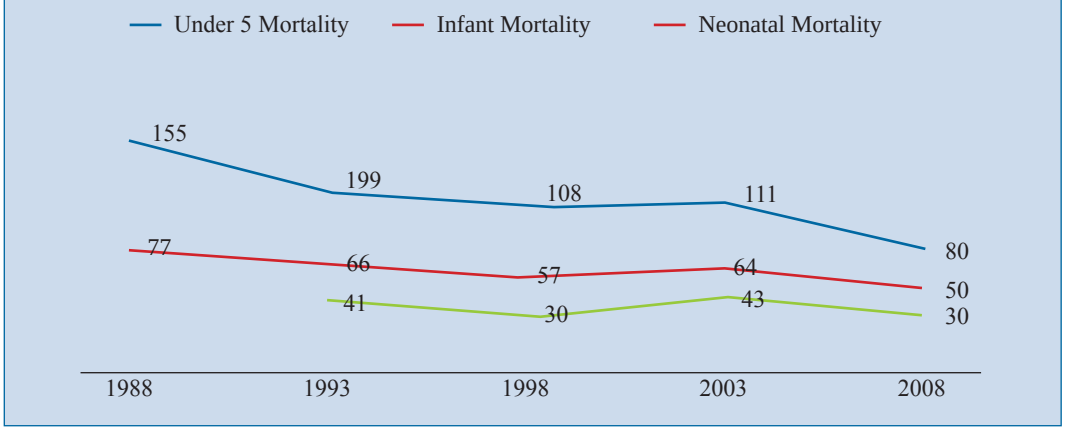


Source: GHS, 2010

Neonatal, infant and under-five mortality rates have dropped substantially since 2003. Infant mortality declined from 77 per 1000 live births in 1988 to 66 in 1993 and 57 in 1998 but rose to 64 in 2003. Currently, infant mortality rate (IMR) in Ghana is 50 per 1,000 live births. Under-five mortality has shown a similar trend, declining from 155 in 1988 to 119 in 1993, 108 in 1998 and then rising to 111 in 2003 with slightly higher rates for males than for females and further declining to 80 per 1,000 live births in 2008. This means that 1 in every 20 Ghanaian children die before reaching age one, and 1 in every 13 dies before her/his fifth birthday. Even though the country has experienced declines in

infant and child mortality as illustrated in Graph 4.4, the current record of infant and child mortality is still considered high and this decline has to accelerate if Ghana is to achieve MDG 4. Government therefore has to strengthen and scale up existing programmes and strategies to reduce mortalities drastically in order to meet this development agenda.

Graph: 4.5 **Trends in Neonatal, Infant and Under-5 Mortality Rates (1988–2008)**

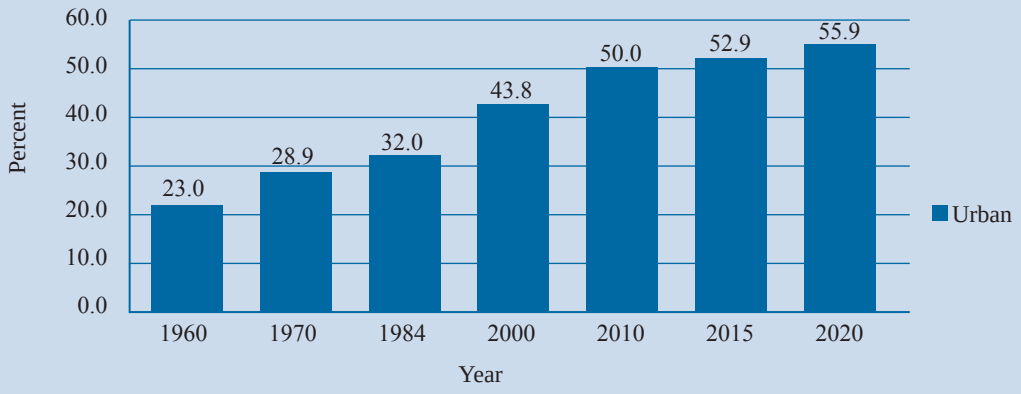


Source: GHS, 2010

Urbanisation

Urbanisation has been identified as an important indicator for socio-economic development. Studies have shown that across countries and over time, as the urban share of the total population rises, the overall (urban and rural) poverty rate tends to fall. This effect is transmitted largely through higher economic growth associated with more rapid urbanisation rather than through re-distribution. Over the past four decades Ghana has experienced rapid growth of the urban population. According to the Census reports, the proportion of the population that is urban increased from 23.0 per cent in 1960 to 43.8 per cent in 2000. It further increased to 50 per cent in 2010 (Graph 4.5). It is estimated that by 2020 the urban population would have increased to 55.9 per cent. At this prevailing rate of increase, urban areas in the country are expected to absorb more than half of the country's population growth over the coming years through natural increase while at the same time drawing in some of its rural population.

Graph: 4.6 **Trends in Urban Population (1960–2020)**



Source: 2000 PHC Report, 2010 PHC Results GSS

In the Greater Accra Region, the most urbanised region in Ghana, the proportion of urban population increased from about 73 per cent in 1960 to 85 per cent in 1970, then went up as high as almost 89.2 per cent in 2010. The Ashanti Region has long been the second most urbanised region in Ghana after Greater Accra (Table 3). In fact, in 2000, the Ashanti Region stood with Greater Accra Region as the only regions that had a relatively higher urban than rural population. In contrast, the Upper West Region stands out as the least urbanised region in Ghana, as per the 2010 Population and Housing Census.

Table 4.3: Trends in Urbanization, by region in Ghana, 1960–2010 (%).

Region	1960		1970		1984		2000		2010	
	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural
Western	24.7	75.3	26.9	73.1	22.6	77.4	36.3	63.7	41.7	58.3
Central	28.0	72.0	29.1	70.9	28.8	71.2	37.5	62.5	47.1	52.9
Greater Accra	72.6	27.4	85.3	14.7	83.0	17.0	87.7	12.3	89.2	10.8
Volta	13.1	89.9	16.0	84.0	20.5	79.5	27.0	73.0	33.7	66.3
Eastern	21.1	78.9	24.6	75.4	27.7	72.3	34.6	65.4	43.7	56.3
Ashanti	24.9	75.1	29.7	70.3	32.5	67.5	51.3	48.7	57.5	42.5
Brong Ahafo	15.6	84.4	22.1	77.9	26.6	73.4	37.4	62.6	55.5	44.5
Northern	13.0	87.0	20.4	79.6	25.2	74.8	26.6	73.4	29.8	70.2
Upper East	3.9	96.1	7.3	92.7	12.9	87.1	15.7	84.3	22.1	77.9
All regions	23.1	76.9	28.9	71.1	32.0	68.0	43.8	56.2	50.0	50.0

Source: NPC Population Distribution and Urbanisation Papers & Census Results, 2010

With half of the Ghanaian population now living in urban areas, the Government needs to put in place effective policies that harness the opportunities that urbanisation presents while dealing with the challenges.

Migration

Ghana's contemporary migration patterns are both complex and dynamic. Internal migration particularly from the north to the south has been practised in Ghana for several decades, with historical antecedents. Until recently this pattern of north-south migration was male-dominated, however in recent times this pattern has changed with more female adolescents, migrating to urban centres in the country. Population Censuses in Ghana since 1960 have shown that six regions namely Central, Eastern, Volta, Northern, Upper East and Upper West have largely been net-out migration regions with the three northern regions having the highest out migration rates. In recent years although emigration from Ghana has increased at a faster rate than migration, Ghana still remains an important destination for migrants and refugees from other parts of Africa. According to recent census-based estimates, the migrant population constitutes the other Economic Community of West African States (ECOWAS) countries. In 2007, Ghana hosted the largest refugee population in the West African sub-region.

Tangible economic benefits that have been derived from migration as a result of the remittances from Ghanaians living abroad were estimated at US$2.14 billion in 2010. There are also un-recorded transfers from abroad that go through friends and relatives directly to households. These remittances play a very important role in improving livelihoods in migrant households and in general, reducing poverty.

INTEGRATION OF POPULATION INTO NATIONAL DEVELOPMENT FRAMEWORKS

Introduction

Development is linked in various ways to population change. The transformation in demographic regimes from high to low death and birth rates – the demographic transition – can be added to the list of structural changes constituting development: indeed, in terms of its direct effect on human well-being and its social and economic implications, it is arguably the most important of those changes (McNicoll, 2003). Thus understanding the complexities of population change and integrating this into development planning are essential to sustainable development.

Integration of Population Factors in Ghana

Ghana adopted an explicit and comprehensive policy on population in 1969, the third in sub-Saharan Africa after Mauritius (1958) and Kenya (1965). This policy recognised the negative effects which unregulated population growth and distribution could pose to individual and family welfare and the nation's efforts at social and economic development. The 1969 Population Policy indicated that population policies and programmes were to be developed as organic parts of social and economic planning and development activity.

Twenty five years after this policy was first adopted, the country's rate of population growth still remained at an unacceptable high level and the population factor continued to act as a serious impediment to the country's march towards economic modernisation, sustainable development and eradication of poverty. This, in addition to other emerging issues, led to the revision of the 1969 policy in 1994. The revised population policy aimed to improve the quality of life of the population. Specifically, population issues were to be systematically integrated in all aspects of development planning and activity at all levels of the administrative structure. Thus development issues such as education, health, environment, agriculture, governance and others were to be informed by appropriate assessment of population factors.

The first medium-term development plan (1997–2000) based on vision 2020 was aimed at making Ghana a middle-income country in 25 years. This and subsequent development frameworks including the Ghana Poverty Reduction Strategy 2003–2006 (GPRS I) and the Growth and Poverty Reduction Strategy 2006–2009 (GPRS II), represented comprehensive policies, strategies, programmes, and projects to support growth and poverty reduction. They sought to ensure that all Ghanaians, irrespective of their socio-economic status or where they reside, had access to basic social services such as healthcare, quality education, potable drinking water, decent housing, security from crime and violence, and the ability to participate in decisions that affect their own lives.

The follow-up programme, the Ghana Shared Growth and Development Agenda (GSGDA), 2010–2013 is aimed at ensuring that the new growth poles are reinforced to accelerate poverty reduction without becoming enclaves. In pursuance of this mandate, the national policy framework has integrated some population factors into the policy framework. The social and economic goals cited indicated the importance of population factors in achieving socio-economic development. Some of the goals cited in the framework are:

- Providing citizens with secure and sustainable jobs.
- Ensuring gender equity in access to productive resources such as land, labour, technology, capital/finance and information.
- Expanding access to potable water and sanitation, health, housing and education.
- Embarking on an affirmative action to rectify errors of the past, particularly as they relate to discrimination against women.
- Pursuing an employment-led economic growth strategy that will appropriately link agriculture to industry, particularly manufacturing.
- Rehabilitating and expanding infrastructural facilities.

Furthermore, Population Management constitutes a key segment of the Human Development Productivity and Employment thematic area of the GSGDA with specific objectives, among others, to ensure the integration of population into development planning and reposition family planning as a priority in national development.

Since the adoption of the decentralisation policy in 1987, the districts have become the unit for development planning in the country. The establishment of a new development planning system and the creation of the National Population Council (NPC) and the National Development Planning Commission (NDPC) by Government were all aimed at making population issues central to development. Furthermore, the NDPC also developed guidelines for the preparation of sector and district medium-term development plans as well as monitoring and evaluation plans which specified population as a cross-cutting issue. These guidelines underpin the preparation of development plans as well as an integrated national monitoring and evaluation system to ensure that the implementation of sector and district medium term development plans (DMTDP) are monitored.

Furthermore, the NPC, in collaboration with the Kwame Nkrumah University of Science and Technology (KNUST) and with funding from the Government and the United Nations Population Fund (UNFPA) developed 15 training modules on various sectors including health, education, housing, water and sanitation, etc., in order to facilitate the integration of population factors into development planning. The modules are being used to build the capacity of district assembly staff to enable them in practical ways to integrate population concerns into the district development planning process.

The modules use Microsoft Excel to analyse and project future needs of the population. They examine in general terms the dynamic links among population, economic development and social needs. It is used to determine the development needs of a particular area based on the structure of the population. It has been used as an advocacy tool to sensitise politicians at the district level in the allocation of resources for population activities and also to mobilise support for the programme.

The sensitisation and involvement of the administrative heads and coordinators in the training facilitated the utilisation of the modules. One of the main factors hindering the use of integration analysis in development plans is the scarcity of planning personnel with the requisite skills. In order to achieve the population policy objectives there is the need to train a large body of personnel, particularly district planning officers, in integration analysis. The long-term objective is to incorporate integration analysis into development/economic studies curricula, particularly at the tertiary level.

POPULATION POLICIES AND PROGRAMMES

Introduction

Since Ghana attained her independence in 1957, a number of policies and programmes have been put in place to improve the quality of life of the people with varying degrees of success. This chapter presents a review of some of these policies and programmes and their impact on slowing population growth and poverty reduction.

Education

Ghana has, since Independence, made significant strides in the educational system. Article 25(1) of the 1992 Constitution of the Republic of Ghana endorses educational rights by stating that all persons shall have the right to equal educational opportunities and facilities. In recognition of this right, the Government introduced the Free Compulsory and Universal Basic Education (FCUBE) in 1996 to expand access to good quality education and to promote efficient teaching and learning.

Formal education in Ghana begins with six years of primary education (ages 6–11), three years of Junior High School (ages 12–14) and three years of Senior High School (ages 15–18), concluding with the tertiary level of universities, polytechnics and other higher level institutions. The number of children of primary school-going age (6–11 years) doubled in three decades from 1.5 million in 1970 to 3.1 million in 2000 (Table 4). Over the same period, the number of children of JHS age increased from 595,000 to 1.3 million and from 476,000 to 1.6 million in Senior High School. This doubling of the school going age population is the outcome of high population growth in the period concerned.

Table: 4.4 Changes in Ghana's population of school-going age, 1970–2000

Year	Primary (6–11)	Junior High School (12–14)	Senior High School (15–18)
1970	1,533,734	594,618	476,101
1984	2,166,482	910,139	761,101
2000	3,154,146	1,321,159	1,583,615

Source: State of Ghana Population Report, 2003

In support of Governments' policy for free and compulsory education, in the 2003/2004 academic year, Government introduced the Capitation Grant Policy. Closely linked to the Capitation Grant is the School-feeding programme which provides one hot meal a day for pre and primary school children. This policy increased enrolment by 15 per cent across the country. However, the number of teachers to cater for these new numbers is also yet to be addressed to ensure good quality education.

One of the goals of the population policy is to increase the proportion of females entering and completing at least Senior High School. In line with this goal, the policy's education target is to increase the proportion of 15–19 year old females with secondary education and higher by 50 per cent by 2005 and up to 80 per cent by 2020. In 1997, the Ministry of Education (MOE) established the Girls' Education Unit of the Ghana Education Service (GES) to increase the enrollment of girls in schools to equal that of boys by the year 2005. The Unit was also tasked to reduce the dropout rate for girls from 30 per cent to 20 per cent in the primary schools and from 29 per cent to 15 per cent in the JHS. Considerable progress has been made in this area. For example, while in 1990/1991, girls' enrolment at

the primary level was 45 per cent, the percentage in 2000/2001 was 47.2 per cent. That of JHS went up to 45.3 per cent in 2000/2001 from 40.8 per cent in 1990/1991.

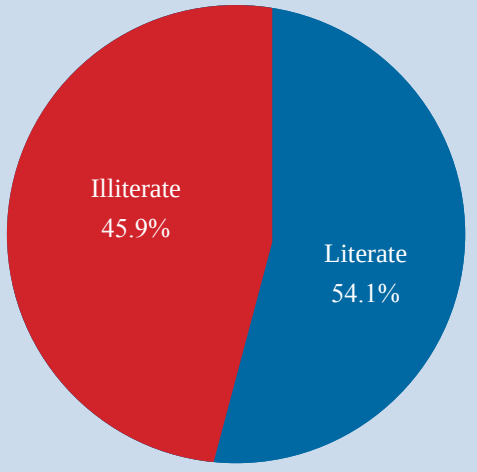
In addition, several programmes were undertaken under the affirmative action policy to bridge the gap between males and females. The University of Ghana has a policy to encourage the enrolment of females at the University and for this, as such the cut off grades for females are lowered to give more room for female students entering the university.

Literacy

In 1948, only four per cent of Ghanaians had ever been to school. Despite significant improvements over the years, the situation leaves much to be desired. Indeed, the absolute numbers of illiterate people in Ghana rose in 30 years from 3,791,762 in 1970 to 6,635,168 in 2000, representing 45.9 per cent of the population (Graph 4.6). This increase was partly due to high population growth rates and inability of the Government to keep up with the pace of education for such numbers (SGPR, 2006). On the other hand, decline in illiteracy is a result of increase in school enrolment.

The 2000 Population and Housing Census results show that illiteracy is more prevalent among adult Ghanaian females (54.3%) than males (37.1%). This low level of literacy among females has far reaching consequences for demographic processes such as fertility behaviour, mortality prevalence as well as sustainable development. Illiteracy among adult females tends to be associated with high fertility and high maternal mortality and low level of empowerment. Table 4.5 indicates that a high rate of illiteracy exists among females. This huge deficit is among rural and urban poor women which deny them full participation and partnership in economic and social issues in the country. These tendencies make it difficult for women to utilise their full potential in the development process.

Graph: 4.7 **Literacy rates for Ghana, 2000**



Source: State of Ghana Population Report, 2003

Table 4.5: Literacy rates for adults, 15 years and over by sex			
Literate 15 years and over (National)	**Total (%)**	**Male (%)**	**Female (%)**
Not Literate	45.9	37.1	54.3
Literate in English only	12.7	14.4	11.1
Literate in Ghanaian Language only	6.4	6.1	6.7
Literate in English and Ghanaian Language	34.2	41.6	27.2
Literate in other Languages	0.8	0.9	0.7
Total	100.0	100.0	100.0

Source: Population and Housing Census, 2000

The Functional Literacy Programme aimed to increase the number of Ghanaian adults, particularly the rural women and rural poor to acquire literacy and functional skills. The first phase of the programme ended in 1997 having successfully enrolled and trained 1.3 million adults. The second phase of the programme was launched in 2000. The project recorded some achievements. Sixty per cent female participation was recorded against 40 per cent for males. It also resulted in behavioural changes and better awareness in health and child care, schooling of children and decision making and participation in national development efforts.

Labour Force and Employment

The Draft National Employment Policy of Ghana states that it is the intention of the Government to overcome structural impediments in the economy and make the ultimate development goal of full employment attainable through the effective implementation of the National Employment Policy.

In 1984, the active population (15–64 years) which constitutes the bulk of the labour force, was 6.3 million (51.2% of the population). This increased to 10.1 million in 2000 (53.4% of the population) and to 14 million (57%) by 2010. By inference, the age dependency ratio reduced from 95.3 per cent in 1984 to 87.3 per cent in 2000 and to 75.6 per cent in 2010. The increased labour force size and a declining dependency ratio suggest fertility reduction, which is shown by the reductions in total fertility rate. In spite of the observed decline in both dependency ratio and fertility in the country, unemployment has shown some increases during the same period despite several interventions by both Government and the private sector.

Reproductive health

To ensure effective reproductive health (RH) care of the population, a number of policies were developed to guide the implementation of programmes. They included the National Reproductive Health Service Policy and Standards, the National Reproductive Health Service Protocols and the Reproductive Health Strategic Plan (2007–2011). In addition, the Safe motherhood programme was started in 1987 as a component of the larger reproductive health programme.

The national (RH) policy recommends a minimum of four visits during pregnancy. In 2009, 92.4 per cent of expected pregnancies were registered for antenatal care services, an increase from the 88.7 per cent in 2005. About 82 per cent of registrants made at least four visits in 2009. The free maternal care services introduced by the Government with support from the UK Department for International Development (DFID) have improved access to maternal health services significantly.

In Ghana, Antenatal Care (ANC) Services are provided by public health facilities and other private agencies including, Christian Health Association of Ghana (CHAG), Planned Parenthood Association of Ghana (PPAG) and private healthcare facilities including private maternity homes. In places where these health facilities are not available, trained Traditional Birth Attendants (TBAs) are supported to provide ANC services within their capabilities in the communities. The maternal mortality ratio reduced markedly from 740 to 350 per 100,000 live births from 1990 to 2008 but increased again in 2010. Under-five mortality reduced modestly from 110 to 80 per 1000 live births within the period, 1990 to 2008. These achievements were accrued from the various policies, strategies and programmes put in place. However, challenges still persist and there is growing need to strengthen intervention programmes.

The policy and strategies for improving the health of children under-five was developed due to the vulnerable nature of the under-five age group who contribute to more than half of the deaths in all ages. The policy focuses on neonatal health care, prevention and control of growth and nutritional problems, prevention and control of infectious diseases and injuries, clinical care of the sick and injured child and health related interventions. The following are some Integrated Maternal and Child Health Campaigns organised in the country and which have received encouraging results:

- Polio immunisation for children from birth to 5 years.
- Vitamin A Supplementation for children aged 6months to 5 years.
- Vitamin A Supplementation for lactating mothers within 8 weeks of delivery.
- Deworming for children aged 2 years to 5 years.

Abortion, although illegal in Ghana (Criminal Code, 1960), is permitted under certain stipulated conditions such as when pregnancy is the result of rape or defilement or the pregnancy is detrimental to the physical or mental health of the pregnant woman. The reproductive health programme includes the provision of safe abortion services including post abortion care (PAC). Unsafe abortion is a major cause of maternal mortality in Ghana. The Ghana Health Service (GHS) developed a strategic plan in 2003 to combat the high levels of unsafe abortion in the country.

Although the country is on track regarding its targets for fertility, indicators for contraceptive prevalence do not paint the same picture. The current family planning acceptor rate reduced from 33.8 per cent in 2008 to 31.1 per cent in 2009 (2009, Service Statistics, Ghana Health Service) and preference for shorter term methods continue to remain high compared to other modern methods. The use of contraceptives in Ghana for

any modern method is 16.6 per cent, a reduction from 19 per cent in 2003 for modern methods (GDHS, 2008).

Barriers to the use of family planning exists among various categories of people. Misconceptions and the barriers could be employed as opportunities and new strategies in addressing the gaps in the implementation of the family planning programme. A Road Map for Repositioning Family Planning in Ghana was launched by the Ghana Health Service in 2006 for a five year period (2006 to 2010). This was to re-emphasise the importance of family planning in both health and socio-economic development. It also aims to ensure that family planning becomes the focus for strengthening and advancing reproductive health care and rights. The period of implementation of the road map has been extended and incorporated in the current National Medium Term Development Policy Framework, GSGDA (2010–2013).

Age at Cohabitation or Marriage

Marriage marks the point in a woman's life when childbearing becomes socially acceptable in Ghana. To reduce the proportion of women who marry before age 18 by 50 per cent by year 2000 and by 80 per cent by the year 2020 is one of the targets in the 1994 Revised National Population Policy To reduce the proportion of women below 20 years and above 34 years giving births to 50 per cent by the year 2010 and to 80 per cent by the year 2020 is another policy target. Judging from progress achieved so far, it is likely that these targets may not be achieved.

The median age at first marriage for women aged 25–49 was 19.8 years in 2008 which is a slight increase over the median age reported from the 2003 GDHS (19.4). According to the report, across all age groups, the proportions of women married are larger than the proportions of men married.

According to the 2008 GDHS report, median age at first marriage is consistently lower among women in the rural areas than those in urban areas. There are equally regional discrepancies ranging from 22.9 years in Greater Accra to 17.8 years in Upper East region among women aged 25–49. It was also noted that women with little or no education are more likely to marry at a younger age than those with higher levels of education. As mentioned earlier, the report confirmed that because of poverty, women with low levels of income are likely to marry earlier than women in the higher income class. Comparing the 2003 and 2008 GDHS results, there are indications that over the past five years, both men and women have been marrying at later ages.

Age at first sexual intercourse is another indicator of a woman's exposure to the risk of pregnancy than age at first marriage. Although in Ghana sexual relations with a girl less than 18 years is considered as rape, the 2008 GDHS report that by age 18, more than two-fifths of women (44 per cent) and 26 per cent of men (married/unmarried) have had sexual intercourse and nearly all men and women are sexually active by age 25.

Opportunities for Birth Spacing and Reinforcing the Value of Small Families

The revised population policy aims at reducing TFR from 5.5 in 1993 to 5.0 by the year 2000, and 4.0 by 2010. The policy accordingly aimed at increasing CPR to 15 per cent for modern methods by the year 2000 and 28 per cent by 2010.

It is worth noting that the country has made some progress in reducing fertility. The GDHS results showed a decline in (TFR) from 6.4 births per woman in 1988 to 5.5 in 1993, to 4.6 in 1998, to 4.4 in 2003 and 4.0 in 2008 indicating that, there was a minimal drop between 2003 and 2008. Although fertility is declining in Ghana, it is still high, particularly among some geographic groups. For example, the regional disparities range from as low as (2.5 per woman) in the Greater Accra Region to as high as (6.8 per woman) in the northern regions. The increase in human numbers is a source of concern to policy makers and planners because of lack of commensurate increase in available resources, which affect the quality of life of the people.

According to the 2008 GDHS report, about 35 per cent of married women have an unmet need for family planning. Unmet need for child spacing is higher than the unmet need for limiting children (23% and 13%) respectively.

Access to Primary Health Services

In adopting the Primary Health Care (PHC) concept, the Government of Ghana acknowledged the need for an integrated, multi-sectoral programme of health and wellbeing of the population, especially those living in disadvantaged communities.

The Ministry of Health (MOH) launched the Community-Based Health Planning and Services (CHPS) programme in 1999 to provide community-based health service through partnerships with community leaders, and social groups. CHPS compounds are established in areas without health facilities with stationed community Health Officers to attend to the health needs of the people. Basic health care services are integrated with reproductive health care services.

To increase access to health at the community level, in the year 2005, the Government of Ghana began the implementation of the National Health Insurance Scheme (NHIS) after the Bill was passed in October 2003. This was to replace the cash and carry system. Pregnant women were given free antenatal care, delivery and postnatal care. This led to the increase of patients visiting the health facility to seek medical care and the steady improvement in women's health, thereby putting pressure on the existing facilities.

The 2008 GDHS shows 95 per cent antenatal care was received from a health professional. Differences exist in the use of antenatal care services between women in the urban and rural areas and those with different educational levels. Health professionals provide antenatal care for 98 per cent of mothers in urban areas compared with 94 per cent of mothers in the rural areas. 99 per cent of mothers with at least some secondary education receive prenatal care services from a health professional compared with 94 per cent of mothers with primary or no education.

Delivery and Postnatal Care

With the introduction of free maternity services and the introduction of the CHPS compounds, some barriers for accessing skilled maternity care have been removed. 57 per cent of deliveries now occur in health facilities (48% in the public sector as against 9 per cent in the private sector). Home births are much more common in rural areas (58 %) than in the urban areas (17%). Postnatal care helps prevent complications after childbirth. More than two-thirds of women now receive a postnatal check-up within two days of delivery. However 23 per cent of women do not receive any postnatal care within 41 days of delivery.

Adolescent reproductive health

The Government has strengthened efforts to curb the difficulties facing the youth in accessing RH services. Agencies such as Ghana Health Service (GHS), Christian Health Association of Ghana (CHAG), Planned Parenthood Association of Ghana (PPAG), contribute immensely in championing the cause of adolescent reproductive health in Ghana.

Demographic and social factors associated with adolescent pregnancy

Certain socio-cultural and demographic factors continue to pose challenges in addressing the reproductive health needs of Ghana's young people. These challenges include early age at first marriage, early age at first sex, increasing indulgence in premarital sex and low use of contraception. Data from the Ghana Demographic and Health Surveys (1998, 2003 & 2008) show an increase in age at first sexual intercourse; marriage and childbearing. As indicated in Table 6, the age at first sex has increased over the years. Though the increment is gradual, the target as stipulated in the Adolescent's Reproductive Health Policy to motivate young people to increase the age of onset of sexual activity from around 12 years to over 15 years by 2010 has been achieved. Furthermore, early births for the female population below 20 years (adolescents) have declined tremendously over the years. These successes have been achieved due to the strategies and effective programmes being put in place by Government and other stakeholders.

Table 4.6: Demographic and Social factors associated with adolescent pregnancy

Fertility Indicators	Years		
	1998	2003	2008
Age at first sex	17.5 years	18.3 years	19.2 years
Age at first marriage	19.1 years	19.6 years	20.1
Early births <20 years	32 per cent	23 per cent	13 per cent
Adolescent Birth Rate	90/1000	74/1000	66/1000
Adolescent Contraceptive use	5 per cent	6.9 per cent	8.5 per cent

Source: Ghana Demographic and Health Survey Reports (1999, 2004, 2009)

Policies and existing programmes on Adolescent Health Promotion and Advocacy

Government of Ghana

In its efforts to ensure the health and development of adolescents in Ghana, the Government of Ghana developed a 7-year (2009–2015) National Strategic Plan for the Health and

Development of Adolescents and Young People. The plan emphasises their right to information and education, life and livelihood skills, leadership skills, youth friendly services and counselling, safe and supportive physical, psychological and social environment as well as opportunities to participate in programmes that affect them (Standards and Tools for Monitoring Adolescent and Youth Friendly Health Services in Ghana, 2010).

The Adolescent Health and Reproductive Health Programmes in Ghana are making strides in promoting the objectives of the National Strategic Plan in the health and development of young people. Youth corners and youth friendly services are being established nationwide by the Ghana Health Service, (GHS), CHAG and PPAG. Analysis of the progress of the regional youth corners, as reported by the annual report of the Adolescent Health Development Programme (AHDP) 2009 shows that 129 youth corners are functioning nationwide (Table 7). The Ministry of Health and its partners have implemented a number of adolescent reproductive health actions recommended in the Adolescent Reproductive Health Policy, 2000. These programmes are found in the broad areas of education (school curriculum for basic education, and other informal settings), media campaigns, counselling, youth development, peer education and service provision. The challenge however is to ensure the translation of all policy objectives into effective programmes and activities. Various NGOs have contributed and are still contributing to the promotion of adolescent reproductive health programmes and activities in Ghana. They continue to advocate for the need to put adolescent sexual and reproductive health issues constantly on the development agenda of the country.

Table 4.7: Number of regional persons available, trained frontline workers and functional ADH Corners, 2009

Regions/ Institutions	No of regional persons available	No of trained frontline health workers	No of functional ADH corners*
Upper East	16	92	4
Upper West	15	-	3
Northern	34	72	12
Brong Ahafo	1	N/A	3
Ashanti	8	N/A	3
Volta	10	N/A	34
Eastern	17	197	54
Central	3	N/A	15
Western	2	-	0
Greater Accra	5	9	9
PPAG	-	-	4
CHAG	20	N/A	11
Total	133	370	129

Source: Adolescent Health and Development Program Annual Report, 2009

Proposed Strategies

Evidence from the GDHS suggests that the adolescent population who are most at risk of adolescent pregnancy are the poor (both urban and rural ethnic minority, and youth with limited opportunities). Strategies must therefore target in-school adolescents, out-of-school adolescents and special groups as defined in section 5.0 of the Adolescent Reproductive Health Policy. The proposed strategies include youth development, education, access to reproductive health information and research, monitoring and evaluation.

Youth Development

In line with the public health framework towards adolescent pregnancy prevention, the strategy which seeks to address adolescent poverty through livelihood skills, education, gender and other traditional programmes should be strongly featured while addressing adolescent pregnancy. This strategy can contribute to the delay in initiating sexual activities and preventing pregnancy and STIs through primary and secondary abstinence.

The National Youth Employment Programme (NYEP) is already making headway as more of the youth and especially adolescents find themselves in employment/with employable skills and thereby reducing their dependence on others. The programme could be strengthened by including a combination of job readiness training: training for readily available jobs, youth-led business ventures, peer teaching or counselling (as done by PPAG Young and Wise/ Youth Action Movement), and life planning skills.

Access to Contraceptives and Reproductive Health Care Information

Adolescents are gradually becoming more knowledgeable about reproductive health issues, as more programmes are being targeted to reach them. Adolescents may however have concerns about the cost, confidentiality, and accessibility of family planning services that may prevent them from accessing these services from the providers.

As shown in Table 7 above, access to and utilisation of health services by adolescents are very poor. Some of the Adolescent Health (ADH) Corners in the regions have been closed down due to inadequate human, material and financial resources. The number of resource persons are said to be decreasing as a result of transfers, retirement and pursuit of education. Some youth centres, as noted in the report now, serve as canteens and some have been converted into National Health Insurance Scheme (NHIS) offices.

Prevention of mother-to-child transmission (PMTCT) of HIV

The number of health facilities providing Prevention of mother-to-child transmission (PMTCT) services increased from 408 in 2007 to 793 in 2009. The number of women counseled and tested also increased from 104,045 to 381,874 during the same period. The HIV positive rates among these women were 3.2 per cent and 1.7 per cent in 2007 and 2009 respectively. The number of ANC clients accepting counseling and testing services increased over the 3-year-period but there was a decrease in the number of women on

ART in 2009 as compared with the two previous years. All regional hospitals and most district hospitals are currently providing antiretroviral therapy services for HIV positive clients. HIV positive clients are therefore encouraged to access these sites to receive the needed care and support. Backing these activities are the National HIV/AIDS and STI Policy 2000 and the National HIV and AIDS Strategic Plan (NSP 2011–2015)

Population and Gender Issues

Role and Status of Women

Given the strategic position of women in the process of human reproduction, gender equality and equity, women's empowerment should be a central policy concern in addressing demographic issues. This has resulted in the shift from emphasis on demographic targets to the promotion of reproductive health and rights as an imperative for the improvement of the quality of life of all people, particularly women and children.

The 1994 Revised Population Policy recognises the centrality of women's role in production, reproduction and as agents and beneficiaries of socio-economic development and change. It recognises the disparities that exist between men and women in accessing basic services and economic opportunities and outlines strategies to address these challenges.

Economic Empowerment

In Ghana, Most economically active women operate in the informal economy, where they outnumber men, and are particularly involved in various micro-enterprises and retail trade (IFC report, 2007).

In its contribution towards poverty reduction through women's empowerment, the Ministry of Women and Children's Affairs (MOWAC) disbursed over 24 billion cedis to 41,000 women in small-scale enterprises through the first phase of its micro credit programme. MOWAC reports that as a result of the project, several farmers have taken to saving in banks and those rural banks were more willing than in the past to extend credit facilities to them, even without collateral. In the second phase of the project, the Japanese Government provided 26.5 billion cedis to be distributed through the Women's Development Fund. Reproductive health activities were integrated into the micro-credit scheme. This was to ensure that both the reproductive and productive roles of women were effectively addressed. By the end of 2004, 991,000 women had benefited from about $54b, and the recovery range is encouraging. The Ministry of Food and Agriculture has developed skills training and other programmes targeted at women. Programmes have also been organised by the Ministry to sensitise extension officers to mainstream gender concerns in their service delivery.

Although there have been a number of donor supported schemes for direct lending, the Government at various times has operated lending schemes for Small and Medium Enterprises (SMEs). The schemes included the Export Development and Investment

Fund (EDIF). Under this scheme, companies with export programmes can borrow up to $500,000 over a five-year period at a subsidised cedi interest rate of 15 per cent. While the scheme is administered through banks, the EDIF board maintains tight control, approving all the credit recommendations of the participating banks. Several NGOs have also assisted women to enhance their wages, standard of living, and confidence by helping them to own businesses and expand their operations.

Women in Governance

Article 17 of the 1992 Constitution of Ghana prohibits discrimination on the basis of gender. An Affirmative Action Policy of 1998 provides for 40 per cent quota of women's representation on all government and public boards, commissions, councils, committees and official bodies, including Cabinet and Council of State. There are a lot of organisations advocating for women's rights, but so far ABANTU for Development, through the Women's Manifesto Coalition and Women in Law and Development in Africa (WiLDAF) Ghana, are the two major women's rights organisations. They have been championing the cause for Affirmative Action Policy for Women's Rights.

Progress in getting women to occupy political positions has been slow in Ghana. Women currently represent only 8 per cent of Members of Parliament, down from 11 per cent in the 2004 Parliament. Since 1993, the number of female parliamentarians has increased from 19 to 23 in 2005 and decreased to 19 in 2010. It is however, encouraging to note that for the first time in the history of Ghana, women, have been appointed to the highest offices of the Speaker of Parliament, Chief Justice and Chairperson of the Public Services Commission.

FUTURE PROSPECTS AND PROJECTIONS

The main subject of this chapter relates to the relationships between population and development and the consequences in terms of the quality of life of the population. These relationships can be measured through income levels, nutritional status, health, education, housing and general welfare. Fertility, mortality and migration levels and trends are essential information needed for planning for the future. Surveys have shown a gradual decline in fertility levels since 1988, estimates however indicate that the TFR will not reach replacement level of 2.1 live births per woman with the current level of investments. Therefore assessing the future population and other demographic variables would reveal realities that reflect some of the development challenges facing the country.

Thefuture prospects and projections of Ghana's' population are based on the results of the 2000 Population and Housing Census (PHC) and available data from the 2010 PHC, as well as sample surveys conducted to provide information on fertility, mortality, contraceptive usage and other indicators.

Population Change

One of the major challenges facing Ghana is reducing its high population growth rate of 2.5 per cent per annum in the 2000–2010 intercensal period. A decrease from the

2.7 per cent estimated in 2000. Projections of population growth rates using low, medium and high assumption variants put the population growth rate at between 1.54 per cent per annum (low variant) and 2.4 per cent per annum (high variant) for 2015. For 2020, the projected growth rate figures for low and high variants are between 1.37 per cent and 2.4 per cent per annum respectively. Corresponding medium variant estimates for the two projection years are 2.0 per cent and 1.9 per cent respectively (Ghana Statistical Service, 2005).

It is estimated and has been articulated at various fora that with Ghana's high population growth rate, a GDP growth rate of between 7.0 per cent and 9.0 per cent (i.e. approx. 4.6 percentage points and 6.6 percentage points above the population growth rate) is required to achieve poverty reduction and raise the standard of living of the population. Thus, the 5.7 per cent per annum growth in the GDP in 2010 did not meet the criterion for achieving poverty reduction. However, the Ghana Statistical Service has announced that during the first and second quarters of 2011, the growth in the GDP averaged 30.4 per cent and 34.0 per cent respectively. This sharp increase in the GDP growth rate has been attributed to oil production and the mining and quarrying sectors. If such high levels of GDP growth can be sustained in the future then there is hope for Ghana's poverty reduction programme.

Fertility Levels

A marked reduction in fertility levels would substantially reduce the present high dependency burden imposed by the youthful age structure of Ghana's population. The high proportion of people entering the reproductive or childbearing age, which is a key factor influencing the future number of births, will eventually decrease. The fertility decisions that young people make today will determine, to a large extent, the demographic scenario of the country in the future. These decisions would depend on family planning information and the range of services made available to Ghanaians, especially young people, to empower them to manage their fertility and to determine the timing and number of children they want.

Fertility levels as estimated by five Ghana Demographic and Health Surveys (GDHS) conducted during the 20-year period from 1988 to 2008, have shown a general declining trend. Based on the assumption that Ghana's fertility level will reach replacement level (defined as a TFR of 2.1 live births per woman) by 2050, TFR has been projected to decrease to 3.8 live births per woman by 2015 and 3.5 live births per woman by 2020.

In order to sustain and also hasten the fertility decline, there is the need to up-scale programmes to encourage more women and men to use contraceptives both as a means of controlling and spacing births. Actions that would retain the girl-child in school up to the secondary or even tertiary level would go a long way in checking the high fertility level.

Mortality

Levels of expectation of life at birth for the periods 1960–1965 to 1995–2000 have been derived from estimated under-five mortality values based on the North model live tables.

Future mortality levels were determined by fitting a logistic function to the estimated mortality values. Two sets of estimated mortality levels were derived: one considering the impact of AIDS and the other set without AIDS. Table 4.8 presents the estimated life expectancies at birth for the periods 1995–2000 to 2015–2020.

Table 4.8: Estimated and Projected Values of Expectation of Life at Birth

Period (Years)	Without AIDS		With AIDS	
	Male	Female	Male	Female
1995–2000	56.6	60.3	55.0	57.6
2000–2005	58.3	62.0	56.5	59.3
2005–2010	60.0	63.6	585	60.9
2010–2015	61.7	65.2	60.5	62.9
2015–2020	63.6	66.7	62.3	64.2

Source: Ghana Statistical Service, 2005: Population Data Analysis Report Vol. 1, Socio-Economic and Demographic Trends Analysis

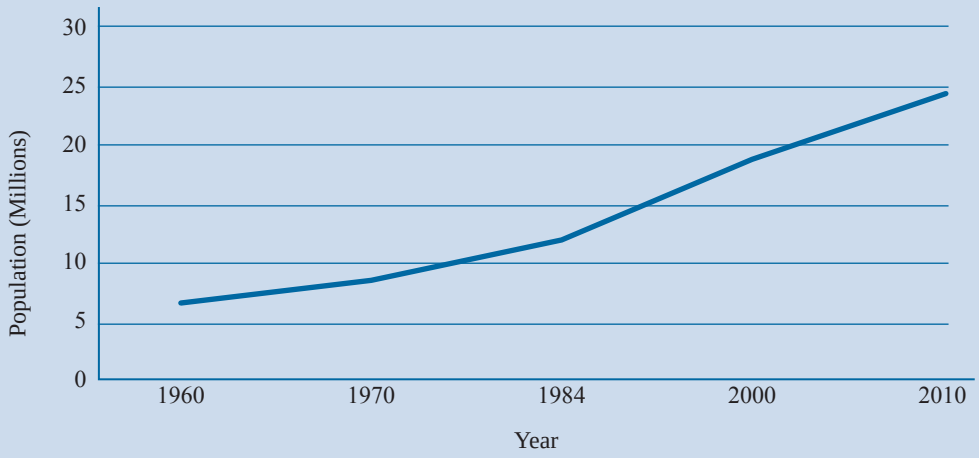
Without the impact of HIV and AIDS, life expectancy at birth was estimated at 60.0 years and 63.6 years for males and females respectively during 2005–2010. These are expected to increase gradually to 63.6 years for males and 66.7 years for females during 2015–2020. Incorporating the impact of HIV and AIDS, the projected figures for the period 2015 to 2020 are 62.3 years and 64.2 years for males and females respectively.

The gradual increase in expectation of life at birth corresponds to reduction in the level of infant and under-five mortality over the past two decades. Generally, there have been downward trends in both infant mortality and under-five mortality levels in Ghana. If these trends are maintained into the future, infant mortality rate and under-five mortality rate are expected to reach about 46 per thousand live births and 70 per thousand live births respectively by the year 2020. With improved health care services and better sanitation, it is expected that the increase in expectation of life will improve significantly in the future, and would reduce the need to have many children as a means of replacing those that do not survive.

Population Size and Structure

Results of the 2010 Population and Housing Census put the population of Ghana at about 24.6 million. This implies an increase of 30.4 per cent over the period 2000–2010. The trend in population growth in Ghana is shown in Graph 4.8.

Graph:4. 8 **Population of Ghana, 1960–2010**



Source: Ghana Statistical Service Census Reports, 1960–2010

The Graph shows that the population of Ghana grew relatively slowly between 1960 and 1970, after which the annual additional numbers increased slightly up to 1984. Between 1984 and 2000 additional numbers increased slightly; however, the scenario during the period 2000–2010 indicates a possible stabilisation or reduction in annual additional numbers in the future. If the current trend continues, the population of Ghana will stand at around 29.5 million by 2020.

The population of Ghana is young with a substantial proportion aged below 15 years. However, over the years, evidence indicates that the age structure of the population of Ghana is changing gradually with the proportion aged below fifteen years declining. This is typical of a population that has begun the demographic transition from high to low fertility. During the transition from high to low fertility levels, populations tend to be characterised by large numbers of women and men in the reproductive ages, which lead to large numbers of children being born. Women in the reproductive ages (15–49 years) will constitute a comparatively large group in the population. The proportion of the population aged below fifteen years increased from 44.5 per cent in 1960 to 46.9 per cent in 1970, and then decreased to 45 per cent in 1984 and 41.3 per cent in 2000 and 38.3 per cent in 2010. Projections indicate that the proportion of Ghana's population aged below fifteen years will continue decreasing to 35 per cent by 2020. The population will remain young and therefore will maintain a high growth potential.

Urbanisation

There have been considerable migration movements in Ghana since the colonial period. These have been great movements of population from one locality to the other, the more recent movements reflecting the socio-economic changes taking place within the country. Four types of internal migratory movements have been identified: rural to rural, rural to

urban, urban to urban and urban to rural. Of these, the most significant in its impact on social and economic development is migration from rural to urban areas.

Ghana exhibits one of the fastest urban growths in the world. In 1960, almost one-quarter (23 per cent) of the population lived in urban areas. By 2010, half of Ghana's population lived in urban areas, and it is projected that 55.4 per cent of the population will be residing in urban areas in 2015, increasing to 59.2 per cent by 2020. Internal migration has been a population response to the changing social and economic conditions in the country. As the socio-economic conditions changed, so did the type of migrant and purpose of movement with an increase in female migrants. Urban centres emerged as destinations of the major structural flows of people across the country. Furthermore, urbanisation is an integral part of the socio-economic transformation taking place in Ghana, which has led to the redistribution of the population in such a way as to effect more social change.

Urbanisation, as a component of the modernisation process, should be seen as a nucleus of the development process to which decision-makers should pay greater attention if the country is to make significant progress toward poverty reduction. The pattern of future development will depend, among others, on the manner in which the country deals with the changing phenomena of internal migration and increasing urbanisation. These observations bring into focus other related phenomena: size, composition and growth of the rural population and their impact on the rural agricultural sector of the economy.

Urbanisation, as has been observed, is an integral part of the social and economic transformation taking place in the country. However, cognisance should be taken of the impact of rapid urban growth on the population of rural areas in so far as it affects the agricultural base of Ghana's economy. It should be noted that information on international migration is so scanty and unreliable that immigration and emigration are assumed to cancel out and are therefore not factored into the projection of the total population.

CONCLUSION AND RECOMMENDATIONS

Ghana is currently experiencing economic growth of between 7 per cent and 14 per cent per annum. This is occurring alongside considerable backlogs in developing human capital, improving living standards, building the needed infrastructure, as well as expanding access to services such as health, education and energy. The transition to a more favourable demographic regime will thus remain a critical and difficult period for Ghana for some decades. The demographic transition has more or less stagnated, the challenge, therefore, is to stimulate further reductions in fertility and mortality in order to take advantage of the "demographic window of opportunity". This has significant implications for labour force supply, savings and human capital and ultimately to the development of the country and attainment of the objective of becoming a higher middle-income country and improvement in the quality of life of the people.

Recommendations

To improve Ghana's population and development indicators and ultimately the quality of life of the people, the following recommendations are made:

- **Political will/Leadership for population and reproductive health programmes:** There is need for continuous political will to promote and support population and development programmes in the country.
- I**mprove sexual and reproductive health and rights:** Increased attention should be paid by the government to the sexual and reproductive health needs of the population, including adolescents. An improvement in this area has a direct effect on maternal and child health, as well as on birth rates. The implementation of the Road Map for Repositioning Family Planning should be prioritised including access and availability of contraceptives.
- **Increase sexuality education:** Access to information on sexuality and family planning should be increased. This would facilitate broader acceptance of smaller family sizes and provide families and individuals with appropriate information.
- **Ensure Universal Primary Education/Retention of Girls in School:** Education influences a person's behaviour. It is well-known that mortality and fertility levels tend to decrease with improved levels of education. Retention of girls in school delays marriage and the onset of births. In addition, education increases human capital. Thus education is one of the key strategies for slowing population growth.
- **Provide micro credits to youth and women:** The provision of credit to the disadvantaged and vulnerable yield positive results. These facilities empower the vulnerable in society and contribute to the improvement in livelihoods including choices in reproductive health.
- **Create employment opportunities:** Creating employment opportunities must be a priority to offer Ghanaians, including the teeming youth and women productive employment. It is expected that family sizes will be affected positively when the population is productively engaged.
- **Increase resource allocation to population sector:** Population issues are cross cutting, funding for population programmes is therefore often inadequate. Government, NGOs, development partners and other stakeholders including the private sector should rethink the close relationship between population and development and devote more resources to the population sector.

AUTHOR'S NOTES

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CHAPTER 5

POPULATION STABILISATION: KENYA CASE

Charles Oisebe

INTRODUCTION

Kenya was one of the 179 countries that participated in the Internal Conference on Population and Development (ICPD), in Cairo Egypt in 1994 where the issue of population stabilisation was recognised. The ICPD's Programme of Action (POA) states that early stabilisation of the world population would make crucial contribution towards the achievement of sustainable development (UN, 1994 Para 1.11). Towards this, the World leaders agreed that each country adopt and implement population policies and programmes that will address among other issues the high fertility and rapid population growth in order to attain early population stabilisation. It should be noted at the outset that reduced population growth does not feature as a major objective of the POA. In line with the ICPD Plan of Action (PoA), Kenya adopted the National Population Policy for Sustainable Development in 2000 and developed other related policies and programmes, including the Adolescent Reproductive Health and Development Policy, the National Youth Policy, the National Gender and Development Policy and the National Reproductive Health Strategy. The National Population Policy for Sustainable Development is currently being revised to address continuing and emerging population challenges. Other socio-economic measures and strategies were also put in place including the Economic Recovery for Wealth and Employment Creation that were aimed at reducing poverty and improving the well-being of the majority of the population.

Kenya developed recently its development blue print, "Vision 2030" and its first Medium Term Development Plan for the period 2008–12. Legal and other institutional changes were also initiated culminating to the promulgation of a new Constitution, which has a detailed Bill of Rights including Reproductive Health Rights and introduction of a devolved governance structure. The New Constitution puts gender issues at the centre of decision-making and ensures that men, women, children and the individuals are initiators and beneficiaries of all developments. It is expected that with successful implementation of the Constitution, Vision 2030 and the Revised Population Policy for National Development will spur the country to fast socio-economic development and thereby contribute to early population stabilisation. Rapid population growth due to high fertility levels, regional disparity in population indicators, rapid urbanisation and skewed population distribution still remain key concerns for Kenya now and in the future. It is now almost 18 years since the ICPD and there is need to review population stabilisation

efforts, note the key benchmarks made and challenges experienced, and be prudent and foresighted.

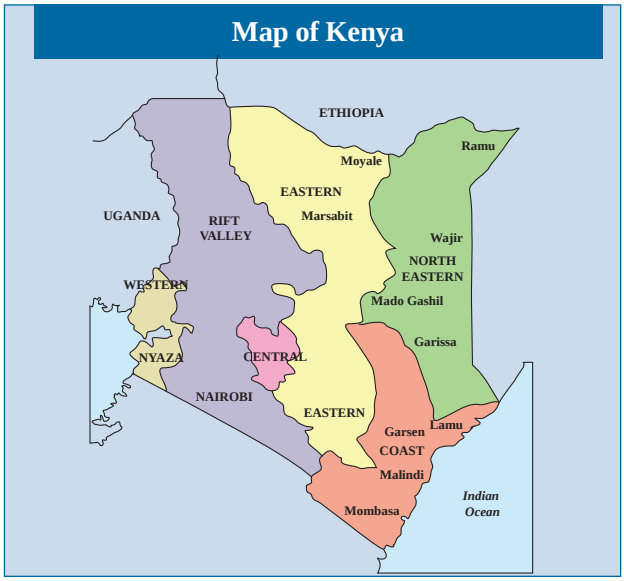
GEOGRAPHICAL LOCATION AND SIZE

Location

Kenya borders the Indian Ocean to the east, Somalia to the north-east, Ethiopia to the north, Southern Sudan to the north-west, Uganda to the west, and Tanzania to the south. The Country has eight administrative provinces. In the New Constitution which is in the process of being operationalised, the country will have 47 counties and the eight administrative districts will be abolished.

Size

Kenya has a total area of 582,650 sq. km (224,962 sq. miles). Land occupies about 569,140 sq km while water occupies about 11,227 sq. km. Only about 17 per cent of the land is arable for agriculture, the mainstay of the economy.



Population Management

Kenya has had, since several years, explicit and implicit population policies and strategies that have contributed to an enabling environment for addressing population and reproductive health issues. The relevant ones include:

- **1955**: Forming of Private Family Planning Associations. The Associations addressed the Reproductive Health (RH) needs of the non-African-White settlers and the Asians.
- **1965:** Highlighting of the population issues challenging development in the Sessional Paper No. 10 on African Socialism and its Application to Planning in Kenya.
- **1967:** Adopting of Population Policy by the Government and launching of National Family Planning Action Programme. Programme emphasised on reduction of family size and spacing of children to lower the population growth rate.
- **1982:** Establishing of the National Council for Population and Development (NCPD) by the government.
- **1984:** Framing of Sessional Paper No. 4 on Population Policy Guidelines.

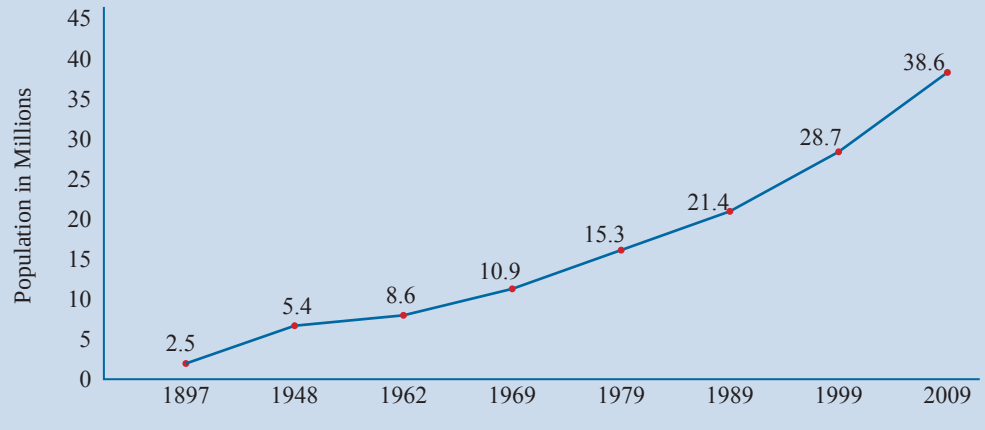
- **1994:** Identifying population growth management as an imperative health strategy by the Kenya Health Policy Framework and re-emphasing it in subsequent National Health Sector Strategic Plans.
- **1996:** Developing of National Population Advocacy and IEC Strategy.
- **1997:** Launching of National Reproductive Health Strategy.
- 2000: Framing of Sessional Paper No. I on National Population Policy for Sustainable Development.
- **2003:** Developing of Adolescent Reproductive Health and Development.
- **2004:** Establishing of National Coordinating Agency for Population and Development.
- **2005/2006:** Establishing of Budget line item for Family Planning.
- **2007:** Publishing of National Reproductive Health Policy.
- **2007:** Including Population, Urbanisation and Housing Section in the Medium Term Strategic Plan of Vision 2030.
- **2010:** Promulgating of New Constitution. Addressing of Reproductive Health issues, including Family Planning in several Articles in the Constitution.

Population Size and Structure

Population Size

The population of Kenya has continued to increase exponentially over time. The 2009 Kenya Population and Housing Census enumerated a total of 38,610,097 million people, representing an increase of about 35 per cent from the 1999 census. Kenya Population increased from 8.6 million persons in 1962 to 10.9 million, 15.3 million, 21.4 million, 28.7 million and 38.6 million persons in 1969, 1979, 1989, 1999 and 2009 respectively (Graph 5.1).

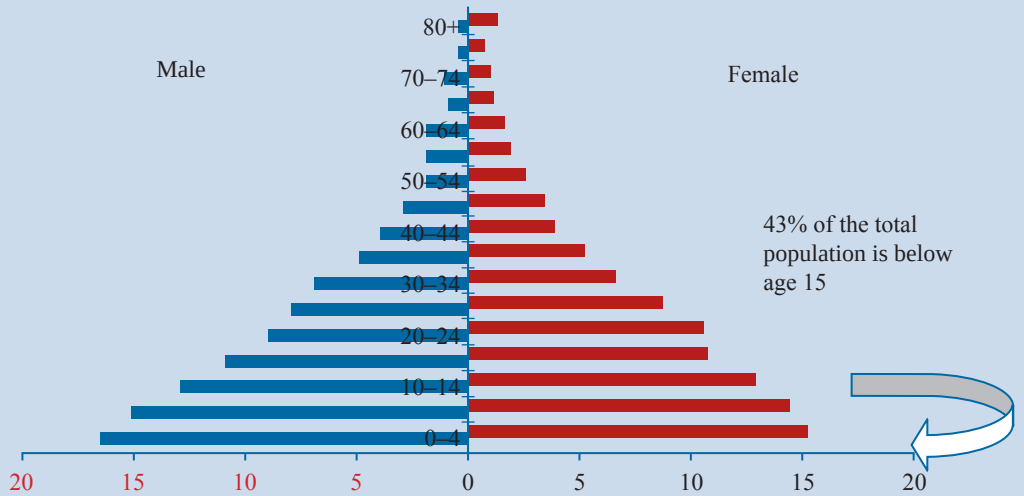
Graph: 5.1 **Population of Kenya since Independence**



Source: GOK 2009 Kenya Population and Housing Census Volume 1C pp.2

The population is growing at about one million two hundred thousand persons per year and is currently estimated at about 41 million people. Kenya's population has therefore doubled over the last 25 years. The high fertility levels have had greater impact than mortality rates on population size and growth, and have been the driving force behind the rapid population growth and a youthful population structure.

Graph: 5.2 **Kenya Population by Sex, 2009**



Source: GOK 2009 Kenya Population and Housing Census Volume 1C, p.23

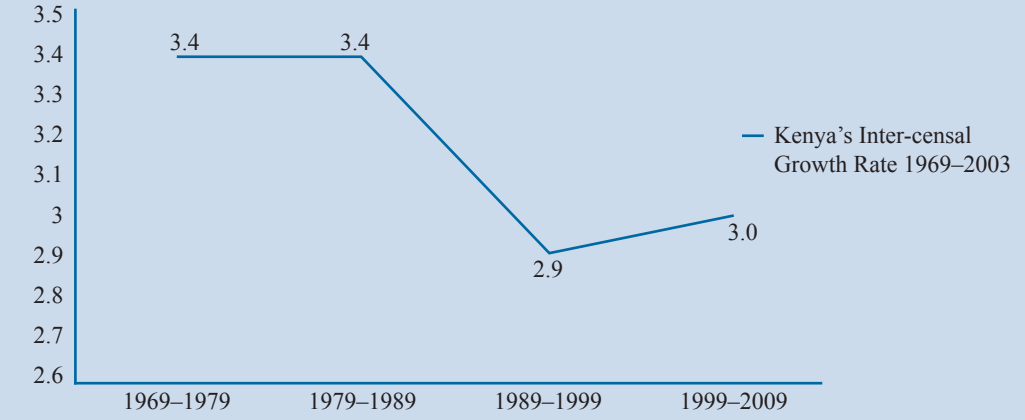
Population Structure

The past and current high fertility rates coupled with improvement in child survival have resulted in a youthful population. The 2009 Kenya population and housing Census revealed that about 43 per cent of the total population is below age 15. Many females will soon enter their reproductive years and have children within the next decade. The 2009 Census revealed that females in the reproductive age (15–49) constituted about 48.3 per cent of the total population. This young age structure creates a powerful momentum for future population growth.

Population Growth Rates

The 2009 Census revealed an increase in the Inter-censal population growth rate from 2.9 per cent in 1989–1999 to 3.0 per cent in the period 1999–2009. This was the second time an increase in population growth rate is being observed. The 1962 Census results had also confirmed an increase in population growth rate which continued until it reached the peak in 1979 before it started easing off.

Graph: 5.3 **Inter-Censal Population Growth Rates 1969–2009**



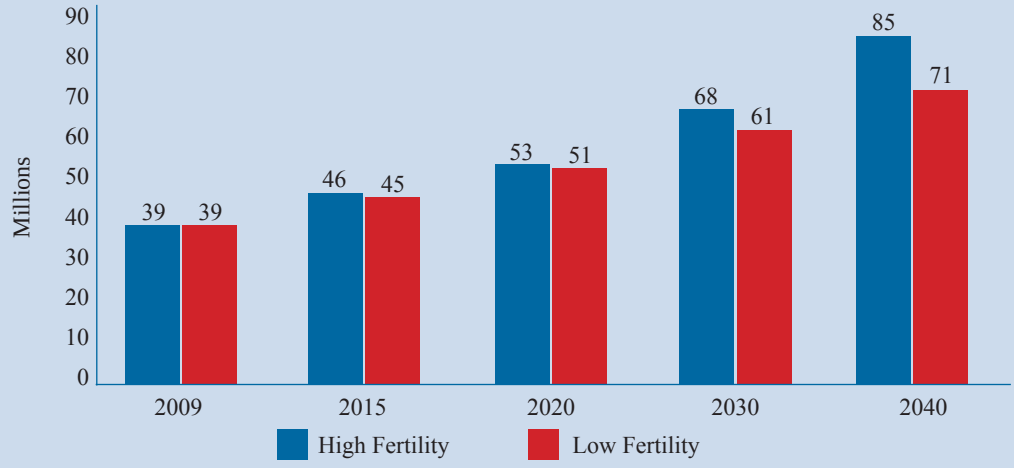
Source: GOK 2009 Kenya Population and Housing Census Volume 1A, pp.22

A time series analysis of the Census results indicates that the natural rate of population increase accelerated from 2.5 per cent per annum in 1948 to 3.3 per cent and 3.8 per cent in 1962 and 1979 respectively. The growth rate then declined from 3.8 per cent per annum in 1979 to 3.3 and 2.8 per cent in 1989 and 1999 respectively, before again registering a marginal increase to 2.9 per cent in 2009. This acceleration in population growth rate between 1948 and 1979 is attributed to increase in fertility levels and decline in maternal mortality, and also to improvement in health, especially child nutrition and socio-economic status. The decline in the growth rate in the period 1979 to1999 was mainly due to Kenya entering the demographic transition as fertility declined. The decline in fertility was due to the use of contraceptives. Kenya experienced a stall in fertility in the 2000s which resulted in the observed marginal increase in population growth rate as reflected by the 2009 census results. This population growth is high considering the prevailing economic growth rates. The rapid population growth and size will therefore be the most important long-term social and economic challenge for Kenya and the realisation of Vision 2030 and attainment of early population stabilisation.

Projected Population

The future population size of Kenya will depend on the nature of future fertility levels. Under high fertility scenarios, Kenya's population is projected to increase from 38.6 million in 2009 to 68.1million in 2030 and 85 million in 2040 (Graph 5.4). Likewise, under low fertility scenarios, Kenya's population is projected to increase from 38.6 million in 2009 to 61.3 million in 2030 and 70.9 million in 2040 (Graph 5.4).

Graph: 5.4 **Projected Population Size in Kenya**



Source: Spectrum using the 2009 Kenya Census

Population Distribution and Densities

The Kenyan Population is unevenly distributed throughout the Country. The population is concentrated in mainly three clusters:

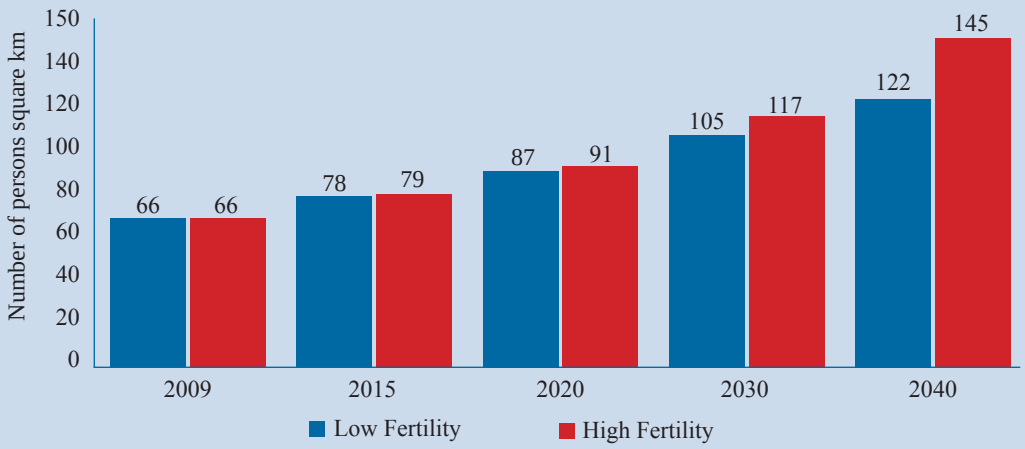
- Around Lake Victoria – Western highlands.
- The area extending from Nairobi north to mount Kenya-Central/Eastern Highlands.
- Along the Coast of the Indian Ocean.

About 90 per cent of Kenyans living in rural areas derive their livelihood directly from the land. Rapid population growth due to high fertility rates in the past and declining mortality have resulted in land scarcity in many areas due in part to the traditional land tenure system in which parents divide their land among their children especially the sons. Pressure on natural resources is bound to increase over time due to increasing population densities in the country. Between 1969 and 2009, population density as measured by the number of persons per square kilometre increased by more than four times from 19 persons per square kilometre in 1969 to 37 persons in 1989 and to 66 persons per square kilometre in 2009.

The national average masks the diverse regional variations on population densities considering that only 17 per cent of the land is arable for agricultural activities. Nairobi, Kilindini and Mombasa which are predominantly urban have high population densities of 4,515, 4,493 and 4,144 persons per square kilometres respectively. In the rural areas, Kiambaa, Kikuyu, Vihiga, Emuhaya and Kisii central have high population densities of 1,342, 1,126, 1101, 1067 and 1,009 persons per square kilometres respectively.

The population density is projected to increase from 66 persons per square kilometre in 2009 to 122 and 146 persons per square kilometre under low and high fertility scenarios, respectively by 2040 (Graph 5.5).

Graph: 5.5 **Projected Population density in Kenya, 2009–2040**



Source: Spectrum using 2009 census

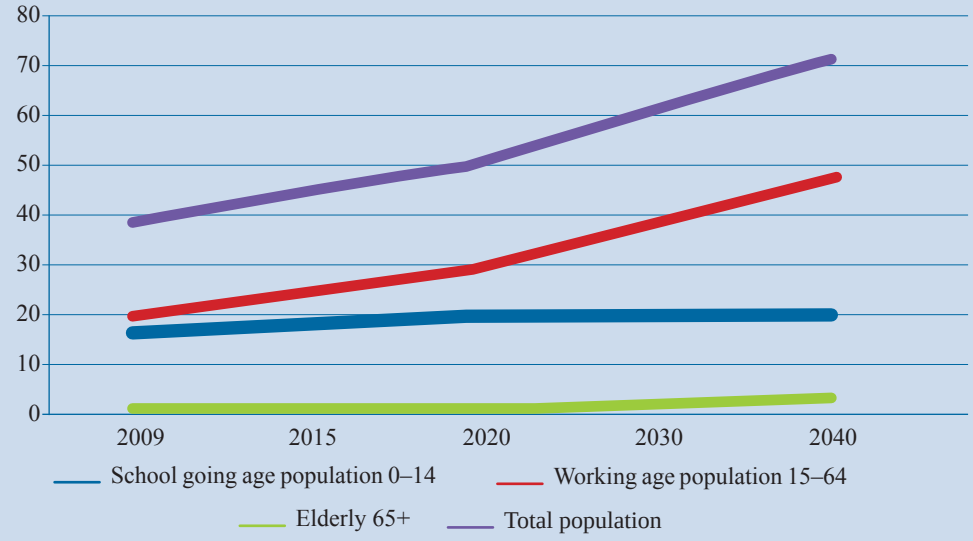
Regions with high population pressure have over time put various coping mechanisms to meet their livelihood needs. The coping mechanism includes adoption of modern agricultural technologies, intensification of agricultural activities, migration to other regions and more importantly, investment in their children's education. This has resulted in a gradual reduction of family sizes and overall total fertility rates. With the ongoing education reforms and gender empowerment activities, the trend in fertility decline is bound to accelerate, and contribute to early population stabilisation.

Demographic Transformation

Demographic Transformation and Demographic Dividend

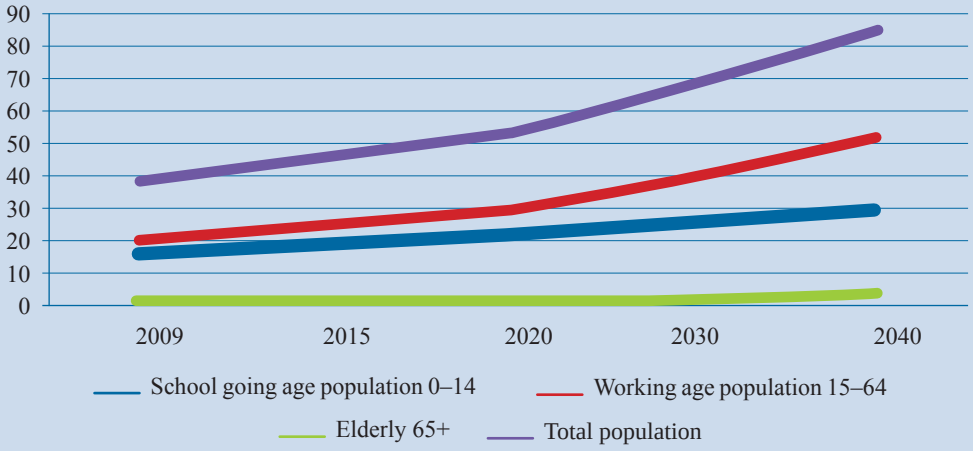
The recent decades of high fertility levels and improvements in child survival has resulted in a fast growing population group of those aged 15–64 years in Kenya. This is the working age population, the labour force. The 2009 Census enumerated a total of 20,864861 million people aged 15–64 years. This working age population is projected to increase to 25,352,395 million in 2015, to 29,619,206 million in 2020, to 38,806,046 million in 2030 and to 47,521,837 million by 2040 under low fertility scenario as reflected in Graph 5.6a.

Graph: 5.6a **Kenya Demographic Transformation**



Source: Spectrum using 2009 Census

Graph: 5.6b **Kenya Demographic Transformation**



Source: Spectrum using 2009 Census

Similarly, the working age population is projected to increase to 25,352,395 million in 2015, to 29,619,206 million in 2020, to 39,627,323 million in 2030 and to 51,707,032 million by 2040 under high fertility scenario as reflected in Graph 5.6b.

Graphs 5.6a and 5.6b clearly indicate that by year 2020 the gap will widen as the proportion of the working age population will grow much faster than dependent population ages (0–14 & 64+ years). The number of people seeking employment will

continue to rise. If high fertility continues, Kenya will need to create twice as many new jobs as it does today. Reduced dependency ratios will allow greater personal savings and government spending. Kenya will therefore be in a position to gain from a "Demographic Dividend" provided that the right enabling environment prevails.

In order for Kenya to gain from the large and expanding workforce, there is need to invest in education and technology, healthcare, improve the investment climate, harness new innovations, infrastructures, and build institutional capacities.

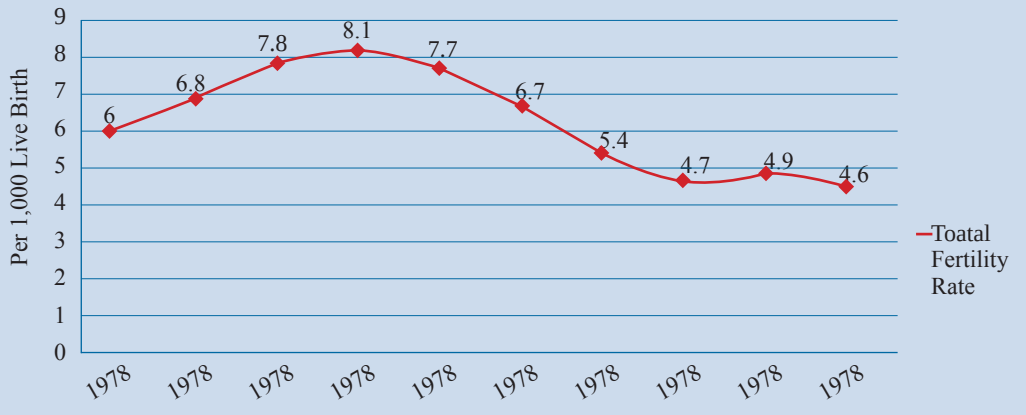
FERTILITY TRENDS

High Fertility

The rapid population growth is set to continue due to the prevailing high fertility and population momentum. The population momentum will cause the population to increase even after fertility rates decline to the replacement level. Kenya's Total Fertility Rate (TFR) increased to 8.1 in 1977/78 from 6.8 children per woman in 1962. The TFR then declined sharply from 8.1 children per woman in 1977/78 to 6.7 children in 1989 and 4.7 children per woman in 1998. The rapid fertility decline observed between 1978 and 1998 was as a result of substantial national and international support of the National FP Programme, including reinvigoration of the Population policy. Human and financial resources were invested in the National FP Programme.

The TFR then increased marginally to 4.9 children in 2003 before again declining to 4.6 children per woman in 2008/09, which is far above the fertility replacement level of 2.1 children per woman. Analysis of trends in TFR indicates that TFR declined to 2.9 children in 2006–08 from 3.3 children per woman in 2000–03 in urban areas while in the rural areas TFR declined to 5.2 in 2006–08 from 5.4 children per woman in 2000–03.

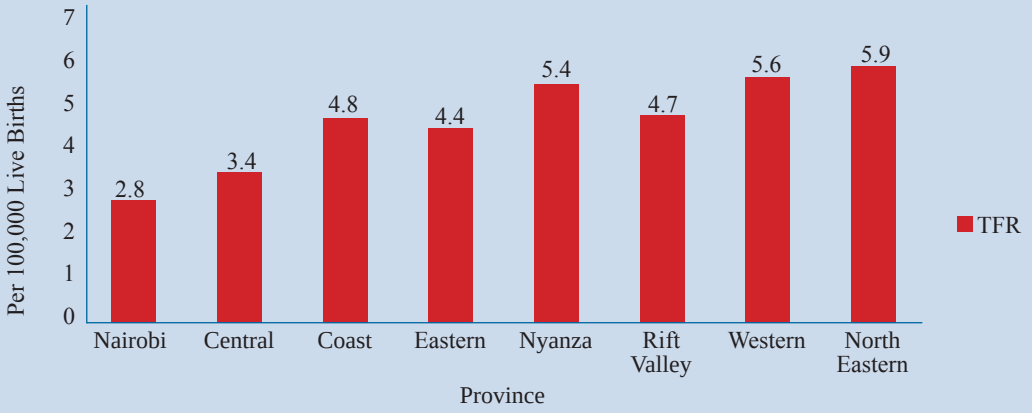
Graph: 5.7 **Kenya Fertility Trends: 1948–2009**



Source: KNBS-KFS, KDHS, Census Reports

There are substantial differences in fertility levels by region and socio-economic groups in Kenya. The TFR is higher in rural than urban areas at 5.2 and 2.9 children per woman respectively. Regionally, the TFR is highest in the North-Eastern province at 5.9 children per woman and lowest in Nairobi at 2.8 children per woman.

Graph: 5.8 **TFR by Province, 2009**



High Teenage Fertility

The 2009 Population and Housing Census revealed that about a quarter (24%) of Kenya's total population of 38.6 million comprise the Adolescents (aged 10–19 years). The 9.2 million adolescents is a very huge number that has major demographic, economic and social implications.

Young Kenyan women experience early sexual debut, early marriages, early child bearing and many of the pregnancies are unintended. Further, contraceptive use among the sexually active adolescents is low, resulting to high unmet need for family planning.

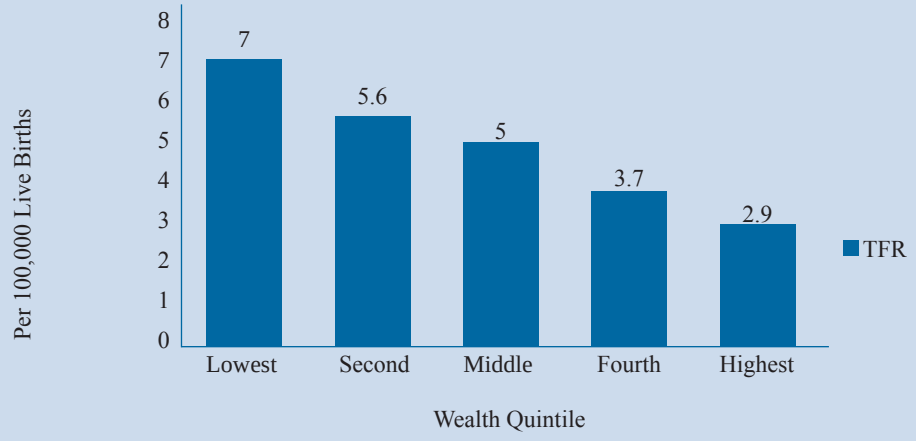
The 2008–09 KDHS results revealed that young women had their first birth at a median age of 19.8 years and that 18 per cent of girls aged 15–19 years had already begun childbearing. Fertility levels have remained high among the adolescents unlike the other age groups. The Age Specific Fertility Rate declined only to 103 in 2008–09 from 114 per 1,000 in 2003. The high fertility rates among the adolescents are mainly attributed to lack of access to Sexual Reproductive health information and services. As with TFR, there are notable differentials in teenage fertility by region. Highest teenage fertility is observed in Nyanza and Coast provinces at 27 and 26 per cent respectively while Central province recorded the lowest teenage fertility at 10 per cent in 2008–09.

The observed differentials are mainly due to the socio-economic development status – Education and poverty levels. Expanding successful education programmes that will

enrol and retain girls at least up to secondary level education will significantly contribute to reduction of teenage fertility and overall fertility. Several studies have over time indicated the correlation between the education level of a woman and fertility.

The 2008–09 KDHs revealed that TFR decrease by more than half from a high of 6.7 for women with no education to a low of 3.1 for women with at least some secondary education. Notable differences are also observed by wealth quintiles. Poor women have on average about four children more than the rich women.

Graph: 5.9 **TFR by Province, 2009**



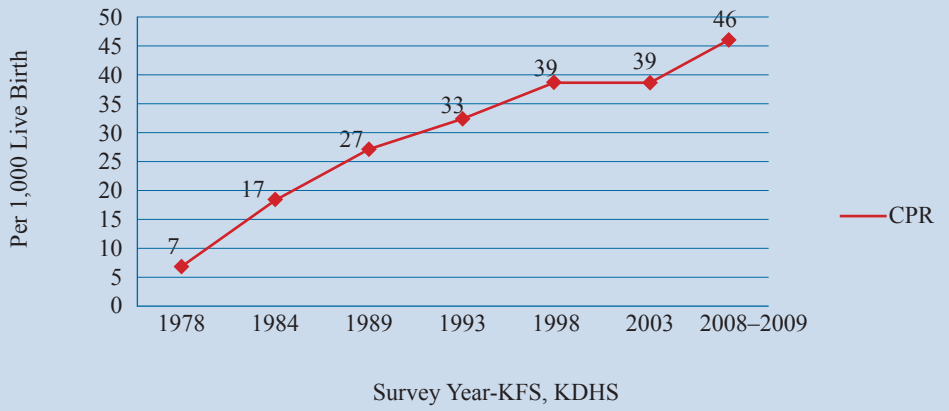
Source: KNBS and ICF Macro.2010 KDHS 2008-09, p. 48

Teenagers from poorer households are more likely to begin childbearing (24%) than those from wealthier households (16%). The high teenage fertility has negative socio-economic outcome for both the individual, families, communities and the nation at large.

Knowledge and use of Contraceptive methods

Since the National Family Planning Programme was launched in 1967, knowledge on FP methods has increased steadily and currently it is almost universal for both men and women. The drastic decline in fertility from the high of 8.1 in 1979 to 4.6 children per woman in 2008–09 has been attributed largely to the use of contraceptives. Contraceptive use for all methods increased from 7 per cent in 1978 to 39 per cent in 1998, and then stalled at 39 per cent up to year 2003 before again increasing to 46 per cent in 2008–09 for married women aged 15–49. Use of modern methods increased to 39 per cent from 32 per cent of married women in 2008–09 and 2003, respectively.

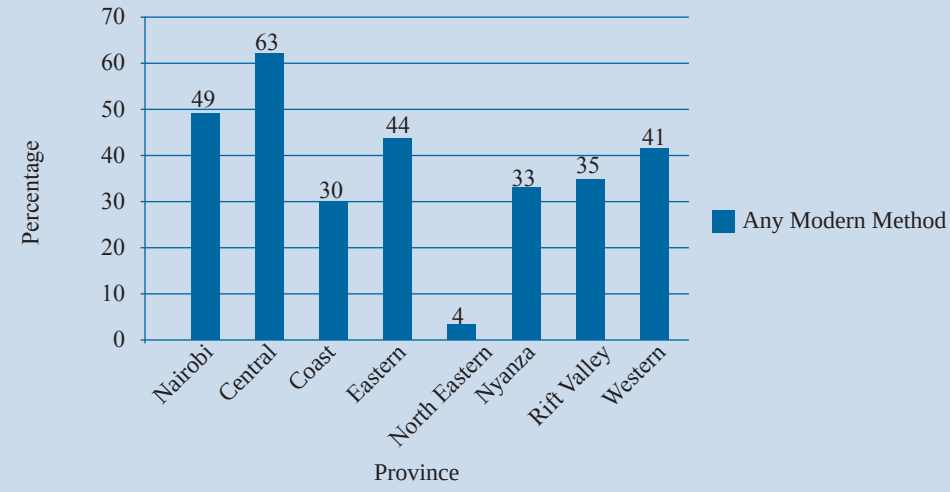
Graph: 5.10 **Trends in CPR use, 1978–2008**



Source: KNBS and ICF Macro.2010 KDHS 2008–09, page 61

Region with high fertility have low contraceptive use. There are wide regional variations in contraceptive use from a high of about 67 per cent in central province to a low of only 4 per cent for currently married women aged 15–49 in the North-eastern province.

Graph: 5.11 **Current use of Any Modern Method by Province**



Source: KNBS and ICF Macro.2010 KDHS 2008-09, page 65

Sustaining and increasing the contraceptive use will be key in fertility reduction and early population stabilisation. Increasing access to Long Acting Lasting Methods of contraception will reduce method discontinuation and failure rates. There have been changes in method mix over time. The use of Pills, IUD, and Rhythm methods have been declining but use of injectables has increased over time. Addressing the regional variations will increase the overall contraceptive use and contribute greatly towards

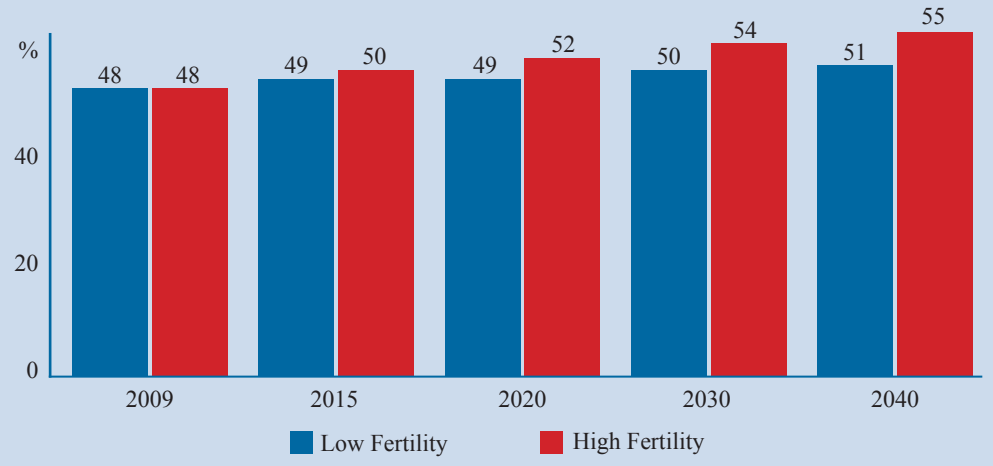
fertility reduction and early population stabilisation in Kenya. The major challenges have been contraceptive commodity insecurity; social, cultural and religious beliefs and practices; coupled with over dependency on erratic donor funding for modern contraceptives.

Population Momentum

Population momentum occurs when a large proportion of women are in the childbearing years. In such a situation, the total number of births can increase even though the Total Fertility Rates falls. Rapid population growth in Kenya has increased the percentage of women of reproductive age to 48 per cent in 2009 and is projected to constitute 51 per cent and 55 per cent assuming low and high fertility scenarios respectively by 2040.

The large number of women of reproductive age implies an increasing demand for reproductive health and related services. There is therefore a need to address the issues of fertility reduction in order to reduce the population momentum.

Graph: 5.12 **Projected % of women of Reproductive age**



Source: Spectrum using 2009 census

The 2008–09 KDHS revealed that three-quarters of currently married women either want no more children or want to wait at least 2 years before their next child, and that about 26 per cent of married women have an unmet need for family planning (13% for spacing & 13% for limiting).

The unmet need is highest in the rural areas and among the poor. As with other indicators, there are wide regional variations on the unmet need for family planning. Nyanza and Rift valley provinces have the highest unmet need for family planning at 31.7 and 31.1 per cent respectively, followed by the Western and Coast Provinces at 25.8 and 25.4 per cent respectively. Nairobi, Central and North Eastern provinces had the lowest unmet need of Family planning at 15.1, 15.6 and 16.0 per cent respectively. This is a very

significant number of women if appropriately targeted and use contraception; fertility rates will drastically drop and contribute to population stabilisation. Investing in Family Planning Programmes now will result in future savings in terms of low expenditures in the number of health care providers; health facilities and related infrastructures, among others. It will also contribute to reduced risks of maternal mortality and morbidity and fewer abortions, improved health for children, reduced burden on schools, and improved life options for women.

Morbidity and Mortality

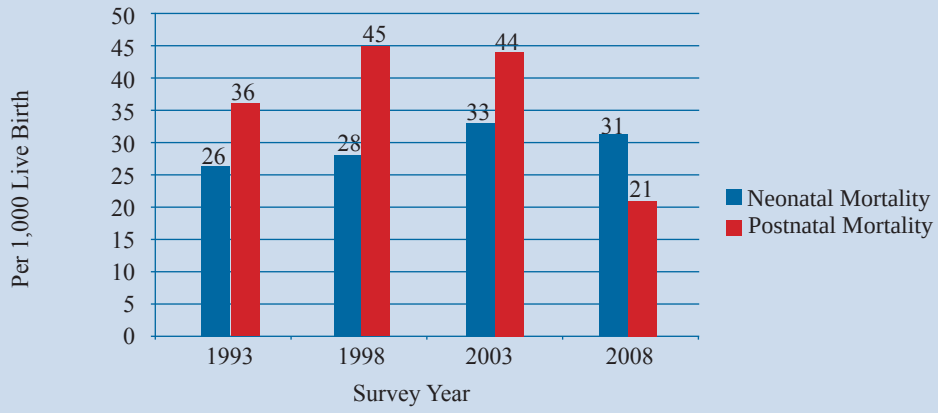
General trends in Mortality

Mortality is one of the key components of population change. Kenya's mortality experience is characterised by high levels in the 1970s; a declining trend in the 1980s and early 1990s; an upsurge in late 1990s and early 2000s; and, a rapid decline in the late 2000s. Crude Death Rate, Infant, child and under five Mortality Rates declined rapidly. Life expectancy at birth improved to 57 years in 2009 from a low of only 35 years for both sexes in 1948. Women have a higher life expectancy of about three years than men. Since mid-1980s, there has been mixed trend in mortality indicators. The mixed trends observed in mid-1980s are associated with emergency and re-emergency of killer diseases such as HIV/AIDS. The leading causes of mortality in Kenya include malaria, diseases of respiratory system, diarrhoeal diseases, pneumonia, anaemia, TB, HIV/AIDS, among others. Kenya is a signatory to the UN Convention on the Rights of the Child and the African Chapter on the Welfare and the Rights of the Child. Childhood mortality still remains high in Kenya despite the various intervention efforts in improving child health and survival. High levels of childhood morbidity and mortality are attributed to malaria, acute respiratory infections (ARI), diarrhoea, childhood malnutrition, measles and HIV/AIDS. Key intervention efforts include immunisation, Maternal and Child Health and Family Planning (MCH/FP), and primary health care (PHC).

Neonatal and Postnatal Mortality

Graph 5.13 indicates trends in Neonatal and postnatal mortality rates for the period 1993–2008/09. The Neonatal mortality increased to 33 deaths in 2003 from 26 deaths per 1,000 live births in 1993 while postnatal mortality also increased to 45 in 1998 from 36 deaths per 1,000 live births. Postnatal mortality stalled between 1998 and 2003 before drastically declining to 21 deaths in 2008/09 from 44 deaths per 1,000 live births in 2003. Neonatal mortality declined marginally to 31 deaths in 2008/09 from 33 deaths per 1,000 live births in 2003. There has been general improvement in childhood mortality indicators including neonatal and postnatal mortality rates since 2003.

Graph: 5.13 **Projected % of women of Reproductive age**

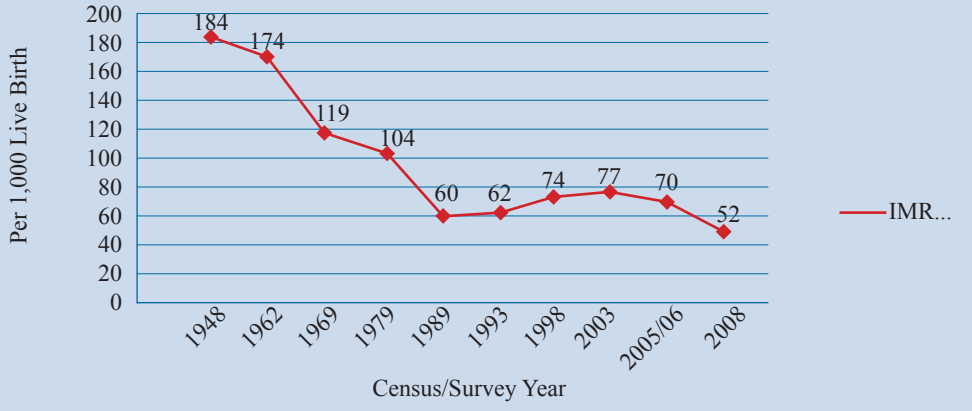


Source: KDHS Reports

Infant Mortality Rates

Infant and under-five Mortality rates are key indicators of child health and overall development of a country. They are sensitive indicators of general public health, sanitation and nutrition status of a country. Infant and under five mortality indicators are used to measure and track MDG 4. Graph 5.16 presents trends in IMR. IMR declined rapidly to 60 deaths in 1998 from 184 deaths per 1,000 live birth in 1948. It also reveals that IMR increased to 77 deaths in 2003 from 60 deaths per 1,000 live birth in 1989. Recent KDHS results indicate that the IMR decline trend has been regained as it declined to 52 deaths in 2008/09 from the high of 77 deaths per 1,000 live births in 2003.

Graph: 5.14 **Trends in IMR Mortality**



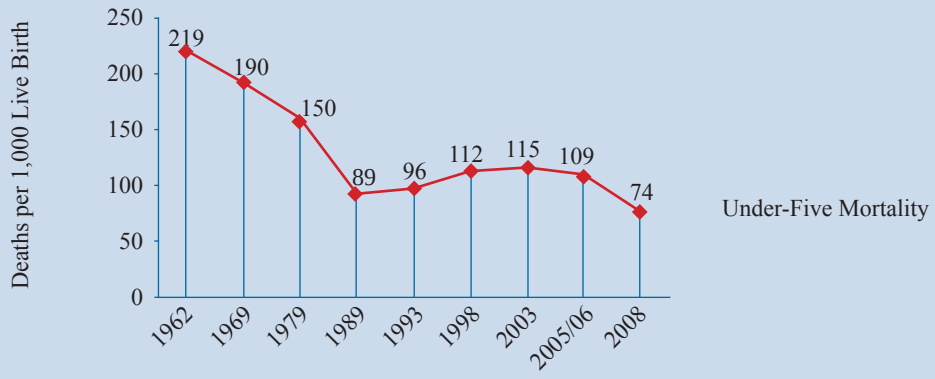
Source: Census, KDHS and KIHBS Reports

There are substantial regional differentials in IMR with Nyanza, N/Eastern and Western provinces recording unacceptably high rates. The Rural areas also record higher IMR than the urban areas. The Provinces with high incidence of Malaria, high poverty levels and low literacy levels record high IMR.

Under-Five Mortality

The under-five mortality rates maintained a consistent decline from a high of 219 deaths in 1962 to a low of 89 deaths per 1,000 live births in 1989 before starting to increase. The under-five mortality rate increased to 115 deaths in 2003 from 89 deaths per 1,000 live births in 1989.The under-five mortality is estimated to have improved to 74 deaths in 2008/09 from 115 deaths per 1,000 live births in 2003. Analysis of under-five mortality indicate high mortality rates in rural than urban areas. Further, Coast, Eastern, North-Eastern, Nyanza and western have higher mortality rates than the other provinces. The deterioration of childhood indicators between 1989 and 2003 has been attributed to the near collapse of health services in Kenya and childhood diseases that had been contained/ eliminated through primary health care programmes, especially through immunisation.

Graph: 5.15 **Trends in Under-Five Mortality**



Source: KDHS and KIHBS Reports

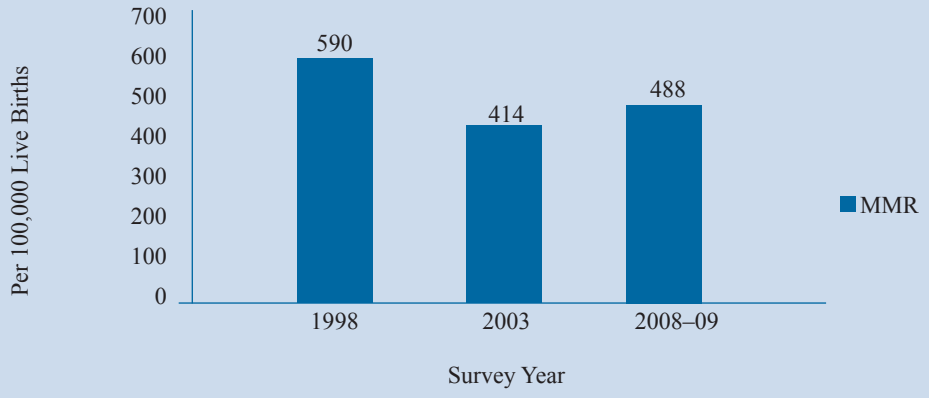
Maternal Morbidity and Mortality

Maternal health is an important area of reproductive health. The MDG 5 Target A aims to reduce MMR by three-quarters between 1990 and 2015, while Target B strives to achieve universal access to reproductive health by 2015. Trends in MMR indicate that this is one of the goals Kenya is not likely to achieve. Graph 5.16 shows that MMR increased to 488 in 2008/09 from 414 deaths per 100,000 live births in 2003.This was a reversal of the pattern that had been observed in the period 1998 to 2003 when MMR reduced to 414 deaths in 2003 from 590 deaths per 100,000 live births in 1998. It should be noted however that mortality data, and moreso the maternal mortality statistics are subject to a lot of error. Various reasons have been advanced for the inadequacy of mortality data,

key among them being the large sampling error, and socio-cultural myths, beliefs and practices associated with death, where family members rarely report the deaths.

Leading causes of maternal morbidity and mortality among Kenyan women are obstetric complications including haemorrhage, obstructed labour and unsafe abortion, with the latter causing more than one-third of maternal deaths

Graph: 5.16 **Trends in MMR**



Source: KDHS Reports

STI, HIV/AIDS

The STI, HIV/AIDS challenges have impacted negatively in the health and economic indicators for Kenya. The HIV prevalence based on general population aged 15–49 years was estimated at 6.7 per cent in 2003, 7.4 per cent in 2007 and 6.3 per cent in 2008/09. There are wide regional variations in the HIV prevalence and among the various population segments. The Prevalence is high among the women than men and among the poor. The three Sample Surveys of 2003, 2007 and 2008/09 revealed that the youth engage in risk sexual behaviour that results in STI, HIV/AIDs and unwanted pregnancies.

Life Expectancy

Change in mortality is reflected in the expectation of life at birth. Expectation of life is the average number of years a newborn is expected to live under the current mortality levels. In Kenya women have a higher life expectancy of about three years more than men. Life expectancy at birth improved to 57 years in 2009 from a low of only 35 years for both sexes in 1948, 49 years in 1969, 54 years in 1979 and 60 years in 1989.

Population Stabilisation Prospects

Attaining early population stabilisation for Kenya will be a challenge considering current Age-Sex structure of the population. The current population structure is broad-based with over 43 per cent of the population below age 15 who will create a forceful population momentum for future population growth. Prospects however abound of

population stabilisation in Kenya depending on the concerted efforts that will be put in place to realise this goal. The prospects include the following:

1. **2009 Census results indicate decrease in growth rates at regional levels.** Analysis of the Inter-censal growth rates between 1969 and 2009 indicate that the growth rates have reduced marginally in all provinces except the Rift valley.

Table 5.1: Trends in Inter-censal Growth Rate by Region, 1969–2009				
Province	**1969–79**	**1979–89**	**1989–99**	**1999–2009**
Nairobi	4.9	4.7	4.8	3.8
Central	3.4	2.8	1.8	1.6
Coast	3.5	3.1	3.1	2.9
Eastern	3.6	3.3	2.1	2.0
North-Eastern	4.2	-0.1	9.5	8.8
Nyanza	2.2	2.8	2.3	2.1
Rift Valley	3.8	4.2	3.4	3.6
Western	3.8	3.4	2.8	2.5
Kenya	3.4	3.4	2.9	3.0
Source: GOK 2009 Kenya Population and Housing Census Volume IA p.22				

Source: GOK 2009 Kenya Population and Housing Census Volume 1A, p.22

Further, population distribution by provinces for the period 1969–2009 indicates that the North Eastern province's population more than doubled since 1999. Nairobi and Coast were also provinces with the highest population increase. The observed increases are attributed to in-migration than fertility contribution. Sustaining the reduction in growth rate will be key to population stabilisation.

2. **Socio-economic and political development**. The social, economic and political development initiatives since 2003 have premised the country into solid development course that will contribute to population stabilisation. The key initiatives include:

- Vision 2030 and its Medium Term Plan: The flagship projects in all sectors of the economy will contribute to improved well-being of the population
- Political Reforms: The promulgation and operation of the new Constitution with devolved governance structure; Bill of Rights, Reproductive Health Rights and gender concerns enshrined in the Constitution
- Health reforms: introduction of budget line item for procurement of contraceptives will address commodity insecurity, reproductive health strategy and related policies and guidelines.
- Education: Free basic education and free secondary education tuition provide opportunities for both boys and girls to pursue education and improve their well-being.

3. **Population Policy for National Development.** The Population Policy for National Development has a clear goal, objectives, principles, and strategies that clearly will contribute to population stabilisation. Implementation through the proposed multisectoral approach will quicken attainment of Demographic, health and development targets.

4. **Development Partners' Support.** The National Population Programme has in recent times received Development Partners' support.

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CHAPTER 6

Demography in Mali: Situation and Implications

Mr Mountaga Toure

INTRODUCTION

Mali is 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.

Map of Mali

The country has eight administrative regions and one district which 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 kilometre 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 per cent of the population. The three northern regions of Gao, Kidal and Timbuktu cover two-thirds of the land area for only 10 per cent 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 highly indebted poor countries (HIPC) category ranks the 160th out of 169 countries in the world in the Human Development Index (HDI) 2010. Table 6.1 provides an overview of the evolution of certain demographic variables.

Table 6.1: Evolution of several variables, Mali

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

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

In Mali, although per capita GDP is at a slightly decreasing rate, it should be noted that economic performance in Mali depends on several endogenous and exogenous factors, including public and private investment, international environment (trade and official development assistance) and transfers of migrants. This decrease in GDP per capita may be due largely to demographic variables (population growth of 3.6 per cent 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 per cent in 2001 to 59.2 per cent in 2005 whereas it was expected 47.5 per cent. In 2009, 43.6 per cent of Mali's population lives below the poverty line.

In terms of recent changes in social conditions (i) the gross enrollment ratio (GER) in the first cycle of basic education increased from 79.5 per cent in 2009–2010 to 80.4 per cent in 2010–2011 but with marked regional disparities often, (ii) the rate of adult literacy (15 years and over) is at 29.4 per cent (ELIM 2009), (iii) only 58 per cent of the population lives within 5 km of a health center, 464 maternal deaths are recorded per 100 000 live births with an Infant mortality rate of 96 per thousand (56% of births are attended by trained personnel), (iv) the rate of prevalence of HIV/\AIDS fell from 1.7 per cent to 1.3 per cent 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 per cent (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.

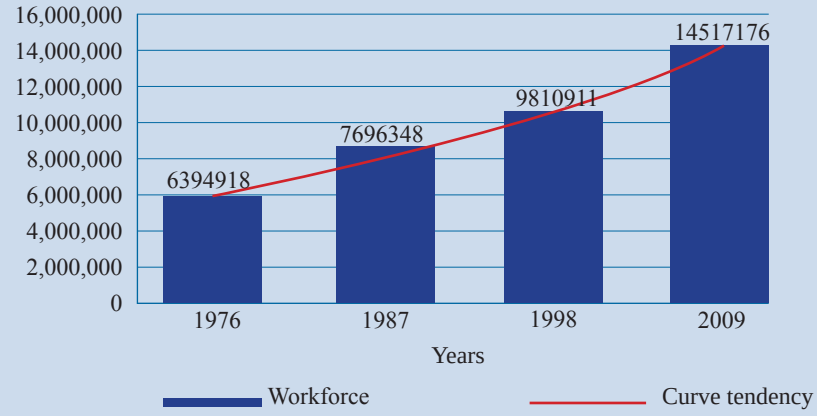
DEMOGRAPHIC TRENDS IN MALI

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 per cent 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 245 inhabitants per km² with its implications (pressure on natural resources, urbanisation/migration rapid growth of social spending). Graph 6.1 shows the evolution of the Malian population since 1976.

Graph: 6.1 **Evolution of the Malian Population**



Source: INSTAT, Preliminary Results RGPH 2009

This density is relativised with respect to the land area (1,241,238 sq.km) and the fact that nearly two-thirds of the country is in the Saharan zone with a density of less than one per km.

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 remained at very high levels.

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

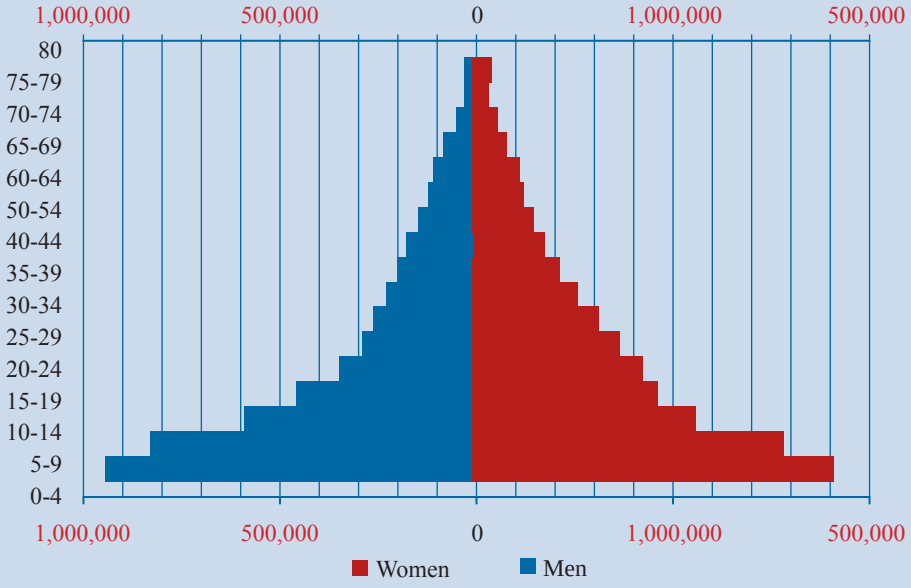
- The crude death rate was almost divided by 2 between 1950 and 2005 (over 30 per thousand to almost 15 miles) while the birth rate has remained almost constant over the same period for more than 50 miles.
- Mortality, especially mothers and children, fell sharply. The maternal mortality rate rose from 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.

Population 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). There are 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 realise how high fertility (6.6 children per woman on average) and the young population (60% are under 25 years).

Graph: 6.2a **Age Pyramid, Mali 1998**



Source: Based on data from the National Population

Concentrated in the south-east quarter of the country, this population is predominantly rural (70%). However, urbanisation 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 as greatly reduced due to rural exodus. Urbanisation today is not only because of the magnitude of this internal migration but also return migration, because of political instability .

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.

Population growth and economics

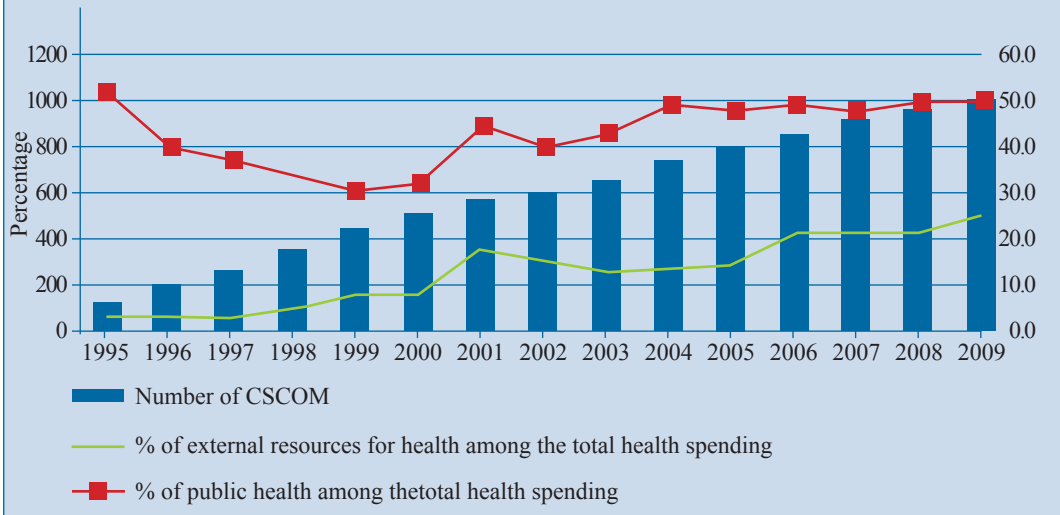
Economic growth, often low, fluctuating and largely dependent on exogenous factors, is a large phase shift with increasing population size and growth rate of the needs of young people. This results in absorption of capital gains and a slowdown in investment (source of growth) in the construction of quality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

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 labour. 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.

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 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 quality services. Graph 6.3 provides an overview of the development of indicators of the health system.

Graph: 6.2b **Infrastructure (CHC), foreign aid and public expenditure on health from 1995–2009**



Source: Note from a contribution of UNFPA to the formulation of Mali CSCRP 2012–2017, July 2011

Population growth and education

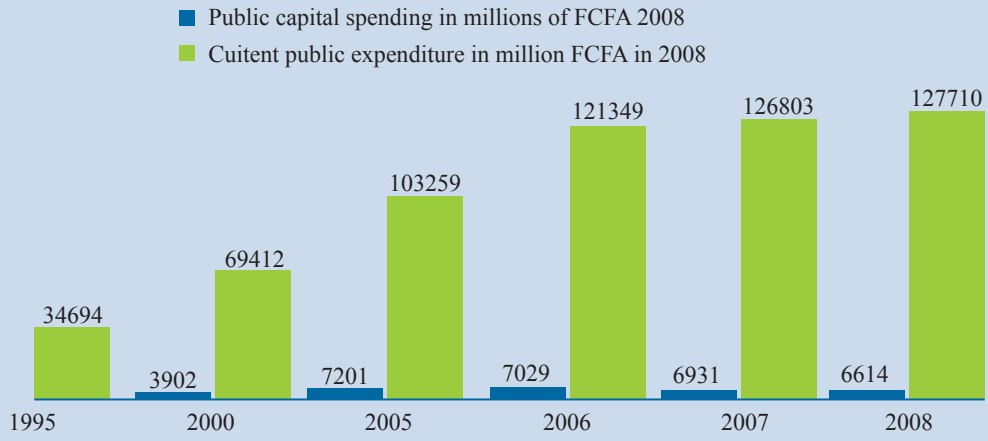
Public expenditure on education has quadrupled between 1995 and 2008. Despite the increasing efforts of the Government for education and partly because of the high population growth, indicators of education fall short of targets and thus constrain achievement of MDG 3. For example, the following table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

Table 6.2: 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

Graph 6.3 shows 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, investment in new infrastructure and equipment. The state, which is facing the rapid growth of the workforce each year, is finally encouraged to spend most of the resources allocated to the management of effects related to the increased demand in the various cycles of education.

Graph: 6.3 **Composition of Public Expenses on Education**



Source: Donnéen RESEN, 2010

Population growth and spatial imbalance

The spatial distribution in Mali is characterised by a large disparity between the North and the South with an average density ranging from 1.3 per km² 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 per cent of the population occupies less than 25 per cent of the country. The pace of this imbalance is steadily increasing since the first RGPH of 1976 which provided for the northern 14 per cent of the total population as against less than 9 per cent 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 per cent 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 urbanisation 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 per cent in 1987 to 26.8 per cent in 1998 and is located in 2006 to 31.7 per cent of the total population.

FAMILY PLANNING AS A RESPONSE TO HIGH POPULATION GROWTH

The control of population growth is impacted by 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 realise that since 1987 the fertility rate did not

change significantly, remaining around 6.6 children per woman. Even though a National Population Policy (NPP) exists in Mali since 1991, its implementation through the Priority Program of Action and Investments have failed to achieve the objectives of the population policy.

Overview of the National Population Policy (NPP)

The interest in population transition issues developed amongst the national authorities in 1983 with the creation of a national "population unit" to coordinate the work of multi-sectorial group responsible for developing a population policy. A statement of NPP was adopted in 1991 and was revised in 2003. The infrastructure of the population unit in the government has increased for 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) established in 2004 for the management of the NPP is now affiliated to the Ministry of Economy and Finance. The achievement of the population policy document in 2003 included quantified targets and take into account the recommendations of the ICPD, Cairo (1994). The overall objective assigned to this policy is "improving the level and quality of living" through 10 main objectives and 25 specific objectives.

- In the area of reproductive health, for example, the policy was expected to help the numerical targets. 6 Numerical targets have been identified in three goals based on 10 objectives. These goals are related to education, health and fertility to reduce maternal, infant, and child mortality and improve the reproductive health status of populations. 50 per cent 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 per cent in 2001 to 50 per cent in 2025, and the child mortality rate from 128 per cent in 2001 to 65 per cent by 2025.
- Increasing the rate of uptake of reproductive health services.
- Progressive control of fertility.
- To increase uptake of modern contraceptive prevalence rate from 8.2 per cent in 2001 to 30 per cent in 2025.
- The promotion of 18 as the age for young women's marriage. marriage of the girl 18.

The lack of means on the one hand and the low commitment of the stakeholders on the other (lack of understanding about the scope of the population policy document) 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.

State Family Planning in Mali

As an outcome of numerous interventions in outreach and advocacy with policy makers, a law (No. 02-044) on the reproductive health and an Action Plan to ensure secure contraception were adopted in 2002 by the National Assembly and the government of Mali. This national commitment was to contribute to the promotion of strong family planning services in Mali on the one hand and financing for contraceptive commodities through national funding. However, it is from 2009 that the government has committed to support 10 per cent to 15 per cent of the annual cost for the provision of contraceptives. Several other programmes 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 less prioritisation of financing of the family planning programs and plans, since 2005 Mali has undertaken "repositioning family planning" with a national campaign for one month each year.

At present with the assistance of UNFPA, a strategic plan for Securing Products Reproductive Health (RHCS) was developed and is implemented with four components: a) obstetric and neonatal care, b) family planning, c) STI/HIV/AIDS and d) blood products.

The evolution of family planning acceptance and services are gradual. For instance, only 8 per cent of them use any method, 7 per cent use a modern method and 1 per cent a traditional method. In addition, 3 per cent for the pill, injectables, 3 per cent and 1 per cent for Lactational amenorrhea method (LAM).

Table 6.3: Contraceptive prevalence in Mali

DHS	EDS 1987	EDS 1995–1996	EDS 2001	EDS 2006
Contraceptive prevalence rate (without breastfeeding without LAM) in% of women	4.7	6.7	6.9	7.7
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) mothers decreased from 40 per cent in 2001 to 36 per cent in 2006 (EDS IV), already at that time in their lives, adolescents in this age group account for 14 per cent to total fertility.

Table 6.4 shows that the demand and use of family planning services is low in Mali, especially in women less educated and poorer. As noted above, customs contributes to the non-use of contraceptives, the level of education and poor decision-making skills may also

explain this situation. However, regardless of education and poverty status of women, the average and desired number of children expected by women is between 5 and 7.

Table 6.4: 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	
By educational attainment						
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	38.1	52.4	14.7	67.1	43
By wealth quintile						
poorest women	3.7	31.7	23.6	11.8	35.4	11
very poor women	5	30.6	22.6	12.9	35.5	14
Poor	4.6	30.8	22.3	13.1	35.3	13
Foyennes	8	29.3	26.1	11.3	37.4	22
wealthy women	19.1	33.6	39.3	13.4	52.7	36
TOGETHER	8.2	31.2	26.9	12.5	39.5	21

Source: inspired Guengant Diallo JP and H, (2009)

Recommendations for effective promotion of family planning

The suggestions below are neither exhaustive nor exclusive.

- Provide education opportunities for girls for greater access to information on fertility.
- Develop. and implement a communication plan on reproductive health of women
- Implement a plan of action for FP involving all stakeholders at central and local levels.
- Take into account all population issues such as social, cultural and gender issues effectively while planningpopulation issues..

THE PREVALENCE OF HIV/AIDS AND ITS IMPACT ON POPULATION

The prevalence rate of HIV/AIDS is 1.3 per cent including 1.5 per cent of women and 1.0 per cent of men. This rate fell by 0.4 per cent between 2001 and 2006 (from 1.7% to 1.3%). The prevalence ranged from 0.5 per cent to 1.9 per cent in Timbuktu to Bamako. The more educated and those living in the richest households have a high prevalence.

- The prevalence of HIV among widowed and divorced is higher than the married or single.
- The risk of women with a risk partner is equivalent to a man who have had three or more high-risk partners.

- The vast majority of women and men with HIV do not know their HIV status.
- Although the existing research and monitoring data is minimal, it indicates the need for strong action in reducing the risk and vulnerability.

The strategy against HIV and AIDS

In Mali, the context of the fight against AIDS is marked by several challenges. The country is signatory to major international and sub-regional commitments in the fight against HIV/AIDS such as MDGs, UNGASS and the Abuja declaration. The list below discusses a snapshot of opportunities and challenges in the fight against HIV/AIDS:

- The march towards democracy and the general framework of shared governance are major assets against the fights against HIV.
- HIV is part of fight against poverty and sustainable development.
- The country's geographical location presents significant challenges and constraints to development.
- The economic context of the country is another challenge.
- The levels of access to education and communication are below the required threshold for effective HIV response.
- There are great human resource development challenges.
- The national policy statement of the fight against HIV and AIDS recommends provision of free care and medications of ARVs to people living with HIV.
- The National Strategic Framework to fight against AIDS and the AIDS Sector Plan of the Ministry of Health (2005–2009) emphasises the decentralisation of the prevention, care and treatment.

Sentinel surveillance

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

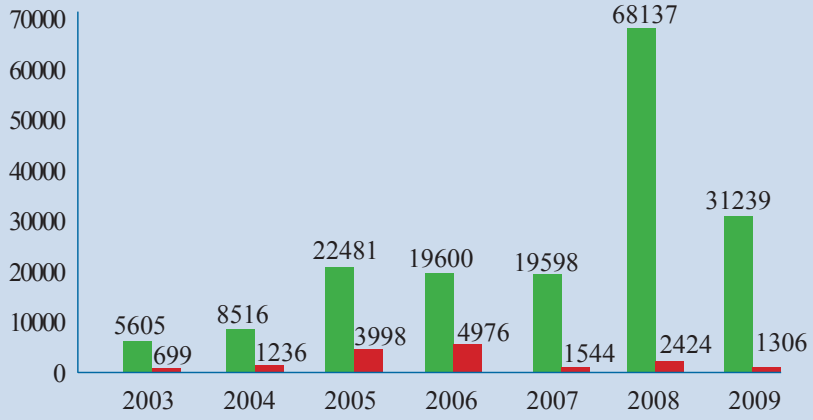
- Sex workers: 35.3 per cent;
- Street vendors: 5.9 per cent;
- Touts: 2.2 per cent;
- Caregivers: 2.2 per cent.

Blood safety

- Development of national blood transfusion programme.
- 8 satellite transfusion centres were created in areas in addition to the National Blood Transfusion Centre (N) in Bamako.
- 140,743 units of blood were collected and tested at the eight satellite centres and the District of Bamako since 2006 including 28,762 of January to June 2009.

- In addition to HIV, testing for Hepatitis B (HBV), Hepatitis C (HCV) and Syphilis are performed. A national policy document on injection safety was developed.
- Training of the staff at central and operational levels.
- Implementation of care proptical for accidental exposure to infected or contaminated blood. Supervision of activities to implement the policy of prevention in health care.

Graph: 6.4 **Number of people screened in the CDS sites**



	2003	2004	2005	2006	2007	2008	2009
	5605	8516	22481	19600	19598	68137	31239
	699	1236	3998	4976	1544	2424	1306

The main determinants of the HIV epidemic in Mali are unequal gender relations, internal and external migration, widespread poverty stigma and discrimination of PLHIV, their families and communities affected by HIV/AIDS that put people in marginalised and vulnerable positions. Finally, the impact of socio-cultural practices create a culture of risk.

The impact of the epidemic affects all development sectors through direct and indirect costs that potentially reduces the productivity of the work force. The national response against the HIV is marked by both strengths and weaknesses. Among the strengths include a strong political will and commitment and responsive civil society. The technical and financial partners also create the conditions to implement to take strategic control. The national policy statement to fight against HIV/AIDS was adopted in April 7, 2004 and since then the High Council of National AIDS Control (HCNLS) was reorganized. It has equal representation between the public sector, private sector and civil society that counts among its members including representatives of associations of people living with HIV.

CONCLUSION AND RECOMMENDATIONS

High population growth (3.6%) can be regarded as a constraint to growth and economic development. The large proportion of young people under 25 can constitute a threat to social stability due to unemployment, lack of schooling and welfare system and/or opportunities. However, the Government of Mali seems to have realised the urgency

to act and embody this and have begun the process of formulating the next CSCRP: taking into account the demographic and population issues in general. Having said this, it remains a challenge to integrate this into CSCRP due to the weak technical capacity of institutions-in-charge for the formulation and implementation of population development policies.

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	1.3%
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	105
Infant – juvenile mortality rate (per 1,000 live births)	2008	191
Maternal mortality rate (per 100,000 live births)	2009	464
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

Source: Document draft CSCRP, 2012–2017

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CHAPTER 7

NIGERIA'S PROGRESS IN ACHIEVING POPULATION STABILISATION

Falilat Nike Abdul-Raheem

INTRODUCTION

Nigeria lies in the heart of West Africa, and occupies a land mass of approximately 923,763 sq. km. It has borders with the following Republics: Niger and Chad to the north; Cameroon to the east; Benin to the west; and the Atlantic Ocean to the south. Nigeria is the 6th largest country in the world after China, India, USA, Indonesia and Brazil and the most populous in Africa, with a 167 million population. At least one in every five African is a Nigerian. With a wide range of climatic, vegetation and soil conditions, the country is blessed with minerals, forests and water resources.

At the current annual population growth rate of 3.2 per cent, the population is expected to double by the year 2030. The rapid population growth rate can be attributed to the high total fertility rate (TFR of 5.7), a large proportion of women in the reproductive age group (about 22% of the total population) have a low contraceptive prevalence rate of 15 per cent for all methods and 10 per cent for modern methods and unmet need of 20 per cent for family planning. The life expectancy at birth for women and men is estimated at 47.1 years and 46 years respectively.

History of Nigeria

Before 1914, the two territories in Nigeria-Northern and Southern Protectorates were administered separately. The two territories were brought together to form one Nigeria in 1914 under a colonial rule. During this period there were prolonged demands for participation in the government at all levels, culminating in political Independence on 1st October 1960 with three regions namely – Northern, Western and Eastern regions. These regions were replaced by 12 states in 1967. In 1976, seven new states were created resulting in 19 states. In 1987, two more new states were formed, making 21 states in all. 1991 saw the creation of nine more states bringing the total to 30. Currently, Nigeria has 36 state and 774 Local government areas (LGAs) while the Federal Capital Territory (FCT) is divided into 6 local area councils.

Nigeria had tried the parliamentary form of governance and currently the American type of Presidential system is being practised with three tiers of government:

- Federal with the national assembly (made up of the Senates and the Federal House of Representatives). There are three distinct arms of government at the Federal level – the Legislature, the Executive and the Judiciary.
- State with the State legislature under the State governor;
- Local Government with the counselors under the leadership of the LGA chairperson.

Population of Nigeria

The history of census-taking in Nigeria dates back to 1911. Since then until the most recent Census in 2006, the country has recorded about 12 censuses. The most recent was held in 2006. The 2006 Census, in addition to demographic variables, collected information on Housing and Amenities for the first time in the history of census-taking in Nigeria.

All these have provided valuable data for Programme Managers and Policy Makers at various tiers of Nigerian government. To deepen the understanding of the interrelationships between population dynamics and sustainable development, Nigeria has conducted various surveys such as the Nigeria Demographic and Health Survey (NDHS) in 1999, 2003, 2008; Education Survey (ED) 2003, 2008; Malaria Survey 2010, etc.

The total population of Nigeria from the 2006 Census is 140,431,790 with 71,345,488 males and 69,086,302 females respectively with an annual growth rate of 3.2 per cent. Nigeria therefore has one of the fastest growing populations in the world. One peculiar characteristics of the population is that it is a youthful population. With ages 0–24 years constituting 62 per cent of the total population (NPC, 2009), this has serious implications for development.

The average population density for the country in 2006 was 150 persons per square kilometre. With more than 350 ethnic/linguistic groups and a variety of social groups in the country, the main religions are Christianity and Islam. Majority of the population reside in rural areas. The 1991 Census revealed that only 36 per cent of the population was urban, and this was to increase to 39 per cent and 42 per cent in 2000 and 2010 respectively. Projections show that the urban population will be 46 per cent in 2020.

Economy

Agriculture has traditionally been the mainstay of the Nigerian economy. At the time of the country's Independence in 1963, more than 75 per cent of the country's formal labour force was engaged in agriculture which also provided a satisfactory livelihood to more than 90 per cent of the population. With the discovery of oil, the dominant role of agriculture in the economy, especially in terms of the country's foreign exchange earnings, gave way to petroleum. By 2006, the contribution of agriculture to gross domestic product (GDP) was 32.5 per cent compared with 38.8 per cent contribution from oil and gas. Oil and gas now dominate the economy, contributing 99 per cent of export revenues and 78 per cent

of government revenues. Within the non-oil sector, agriculture still plays a substantial role, followed by industry, service, and wholesale/retail trade.

Global financial and economic crises commenced in 2008/2009. However, recovery began in 2010 with the global GDP growth rate rising to 5.3 per cent from 0.6 per cent in 2009. Recent data from NBS revealed that the overall real GDP growth rate was 7.36 per cent in 2011 as against 7.98 per cent in 2010. The macro-economic environment in Nigeria remained stable in 2011, resulting in an enhanced overall performance of the economy. Growth was robust across major sectors and quarters of the year, however this growth did not translate into commensurate level of job creation. Nigeria was rated the 3rd fastest growing economy in the world, after China and Mongolia. Nigeria has the largest economy in the West Africa Region, 3rd largest economy in Africa (following South Africa and Egypt), and on track to becoming one of the top 30 economies in the world.

Nigeria's economic size and per capita GDP have increased, though, at a slightly lower pace, nominal GDP and per capita GDP increased from $226.14 billion and $1, 419.69 to US$242.4 billion and $1,474.56 respectively in 2011. This translated into a GDP and per capita growth rates of 7.36 per cent and 4.16 per cent respectively, falling short of the double-digit GDP growth requirement for attaining our objective. But these increments in GDP were not enough to keep up with the population growth and as a consequence, per capital income did not increase greatly, implying that the welfare of the average Nigerian has not improved significantly. The population living below the national poverty line is 54.4 per cent (UNFPA, 2011).

Inflation, though declining, fell short of the single digit target under the ECOWAS' Convergence Criteria. Inflation on a 12-month average basis plunged downwards from 13.7 per cent in 2010 to 10.8 per cent in 2011. The rate of unemployment declined from 13.1 per cent in 2000 to 12.6 per cent in 2002. From 2005 to date however, the national unemployment rate has been increasing from 11.9 per cent in 2009 to 12.3, 12.7, 14.9 and 19.7 per cent in 2006, 2007, 2008 and 2009 respectively. The Latest results released by NBS show that the national unemployment rate was 23.9 per cent in 2011 as compared with 21.7 per cent in 2010. Significant group of the unemployed citizens are the youth. Total labour force employed stood at 51.18 million or 76.1 per cent of the workforce in 2011 as against 51.22 million in 2010. This is an indication that over 42 thousand persons lost their jobs in 2011.

Nigeria's external reserves position witnessed a modest improvement in 2011 due to favourable trade balance, particularly from crude petroleum. The external reserves stood at US$32.64 billion end-December 2011 compared with US$32.34 billion end-December 2010 indicating a slight increase of 0.93 per cent. The non-oil sector GDP growth is projected to rise from 8.85 per cent in 2011 to 9.11 per cent in 2012. Nigeria's GDP growth rate is projected at 7.61 per cent for 2012 and 7.93 per cent by 2015.

Despite the enormous income from oil and other sectors of the economy, such as agriculture, entertainment and industry, over 52.6 per cent of Nigerians are still poor. The majority of these are women living in the rural areas. Access to quality and affordable health services and other basic amenities, including safe drinking water and improved sanitation facilities is limited and, economic opportunities remain poor.

To sustain Nigeria's prospects in the medium term, a home-grown long term strategic framework was introduced with NV 20:2020 as foundation; this was aimed at repositioning Nigeria to be among the top 20 economies measured by GDP by year 2020. The 1st National Implementation Plan (NIP), States Plans, Millenium Development Goals (MDGs), and Government's Transformation Agenda, Subsidy Reinvestment Programme (Sure-P) are all medium term implementation plans for effective implementation of NV20:2020

Aim and Objectives

The aim of the population stabilisation chapter is to track the Nigerian's progress towards achievement of a National Policy on population for sustainable development. This report was necessitated by the desire of the International Conference on Population and Development (ICPD) to assist developing countries to address the challenges of population and development through information sharing and policy tracking. The population of the world cannot be growing indefinitely without commensurate infrastructural facilities to cater for the people; hence there is need for effective population management especially among the developing countries.

The key objectives are:

- Review the current demographic projections of the 2004 NPP goals, indicators and targets beyond 2015 vis-à-vis the period that the country's population is likely to stabilise.
- Assess the current status and future requirements (short, medium & long-term) of demographic, socio-economic behaviour for meeting service delivery for women, children and newborn, young people (including adolescents) and the aged, beyond 2015 in line with Vision 20:2020.
- Project financial implications for implementation of family welfare programme during the Vision period, including the plan and non-plan requirements; and the Centre-State participation in the funding.
- Make recommendations and policy implications, and suggest effective strategies for achieving early population stabilisation.

Methodology

To prepare this chapter, the National Planning Commission (NPC) commissioned a consultant to provide a draft Population Stabilisation Report. The draft report was reviewed by the National Task Force (NTF) for South-South Cooperation (SSC) on Partners for Population and Development (PPD) in its quarterly meeting and during

which a Technical Committee (TC) was constituted to revise the draft report based on its inputs. The TC collated the suggestions from various members of NTF and worked in two sub-committees to revise the draft report, which was validated by the NTF.

Sources of data

The report was based on qualitative research methods, derived from secondary data obtained from the current Country based reports from the National Bureau of Statistics (NBS), National Population Commission, Federal Ministry of Health, Federal Ministry of Youth Development, Ministry of Women and Social Development and National Planning Commission. Sources of data are as follows:

- 2006 Population and Housing Census priority table Reports.
- 2008 Nigeria Demographic and Health Survey Report.
- 2010 Nigeria Ed Data Survey Report.
- 2010 Nigeria Ed Data Survey Report.
- Nigeria Vision 2020:2020 Economic transformation blueprint Report.
- 2009 National Youth Development Report.
- 2011 GPRHCS Survey.

THE POLICY ENVIRONMENT

International Treaties and Conventions

Nigeria has ratified a number of conventions which include the International Conference on Population and Development 1994, the Banjul Charter (1983), Beijing Platform for Action (1985), Convention on the Rights (1991), Civil and Political Rights Covenant (1993), Economic, Social and Cultural Rights Covenant (1993). Convention on the Elimination of All forms Discrimination Against Women (CEDAW) adopted in 1979 and was ratified in 1984 and the African Human Rights Charter adopted in 1981 and came into force in 1986. However, many of these Conventions have not been domesticated and are therefore not enforceable.

National Policy on Population

The Federal Government of Nigeria approved the National Policy on Population (NPP) for Development, Unity, Progress and Self Reliance in 1988, in response to the pattern of population growth and its adverse effect on national development. However, the NPP was widely criticised due to unrealistic and unachievable targets, gender insensitivity and preservation of obnoxious values, which ran contrary to the principles of gender equity and equality as recommended in the International Conference on Population and Development (ICPD) Egypt 1994 and other consensus documents and Treaties. In addition, the emergence of HIV/AIDS, Poverty, Gender Inequality among several others issues have necessitated the review of the 1988 NPP. The new National Policy on Population for Sustainable Development was developed and approved by the government

in 2004 and launched in February 2005. The overall goal of the New National Policy on Population for Sustainable Development is:

- Improve quality of life and as well as living standards of Nigerians (FGN, 2004).
- Achievement of sustained economic growth, poverty eradication, protection and preservation of the environment and provision of quality social services.
- Achievement of a balance between the rate of population growth, available resources, and the social and economic development of the country.
- Progress towards a complete demographic transition to a reasonable growth in birth rates and low death rates.
- Improvement in the reproductive health of all Nigerians at every stage of the human life cycle.
- Acceleration of a strong and immediate response to the HIV/AIDS and other related infectious diseases.
- Progress in achieving balanced and integrated urban and rural development.

The new National Population Policy targets are:

- Reduce the national population growth rate to 2 per cent or lower by 2015.
- Reduce the total fertility rate by at least 0.6 children every five years by encouraging child spacing through the use of family planning.
- Increase the contraceptive prevalence rate for modern methods by at least two percentage points per year through the use of family planning.
- Reduce the infant mortality rate to 35 per 1,000 live births by 2015.
- Reduce the child mortality rate to 45 per 1,000 live births by 2010.
- Reduce the maternal mortality ratio to 125 per 100,000 live births by 2010 and to 75 by 2015.
- Achieve sustainable universal basic education as soon as possible before 2015.
- Eliminate the gap between males and females in school enrolment at all levels and in vocational and technical education by 2015.
- Eliminate illiteracy by 2020;
- Achieve at least a 25 per cent reduction in HIV/AIDS adult prevalence every five years.

In realisation of the fact that the implementation of the NPP is a complex and multi-sectoral activity, the institutional framework for its implementation saddled the task of implementation on all tiers and relevant agencies of the government, the private sector, non-governmental organisations and communities.

Other Relevant Policies and Programmes

Social policies and programmes

A number of policies and strategic plans and frameworks were formulated towards creating the right environment for population stabilisation,. These include, the National Strategic Health Development Plan 2011, Integrated Maternal Newborn and Child Health Strategy 2007 (currently being revised), National Reproductive Health Policy and Strategy launched (2001) and revised in 2010, National Reproductive Health Commodity Security Strategic Plan (RHCS) 2011–15, National Policy on Adolescent Health and Development (2007), National Gender Policy 2006, Child Rights Act 2003, National Agency for Prohibition of Traffic in Persons and other Related Matters NAPTIP Act 2003 (Amendment, 2005) National Policy on the Elimination of Female Genital Mutilation (1998), National Policy on HIV/AIDS/STIs Control (2009), National Food and Nutrition Policy (1995), Breast Feeding Policy (1994) and Maternal Child Health Policy (1994) and the Plan of Control on non-communicable diseases in Nigeria (1999), National Human Resources for Health 2006 and National Youth Policy, 2009.

In view of the above, the Government of Nigeria has taken several actions to ensure that population concerns are fully incorporated into Government policies and programmes. These include:

- Vision 20:2020.
- National Food Security Programme, 2007–2012.
- National Gender Policy (2006).
- National Poverty Eradication Programme (NAPEP).
- National Health Insurance Scheme.
- National Primary Health Care Development Agency.
- Midwifery Service Scheme.
- Subsidy Reinvestment programme (SURE-P).

Impact of Policies on Population and Development

In planning programmes to improve the health and socio-economic well-being of citizens, the Government of Nigeria, as a matter of priority, has taken into account the importance of socio-demographic indicators in developing its policies and programmes.

Health

The National Strategic Health Development Plan, Integrated Maternal, Newborn and Child Health Strategy, and other reproductive health as well as adolescent health policies and frameworks provide the guidance needed for the provision of quality reproductive health services. The Policy documents also contain measures relating to reproductive and sexual rights and the freedom to make an informed choice without discrimination,

coercion and violence. But currently there is no legislative provision or visible institution framework in place to enforce reproductive rights.

The components of reproductive health such as the provision of family planning and information services, provision of Antenatal care services, emergency obstetric care, prevention and management of the consequences of abortion, prevention and appropriate treatment of infertility as well as the elimination of harmful practices have been integrated into existing guidelines and standing orders for primary health care.

Studies have shown that the provision of family planning services has the potential of reducing maternal and child mortality by as much as 30 per cent and 25 per cent, respectively. Recognising the importance of family planning to improve the health and well-being of Nigerians, the Ministry of Health has put in place a National Reproductive Health Commodity Security Strategic Plan (RHCS) 2011–15 and is committed to meeting the country's unmet need for reproductive health services and commodities.

Presently, the government releases three million dollars annually for the purchase of reproductive health commodities. In addition to this commitment, the government of Nigeria further pledged an additional eight million three hundred and fifty thousand dollars annually for the next four years at the recent global family planning summit held in London in July 2012. This is meant to expand access to contraceptive commodities with also free access to contraceptive commodities in all Primary Health Facilities nationwide.

Socio-cultural beliefs and negative health seeking behaviours are barriers to the uptake of reproductive health services in Nigeria. Advocacy, sensitisation and awareness creation on sexual and reproductive rights issues using the international and national instruments are some of the strategies being used. A number of national instruments, including laws and policies have clearly articulated provisions against forced marriages, teenage pregnancy, discrimination against women and gender-based violence of whatever form. The government is also working with Campaign Against Unwanted Pregnancy to develop a bill on expanded access to post abortion care and management of post abortion complications as a sexual and reproductive right choice. Government has also been responding favourably to demands for reforms, review of the law, the constitution and policies. One area where a lot of gains have been made is in breaking the silence on Sexuality and reproductive health education especially as it concerns adolescents. There is a general awareness, however a lot is still required to educate the populace sufficiently and diverse strategies including translations, production of simplified versions, radio jingles posters, drama, etc., are some of the strategies being considered to increase the knowledge base of sexual reproductive rights in addition to already existing initiatives.

The national adolescent health policy was developed in 1995 and revised in 2007 to address issues relating to the reproductive health and rights of adolescents. The National curriculum and guidelines on sexuality education have been developed and approved by the Federal Ministry of Education and it is being implemented in most parts of the

country. Youth friendly clinics, catering to in- and out-of-school youths, have been built and NGOs and CBOs are encouraged to support programmes for young persons. A programme, which integrates population and family life education into 7 key subjects in post primary schools, is being implemented in most parts of the country.

Gender Mainstreaming

A National Gender Policy and its Implementation Framework have been developed and is being implemented incorporating the principles of the ICPD, Accra Agenda for Action (AAA) as well as the Beijing Platform for Action. The policy provides statements into national goals and sectoral objectives by analysing the ways and manner that gender inequality intervenes with the achievement of local, national, regional and global policy outcomes. However, there is an intense advocacy at all levels by the government to promote funds mobilisation towards the reduction of maternal death and improvement in child health. To do this, there is currently an Emergency Ambulance Intervention Scheme and Essential commodities implemented by the government aimed at accelerating the reduction of Maternal and Child Mortality among several other initiatives with partners.

National policies and standards are centrally developed, articulated and monitored. An appropriate and conducive policy environment exists in Nigeria for the implementation of the National Policy on Gender in Basic Education. Already there are many education policies on specific aspects. These include: The National Policy on Education; the Universal Basic Education Policy; an Integrated early Child Care and Education policy and a National Policy on Women among others. Nigeria is a signatory to many conventions on education. These include the 1990 World Conference on Education for All (EFA) in Jomtien, the Ouagadougou (1992) 'Declaration on the Education of Women and Girls', the Dakar (2002) Framework for Action which declared the basic learning needs of all – 'Education for All (EFA). Improvement on the Universal Primary Education commenced in 2001 with the implementation of the Universal Basic Education programme while technical and vocational educations were revitalised to produce qualified middle-level human resources. Other programmes in the education sector include Adult Literacy Programmes and Nomadic Education.

Environmental Sustainability

Environmental factors are taken into account as a matter of policy. In the industrial sector, environmental impact assessment has been made a requirement for sitting industries. The Federal Ministry of Environment is established to work with relevant Government ministries to ensure consideration of environmental issues in the national and sectoral plans.

Population, Sustained Economic Growth and Poverty

The Government, realising that poverty is a major impediment to sustainable development, has put in place a number of programmes designed to increase people's access to employment, education, skills development, information and quality general and reproductive health services to reduce the scourge of poverty in the country. The

programmes to address poverty include the National Poverty Eradication Programme (NAPEP) including the Youth Empowerment Scheme (YES) and Rural Infrastructures Development Scheme (RIDS), the Social Welfare Services Scheme (SOWESS), National Directorate of Employment (NDE).

Initiatives include Urban Mass Transit Programme, Community/People's Banks, development of Small and Medium Scale Enterprises, the National Economic Empowerment and Development Strategy (NEEDS) and Vision 20:2020 which captures the key principles and thrusts of NEEDS and the Seven Point Agenda.

Population and Environment

One of the objectives of the National Policy on Environment is to encourage measures which would sustain a balance between population and environment. Some of the strategies for the realisation of this objective include addressing the issues of population growth and resource consumption in an integrated way, integration of population and environmental factors in national development planning among others. The institutional framework for the implementation of the policy was put in place and strengthened to ensure infusion of environment consciousness into the national planning and development processes. However, the environment continues to be threatened with the proportion of land area covered by forest dropping from 14.6 per cent in 2000 to 12.6 per cent in 2007 and to 9.9 per cent in 2009. The forests provide employment for more than two million people, especially in fuel wood harvesting and poles. Gas flaring also constitutes environmental menace in the oil producing areas with the proportion of gas flare falling from 53 per cent in 2000 to 34 per cent in 2007. Progress towards achieving total elimination of gas flaring has been encouraging, especially with the 2008 deadline given to oil producing companies to stop gas flaring. With respect to portable water, the proportion of people with access to safe drinking water dropped from 54 per cent in 2000 to 49.1 per cent in 2007. The proportion increased to 55.8 per cent and 58.9 per cent in 2008 and 2009 respectively. It is targeted that by 2015, the proportion should increase to 77 per cent. Also, the proportion of population using an improved sanitation facility increased from 33 per cent in 2006 to 42.9 per cent and 53.8 per cent in 2007 and 2008 respectively. It then declined to 51.6 per cent in 2009. It is targeted that by 2015, the proportion of population using an improved sanitation facility should be 70 per cent (FGN, 2010).

The growing problem of urban air pollution due to increasing number of highly polluting vehicles is a major challenge. At the moment, the institutional framework for environment management is still weak, especially at the state and local government levels while appropriate framework for the participation of the private sector in environmental conservation and management is still lacking. Slow rate of introduction and adoption of efficient and environment friendly technologies in waste management, power generation and air pollution control in industries remains a problem. While poor housing financing and delivery systems have persistently excluded the poor from access to affordable housing, the high cost of land also compounds access of the poor to land.

POPULATION SITUATION

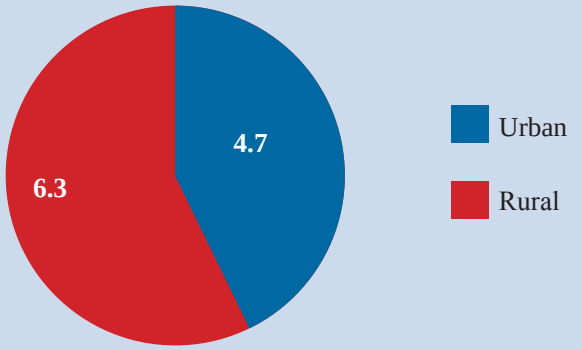
Population Size and Growth

Nigeria, the most populous country in Africa and one of the ten most populous countries in the world has experienced rapid population growth over the years. The post colonial censuses indicate that the population has been increasing from 55.66 million in 1963 to 79.76 million in 1973, 88.99 million in 1991 and 140.4 million in 2006. Present projections put the population of the country at 167 million (NPopC, 2011). The population growth rate over the years has not been stable, varying from 6.04 per cent in 1963 to 4.82 per cent in 1973, further declining to 2.82 per cent in 1991 and then rising to 3.18 per cent in 2006. This growth rate raises concern on the possibility of achieving the target 2 per cent or lower by 2015.

Fertility Rate

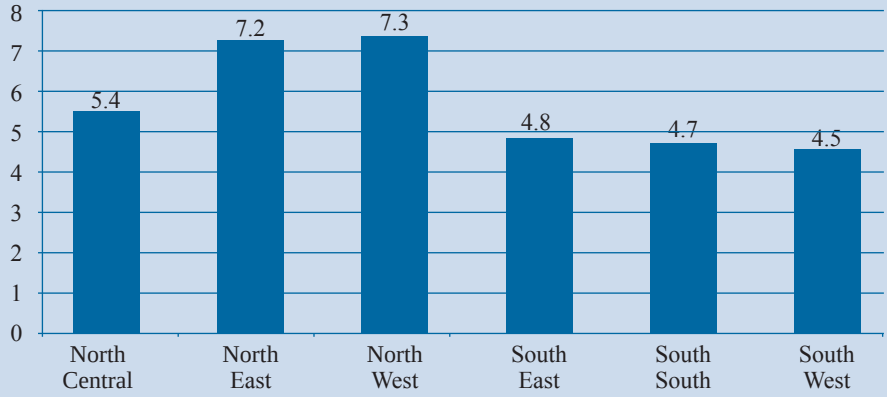
The 2008 Total Fertility Rate (TFR) for Nigeria is 5.7 births per woman, indicating no change from the 2003 NDHS figure of 5.7. These figures are slightly higher than the 1999 TFR of 5.2, but they are lower than the TFR of 6.0 in 1990 (NPC and ICF Macro, 2009). The 2008 NDHS data show variations in TFR by area of residence, zone, education and wealth quintile. Rural areas have a higher TFR of 6.3 compared with 4.7 for urban areas (Graph 7.1).

Graph: 7.1 **Total Fertility Rate by Place of Residence, 2008**



Similarly, the more urbanised zones – South-east, South-South and South-west have lower TFRs of 4.8, 4.7 and 4.5 respectively compared with the less urbanised zones – North west (7.3), north-east (7.2) and north central (5.4) (Graph 7.2).

Graph: 7.2 **Total Fertility Rate by Region, 2008**



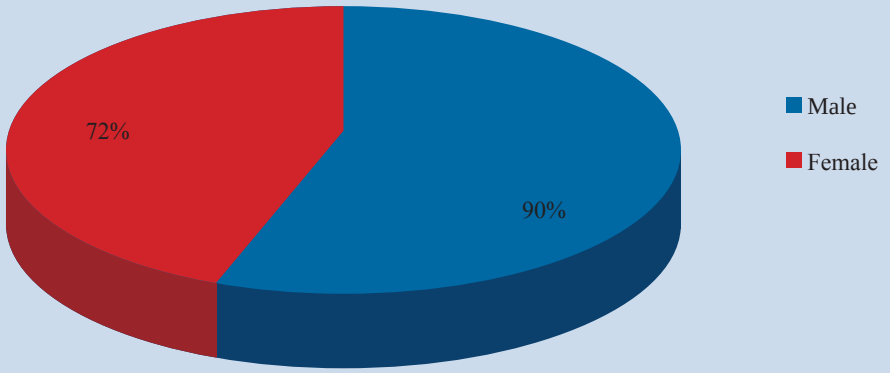
The TFR also decreases with increasing level of education: from 7.3 births per woman for women with no education to 2.9 for women with more than secondary education. On the basis of wealth, women in the highest wealth quintile have a TFR of 4.0 compared with 7.1 for women in the lowest quintile. The 2008 NDHS also revealed that 4 per cent of births are unwanted, while 7 per cent are mistimed. If the unwanted births were prevented, women would have an average of 5.3 children compared with the 5.7 recorded. Generally, the data thus imply that for fertility to decline, the conditions in rural areas promoting high fertility must be addressed. Similarly, the education of women beyond secondary school level should be encouraged and efforts at reduction of poverty level should be intensified by all stakeholders.

Family Planning

Family planning refers to a conscious effort by a couple to limit or space the number of children they want to have through the use of contraceptive methods (NPC and ICF Macro, 2009). Low level of family planning is a major factor in the fertility pattern and population growth rate. According to NDHS 2008, the contraceptive prevalence rate for Nigeria is 15 per cent for any method and 10 per cent for modern methods while our unmet need is 20.2 per cent. Contraceptive prevalence rate varies with the age of the woman. In 2008 NDHS, it was 3 per cent for the 15–19 year old group and 20 per cent for the 35–39 year old group. Contraceptive use also increases as the number of living children a woman has increases. Three per cent of women who have no children are currently using family planning, compared to 13 per cent of women with one or two children. Use of family planning methods, in 2008 was lower in the rural areas compared to the urban areas; 9 per cent versus 26 per cent for any method, and 7 versus 17 for modern methods.

Women's educational levels are positively correlated with the contraceptive prevalence rate. Four per cent of women without education in Nigeria currently use family planning, compared to 37 per cent among those with more than secondary education. There is general widespread knowledge of contraceptive methods in Nigeria. Knowledge is higher (90%) for men than women (72%) (Graph 7.3).

Graph: 7.3 **Knowledge of Contraceptive Methods by Sex**



Unfortunately, the knowledge of methods of contraceptives is not matched by the use. Only 28.6 per cent of women reported ever using a method of contraception. The male condom is the most commonly used modern method (12%), followed by the pill (6%) and the injectables (5%). Among males, 40.2 per cent reported ever using a method. The male condom is the most widely used (33%) modern method while the male sterilisation is the least used (< 1%). The lack of use of contraception implies sustaining the current relatively high fertility levels.

Sexually active unmarried women are more likely to know of a contraceptive method than currently married women (95% compared with 68%, respectively). Factors ssociated with the low contraceptive prevalence level include a culture that is highly supportive of large family size, misconceptions about family planning methods, and male child preference. In addition are the challenges of inadequate access to family planning services, poor quality of services and inadequate demand creation effort to ensure reproductive health commodity security in Nigeria.

Maternal Mortality and Safe Motherhood

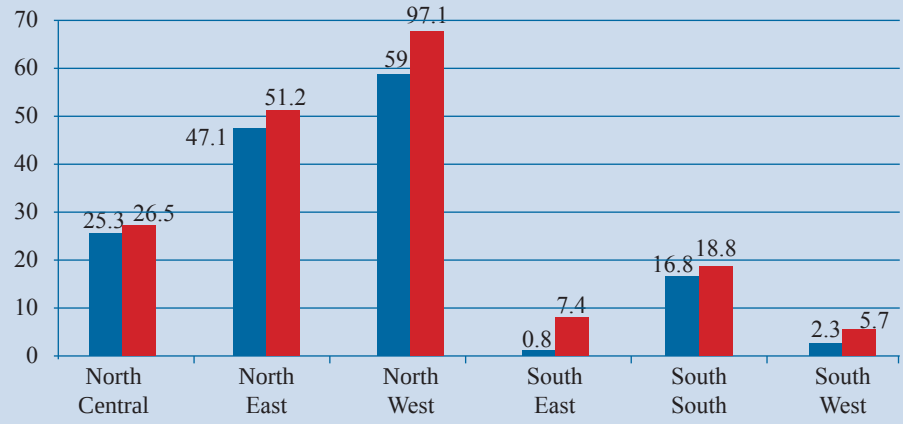
Goal 5 of the Millennium Development is to 'improve maternal health', with a target of reducing maternal mortality ratio to 250 per 100,000 live births by 2015. The NPP also targeted reducing the maternal mortality ratio to 125 per 100,000 live births by 2010. Available data shows that Maternal Mortality Rate (MMR) in the late 1990s was 1,000

per 100,000 live births. It declined to 800 per 100,000 live births in the year 2003 (FMOH aggregated), Current estimates indicate that our MMR is 545 NDHS 2008. However there are wide regional variations. This trend indicates some degree of progress, but not at a rate enough to reach the MDGs come 2015.

The health care received by pregnant women during pregnancy, at delivery and after delivery is important for the mother and child's survival. The care received by a mother during pregnancy and at delivery indicates the status of maternal and child health in a society. Antenatal care (ANC) is aimed at ensuring that both the mother and baby have the best possible health outcomes.

The proportion of Nigerian women with live birth in the five years preceding the 2003 and 2008 NDHS surveys who did not receive antenatal care at all decreased only slightly from 36.9 per cent in 2003 to 36.3 per cent in 2008. In fact, there is a slight decline in the proportion of pregnant women who receive antenatal care from professional medical workers from 60.1 per cent in 2003 to 60 per cent in 2008. However there is largely zonal disparity in the proportion of women who did not receive antenatal care (Graph 7.4).

Graph: 7.4 **Proportion of Women who did not received Antenatal Care by Zone**



The zones with the highest proportion are the North-West (59.0% in 2003 and 67.1% in 2008), while the South-East and South-West have the lowest per centages of 0.8 and 2.3 in 2003 and 7.4 and 5.7 in 2008 respectively.

Also, the place of delivery and type of assistance rendered during delivery is crucial to maternal survival. Complications and emergencies leading to mortality more often than not arise. There is a slight decrease in the proportion of mothers whose deliveries occur at home from 66.4 per cent in 2003 to 62 per cent in 2008. Thus, only 32.6 per cent deliveries took place in health facilities in 2003 compared with 35 per

cent in 2008. Overall, in 2003, only 36.3 per cent of births were attended to by doctors, nurses/midwives or community health extension worker, 20.4 per cent by traditional birth attendants, 25.6 per cent by relatives or untrained persons, and 16.9 per cent by no one, compared with 38.9 per cent, 21.6 per cent, 18.8 per cent and 19.3 per cent of births attended to by doctors, nurses/midwives or community health extension worker, traditional birth attendants, relatives or untrained persons, and by no one respectively in 2008 (NPC and ICF Macro, 2003, 2008).

Under the Integrated maternal, newborn and child health strategy adopted by the Federal Government addresses the issues of mother and child using an integrated approach along the continuum of care from pre-pregnancy, pregnancy, during labour and child birth, immediately after delivery, infancy and early childhood. Interventions target all these stages to maximise impact. The continuum is also across the health system and includes the level at which the interventions are delivered: home and community, first level facility and referral facilities. This helps to build bridges across different programmes that impact on maternal health and well-being, e.g., Nutrition, Safe motherhood, Roll Back Malaria, Immunisation and HIV/AIDS. This is aimed at accelerating the reduction of maternal, neonatal and infant morbidity and mortality by the year 2015.

Newborn

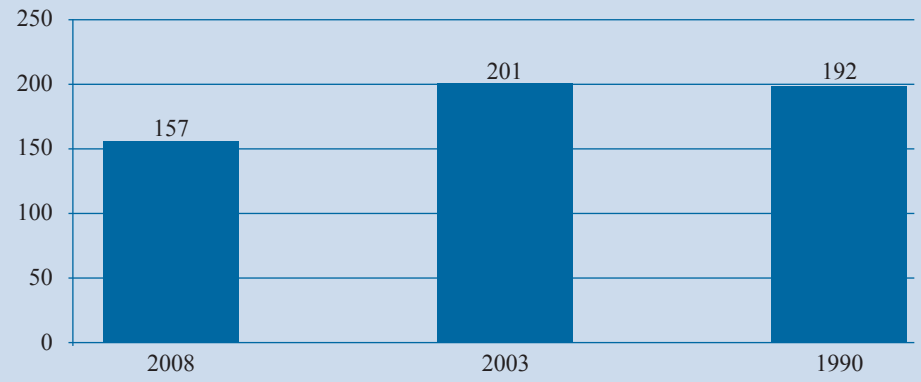
The health of a mother is inextricably linked to the health of her newborn and maternal mortality and morbidity contribute significantly to still births and neonatal deaths. For every maternal death at least 7 newborns die and a further four babies are stillbirths. Hence measures aimed at reducing maternal mortality and improving maternal health invariably improve newborn health and reduce neonatal deaths.

Neonatal mortality rates (NMR) estimate the probability of a baby dying within the first four weeks of life. In Nigeria, the NMR is 40 per 100 live births (NDHS 2008). Wide regional variations exist and according to NDHS 2008, the highest NMR is seen in the North-East zone of the country with 53 per 1000 live births while the lowest is in the south west zone with 37 per 1000 live births. Similarly, there is a difference in NMR in the urban areas with 38 per 1000 live births as compared to the rural area with 49 per 1000 live births.

Children Under Five Years

Nigeria has made several policies that will positively affect the health of the population even before making a commitment to the achievement of the MDGs. These policies notwithstanding, emerging trend in Under-five Mortality (U5M) is of grave concern as indicated in Graph 7.5.

Graph: 7.5 **Trend of Under-Five Mortality Rate (1990–2009).**



These current mortality rates for Infants and U5 fall short of the national goals articulated in the NPP target to reduce IMR (to 35 per 1000) and U5MR (to 63.7 per 1,000) or by two-thirds of 1990 Graph 7.5 by the year 2015 MDG target indicating that the lag existed for a while and attempts at improvement had been ineffective. Nigeria is one of the countries that have had marginal significant improvement in child survival over the past forty years. Compared to other African countries, Nigeria had a 10 per cent reduction in U5MR whilst Ghana, and Malawi achieved 53 per cent and, 50 per cent reductions, respectively.

The proportion of one-year-olds fully immunised increased from 32.8 per cent in 2000 to 60 per cent in 2007. This represents an increase of 50 per cent increase over a period of seven years. However there are some regional disparities. The three regions with the lowest percentage of children receiving no vaccination are the South-West, South and

South-East respectively. In the South about 6.5 per cent of children age 12–23 months did not receive vaccination. The figure rose to 74.3 per cent in 2009 thus, giving a strong indication that the target of 100 per cent coverage by 2015 may be possible. The success of vaccination is attributable to the national programme on immunisation, which lays out the plan of action for achieving total coverage.

Limited impact has been made in addressing the determinants of ill health such as malnutrition, unhealthy environments and low level of access and utilisation of quality health care services by women and children. Other determinants of child survival include low female literacy levels and poor family/household health-care practices. In addition, access to safe water and adequate sanitation are important in improving household hygiene practices. Less than half the population has access to safe water (42.8%) and about a quarter have no access to adequate sanitary facilities.

Gender mainstreaming, women empowerment and child development

Gender Policy

The democratic setting in Nigeria has given rise to an increased agitation of Women's empowerment and participation in the National Development Plans. The enabling environment created by the democratic nature of the nation's polity has given rise to a vibrant civil society, engaged in the promotion and protection of the rights of women and girls to freedom from all forms of discrimination. In accordance with treaties signed and ratified, pertinent actions, including the design and implementation of programmes and activities aimed at challenging structures and systems that often negate the definition of non-discrimination, dis-empower women and promote inequalities have been taken.

In the same manner, the implementation of the Beijing Declaration and Platform for Action and the provisions of CEDAW have considerably improved the status of women, given visibility and raised consciousness about women's issues in organisations and other male dominated institutions. This has led to:

- Increasing acceptance of gender equality, equity and gender mainstreaming concepts and principles;
- Development of a Comprehensive National Gender Policy and its Strategic Implementation Framework which defines roles and responsibilities in designing programmes for women in rural areas;
- Development of specific gender policies in different sectors among other measures.

Gender equality and women's empowerment were extremely important for the growth and development of any society. In March 2010 the Ministry secured the approval of the Federal Executive Council to establish a Gender Unit in all Ministerial, Departments and Agencies (MDAs) which would replace the then Gender Focal Person in the MDAs. With this, they were able to make effective the implementation of the National Gender Policy (2006) and respect the resolution to mainstream a gender perspective into all policies and programmes in the country programming .

Nigeria recognised the fact that investing in women and girls has a multiplier effect on productivity efficiency and sustained economic growth. Challenges continued to prevent women and girls from exercising their right to education. Significant constraints on women's access to full employment and decent work remained in many parts of the world. A gender gap in education had far reaching implications for development. Gender equality concerned both women and men and achieving gender equality would undoubtedly contribute to economic growth and the growth of employment, competitiveness and social coherence. In relation to this, the Government has instituted

several reform measures in the education sector to achieve increased enrolment rate, particularly for girls, some of which include:

- Payment of examination registration fees.
- Scholarships scheme.
- School feeding programme.
- Provision of water and toilets, particularly for girls.
- Flexible adult literacy classes for women.
- Second chance education programme for women.
- The National Poverty Alleviation Agency's two-thronged conditional grants to the poorest of the poor family, to enable them to engage in income generating activities and at the same time send their wards to school.
- Increase in government budgetary allocations to the Ministry of Education in the last five years has contributed to an increase in access to education at all levels.
- Advocacy, sensitisation and mobilisation of communities on importance of girls' education.
- Existence of laws in some States for retention of girls in the school as well as also laws prohibiting the withdrawal of girls from school for marriage. For example, Katsina has a policy that every Local Government Area must have one primary and one secondary school for boys and girls respectively within 3km from the place of residence of the child.

Table 7.1: Net Primary and Secondary School attendance Ratio 1999–2010

Year	Primary	Secondary	Primary	Secondary	Primary	Secondary
1990	51	24	48	22	54	26
2003	60	35	57	33	64	38
2010	61	44	58	44	64	44

Reducing Poverty

The democratic setting in Nigeria has given rise to an increased agitation for women's participation in the National Development Plans and measures to address female headed households. The enabling environment created by the democratic nature of the nation's polity gave rise to a vibrant civil society, engaged in the promotion and protection of the rights of women and girls to freedom from all forms of discrimination. Pertinent actions include the design and implementation of programmes and activities aimed at challenging structures and systems that often negate the definition of non-discrimination, dis-empower women and promote inequalities. Government has also been very active in the quest for gender equity and equality in the country. Other key initiatives to address poverty amongst women include:

- Civil Society Groups are also promoting poverty reduction programmes by genuinely targeting women, some of these groups are the National Council of Women Societies

(NCWS), National Association of Women Entrepreneurs (NAWE), National Association of Small Scale Women Industrialists (NASSWI), and National Association of Women Exporters. Most of these groups are the vehicles through which most poverty alleviation programmes targeted at women are carried out.

- Development Partners have also initiated community self-help programmes, though communities receive direct intervention through an existing agreement with government programmes using community-based organisations.
- Cottage industries and skills acquisition centres are established across the country for women empowerment and vocational programmes.
- Commercial Banks in the country have also been proactive in reducing feminised poverty, through establishment of various loan schemes at lower interest rates to make them more productive and self-reliant.
- There are also funding schemes for small and medium scale women entrepreneurs established by the Ministry of Women Affairs called – Women fund for Economic Empowerment (WOFEE) and Business Development Fund for Women (BUDFOW).

Table 7.2: Mean Gender Income Disparity

Monthly income	Pre-1999	Post 1999	Difference
Male	N102.13 (N242.69)	N142.64 (N283.63)	N40.51
Female	N71.98 (N254.59)	N89.49 (N231.75)	N17.51
Difference in difference	-N30.14	-N53.14	-N23.00

Participation in Governance

Advocacy and social mobilisation is one of the key Government strategies to realising gender equality. Towards this end, the Government has undertaken advocacy sensitisation programme to the top level officials at both the State and National levels in order that they support women empowerment – provide improved funding for this and for promotion of gender equity and equality.

As an aftermath of sustained advocacy and agitation for 35 per cent women's representation in decision-making positions during the 2011 general elections campaign promises, Nigerian women have for the first time ever achieved 35 per cent affirmative action in the political appointments of female Ministers at the national level. Currently there are 13 women out of 42 appointed Ministers. Nigeria's House of Representatives has 360 members with 25 being women. Nigeria's Senate has 109 Senators, of these, 7 are women.

Other measures taken include:

- Aggressive Media engagement.
- Nationwide advocacy and social mobilisation of women groups and partners;
- Mobilisation and campaigns with Opinion leaders, particularly men in policy making positions at the highest level.

- Lobbying and negotiations for a waiver of Political Parties Registration fee for women, and for the entrenchment of Affirmative Action principles in Party Constitutions with specific and actionable commitments of elected political spaces for women.
- Advocacy visit to the Independent Electoral Commission for the entrenchment of Affirmative Action principles in elective positions

Table 7.3: Women elected to public office in Nigeria 1999–2011

Sector	1999		2003		2007		2011	
Office	Seats Available	Women	Seats Available	Women	Seats Available	Women	Seats Available	Women
President	1	0		0		0		0
Senate	109	3(2.8)	109	4(3.7)	109	9(8.3)	109	7(6.4)
House of Representative	360	7(1.9)	360	21(5.8)	360	27(6.9)	360	19(5.3)
Governors	36	0	36	0	36	0	36	0
State House of Assembly (SHA)	990	24(2.4)	990	40(3.9)	990	57(5.8)	990	69(7)
SHA committee chairpersons	829	18(2.2)	881	32(3.6)	887	52(5.9)	887	_
LGA chairpersons	710	13(1.8)	774	15(1.9)	740	27(3.6)	740	_
	Total	Female	Total	Female	Total	Female	Total	Female
Councilors	6368	69 (1.1)	6368	267 (4.2)	6368	235 (3.7)	6368	NA
State Assemblies	NA	NA	NA	NA	NA	5.8%	NA	5.8%
National Assembly					434	35 (7.5%)	439	31 (6.5%)

Human Rights of Women

Following the 1995 Beijing declaration and PFA, a number of States in the Federation have legislated on gender discriminatory practices prevalent in their areas to give effect to some of the international protocols on human rights of women, especially to eliminate harmful traditional practices. Some of these legislations aimed at protecting and promoting the rights of women include:

- Administration of Estates (Small Payments) Law, 2006, Lagos State.
- Imo State Gender and Equal Opportunities Law No. 7, 2007.

- Anambra State Gender and Equal Opportunities Commission Law, 2007.
- National Gender Policy, 2006.
- Strategic Implementation Framework and Plan for the National Gender Policy, 2008.
- National Child Policy and Plan of Action, 2007.
- The Child Rights Act, 2003–23 States out of the 36 States of the Federation have adopted the Act and passed Child Rights Laws.
- Setting up of the Child Rights Implementation Committees at the Federal, State and Local Government levels towards the implementation of the Child Rights Act, 2003 and the corresponding Child Rights Laws in the states.
- Establishment of Offices of Citizens Rights Directorate at Federal and State Ministries of Justice.

In 2010, an Executive Bill to domesticate CEDAW/Equal Opportunity Bill was represented to the National Assembly. High level advocacy was carried out by stakeholders from both government and non-governmental agencies towards ensuring the passage of the Bill at the 7th Assembly.

A National Action Plan (NAP) on the Promotion and Protection of Human Rights in Nigeria was also developed by the Nigerian Government with a Chapter devoted to the Rights of Women and children. This action plan has been deposited with the United Nation Human Rights Committee in Geneva at a landmark ceremony in July 2009.

The NAP focused on the protection and promotion of women rights issues such as:

- Women's Rights to protection in peace and armed conflict situations, against all forms of discrimination, abuse, exploitation and harmful practices, etc.
- Women's rights in public and political life/decision-making.
- Women's social, economic and cultural rights.
- Women's rights to equality before the law, access to justice, safety and security.
- Women's rights to equality in marriage and family relations.
- Women's Reproductive and Sexual health rights.
- Women and HIV/AIDS and related issues.
- Women Empowerment.

Women and Armed Conflicts

The sustained advocacy and campaigns by Government and members of civil society groups with support from Development Partners have brought about the development of policies and setting up of institutional mechanisms and strengthening existing ones to address this issue.

An Inter-Ministerial Committee on Women and Peace was also established to address the UN Resolutions 1325 and 1820 with membership from the Military, Para-Military,

the Police, line Ministries and Departments as well as Civil Society Groups working in the area of peace building. It also aimed at working towards increasing women's representation in peace building and conflict resolution. For example:

- There is a deliberate policy to recruit women into Defence and Police establishments at the national level and subsequently facilitating their deployment in peace-keeping missions.
- Gender training for Peace-Keepers at the national level is now compulsory.
- Security sector and Defence Policies in Troop/Police contributing countries have been revised with a view to implementing UN SCR 1325 (2000).
- Nigeria took the lead in providing female Police Officers to the United Nations Police. As at the end of 2006, 49 out of the 454 female police officers sent out were from Nigeria, ahead of India, Bangladesh and the United States.
- Nigeria also provided an all-woman police contingent to support the African Union in Darfur in early 2007.
- The conditions of service for Nigerian women who are deployed in peace keeping missions have greatly improved.
- Mainstreaming Peace building in Development Programming in Nigeria: A Framework was produced by the Institute for Peace and Conflict Resolution (IPCR).
- Counseling/Care Centres as well as Skills Acquisition Centres have been set up to provide recovery interventions for their physical and mental rehabilitation in 6 operational offices and shelters (Lagos, Kano, Benin, Uyo, Enugu and Sokoto).

Intensification of Efforts to eliminate all Forms of Violence against Women

The national legal framework is constantly being reformed and strengthened for effective response to emerging challenges by the day. However, the African Charter on Human and Peoples' Rights on the Rights of Women in Africa and CEDAW provisions are yet to be domesticated. In fulfillment of the provisions of the 1999 Constitution of the Federal Republic of Nigeria, some of the Commitments of the Protocols are being implemented. Furthermore, some of the actions on course for the domestication of the protocols are:

- A Bill on "Abolition of all forms of discrimination against women in Nigeria and other related matters, 2006" is still before the National Assembly. The Bill's title now reads "Abolition of all forms of discrimination against persons in Nigeria and other related matters, 2008".
- There is in place an Act legislating against Trafficking in Women and Children as well as the establishment of a National Agency for the Prohibition of Trafficking in Persons and Other Related Matters (NAPTIP) to curb the high incidence of trafficking and exploitation in the country.
- A Trust Fund for Victims was also established as "Trafficked Victims Trust Fund" in 2008; as a result of the Amendment of the Trafficking in Persons (Prohibition) Law

Enforcement Law in 2006 to incorporate the establishment of a Victims Trust Fund and give the NAPTIP powers to impound the properties of convicted traffickers.

- There is also in existence a National Policy on Victims Assistance and Protection, 2008.

Despite efforts at the national level, some State Houses of Assembly have also enacted specific laws that adequately address violence against women (in the home, the workplace, the community or society), in compliance with global and regional instruments. Examples of such State laws are:

- A Law to Prohibit Girl-Child Marriages and Female Circumcision Bill No. 2 of 2000, Cross Rivers State Government.
- Abolition of Female Circumcision Law, No. 2 of 2001, Rivers State.
- A Law to Prohibit Domestic Violence Against Women and Maltreatment Law No. 10 of 2004, Cross Rivers State Government.
- Inhuman Treatment of Widows (Prohibition) Law 2004, Edo State.
- Malpractices Against Widows and Widowers (Prohibition) Law 2005, Anambra State.
- Gender and Equal Opportunities Commission Law, 2007, Anambra State.
- Gender and Equal Opportunities Law No. 7, 2007, Imo State.
- Street Hawking Prohibition Law 2008, Lagos State.
- Court of Appeal amply demonstrated its competence and effectiveness by declaring three customs in Enugu and Anambra States as discriminatory against women and violating women's rights and human dignity.
- Legislations prohibiting early marriage (Kebbi, Niger States); Retention in schools and Against withdrawal of Girls from schools (Kano, Borno, Gombe and Bauchi States).
- Establishment of Legal Aid Council, which provides free legal counsel to women.
- The Federal Ministry of Women Affairs and Social Development in the wake of calls to protect survivors of VAW, launched a well equipped Women's Temporary Shelter in 2007 to provide a safe place for traumatised women and support the re-integration of victims through a capacity building support scheme.
- Safe Houses for victims of domestic and sexual violence have also been established in some states of the Federation.

The Child Rights' Act (2003) (the domesticated version of the UN Convention on the Rights of the Child) protects the girl-child against forced marriage and places minimum legal age for marriage at 18 years. However, this only applies to marriages within the country's civil legal system – as opposed to its customary and Islamic (Sharia) systems – and is implemented differently by different states. As a follow-up, Child's Rights Bills have been passed into law by 24 out of the 36 states, including FCT.

In spite of the constitutional guarantee of equality, freedom of association and freedom from discrimination, women remain on the fringes of Nigerian political life. A number of

measures initiated to improve the situation are yet to reach fruition due to resistance. The protection of the rights of women remained unrealised because of increased poverty, non enforcement of laws and policies and inadequate public education and enlightenment on the rights of women.

Women's economic and political empowerment through employment and participation is very crucial in population stabilisation for the following key reasons:

- It enhances their status and increases their control over income and resources and a greater say in family decision-making, including fertility decisions.
- The conflict between their productive and reproductive roles increases the opportunity cost of having children.
- Their employment and income earning capacity enhances their economic and financial independence thereby, reducing the need to have children as a form of old age security as well as reduce sex preference for children and changes their attitudes toward the value of daughters.
- It increases their investment in the girl child's education thus raising the age at marriage and age at first pregnancy.

Youth and Adolescents

Nigeria's population is predominantly young. One-third of the nation's 167 million people are young people between the ages of 10 and 24. The recognition of this fact led to the development of the National Youth Policy and the action for advancing young people's health and development in Nigeria 2010–2012. The pace of implementation of national strategies and policies for youth development, especially in Africa has continued to be very slow. Extreme poverty, unemployment and disease, social exclusion, exploitation and violence have continued to characterise the plight of the young in most of Africa. More than 60.7 million young people live on less than 1 Dollar a day. Employment and social exclusion ranges from 28 per cent in Nigeria to 50.2 per cent of 15–24 years old in comparison to the other African countries such as South Africa whereby social exclusion and employment can be witnessed at 28.5 per cent in 25–35 years old. Furthermore, an estimated three quarters of the 12 million young people between ages 15-24 living with HIV/AIDs are in Sub-Saharan Africa and women and young girls continue to be the most vulnerable to infection.

According to the 2006 national Census, 33.6 per cent of the total population of Nigerians are young people between 10–24 made up of 50.1 per cent males and 49.9 per cent females and it is estimated that by 2025, the number of youth would exceed 54 million. Nigeria is signatory to a number of international and national instruments that relate to youth empowerment and development:

- The International Conference on Population and Development and its Plan of Action 1994.
- Maputo Plan of Action on sexual and reproductive health.

- African Youth Charter and Plan of Action.

Unfortunately, not much impact has yet been seen on how this translates to an improved quality of life for young people. Early sexual initiation (the 2008 NDHS data revealed that 16 per cent of young women and 6 per cent of young men aged 15–24 initiated sexual activity before age 15), high level of unsafe sexual practices, forced marriages of girls to older men, limited access to appropriate adolescents sexual and reproductive health services and information and low utilisation of modern family planning methods estimated at 4.7 per cent have continued to be major challenges. In addition, young people constitute two-thirds of the estimated 610,000 abortion records per annum and 60 per cent of annual new HIV infections nationally. Socio-economic and cultural factors still play a significant role in influencing the behaviour and practices of the youth.

The proportion of adolescents married, use of contraception, age at first marriage, family size and family size preferences all have implication for population stabilisation. Delaying the age at first coitus, delaying the age at first marriage, increase use of contraception, and increase in child spacing and reduced family size would more likely to observepopulation stabilisation in the near future.

Education

Literacy and educational attainment are basic indices of human development. There is a correlation between education and development such that countries which are developed are those which invest in education.

In 2000, the government replaced the Universal Primary Education (UPE) providing for only six years free and compulsory education with the Universal Basic Education (UBE) which stipulates nine years of free and compulsory education. This was aimed at improving access to primary, and at least three years of secondary education where vocational courses are encouraged.

The country is steadily marching towards achieving the goal of Universal Basic Education by 2015. Net enrolment ratio in primary education has consistently increased from about 81.1 per cent in 2004 to 88.8 per cent in 2008. However, there are slight decreases in the proportion of pupils starting Primary 1 who reach Primary 5 from 74 per cent in 2004 to 72.3 per cent in 2008 and from 82 per cent to 67.5 per cent in Primary 6 completion rate. But there is a gradual increase in literacy rate of 15–24 year olds from 60.4 per cent in 2004 to 80.0 per cent in 2008 (Table 7.4). This might not be unconnected to the upsurge in the establishment of private schools, especially in the urban areas.

Table 7.4: Net Enrolment Ratio in Primary School, Proportion Enrolled who Reach Primary 5 and Complete Primary 6 (2004–2008)								
Indicator (%)	2004	2005	2006	2007	2008	2009	2010	2015
Net Enrolment in Primary Education	81.1	84.6	87.9	89.6	88.8	NA	NA	100
Proportion of Pupils Starting Primary 1 who Reach Primary	74.0	74 .0	74.0	74.0	72.3	NA	NA	100
Primary 6 Completion Rate	82	69.2	67.5	67.5	NA	NA	NA	100
Literacy Rate of 15-24 Year Olds	60.4	76.2	80.2	81.4	80.0	NA	NA	100

Source: FGN (2010) Nigeria Millennium Development Goals Report, 2010.

On the girl child enrolment, the proportion of girls enrolled for primary, secondary and tertiary education is still lower than boys (about 8 girls to every 10 boys) but there had been gradual increase from 2000–2007 for primary schools while steady increase was observed for secondary school enrolment from 2005. The ratio of girls to boys in primary education rose from 78 in 2000 to 93.6 in 2007 with a target of 100 in 2015. The ratio of girls to boys in secondary education also rose from 90 in 2005 to 97.6 in 2007 with a target of 100 in 2015 (FGN, 2008).

The curriculum for sexuality education had been adopted by the Federal Ministry of Education and is being implemented in schools in many States. The curriculum integrates gender relations which ensures that attitudes encouraging both sexes to view and relate to each other as equals are taught in schools. As part of the general guidelines for the production of educational materials including textbooks, those that promote gender bias and disrespect for women and the girl child are disallowed.

HIV/AIDS prevention

The first case of HIV/AIDS in Nigeria was reported in 1986, and Nigeria is said to rank second after South Africa in the number of people living with the disease. The country is committed to monitoring progress in reducing the spread of the disease. It is also committed to achieving the MDG of combating HIV/AIDS, Malaria and other diseases. As a step towards strengthening the HIV national response, Nigeria's HIV/AIDS policy was reviewed. The national strategic framework 2005–2009 was also reviewed for a new one for 2010–2015. This is towards promoting behavioural change to reduce new HIV infections.

A multi-sectoral approach has been established in the fight against HIV/AIDS. There are action committees at all levels including the National Agency for Control of AIDS (NACA), State Agency (SACA), Local Government Agency and a Community Agency for Control of AIDS NGOs, private sector and faith based organisations and network of People Living with AIDS actively involved and they partner with government in the fight.

Trends in HIV/AIDS prevalence show an increase from 1.8 per cent in 1991 to 3.8 per cent in 1993, 4.5 per cent and 5.4 per cent in 1995/96 and 1999 respectively. It reached a peak of 5.8 per cent in 2001 before beginning to decline to 5 per cent in 2003 and then 4.4 per cent, 4.6 per cent and 4.1 per cent in 2005, 2008 and 2010, respectively (NACA, 2011).

HIV prevalence among youth age 15–24 declined from 6 per cent in 2001 to 4.3 per cent in 2005, 4.2 per cent in 2008 and 4.1 per cent in 2010 (NACA, 2011). Generally, HIV prevalence varies based on some demographic and social characteristics. For instance, prevalence was higher among females (4.0%) than among males (3.2%), slightly higher in urban areas (3.8%) compared with rural areas (3.5%), highest in the north central (5.7%) compared with the south east (2.6%) and higher among those with tertiary education (4.0%) compared with those without education (2.7%) (NACA and UNAIDS, 2010).

Among the key population at higher risk, HIV prevalence was 24 per cent among sex workers, 17 per cent among men having sex with men and 4 per cent among injecting drug users.

Heterosexual sex is the primary source of the epidemic accounting for more than 80 per cent of HIV transmission in Nigeria. The drivers of the epidemic in the country include high illiteracy, high rates of Sexually Transmitted Infections (STIs) in vulnerable groups, poverty, low condom use and general lack of perceived personal risk (ref. Table 7.5).

Table 7.5: HIV/AIDS Status at a Glance (Nigeria)

National Median HIV prevalence (ANC)	4.1%
Estimated number of people living with HIV/AIDS	Total: 3.1 million
Annual HIV Positive births	Total: 56,681
Cumulative AIDS death	Total: 2.1 million (Male 970,000; Female 1.61 million)
Annual AIDS death	Total: 215,130 (Male 96,740; Female 118,390)
Number requiring Antiretroviral therapy	Total: 1,512,720 (Adult 1,300,000; Children 212,720)
New HIV infection	Total:281,180 (Adult 126,260; Children 154,920)
Total AIDS Orphans	2,229,883

Source: NACA, 2011

The data shows that generally females are more affected by the disease than males. Therefore, addressing gender issues, especially inequality, is crucial for the control of the disease.

Strategies involved in HIV prevention include voluntary counselling and testing, condom use and its availability and targeted interventions to most vulnerable groups. Between January to December, 2010, the numbers of health facilities providing HIV counselling and testing were 1064. In the same period, 2,287,805 people aged 15 years and older were counselled and tested. The results were 656,706 men and 1,631,099 women.

NACA and her partners also developed a six-year strategic Plan programme implementation framework to address vulnerability issues and mitigate the impact of HIV/AIDS on women and girls through a number of strategic interventions which include, among others, strengthening the capacity of females and male agents and champions to act to reverse harmful traditional/cultural practices; strengthening women and girls leadership and life skills in schools, workplaces and community; integrating HIV into reproductive health services; improving access of all pregnant women to HIV counselling and testing and positive women to medicines to reduce mother-to-child transmission, as well as food supplements and quality infant feeding counselling; advocating for all HIV exposed infants to have access to early infant diagnosis and antiretroviral ARV prophylaxis (NACA, 2011).

Reported cases of malaria and tuberculosis are also on a downward spiral. The prevalence rate of malaria declined from 2,024 per 100,000 in 2000 to 1,157 per 100,000 in 2007 while the deaths per 100,000 declined from 0.23 in 2000 to 0.16 in 2007. Tuberculosis prevalence also declined from 15.74 per 100,000 in 2000 to 7.07 per 100,000 in 2007, while the death rates also fell from 1.57 per 100,000 in the year 2000 to 1.50 in 2007. Remarkable achievement has been recorded in reversing the incidence of malaria and other major diseases with the introduction of the Roll Back Malaria initiative in Nigeria and several control activities under the major strategic intervention.

Population Information, Education and Communication

Some responses have been made to promote general awareness on population and development issues and to reduce resistance to issues such as family planning, reproductive and sexual health rights and elimination of harmful traditional practices such as female genital circumcision, human trafficking and other forms of gender-based violence. To this end, steps have been taken to ensure relevant portions of international conventions are incorporated into local laws and policy frameworks. In response to the need for dissemination of information, the Population Information and Communication Bureau was established in 2002.

The News Agency of Nigeria under the "Partnership with the Mass Media to Increase Awareness about Population Issues" project trained journalists in reporting of population-related issues. This project has resulted in wider coverage and better quality of reports of reproductive health and reproductive rights issues in the mass media. Media organisations, including government television and radio network have established desks devoted to population and development, including reproductive health, gender and related issues.

Some NGOs are engaged in advocacy to stop trafficking of Nigerian women for sexual exploitation. The traditional folk media that remain critical to information dissemination in rural Nigeria complements these initiatives.

PARTNERSHIP AND FUNDING

This section reviews issues of partnership and funding, including South-South cooperation to strengthen population stabilisation.

South–South collaboration

The Government is also involved in South-to-South partnerships. In 2002 Nigeria formally became a member of South-South collaboration, Partners in Population and Development with headquarters in Bangladesh. The forum provides and opportunity for experience sharing amongst members and developing countries of the world to lobby for policy change on population issues and a platform upon which member states developed and presented a common front on population issues. Nigeria is the current chair of the ECOWAS initiative aimed at reversing the trend in human trafficking. Also under the South-South partnership, many NGOs are members of the Reproductive Health Partnership of NGOs in Sub-Saharan Africa, Nairobi. Nigeria is also a member of AMANITARE, a network of African Feminist working in areas of Sexual Reproductive Health and Rights.

Partnership with INGO

Since Independence, Nigeria has been a beneficiary of External Assistance; hence, the need for clear structures and guidelines for mobilisation and management of External Assistance for Development. The large concentration of external donors commitments and funding disbursement into Human Capital Development sectoral programmes/ projects have covered Education and Capacity building, Health Sector Development, Gender, and Labour & productivity.

Over the years, partnership has remained an important source of funding development programmes. In Nigeria, Official Development Assistance (ODA) is yet to play the critical role expected of it. ODA flows into Nigeria during the 4 year period, 2008–2011 was $2.97 billion, slightly higher than 1 per cent of GDP, hence the need to enhance aid inflows into Nigeria. It is also important that this aid is channelled in a coordinated manner to national priority areas of the country.

Nigeria has 12 main donor countries and agencies, seven of which are in the United Nations System. Over the years, the biggest recipient sector has been the health sector with 54 per cent (US$1.3 billion) followed by poverty alleviation with 18 per cent (US$481 million) and Women and Empowerment 4 per cent. Agricultural sector received 1 per cent, energy and environment 1 per cent and finance 1 per cent. Indications are that the aid was disbursed by the donors themselves through

direct project support. This made it impossible for country ownership and mutual accountability since the government of Nigeria (sub-national governments inclusive) was unable to claim ownership or account for funds it did not receive (AFRODAD, 2011). Total ODA in 2006 reached US$280 million, equivalent to US$2 per capita, compared with the average of US$28 per capita for Africa. ODA plays a minimal role in Nigeria. Principal donors are the European Union, World Bank, UNDP, and Department for International Development (DFID) of the United Kingdom and the United States Agency for International Development (USAID).

The UN agencies including UNICEF, UNFPA, UNDP, World Bank and USAID have supported efforts at data collection analysis and dissemination on population and health issues, which could be accessed for population, programme formulation, monitoring and evaluation. A major obstacle to increasing resource mobilisation in line with ICPD resource goals has been a downward trend in ODA. The ODA for Africa declined from US$17.4 billion in 1998, US$15.9 billion in 1999, and US$15.6 billion in 2000 due to budgetary constraints from donor States and the diversion of limited resources to humanitarian and peacekeeping efforts. In 2001, it rose to US$16.2 billion (ADB, 2002). Other problems identified include insufficient financial management capacity for resource allocation, tracking and reporting on the use of funds, lack of resource coordination mechanisms, and difficulties in absorption of the funds allocated because of complexity of withdrawal and management procedures.

Partnership with the NGOs and CSOs

In an effort to mobilise the different sectors in the fight against HIV/AIDS in 2002, the Presidential Forum on HIV/AIDS organised the private sector, the public sector and civil society groups to discuss strategies and commitments to synergise the fight against the scourge. The Government has also entered partnership with Bill Gates Foundation and drug manufacturing companies, which are currently providing support for the prevention of mother-to-child transmission. Presently some civil society organisations (CSOs) are working with the bank sector and pharmaceutical companies to implement activities in the area of HIV prevention and support to those affected with the virus.

The Federal Ministry of Health in collaboration with civil society develops Sexual Reproductive Health manuals, medical protocols and guidelines. Drafting of policies and bills, and review of laws have been done with the input of civil society groups. Many NGOS in Nigeria enjoy moral and logistics support from the government while some NGOs assist some government departments in capacity building.

There is also collaboration between NGOs in the implementation of programmes of common interest. Civil societies have also collaborated with UN agencies, bilateral, multilateral and international NGOs to implement programmes.

Partnership with the media

Some response has been made to promote general awareness on population and development issues and to reduce resistance to issues such as family planning, reproductive and sexual health rights and elimination of harmful traditional practices such as female genital circumsion, human trafficking and other forms of gender-based violence. To this end, steps have been taken to ensure relevant portions of international conventions are incorporated into local laws and policy frameworks. In response to the need for dissemination of information, the Population Information and Communication Bureau was established in 2002.

The News Agency of Nigeria under the "Partnership with the Mass Media to Increase Awareness about Population Issues" project trained journalists in reporting of population-related issues. This project has resulted in wider coverage and better quality of reports of reproductive health and reproductive rights issues in the mass media. Media organisations including government television and radio network have established desks devoted to population and development, including reproductive health, gender and related issues.

Some NGOs are engaged in advocacy to stop trafficking of Nigerian women for sexual exploitation. The traditional folk media that remain critical to information dissemination in rural Nigeria complement these initiatives.

Partnership with relevant Ministries, Departments and Agencies

The national taskforce on partners in population and development was inaugurated to serve as a rallying point for all stakeholders MDAs on the issue of population, health and development in Nigeria. Members of the taskforce were drawn from the Federal Ministry of Health, Federal Ministry of Youth, Federal Ministry of Education, Ministry of Women Affairs and Social Development National Bureau of Statistics, National Population Commission, the News Agency of Nigeria (NAN), The Reproductive Health Council and National Planning Commission as the Coordinating Ministry and the Secretariat. The major outcome of the partnership is mostly for cross fertilisation of ideas and to present a common front on the issues of population, health and development.

CONCLUSION

Population growth rate is determined by three main factors: fertility, mortality and migration. Of all the three factors, fertility and mortality trends have resulted in a very high rate of population growth. Forty-four per cent of Nigerians are within the reproductive age bracket. With a population of 167.9 million, Nigeria is by far the most populous country in Africa and among the ten most populous countries in the world. The people of Nigeria are the most important and valuable resource of the nations as captured in the principles for the National Policy on Population for Sustainable Development which was derived from the Programme of Action of the International Conference on Population and Development and in tandem with the development blueprint of the Federal Government (Nigeria Vision 2020:20). However, to meet this laudable aspiration, the growth of the

economy and the provision of social services would have to be much higher than the rate of population growth. While efforts are being made to improve the economy, an effective population management programme should be aggressively pursued to control the population growth rate. While population is a natural resource, if its growth rate is not properly managed it could be one of the constraints to the efforts of the government to fulfil its commitment to improve the quality of live and standards of living for the people of the country.

Recommendations

The population policy is designed to influence population policies, strategies and programmes that contribute to the sustainable development of the country. The policy recognises that population factors, social and economic development, and environmental issues are irrevocably entwined and are all critical to the achievement of sustainable development in Nigeria. To achieve this, the government needs to scale up efforts in the following areas:

- Adequate funding of the relevant agencies in the field of population and development
- Ensure timely and adequate financial approval for population related activities
- Policy coordination of all relevant agencies should align with the NPP document
- The government should ensure strict compliance to the policy of basic education for all children in Nigeria
- Deliberate and sustained Advocacy awareness campaign on population, reproductive health and the use of contraceptives in the rural areas and among the youths.
- Encourage traditional institutions, including religious and opinion leaders to be bought in on the population policy and to act as agents for change
- Government should use population data for development planning.

Government should invest more on the provision of social services in education and health than in the provision of infrastructure to achieve sustainable development.

Policy implications

The major target of the Government of Nigeria is to peg population growth rate to 2 per cent by 2015. The current population growth rate is 3.2 per cent, and to achieve the control of population growth, the following target were set: reduction in the total fertility rate from current 5.7 per cent to 0.6 per cent. Increase the modern contraceptive prevalence rate by at least 2 percentage point every year, achieve sustainable universal basic education as soon as possible and eliminate the gap between men and women in enrolment in schools and vocational and technical education by 2015.

With just three years to reach the MDG deadline, the government is lagging behind in the area of capacity building for implementing personnel, especially with respect to skilled humanpower in the public sector. Lack of commitments and lip service in the area of

implementation of policies by all tiers of the government had further slowed the process of achieving the population growth targets.

Policies among relevant Government Agencies are not geared toward the achievement of population growth control. This is obviously evident in the MDA policy document as each MDA is pursuing their personal agenda without linkage to the overall targets. Multi-sectoral collaboration is lacking. Promotion of awareness and advocacy which stimulate behavioural changes are not effectively implemented as budgetary allocation for such activities are very thin.

The issue of culture and religious beliefs are impediments to the achievement of the population growth rate target. Policies are not explicit on how to address the issue of culture and religious obstacles for achieving the targets. Moreover, programmes towards achieving the MDGs on Health, Education and Gender equity are not sustainable.

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CHAPTER 8

THE EVOLUTION OF THE POPULATION IN SENEGAL

El Hadj Boubacar Samba Dankoko

Geography of Senegal

Senegal is a country in West Africa. It is bordered by the Atlantic Ocean to the west, Mauritania to the north and east, Mali to the east, Guinea and Guinea Bissau to the south. The Gambia forms a virtual enclave within Senegal, penetrating more than 300 km inside land. The Cape Verde Islands are located 560 km from the coast of Senegal.

Map of Senegal

The country is named after the river that borders the east and north, which rises in the Fouta Djallon in Guinea.

Senegal is a member of the Economic Community of West African States (ECOWAS), the Economic and Monetary Union of West Africa (UEMOA), the Community of Sahel-Saharan States (CEN-SAD), the African Union (AU) and the Organization for Economic Cooperation Conference (OIC).

The Senegalese territory is between 8° and 12° 16° 41 north latitude and 11° 21 and 17° 32 west longitude. Its western tip (Dakar) is the westernmost part in West Africa. The country covers 196722 sq. km. It consists of 14 administrative regions and 45 departments. The climate is desert in the north and tropical in the south, with two seasons: dry season and rainy season. This covers, overall, the period from May to October, with a variable length depending on the region of the country (the southern regions are more rainfed). In the West, temperatures are about 16°C to 30°C, but the central and eastern Senegal may have temperatures up to 46°C.

Demography of Senegal

Most population studies conducted in Senegal are based on the three Censuses in 1976, 1988 and 2002. In 2004, the Directorate of Forecasting and of Statistics, now National Agency of Statistics and Demography (ANSD) since 2006, also published in "Projections from the populations of Senegal 2002 Census" anticipating the likely evolution of the population until 2015. Senegal, in terms of its age and sex structure is still a young country population with predominance of females. Senegal's population is unevenly distributed with a density average of 50 inhabitants per sq. km, a minimum of 10 inhabitants south-east of the country and up to 3963 people in Dakar, the administrative and economic capital.

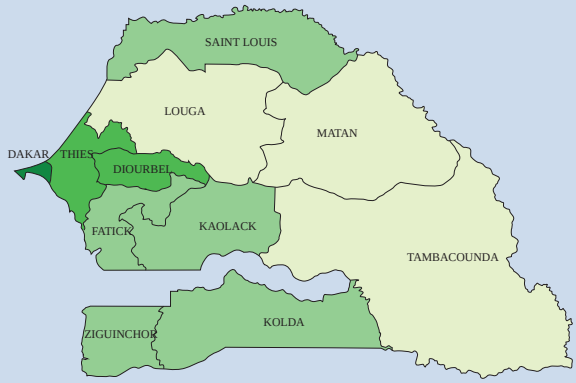
In December 2002, the population was 9,858,482 people. Women were more numerous and represented 50.8 per cent of the population.

Between 1976 and 1988, the intercensal growth rate was 2.7 per cent with a slight decrease between 1988 and 2002 when it stood at 2.5 per cent. In 2002, just over 1 out of every 5 Senegalese was living in the region of Dakar, the capital. 56.9 per cent of Senegal's population lived in 3 areas of the Midwest, namely Dakar, Kaolack and Thies. The urban population was about 41 per cent, which reflected a slow progression of urbanisation from 1988 when the urbanisation rate was estimated at 39 per cent. The region of Dakar continued to hold 97.2 per cent - the largest.

Table 8.1: Distribution of population by sex and residence in 2002

Residence	Male	Female	Total population	Effective %	Effective %	Effective %
Urban	1 987 500	49.6	2 021 465	50.4	4 008 965	40.7
Rural	2 865 264	49.0	2 984 253	51.0	5 849 517	59.3
Total	4 852 764	49.2	5 005 718	50.8	9 858 482	100.0

Density of the Population Regionwise in 2002



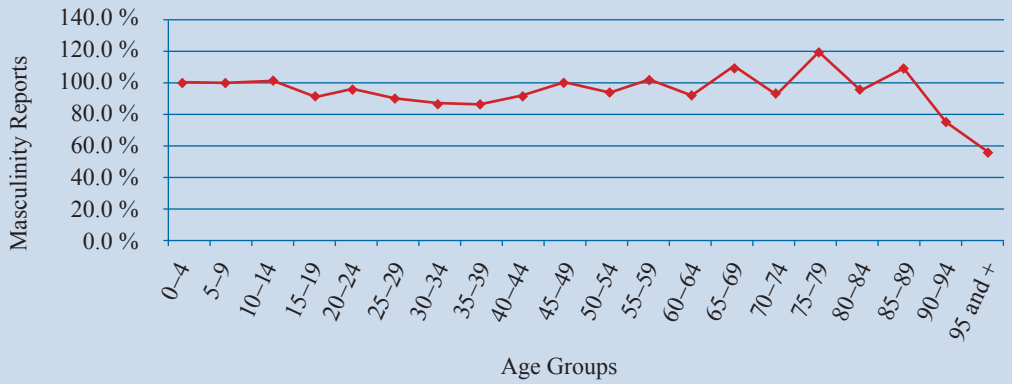
The 2002 Census confirms the youth of the Senegalese population: 54.7 per cent of the population is under 20. The overall ratio of male is 96.9 per cent, for 100 women.

Table 8.2: Distribution of Population by Age Group and Sex in 2002

Age Group	Gender				Total		Reports of Masculinity
	Masculine		Feminine		Workforce	%	
	Workforce	%	Workforce	%			
0–4	728605	7.4	716100	7.3	1444705	14.7	101.7
5–9	743683	7.5	727756	7.4	1471439	14.9	102.2
10–14	661917	6.7	643284	6.5	1305201	13.2	102.9
15–19	562066	5.7	606807	6.2	1168873	11.9	92.6
20–24	451791	4.6	472763	4.8	924554	9.4	95.6
25–29	355694	3.6	390984	4.0	746678	7.6	91.0
30–34	284309	2.9	323265	3.3	607574	6.2	87.9
35–39	221619	2.2	255480	2.6	477099	4.8	86.7
40–44	199620	2.0	219887	2.2	419507	4.3	90.8
45–49	155332	1.6	155492	1.6	310824	3.2	99.9
50–54	136828	1.4	141942	1.4	278770	2.8	96.4
55–59	87092	0.9	84448	0.9	171540	1.7	103.1
60–64	86658	0.9	93546	0.9	180204	1.8	92.6
65–69	59427	0.6	53578	0.5	113005	1.1	110.9
70–74	54083	0.5	58027	0.6	112110	1.1	93.2
75–79	31472	0.3	26209	0.3	57681	0.6	120.1
80–84	18811	0.2	19317	0.2	38128	0.4	97.4
85–89	6729	0.1	6122	0.1	12851	0.1	109.9
90–94	3257	0.0	4145	0.0	7402	0.1	78.6
95 >	3771	0.0	6566	0.1	10337	0.1	57.4
Total	4852764	49.2	5005718	50.8	9858482	100.2	96.9

The age and sex ratios reveal several disparities and distortions: in the young ages (0–14 years) men and women are numerically almost equal. This demographic equality fades from 15 years where there is a greater percentage of women living longer than men, which is maintained up to 54 years. This appears to be due to gender differential in migration, which impacts men aged between 15 and 44.

Graph: 8.1 **Curve of sex ratios in 2002**



The population pyramid confirms that the young population base is large. This could result in high level of fertility and subsequently high level of child mortality even though this has fallen sharply over the past decade. The publication, *Population, Development and Family Planning in Francophone West Africa: the urgency to act* (Ouagadougou, 8–11 February 2011) based on a study coordinated by Jean-Pierre Guengant, Research Director Emeritus IRD, projected significant increase in Senegal's population between 1960 and 2010. This analyses was a result of a rapid decline in mortality and the maintenance of high fertility over a long period of Time.

In 2010, life expectancy at birth was estimated at 58 years (against 41 in 1960) and fertility was estimated at 4.9 children per woman. In Senegal,the first phase of the demographic transition (lower mortality) is well advanced and in the second phase the fertility seems to be declining .

Table 8.3: Evolution of Population from 1960–2010

Indicator	1960	1980	1990	2000	2010
Total population in 1000s	3082	5636	7538	9427	12331
Rate of annual growth in %	2.7	2.8	2.9	2.6	2.6
Urban population in 1000s	709	2016	2932	3799	5229
Percentage of urban population	23.0	35.8	38.9	40.3	42.4
Estimate of Dakar population in 1000s	353	957	1405	1930	2745
Rural population in 1000s	2373	3620	4606	5628	7103
Percentage of rural population	77.0	64.2	61.1	59.7	57.6

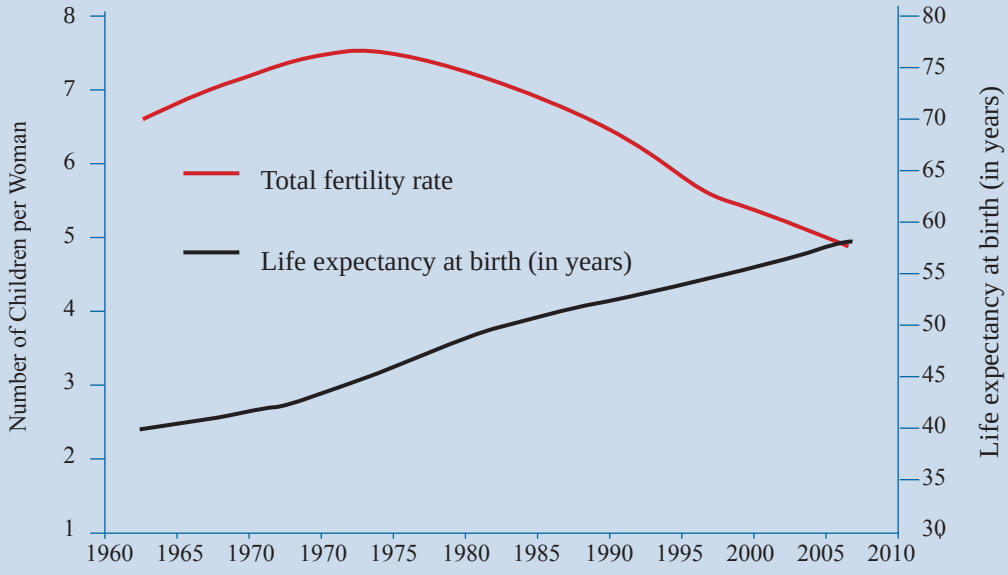
Table 8.4: Evolution fertility, life expectancy of fertility, mortality and natural increase from 1960–2010

Indicator	1960	1980	1990	2000	2010
Total fertility rate	6.6	7.5	6.7	5.6	4.9
Life expectancy at birth (in years)	40.3	47.4	52.0	55.0	58.1
Birth rate in 1000s	48.8	48.2	44.2	40.3	38.4
Death rate in 1000s	24.3	18.0	13.9	12.2	10.4
Natural growth rate in 1000s	24.6	30.2	30.3	28.2	28.0

Table 8.5: Evolution per centages of age, the dependency ratio and the ratio active inactive from 1960–2010

Indicator	1960	1980	1990	2000	2010
% of children below 20 years	51.2	56.3	57.7	56.8	53.7
% of population between 20–59 years	43.9	39.4	38.0	39.0	41.6
% of population 60 years and above	4.9	4.4	4.3	4.2	4.6
Rate of dependence (-20 and 60+/20 to 59 yrs)	1.28	1.54	1.63	1.56	1.40
Ratio of active on inactive (-20 and 60+/20 to 59 yrs)	0.78	0.65	0.61	0.64	0.71

Graph: 8.2 **Evolution of fertility and life expectancy from 1960–2010**



OTHER DEMOGRAPHICS

Ethnic groups

Senegal's population comprises primarily of a diverse muslim population from the following major 7 ethnic groups: Wolof 43.3%), Fulani (23.8%) Serer (14.7%), Jola (3.7%), Malinke (3.0%), Soninke (2.1%), Manjaques (2%), and some other ethnic groups smaller and more localised. The Lebanese, Europeans and the Chinese are quite visible in the urban areas. Religions and beliefs in Senegal are important in the culture and everyday life of the country. Senegal's population is overwhelmingly Muslim (over 94%). Christians, mainly Catholics, represent less than 5 per cent. Traditional beliefs (animations) are credited with 1 per cent, but are also often practised by people of other religions. The country is renowned for its religious tolerance.

Education/Literacy

As in many developing countries, illiteracy is a major hurdle in the growth of Senegal. However, public education and the teaching staff are of high quality. The problem lies in the rural areas. In the mid-90s, the "volunteers education" programme was initiated with young graduates volunteering to go into the bush areas to teach the rural children whose parents found it difficult to send them to school. These young teachers were paid a sum of 50,000CFA (76 euros) per month. But the teaching conditions in rural areas are still very difficult: In some rural areas there is only one classroom for the different levels of students who study with a single slate in a hut.

Literacy is less than 50 per cent among the Senegalese population is literate. Therefore, it can be considered that illiteracy of the population of Senegal is still a major obstacle for the development of this country. 45 per cent of the literate people are men (almost one in every two) while the women literacy rate is 20 per cent (one in every five). In fact, girls often have less chances of being sent to school. These differences fade significantly in urban areas. However, in Dakar (the capital), a reverse situation is gradually taking place and several higher education institutions already seeing a majority of girls attending among their students.

Migration

Immigration to Senegal

In 2001, the stock of immigrants was 126,204 people, or 1.2 per cent of the total population (Senegalese Household Survey, 2001) and 220,208 people in 2005 or 2 per cent of the total population. Immigrants are mainly from Guinea (39%), Mauritania (15%), Guinea-Bissau (11%), Mali (8%), France (8%), Cape Verde (4%) The Gambia (3%), Morocco (2%) and Burkina Faso (1%). The exodus of pupils and students has been greatly reduced by a proactive policy establishment of colleges and high schools nearby all local open universities and vocational training centres in the regions. Social categories most affected by migration to urban centres are the informal sector comprising street vendors, domestic workers, car washers, drivers, hotel employees,

Koran teachers who travel frequently with a group of children to train and educate them on Islam.

Fight against HIV/AIDS

With a multi-sectoral progamme introduced in 2002 to fight against AIDS Senegal, is often cited as one of the countries that has contained the epidemic of AIDS. In the area of prevention, Senegal has managed to maintain a prevalence that is 0.7 per cent in the general population. The infection rate amongst men and women is 2 in every 25 women. With this Senegal too fits into the image of feminisation of the HIV epidemic within many of the African Countries.

It is also noted that the epidemic reaches and exceeds 2 per cent in the border regions. Still, in the field of prevention, Senegal has managed to stabilise the epidemic among vulnerable groups like sex workers (SWs) and men who have sex with men (MSM) to about 20 for almost ten years. In the field of counselling and voluntary testing, the number of people screened shows a substantial growth year after year from less than 10,000 people screened in 2002 to over 400,000 people in mid 2011, surpassing the annual target by the programme. In the area of preventing mother to child transmission major strategy have been put place and has seen progress. Until 2005, the number of pregnant women screened rarely reached 10 per cent of the objective, in 2009 almost 75 per cent of pregnant women who need PMTCT have accessed thus approaching almost universal access. Moreover, in the field of prevention, the safety of blood transfusion is a reality throughout the territory. The management of People Living with HIV (HIV-PV) is also a priority.

According to the Senegalese Household Survey of 2001, about one third of the immigrants, or 31.8 per cent, of the migrants immigrated for work-related reasons or economic reasons. Of a total of 126,054 immigrants in 2001, 86,688 were of working age (that is to say aged 15 to 64) including 55.9 per cent reported a 11.2per cent occupancy and were looking for a job. It was estimated that 34.2 per cent were employed in commerce and agriculture 26.4 per cent and 15.4 per cent respectively. In the production and processing, 55.5 per cent had no education.

In 2007, Senegal was home to about 23,800 refugees and asylum seekers, including more than 20, 000 Mauritanians were fleeing ethnic persecution, as well as some of Liberia and Sierra Leone.

Senegalese Emigration

A large Senegalese community is living outside the country. This diaspora is a resource essential for the country, both economically and community identity. These are mainly young men who move to Europe, especially in France, or North America, particularly in Quebec with a proposed return to the country after a few years. According to data available from the Centre on Migration (based on data censuses over the period 1995–2005), the stock of emigrants in Senegal is estimated at 479 515. The main destinations

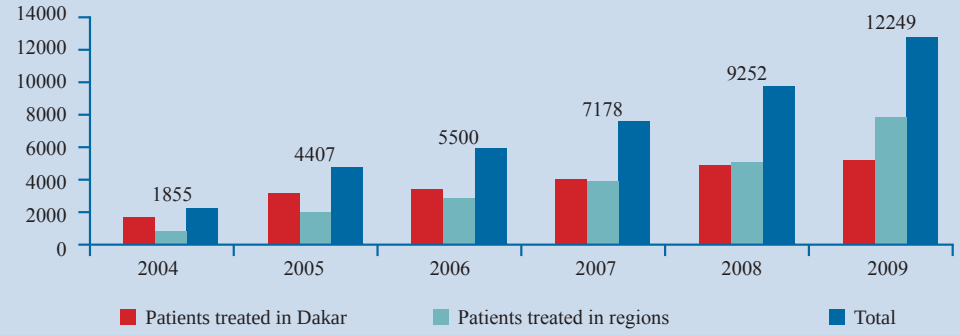
are Gambia (20 per cent), France (18 per cent), Italy (10 per cent), Mauritania (8 per cent), Germany (5 per cent) and Ghana (5 per cent). According to a 2001 survey, 68 per cent of emigrants were aged between 15 and 34; 94 per cent of emigrants were between the ages of 15 and 54. Over the past decade, Senegal has experienced episode of massive emigration of young through improvised canoes to cross the Atlantic Ocean towards Europe (Spain, Italy, and France). Many take huge risks eluded by the success of a few.

Family Planning

The family planning achievements made so far reflects successes particularly in urban areas, but also shows some shortcomings and some constraints. The contribution in reducing morbidity and maternal mortality and newborn health, family planning strategies offer prospects but also has major challenges. In recent decades, contraceptive prevalence among married women has increased slightly. The a contraception use increased from 5 per cent in 1993 to 8 per cent in 1997 and then to 10.3 per cent in 2005 (EDS IV). The basis of the strategies follows:

- Decentralisation of services.
- The partial integration of contraceptives in the Bamako Initiative.
- Improving the logistics system and management, capacity building of the providers and building partnerships.

Graph: 8.3 **Patients Treated under ARV**



It also notes:

- Greater availability of family planning services at the health posts.
- A wider range of methods offered by midwives.
- The extension of intrauterine devices (IUDs) and implants to regions other than Dakar.
- Social marketing of condoms and hormonal contraception through the development and implementation of security plan products.
- Implementation of pilot community-based services to contraceptives and essential drugs.
- The involvement of certain NGOs, including that of the Imams and Ulema.

- Senegal, corporations, private companies and semi government in service delivery family planning.

Despite this progress, modern contraceptive prevalence is still low while the unmet needs remain high (32 per cent).

Declaration of Population Policy in Senegal (DPP)

The Government of Senegal defined and adopted Policy Statement Population in 1988, along with other national programmes like the National Programme Family Planning, which started in 1990). This has placed Senegal among the first French-speaking countries in the South of the Sahara to have initiated the discussion and action on population policy issues.

The DPP is regularly updated to incorporate both the new priorities of Government and the recommendations of international meetings on the issues of population and development. The recommendations of international meetings suggest focusing on reproductive health particularly of the adolescents. The adoption of the Declaration of Population Policy reflects, among other things, the willingness of the State of Senegal to ensure better control of population problems and policies by taking an integrated approach to development. It is based on a number of principles:

- Respect the fundamental rights of the individual.
- The need to preserve the family unit.
- Respect the right of individuals and couples to choose the size of their families and control their fertility.
- The responsibility of individuals as spouses and parents to cope with their procreation as a national development.
- Respect the right of children for their survival, health, education and training.
- The need for an integrated approach taking into account the interrelationships between demographic variables and economic and socio-cultural factors.
- The need to consider the population as a fundamental element in the all strategies and development initiatives.
- Creating a broad consensus in the definition and implementation of the objectives of a population Policy.
- Senegalese commitment to contribute towards the socio-economic recovery and development as part of African solidarity.

DPP OBJECTIVES ARE

Improve the quality of life and promote the establishment of well-being of all population groups, with the realisation of potential links between human resources and development opportunities in the country.

- To reduce morbidity and mortality, particularly that of mothers and children by implementation of programmes including maternal and child health and family planning.
- Reduce the fertility rate and the rate of population growth by the adoption of appropriate measures.
- To support all actions aimed at improving the quality of life in the regions curbing the rural exodus and better spatial distribution of population.
- Ensure better regional coverage of basic needs in all areas (food, nutrition, health, education, housing, training, environment, leisure).
- Improve national expertise in the field of population sciences through training.
- Continuously improve the knowledge of population issues by undertaking.
- Relevant research in demography, sociology, history, planning and development.

To achieve this, the following strategies were used:

- Improving the health of the mother and child.
- Control of fertility and birth spacing.
- Promotion of Women, youth, and well-being of the elderly.
- Preservation of the family.
- Control of migration, urbanisation and land use.
- Promotion of employment.
- Development of IEC in population programmes.
- Legislative and regulatory measures.

For each of these strategies appropriate measures have been taken to make it operational. Various bodies and agencies are promoting the population policy of Senegal

- A decision-making body: the National Council on Population and Resources Health
- CONAPORH) chaired for the President of the Republic.
- A body of planning, coordination, monitoring and evaluation: the Directorate of
- Human Resources Planning Ministry of Planning (HRPD).
- Different implementation structures under different ministries.
- National structures to study and research (Department of Forecasting and
- Statistics, University Cheikh Anta Diop in Dakar, UCAD, the National School Applied Economics, ENEA, etc.).

Based on the results of the 1988 census and demographic surveys, the DPP has developed two scenarios for population projection objectives:

Scenario I: Slow reduction of TFR and small increase CPR

The medium variant assumes a continuation of a trend characterized by: A slow reduction of the TFR (4.48 children per woman in 2015 and 3.8 children per woman in 2025), and a small increase in contraceptive prevalence (18 per cent in 2015 and 23 per cent in 2025.

The low scenario, which wants proactive retained assumptions.

Scenario 2: Faster decline of TFR and faster increase in CPR

The faster decline in fertility (from 4.08 children per woman in 2015 to 3.34 children per woman in 2025), and also faster increase in contraceptive prevalence (23 per cent in 2015 to 30 per cent in 2025).

The scenario 1 is the basis of DPP policy objectives.

CONCLUSION

Population dynamics in Senegal, by the efforts of the state and results are already being achieved and looks assuring for the future policies. The Government has proved through its Population Policy statement, implementation of programmes and finally by the signing of the Population Stabilisation Declaration that it is committed and focused on the well-being of women and children. However, the cost remains high for certain services, including contraceptives and there is the fight against AIDS and lack of attention to Family Planning.

These constraints are related to: inadequate human resources, persistence of some socio-cultural variables, low male involvement in family planning and poor reception of certain family planning services.

Nevertheless, the family planning programmes provide opportunities to address these constraints and accelerate progress towards the goals of population stabilisation.

Some of these opportunities are:

- The political will expressed at the highest level of state by the President for the health of the population.
- Greater political commitment towards managing mother and child health.
- Greater accountability for services.
- Greater involvement of populations, particularly women in managing their health.
- Strengthening partnership for technical and financial support.

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CHAPTER 9

UGANDA POPULATION STABILISATION REPORT

Betty Kyaddondo

The wealth of a nation is not in the stones or minerals in the ground, but in its people, if healthy, educated and employed." – His Excellency, Yoweri Kaguta Museveni

INTRODUCTION

Uganda's demographic profile is one of the country's most salient development challenges. Uganda's population growth rate is still amongst the highest in the world, at 3.2 per cent per annum with a Total Fertility Rate (TFR) of nearly seven children per woman. The population, currently estimated at 33 million, is projected to reach 80 million by 2030 and 130 million by 2050. The population nearly doubled in the past 20 years to 29 million in 2005. This has produced a youthful population of about 50 per cent below the age of 18 years.

Unless measures are put in place to check Uganda's fast growing population, which is among the highest in Africa, sustainable development will be undermined. Uganda's national development is being undermined by high food prices, climate change, forest denudation, land degradation, water shortage, declining oil supplies, species extinction and destruction of ecosystems, all attributable to the high fertility and population growth rate. The root of these problems is the ruthless exploitation of Uganda's resources in terms of charcoal burning, over-cultivation on the small plots of land, over-fishing and misuse of wetlands by the growing population. Plots of land are divided among children, and due to large family sizes, per capita access to arable land is shrinking with each successive generation. More people are crowded into less space. As space is taken up, it is becoming more valuable, eventually affecting the poorest in the country. In the long run, the effect of population growth has started leading to substandard housing or homelessness.

Big families that result from high fertility largely increase the economic and emotional burden of parenthood. High fertility and therefore, rapidly growing populations have negative effects on the health and well-being of women, children, families and communities, and are key factors in poverty enhancement. With the current population growth rate, Uganda faces many challenges to stabilise its population policies and programmes.

High fertility and high population have several challenges for sustainable development and opportunities can only be realised if there is significant investment in social services, which can lead to populations that can afford to purchase industrial products

and participate in sustainable development. In an effort to improve the livelihoods of people, the government is opting for industrialisation. Many of the industries, however, are not environmentally friendly despite environmental impact assessment policies. The Government has also prioritised family planning as a key cross cutting factor in the National Development Plan 2010–14. The relationship between contraception and women's status is a dynamic one, with synergistic improvement in women's educational and economic opportunities and also an important impact on the acceptability and use of contraception. Access to contraceptives allows women to decide the number and spacing of children.

Uganda has faced significant political upheaval in the second half of the twentieth century. After gaining Independence from Britain in 1962, the country experienced two decades of dictatorship accompanied by extreme civil violence. Since 1986, the presidency of Yoweri Kaguta Museveni has brought relative stability and economic growth to the country, but Uganda has also remained involved in internal and regional conflicts. After decades of instability and civil conflict, Uganda has enjoyed relative stability, sustained economic growth, and great improvements in health over the last 20 years. Notable among these have been decreases in infant and child mortality, increased life expectancy, and great strides to reduce the prevalence and spread of HIV/AIDS.

The Government of Uganda is committed to improving the quality of life of her population through, among others, achievement of Socio-economic Development and the Millennium Development Goals (MDGs). During the past 20 years remarkable socio-economic progress was made and this progress is reflected in many sectors, especially in macro-economic stability, economic growth and rehabilitation of social services and infrastructure. It is therefore important to monitor closely the progress and pace of our efforts in implementation of the development programmes, while identifying achievements as well as challenges that need to be addressed.

Every year, the Population Secretariat, in its State of Uganda Population Report, publishes key population concerns that need to be attended to in Uganda's quest to improve the quality of life of its people. The reports elaborate key challenges as well as opportunities at various levels. The reports further highlight the required policy actions that need to be taken in order to catalyse and maximise on the already achieved gains. The State of Uganda Population Reports SUPRE(s), therefore, are significant documents and present opportunities to all policy makers and development partners to pay attention to issues that require serious national response. Previous SUPRE(s) analysed fertility and HIV/AIDS patterns, access to reproductive health, conflict and post conflict situation, socio-cultural practices in relation to gender, culture and human rights in the context of social, health and human development in Uganda.

Population growth becomes a major issue in Uganda's development discourse when the economy is in deep trouble (Kashambuzi, 2010). Although Uganda has devoted an

increasing amount of resources to health interventions, funding for reproductive health services as well as general health sector remains inadequate. As such without improving the efficiency of current reproductive health interventions, Uganda is unlikely to meet some of its Millennium Development Goals relating to maternal health and the population will continue growing at alarming rates.

BACKGROUND

This report describes the process of population stabilisation in Uganda in the context of fulfilling reproductive rights and attaining sustainable development. The report is based on censuses and sample surveys with various sources of information that can be used for understanding population dynamics and illustrates the current projected population and the relation to population stabilisation. Cognisant of the fact that Uganda is far from attaining replacement fertility, the report analyses the determinants of fertility as the main factors of population growth in the country and its connection with development variables.

The chapter is also informed by the national population and development-related policy and programme interventions in achieving population stabilisation. The Report, based on the analysis from the population projections, policy environment and programme interventions, makes recommendations to guide the country in attaining fertility replacement levels that are responsive to human rights and sustainable development.

METHODOLOGY

The report has benefited from the previous population censuses and surveys, as well as some consultations with concerned agencies, experts and other stakeholders in the country. Their inputs have been instrumental in making this Chapter more rigorous and coherent. The contents of this chapter were substantially based on secondary sources from the National Statistics Office, National Statistical Coordinating Board, and other relevant research agencies.

Population Censuses

Prior to 1900, there was limited information on Uganda's population. Decennial population censuses have been conducted in Uganda since 1911. The 1911, 1921 and 1931 Population Censuses were mainly administrative in nature, and separate enumeration procedures were made for the African and non-African population in the country. The Population Census results of 1911, 1921 and 1931 revealed populations of 2.5, 2.9 and 3.5 million persons respectively.

The 1948 Population Census was the first scientific Census to be carried out in Uganda. This was followed by the 1959 Census. The two censuses enumerated the African Population and the non-African populations separately. The first post-Independence Census was conducted in 1969 followed by those of 1980, 1991 and 2002. The 2002 Population and Housing Census was the most comprehensive census ever conducted

in Uganda. The census collected data on the demographic and socio-economic characteristics of the population; household and housing conditions, agriculture; activities of micro and small enterprises; and the community characteristics. Uganda is currently preparing for the 2012 Census and this may have a significant impact in the analysis of this chapter. The chapter is therefore, based on the available Population Censuses and relevant surveys and studies.

Sample Surveys

The Uganda Bureau of Statistics undertakes regular Demographic and Health Surveys. To date, Uganda has carried out four Demographic and Health Surveys (UDHS) in 1988/9, 1995, 2000/1, and 2006. The fifth UDHS is underway, results will be released in 2012 but the panel survey already indicates improvement in some of the health related indicators. UDHS provides information on household characteristics, fertility levels and preferences, awareness and use of family planning methods, childhood mortality, maternal and child health, maternal mortality, breastfeeding practices, nutritional status of women and young children, malaria prevention and treatment, women's status, domestic violence, sexual activity, and awareness and behaviour regarding AIDS and other sexually transmitted infections in Uganda.

The Ministry of Health carries out HIV surveillance surveys dating back to 1989. In collaboration with the Bureau of Statistics, the Ministry of Health carried out a population based HIV/AIDS Sero Behavioural Survey in Uganda in 2004. The surveys have been used as a basis for most of the assumptions made especially on fertility and mortality while the Sero Behavioural Survey provides information on the HIV prevalence.

The UDHS survey is part of a global effort supported by the United States government, to monitor and evaluate population, health and nutrition programmes in developing countries at intervals of five years. Furthermore, the survey is based on a two-stage cluster sampling design. In the first stage, clusters are the principal sampling unit and at the second stage, 25–30 households are randomly selected from each cluster.

Location and Size

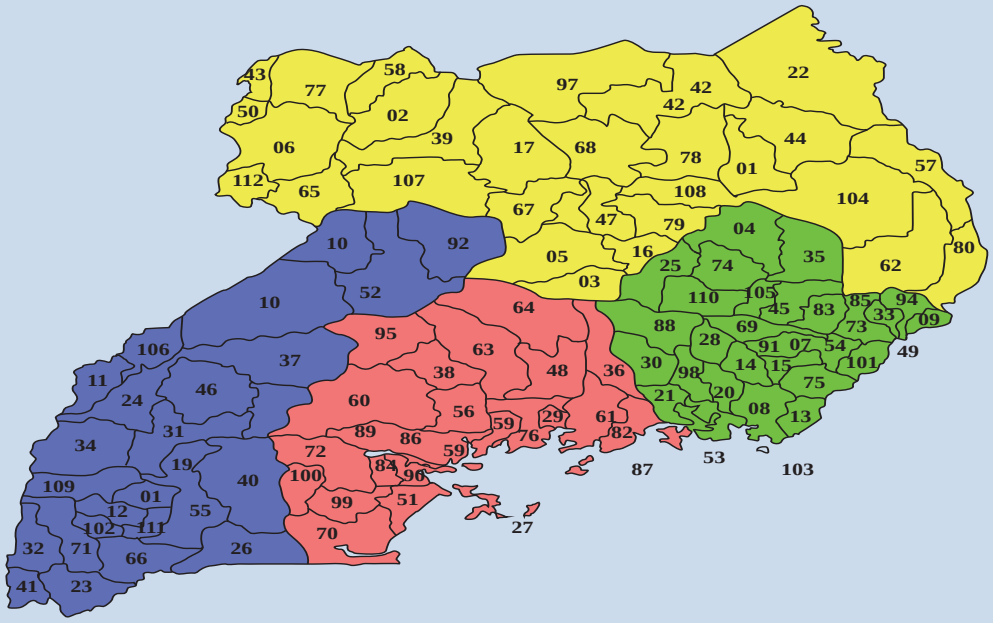
Uganda is a landlocked country in East Africa. It is bordered by Kenya on the east, the north by Sudan, by the Democratic Republic of the Congo on the west, by Rwanda on the southwest and by Tanzania on the south. It has an area of 241,038 square kilometers, of which the land area covers 197,323 sq. km.

Administration

The country is currently divided into 111 districts and one city (the capital city of Kampala) across four administrative regions. Most districts are named after their main commercial and administrative towns. Each district is further divided into counties and municipalities. The head elected official in a district is the Chairperson of the Local Council V.

The districts are sub-divided into lower administrative units. These are counties, sub-counties and parishes. Overtime, the numbers of districts and lower level administrative units have continuously increased (Table 9.1) with the aim of making administration and delivery of services easier. The total number of districts increased from 56 districts at the time of the 2002 Population and Housing Census to 80 in 2007 and currently to 111 with one Capital City authority. This however, had a negative element in that most of the districts do not have time series data and hence it is not possible to do a district level trend analysis and demographic behaviour. In addition to the administrative system, Uganda has a parallel Local Governments System at different levels. These are LC V (District); LC IV (County / Municipality); LC III (Sub-County); LC II (Parish); and LC I (Village). The role of the local governments is to implement and monitor government programmes at the respective levels.

Map of Uganda



Education

Uganda's education system is both formal and informal. Under the formal system, the four-tier educational model is followed. This has seven years of primary education, four years of ordinary level secondary education, two years of advanced level secondary education and the tertiary level of education. Each level is nationally examined and certificates are awarded. University education is offered by both public and private institutions.

Graph: 9.1 **Primary and Secondary School Enrolment in Uganda 1989–2009/10**

The Universal Primary Education (UPE) programme was introduced in 1997 to offer free education at the primary level while Universal Secondary Education (USE) was introduced in 2007. The government also sponsors about 4,000 students every year through the public universities. The private sponsorship scheme is also operational in the public universities. University education can also be obtained from any of the private universities in the country. In addition, a large number of institutions both private and public also offer tertiary education.

To complement the formal education, there exists informal education to serve all those persons who did not receive formal education. Under the informal system, a range of practical/hands-on skills are imparted to those who have not gone through or only partially gone through the formal system of education. The majority of participants in the informal system are the young adults and/or drop out and disadvantaged children. The Functional Adult Literacy (FAL) programme in the Ministry of Gender, Labour and Social Development (MOLGSD) targets older people who did not get chance to go through formal training.

Uganda's economic outlook

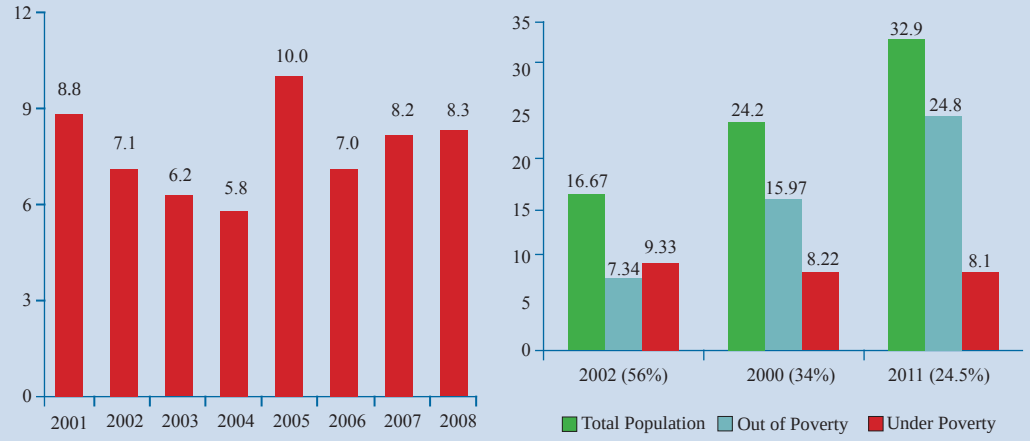
The Government of Uganda is committed to improving the quality of life of her population through, among others, achievement of Socio-economic development and the MDGs. The economy has had an impressive growth over the years. Even during the global economic meltdown, the country's real GDP growth rate was 7.1 per cent. The 2009 Human Development Index puts Uganda's GDP per capita at US $889, lifting Uganda from the lower to the middle rungs/categories of developing countries. However, there are still 31 per cent (2005/6) of the population living below the poverty line.

During the past 20 years, remarkable socio-economic progress was made and this progress is reflected in many sectors, especially, in macro-economic stability, economic growth and rehabilitation of social services and infrastructure. In early 1980s, Structural

Adjustment programmes were introduced which led to strong economic growth of GDP. Hence, the period that followed showed a remarkable increase in productivity and output. This was given impetus by macro-economic stability resulting from the macro-economic reforms that led to the economy reverting to its high GDP growth rates and low and stable inflation and interest rates from the 1990s to the present. According to the Annual Health Sector Performance Report 2007–2008, budgeted public health expenditures equaled about US$8.20 per person per year. This level of expenditure needs to be raised for provision of the minimal level of services. More needs to be done to show the investment case for reproductive health as a vehicle for household poverty reduction and economic transformation.

The economy of Uganda is primarily based on the agricultural sector, with over 70 per cent of the working population being employed by the sector. Agricultural exports account for over 45 per cent of the total export earnings with coffee, tobacco and fish continuing to be the main export commodities that bring in foreign exchange. In the last 5 years, the telecommunication sector has been the fastest growing sector of the economy, and this is due to the expansion programmes and increase in coverage by the major telecommunication companies in the country which have led to increased numbers of subscribers and providers of the services.

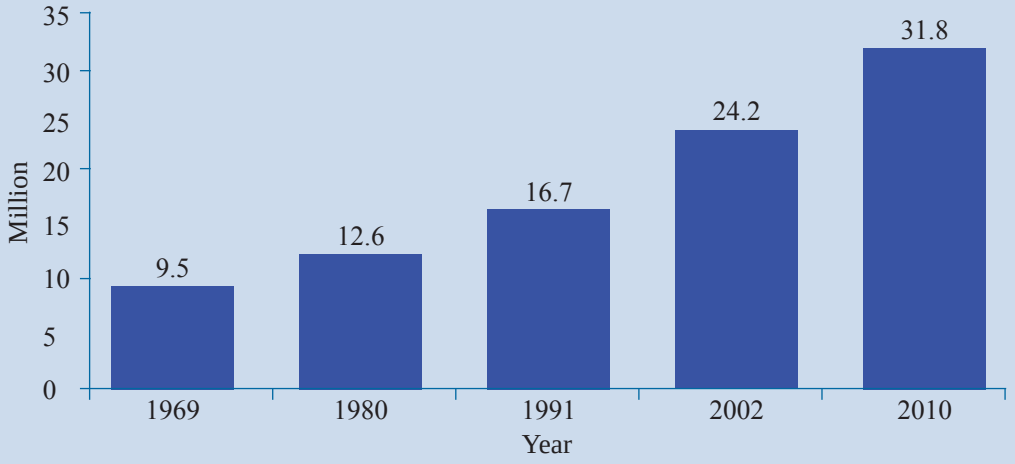
Graph: 9.2 **Macro economy trends**



Uganda's Demographic context

Uganda's demographic profile is one of the country's most salient development challenges. Uganda's population has continued to grow over a period of time. It increased from 9.5 million in 1969 to 24.2 million in 2002 at an average annual growth rate of 3.2 per cent between 1991 and 2002. The projected 2010 mid-year population stands at 31.8 million. The population, currently estimated at 33 million, is projected to reach 80 million by 2030 and 130 million by 2050. More than half of Uganda's population (51 per cent) are females. This has produced a youthful population of about 50 per cent below the age of 18 years.

Graph: 9.3 **Census population, 1969, 1980, 1991 and 2002 and mid year (2010) projection (millions)**



Source: Uganda Bureau of Statistics

The total fertility as estimated by the DHS, stood at 6.7,(UDHS, 2006) largely unchanged over the past twenty years and much higher than in neighboring countries (e.g., Kenya: 4.7; Tanzania: 5.6. Consequently, the population growth rate was about 3.4 per cent per year between 1991 and 2002, which puts Uganda among the countries with the highest population growth rates in the world.

The demographic implications of this high population growth rate can be read from Table 1 that shows demographic projections for Uganda from the United Nations Population Division based on the medium (and thus most probable) variant of the 2002 revision. According to these projections, Uganda's population is expected to reach 103.2 million people in 2050. This projection is based on considerable fertility decline from presently about 7 per cent to only 2.9 per cent in 2045–2050.

Whether this will be achieved is far from certain and will likely to depend on overall economic development in coming decades as well as government efforts to support a fertility decline. But even with this considerably fertility decline, population growth will still be over 2 per cent per year in 2045–50 and Uganda's population is projected to stabilise at a population of some 200 million only in the 22nd century.

Table 9.1: Demographic Projections for Uganda 2000–2050								
Rate	Population ('000)	Pop. Growth	Population Density	TFR	Dependency	Pop. Aged 15–64	Growth 15–64	Pop. Aged 5–19
2000	23487	3.30%	100	7.10	110	11164	3.16%	9504
2005	27623	3.62%	117	6.78	112	13044	3.67%	11167
2010	32996	3.58%	140	6.37	111	15621	3.88%	13467
2015	39335	3.46%	167	5.93	108	18894	4.06%	16167
2020	46634	3.31%	198	5.43	102	23051	4.00%	19115
2025	54883	3.11%	233	4.87	96	28051	3.86%	22143
2030	63953	2.84%	271	4.27	89	33894	3.64%	25287
2035	73550	2.53%	312	3.70	82	40522	3.38%	28395
2040	83344	2.27%	353	3.24	74	47844	3.12%	31096
2045	93250	2.06%	395	2.90	67	55801	2.79%	33051
2050	103248	438	61	64039	34326			
Source: United Nations Population Division								

Sex ratio at birth

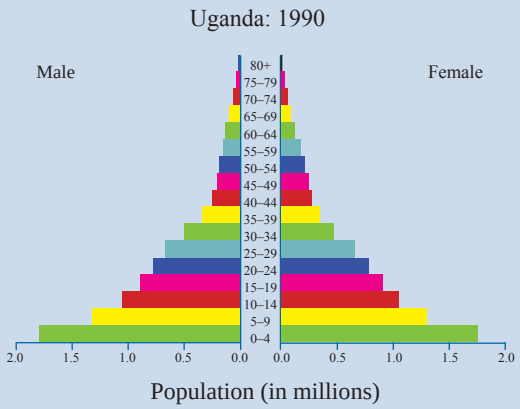
Vital registration provides the most appropriate source of information on sex ratio at birth. However, as noted in section 1, the coverage of vital registration in Uganda is still limited. The UDHS 2006 estimated the sex ratio at birth at 102.6 males per females, and this was assumed to remain so throughout the projection period.

Age-sex distribution of Uganda's Population

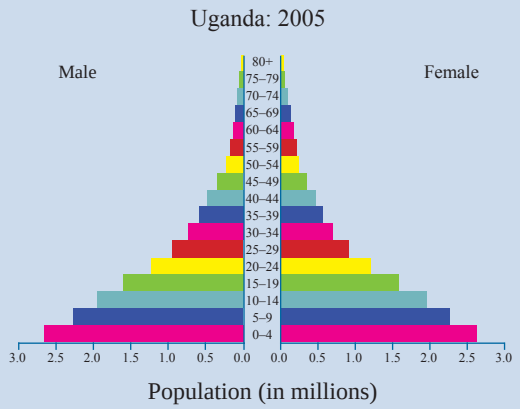
The 2002 Census is the most recent population and Housing Census and hence is the source of information on age sex distribution of the population in Uganda. Graph 9.5 shows the age-sex distribution of the population as reported in the 2002 Census (adjusted to mid-year). The population pyramid is typical of one with high fertility and mortality as depicted in the road base of the pyramid and rapid tapering off with increasing age.

A quick look at the five-year age-sex distribution did not reveal major deviations arising from age errors as five-year age distributions tend to have a smoothing effect on single-year-age distributions. However, a close examination of the age-sex ratios showed fluctuations that could not be explained by demographic factors and were therefore attributed to the quality of the age-reporting arising from differential age shifting by sex and hence necessitating graduation of the reported age-sex distribution.

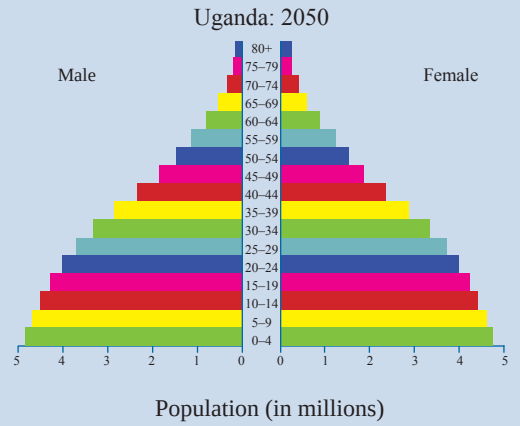
Graph: 9.4 **Uganda Population Pyramids for 1990, 2005, 2010 and the prediction for 2050**



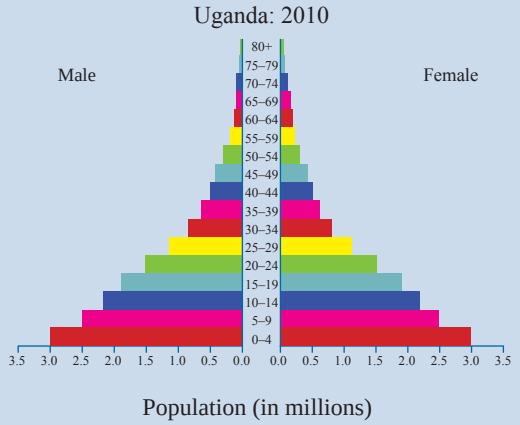
Source: U.S. Census Bureau, International Data Base.



Source: U.S. Census Bureau, International Data Base.



Source: U.S. Census Bureau, International Data Base.

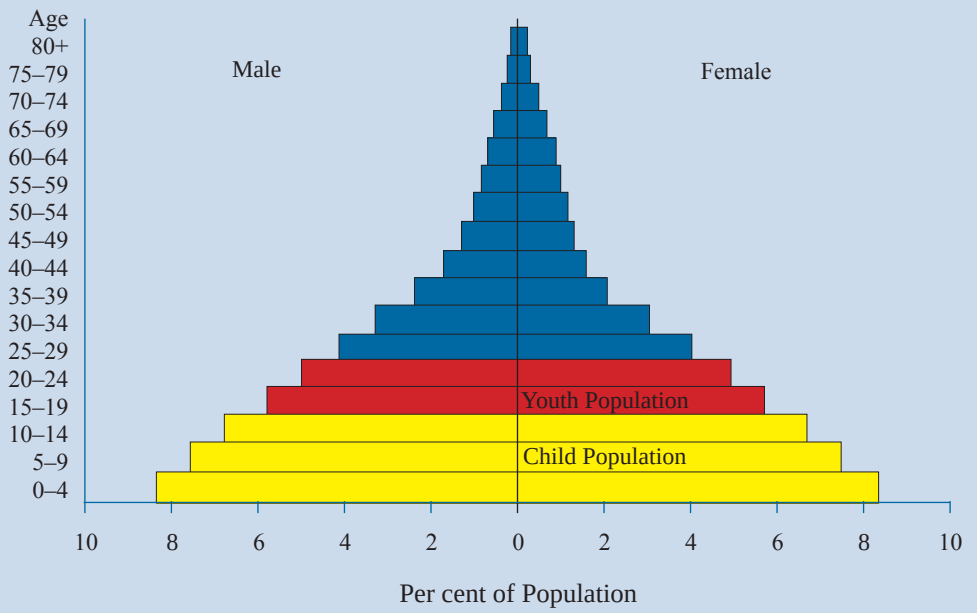


Source: U.S. Census Bureau, International Data Base.

Population Structure

About half of the population in Uganda is below 24 years of age. It is a challenge and opportunity of the country. This demographic surge of people entering their productive and reproductive years is great potential for development – if Uganda can invest wisely in education, health, skills and economic opportunities of youth.

Graph: 9.5 **The Population Structure of Uganda**



Net Migration

Whereas the Population and Housing Census is fairly reliable information about migration into Uganda, there is no reliable source of information about migration out of the country. It is therefore not possible to ascertain the net effect of migration on the population. In the absence of net migration data the assumptions were based on estimates by the United Nations for Uganda. The United Nations estimated net migration during the period 1995–2000 as a net loss of 9,000 people annually. However, this figure was not broken down by age and sex (UBOS, 2007).

Demographic Projections

Population projections are essential for planning at the national, regional and district levels in both the private and public sectors. In order for planners and policy makers to efficiently allocate the scarce resources, they need to know the future size and structure of the country's population as well as their characteristics. Planning for any sector of the economy therefore requires information about the future size and structure of the population in the area.

Although demographic information can be obtained from censuses and surveys, they often do not meet all the needs of planners for the following reasons: Censuses are carried out every ten or five years in different countries and because the census, results are often released at least about two years after enumeration, the information from censuses though informative are technically out of date even at the time of being released. This is because, at the very minimum, planners require information about the current size and structure of

the population, and not two or three or five years ago. However censuses are expensive exercises to conduct therefore, it is not possible to carry out census every year to meet the planning needs of policy makers.

Table 9.2: Mid-year population estimates and projections for Uganda, 1992–2011

Mid Year Population			
Year	Urban	Rural	Total
1992	1,801,100	15,671,900	17,473,000
1993	1,891,700	16,149,900	18,041,600
1994	1,987,000	16,641,700	18,628,700
1995	2,087,000	17,148,000	19,235,000
1996	2,192,100	17,668,800	19,860,900
1997	2,302,500	18,204,800	20,507,300
1998	2,418,400	18,756,300	21,174,700
1999	2,540,100	19,323,800	21,863,900
2000	2,668,000	19,907,400	22,575,400
2001	2,802,400	20,507,700	23,310,100
2002	2,943,500	21,123,700	24,067,200
2003	3,091,400	21,998,000	25,089,400
2004	3,247,000	22,612,700	25,859,700
2005	3,410,500	23,330,800	26,741,300
2006	3,582,200	24,047,100	27,629,300
2007	3,762,600	24,818,700	28,581,300
2008	4,372,000	25,220,600	29,592,600
2009	4,524,600	26,136,700	30,661,300
2010	4,692,200	27,092,400	31,784,600
2011	4,859,500	28,080,300	32,939,800

Source: Uganda Bureau of Statistics

Uganda is still predominantly rural

The Rural population (% of total population) in Uganda was reported at 87.02 in 2008, according to the World Bank. The 2002 Census reported about 12 per cent of the population lived in urban areas. Uganda is one of the world's poorest countries. In spite of high GDP growth rates recorded in recent years, most of the population lives in poverty. Agriculture is the most important sector of the economy, employing over 80 per cent of the work force, with coffee being the main source of foreign trade. The country poses substantial natural resources like fertile soils, regular rainfalls, small deposits of copper, gold, and recently discovered oil.

Uganda is encouraging rapid rural to urban migration in order to speed up the process of modernisation including industrialisation. The economic, social and environmental

challenges are already enormous, posing serious environmental threats, including high levels of water and air pollution and attendant health risks, even with this small percentage (12 per cent) of urban dwellers. There should be adequate plans for jobs, food, transport, housing, schools, health, sanitation and recreation facilities to absorb an influx of poor and functionally illiterate people as being encouraged to reside in towns.

Consequences of rural-urban migration

Teenage Pregnancy (15–19) years

According to New Vision, 25 may 2011, Uganda has the highest teenage pregnancy rate in sub-Saharan Africa, with half of its girls giving birth before the age of 18. Some girls give birth to healthy children, but for many, pregnancy is unplanned, the birth comes too early and the experience is one of fear and pain. Many times girls marry and start their families before ending their own childhood (MOH, 2007).

The median age for women to marry is below the age of consent (17.8 years) as many experience their first sexual intercourse at 16.6 years, compared to 18.1 years for men, according to the 2006 UDHS. New evidence on adolescents reveals that 23 per cent of young women aged 15–19 years have been in relationships with older men before marriage compared to 4 per cent of young men of the same age Darabi et al., (2008). According to the World Health Organization (WHO, 2007), adolescent girls face health risks during pregnancy and childbirth, accounting for 15 per cent of the global burden of disease for maternal conditions and 13 per cent of all maternal deaths.

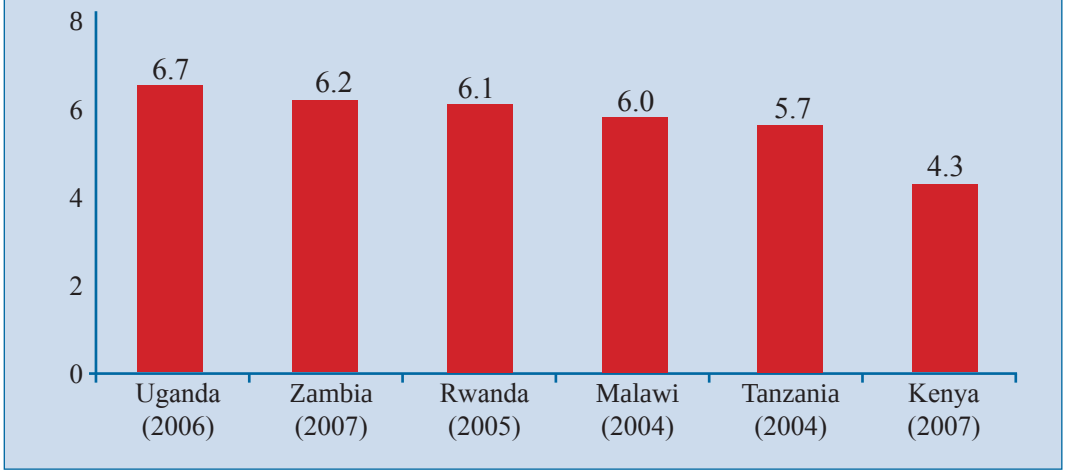
In Uganda, adolescent mothers are twice as likely as older mothers to die during childbirth. Only 41 per cent of births are attended by skilled personnels. For poor young mothers, aged 14 and under, the risk is highest because they have the lowest access to prenatal care, hence, more likely to deliver at home than in hospitals. Ministry of Health data show also that fertility varies markedly with the location, the education and economic status of the mother. Uneducated mothers living in rural areas have almost twice as many

children as women with secondary or higher educations (7.7 children compared with 4.4). The national teenage pregnancy rate of 25 per cent is also high and the leading contributor to high school drop outs.

Fertility

The primary driver of the high population growth rate is the persistently high fertility rate. Census (three past censuses) based estimates show fertility levels have remained fairly constant for over 3 decades remained high over the past 3 decades. The TFR was 7.1 per cent in 1969 and 1991, and decreased slightly to 6.9 per cent in 1995 and 2000, and 6.7 per cent by 2006 according to the 2006 UDHS. However, the UDHS of 2006 showed that a decline was beginning to be realised. It was assumed that the decrease in TFR would continue till the end of the projection period. The TFR was therefore assumed to decline from 7.0 in 1991 to 6.7 in 2006, and remain constant until 2010 and then would steadily decline to 6.0 per cent in 2017 and further to 4.87 per cent by 2025–2030.

Graph: 9.6 **Comparative Fertility rates**



Source: RAPID Uganda 2010.

Key determinants known to sustain this very high fertility level include: gender inequalities and the generally low status of women; a pro-natalist culture that places very high value on children as security for parents at their old age; children are a source of labour; sex preference by some parents; insufficient access to family planning services and poverty. The education of women is a key determinant for fertility as with other reproductive health variables. According to the 2006 UDHS, women with no education have a TFR of 7.8 while the desired number of children for those with primary education is 5.8 compared to 3.8 for those with secondary education. The sexual and reproductive behaviour of adolescents and young people together with the very high unmet need for family planning at 41 per cent are some of the additional determinants of high fertility. Graph 9.7 shows fertility rates for different countries in the region and indicates that

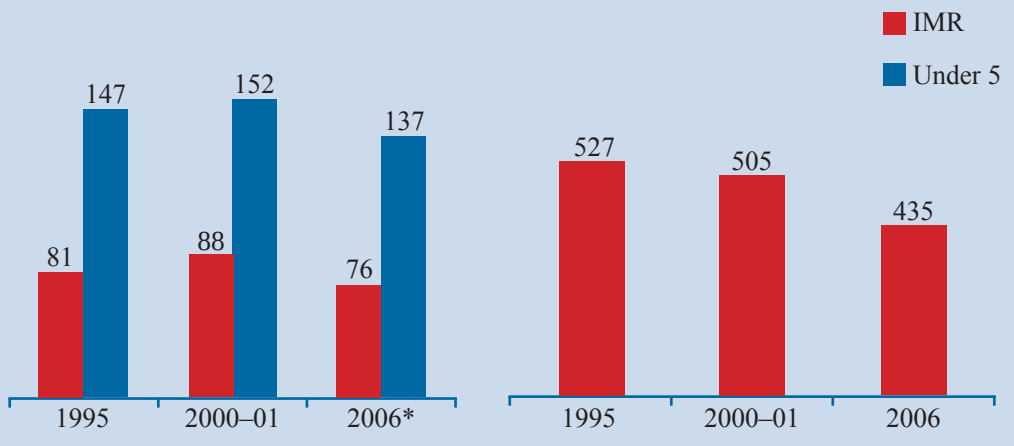
Uganda has the highest fertility rate among neighbouring countries that recently participated in the Demographic and Health Survey programme.

Mortality

There has been a general improvement in mortality levels. The infant mortality rate declined from 122 to 76 deaths per 1,000 live births between 1991 and 2006 while the under five mortality reduced from 203 to 137 deaths per 1,000 live births over the same period. The 2006 UDHS showed that the Infant Mortality Rate (IMR) is lower among children in urban areas as well as those born to educated and wealthier mothers. Maternal mortality ratio (MMR) has also slightly declined from 526 to 507 and further to 435 deaths per 100,000 live births in 1995, 2000 and 2006 respectively. Life expectancy at birth is an estimate of the average number of years a person is expected to live if a particular pattern of mortality is maintained. The over-all life expectancy at birth from 2002 Census was 50.4 years for both sexes. Males registered a lower life expectancy of 48.8 years compared to their female counterparts at 52 years. There was a gain of 2.3 years in life expectancy between 1991 and 2002 for both sexes.

For purposes of population projections, life expectancy at birth is used as a measure of mortality. The life expectancy at birth is projected to increase from 50.5 years for females and 45.7 years for males in 1991 to 54 years and 53 years in 2017 respectively. This was based on the fact that the UDHS 2006 had shown improvement in infant and child mortality (Graph 9.8). The sustained mortality decline coupled with accelerated fertility decline will combine to create the onset of the demographic transition which will eventually lead to the demographic bonus.

Graph: 9.7 **Trends in childhood and maternal mortality**



Source: RAPID Uganda, 2010.

Youth & Employment

One of the key challenges of the future for Uganda's youth is youth unemployment. Reversing this trend is a major challenge for any developing country, moreso for Uganda which has an upright population pyramid with a high dependency ratio. According to the State of Uganda Population Report (SUPRE) 2006, over the past two decades, youth have continued to form a broad base of the population. In 2008 World Bank statistics were showing that Uganda's overall unemployment rate stood at 3.2 per cent, whilst that of youth (15–24 years) stood at a whopping 22.3 per cent. Investing in young people is not only a social obligation, but makes economic sense. Young people's involvement in planning and in all processes of policy formulation is therefore paramount.

Demographic Transition

With a population of 33 million, Uganda is one of Africa's largest and fastest-growing countries. Uganda's population will continue to grow because of the large number of people who are either currently at an age when they are having children or who will soon enter that age group. With half of its population aged 15 or younger, Uganda stands out as one of the world's youngest age structures. As the world reaches 7 billion, countries at the beginning of their demographic transition represent a relatively small proportion – about 9 per cent – of the world's population. However, these countries face similar development challenges.

Despite economic growth in the past decade, many Ugandans live in poverty and confront social and economic inequities. Uganda has entered into its demographic transition by reducing its once-high death rate. (Population Reference Bureau, 2011) As a result of lower mortality but still high fertility, Uganda has developed a very youthful age structure. Fertility and birthrates are very high. The median age at first sex is about 15 years; most Ugandans are still minors. (DISH, 2007) Uganda's current population is just over 30 million, but by 2050 it is expected to be more like 120 million. At that point Uganda – with a land area a bit smaller than Romania – is expected to have more people than Russia (Muir, 2009).

Over the last ten years, Uganda's GDP growth has actually outpaced population growth by a percentage point or two. If this continues, by 2050 Uganda will be a lower-middle income country, albeit a somewhat crowded one. Well, right now Uganda's population density is about 120 people per sq. km, roughly equal to Poland, and only half that of the United Kingdom. Even if the population quadruples, it will only be a bit denser than Lebanon (392) or the Netherlands (395), about the same as the American state of New Jersey (452) and still less than contemporary Taiwan (636) or Bangladesh (1060) (Muir, 2009). Also, Uganda's very rapid growth means it will have a young population. If they can raise their standards of health and education, the youth will be well positioned for the demographic transition in a generation or two.

Fertility transition in Uganda

Uganda is clearly in a very early stage of a demographic transition to low birth rates and low death rates – death rates have dropped significantly without a corresponding fall in birth rates, resulting in a large increase in population. As a result of lower mortality but still high fertility, Uganda has developed a very youthful age structure. Uganda's population will continue to grow because of the large number of people who are either currently at an age when they are having children or who will soon enter that age group. With half of its population aged 15 years or younger, Uganda stands out as one of the world's youngest age structures. Despite economic growth in the past decade, many Ugandans live in poverty and confront social and economic inequities.

High unmet need for family planning

Although use of modern contraception (CPR) among married women in Uganda has more than doubled from 7.8 per cent in 1995 to 18.2 per cent in 2000/01, MOH (1995 - and 2000/01) , the unmet need for family planning has increased, among married women in particular, from 29 per cent to 35 per cent over the same period.

Over 1.4 million women in Uganda would like to delay pregnancy, space their children or stop childbearing altogether, but are not currently using any contraceptive method. Uganda's total fertility rate of 6.7 is among the highest in the world, (Population Reports, 1999) yet the wanted fertility rate is just 5.3. Women and men in Uganda report the lowest "ideal family size" compared to actual fertility in all of sub-Saharan Africa. Nearly 18 per cent of pregnancies in Uganda are unintended, and in many cases are unwanted: an estimated 12 per cent of all pregnancies end in unsafe abortion, and as many as 3000 women die each year in Uganda as a consequence of unintended pregnancy through complications during childbirth or through unsafe abortion Global Health Council (2002).

Reducing the Unmet Need for Family Planning is Critical

More than two-thirds of men and women in Uganda say they would like to delay childbearing or limit their family size. Uganda's high total fertility rate and high population growth rate are due in part to a high unwanted fertility rate of 1.6, (Population reports, 2003) and are the most significant contributing factors to continuing high levels of poverty and high maternal and infant/child mortality throughout the country. The statistics create a major bottleneck for achieving poverty reduction and realising the MDGs. This problem has to be addressed more vigorously, especially through interventions that target child spacing to protect the health of mother and child (Ssendaula, 2003).

Uganda's Poverty Eradication Action Plan (PEAP) (MOFPED, 2004) highlighted improving health outcomes and increasing people's ability to plan the size of their families as key strategies to reduce poverty. PEAP targets included reducing the high unmet need for family planning, thereby reducing the rapidly growing population.

High fertility, especially when unintentional and unwanted, places a heavy burden on women's health, results in high risks to terminate unwanted pregnancies, and significantly affects the health of children as well. Maternal mortality, poor maternal health and large numbers of children in turn have a serious impact on household welfare. Along with poor health, large family size has been identified by communities as one of the major causes of household poverty (MOFPED, 2002). Significant economic gains at household level could be achieved by meeting people's expressed desire for better spaced, smaller families.

Challenges to increasing the use of family planning

Well over two-thirds of Ugandan women and men say they want to space or limit childbearing (71 per cent of women and 67% of men). In fact, a majority (62%) of married women not currently using a family planning method say they intend to do so in future, while 9.7 per cent are still undecided. However, they face many challenges.

Social, cultural, and religious values have a strong influence on reproductive choices for women in Uganda. Early and frequent childbearing and large family size reflect long-standing societal norms among most segments of the population, even though they conflict with the apparent desire reported by the UDHS among individual women and men to space childbearing and to limit family size to a smaller "ideal" number of children. Many women may be discouraged from using family planning by spouses or family members, or by political, religious and community leaders or other community members. Over 14 per cent of married women who are not using family planning and do not intend to do so in future say they, their spouse, their church, or others disapprove.

Lack of accurate information also plays a key role in limiting use of family planning, and knowledge of a wide range of methods is critical to informed decision-making. While most adults in Uganda – 96 per cent of women and 98 per cent of men – (UDHS, 2006) have heard about at least one method of contraception, knowledge about a wider range of available family planning (FP) choices is limited. Many people also have misconceptions about FP and the effects that contraceptives may have on future fertility, unborn children and women's health (PSI Uganda, 2004). Over 23 per cent of married women who are not currently using family planning and do not intend to do so in future, state they do not use contraception due to health concerns or fear of side effects, and another 5 per cent say they lack information about methods and sources (UDHS, 2006). Nearly 7 per cent of these women say their partner opposes use of contraception, yet few programmes target men with accurate information about family planning.

Lack of access to quality services remains a major challenge in Uganda. Many areas still lack basic health facilities, a significant proportion of health centres lack qualified RH service providers, many providers have not been trained in up-to-date family planning skills, family planning is not fully integrated with other health services, community-based family planning services are not in place in most communities, and

family planning commodities and supplies are not consistently available at service delivery points. A significant number of health facilities are operated by the Catholic Church and are unable to offer any level of family planning services apart from natural FP methods, yet alternative channels for providing a full range of family planning services in these locations are not in place.

Prioritisation and resource allocation

The high health and development costs of failing to reduce the number of unintended pregnancies through family planning are not well understood by a number of politicians and other opinion-leaders who publicly "de-campaign" family planning and condom use with poorly-informed arguments. This lack of understanding and commitment from leaders and decision-makers at all levels means that family planning has not received the support and resources it requires at national, district and lower levels.

While family planning was highlighted in the PEAP as a priority strategy to reduce poverty and improve health outcomes, this priority was not reflected in national and district budget allocations and programmes, nor is it reflected in donor-funded programmes. HIV/AIDS, malaria and child health (EPI) access a significant proportion of health resources largely through targeted donor funds, while family planning and reproductive health in general received little or no dedicated funding at national or lower levels.

Family Planning in Uganda

Family planning was introduced in Uganda in 1959. Recently, there has been an urgent focus to revitalise family planning in order to achieve critical benefits at individual, household, community and national levels. If services are not revitalised immediately to reduce the country's high unmet need for family planning, it is unlikely that Uganda will be able to meet its health outcome goals nor will it be able to meet its national poverty-reduction (PEAP) or development (MDG) goals.

Family planning investment is vital

Rapid population growth is like a double-edge sword. For Uganda to benefit from the population explosion there must be an investment in the population, education, training, health and skills. Sufficient jobs to generate the higher level of per capita income and a well-educated labour force to attract the needed investments necessary for economic growth will also play a crucial role.

Population size is not the issue because the population is guaranteed to grow. Variables such as age, structure, spread and type of the population are more important as they determine the quality of the population. If Uganda's population were already healthy, well-educated and had good jobs, then it might be able to deal more effectively with rapid growth. However, given the challenges Uganda faces to development, slowing population may be able to help the country advance economically.

The Uganda National household survey, 2010 indicated that almost two out of every 10 children were conceived against the parents' will. Over 40 per cent of women conceive more children than they want because they have no access to family planning. If every woman in need of contraception got access to it, Uganda's fertility would decrease by 30 per cent and bring the average household from seven to four children per woman.

Girl child education contribution to demographic transition

Demographic transition is a function of many factors. Economic empowerment of women and especially girls' education have been singled out as crucial factors in the transition. Yet young girls in Uganda continue to drop out of school at a high rate and are married off early. Dropout is high due in part to lack of school meals. Despite a resolution by NEPAD urging African governments to provide school meals using locally produced food that puts money into peasants' pockets, the Uganda government has been unable or unwilling to help.

This is how an educated woman reduces fertility. Because she stays at school longer, she marries late. She seeks medical care for herself and her children sooner and houses and feeds herself and children better than an uneducated woman, so her children have a good chance of surviving up to adulthood. Also because she has pension she does not depend on children in her old age. Therefore, she produces fewer children that are more evenly spaced. Her fertility rate drops and she contributes to the country's demographic transition (Workshop report {July 28 2005} on Women's Economic Empowerment UNFPA). The government is urged to reconsider favourably the provision of lunches to keep girls in school longer because there are demographic dividends.

POLICY AND PROGRAMMES

In Uganda, population issues have been high on the country's agenda for addressing Sexual Reproductive Health and Rights. This commitment is reflected and demonstrated by the several policies, implementation frameworks and action plans that address the major population and development issues (Table 9.3). Debates and public discussion whether a high population is a blessing for Uganda, or a curse, are getting intense within Government corridors. Members of Parliament and Ministry of Finance officials are questioning the impact of a high population, saying it is a dampener on the country's insufficient resources. Research institutions are tasked to provide empirical evidence on the likely impact of an increase in spending on infrastructure and sexual reproductive health initiatives, in order to understand the strengths and weaknesses of a high population.

Graph: 9.8 **Interlinkages between population and economic development**

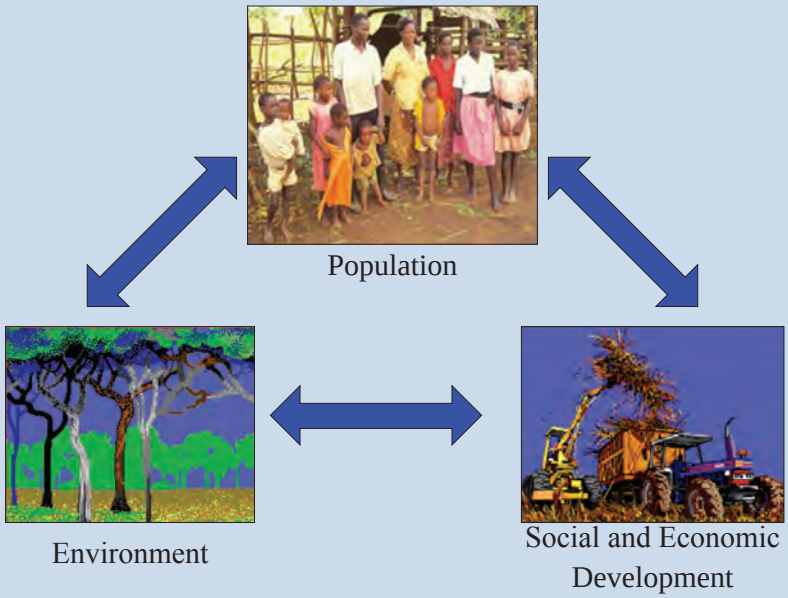


Table 9.3: Policy documents that articulate government's commitment to population and development

Year of Adoption	Policies and Plans	Goals and Objectives
National Policy and Planning Context		
1997, 2000 & 2004	Poverty Eradication Action Plan (PEAP)	This has been the national planning framework for over the last decade (1997–2007/08). It aimed at providing an overarching framework to guide public action to eradicate poverty through increasing people's incomes, improving human development and reducing powerlessness.
2010	National Development Plan (NDP)	The Vision is a transformed Ugandan society from a peasant to a modern and prosperous country within 30 years.

Policies and Plans		
1999, 2010	National Health Policy	The policy derived guidance from the national health sector reform programme and national poverty eradication programme. Goal: Attainment of a good standard of health by all people in Uganda in order to promote a healthy and productive life. Objective: to reduce mortality, morbidity and fertility
1995 & 2008	National Population Policy	First promulgated in 1995 aimed at improving the quality of life of the people of Uganda and transformation of society. After thirteen years the policy was reviewed to accommodate new and emerging challenges leading to the current 2008 policy. The current policy retained the same goal of improving the quality of life of people. It highlights a number of objectives among which is the promotion of improving the health status of the population
2001	National Reproductive Health Policy Guidelines for Reproductive Health Services.	Goal:improve SRH and quality of life of everyone in the country. Objective: guide planning and implementation, monitoring and evaluation of quality integrated gender sensitive RH services; standardise the delivery of RH services and ensure optimum and efficient use of resources for the sustainability of RH services.
Strategic Plans		
2000, 2005 & 2010	National Health Sector Strategic Plan I & II and National Health Sector Strategic Investment Plan III	Was first developed in 2000 to operationalise the 1999 NHP. The HSSP I laid a foundation for health development in the country. In 2005, the HSSP I was reviewed to the current HSSP II and retained the NHP goal. Both HSSP I & II aimed at reducing morbidity and mortality from the major causes of ill-health and premature death. The current HSSP II is guided by 4 main programme objectives, namely: effective, equitable and responsive health care delivery system; strengthening the integrated support systems, reforming and enforcing the legal and regulatory framework and ensuring an evidence-based policy, programme and planning in health development.

2000	RH Division 5-year Strategic Framework-2000-2004	Goal: Contribute to the improvement of quality of life of the people of Uganda. Objective: Reduce MMR by 30% from 506 to 354/100,000 live births, increase Contraceptive Prevalence Rate from 15% to 30%, increase deliveries supervised by skilled health workers from 38% to 50%, increase ANC attendance to at least 4 visits per pregnancy with the first visit in the first trimester, to increase Tetanus coverage among pregnant mothers receiving at least 2 dozes from 50% to 80% and incorporate gender concerns among RH programmes.
2007	Roadmap for accelerating the reduction of maternal and neonatal mortality and morbidity in Uganda	Goal: To accelerate the reduction of maternal and neonatal morbidity and mortality in Uganda. Objectives: increase the availability, accessibility, utilisation and quality of skilled care during pregnancy, child birth and post-natal at all levels of the health care delivery system, promote and support appropriate health seeking behaviour among pregnant women, their families and the community, and strengthen family planning information and service provision for women, men, couples who want to space or limit their childbearing thus preventing unwanted and/or untimely pregnancies that increase the risk of a maternal death.

The Poverty Eradication Action Plan (PEAP)

Through the Poverty Eradication Action Plan (PEAP), which was the overall national development framework between 1997 and 2008/9, the government reaffirmed its commitment to achieving the MDGs and prioritised improving health outcomes under the Human Development Pillar (MoFPED, 2004). PEAP acknowledged the fact that a healthy population is a necessary condition for development and poverty reduction. The PEAP set priorities including increasing spending on preventive care such as family planning commodities, procurement of malaria commodities such as insecticide-treated nets, as well as recruitment and deployment of health workers, provision of free essential drugs and supplies for all the pregnant women, and strengthening family planning, delivery and EmOC services in all health facilities.

The National Development Plan (NDP)

Family planning is among the main objectives of the recently launched five-year National Development Plan (NDP) 2009/10–2013/14 which has replaced the PEAP as a priority for reducing maternal mortality and alleviating poverty. Through the NDP, government

pledges to reduce maternal mortality to 131/100,000 live births by 2015 and increase CPR to 50 per cent from the current 24 per cent (Republic of Uganda, 2010). Based on economic forecasts, the GDP is expected to increase to 7.2 per cent with the nominal per capita income increasing from 506 in 2008/9 to 850 over the NDP period.

The National Health Policy and NHSSP

Within the overall national development framework, addressing health issues in the country is guided by the National Health Policy (NHP) developed in 1999 (MoH, 1999) and reviewed (MOH Policy 2010). Family planning is a key priority area being addressed in an integrated manner through the Uganda Minimum Health Care package (UNMHCP) along with focus on essential Ante-natal and Emergency obstetric care, ASRH, VAW and improving nutrition for pregnant and lactating mothers, among others (MoH, 1999). The 2010 NHP puts emphasis on investing in people's heath, focusing on promotion of people's health and rights, disease prevention and early diagnosis and treatment of disease.

The NHP is operationalised in a five-year National Health Sector Strategic Plan (NHSSP) I & II and the current HSIP III. One of the overriding priorities of HSSP II was the fulfillment of the health sector's contribution to the PEAP and MDG goals of reducing maternal mortality and morbidity; reducing fertility; malnutrition; the burden of HIV/AIDS, among others. The HSSP II prioritised addressing life-threatening health problems, particularly pregnancy and birth-related deaths and childhood killer diseases. HSSP II worked on principles of integrated service delivery, increased efficiency in resource allocation and use of resources, community participation and empowerment, and focus on maximising service outputs, health outcomes and client satisfaction.

The National Reproductive Health Policy

Further commitment to address quality population is clearly articulated in a number of policy documents including the "National Reproductive Health Policy"; the "Sexual and Reproductive Health Care Minimum Package"; the "National Reproductive Health Policy Guidelines for Reproductive Health Services" (MoH, 2006); "Guidelines for Gender Mainstreaming in Reproductive Health and the Strategy to Improve Reproductive Health in Uganda 2005–2010", etc.

To further consolidate the strategies for addressing population issues identified in all the above policies and guidelines, in 2007 the Ministry of Health developed a Roadmap for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Uganda (Republic of Uganda, 2007). The roadmap's vision is "to have women in Uganda go through pregnancy, child birth and postpartum period safely and their babies born alive and healthy". The Roadmap underlines the importance of family planning in reducing maternal deaths and illnesses. The roadmap sets priorities and strategies including: promotion and improvement of the legal framework and policy environment for effective formulation and implementation of maternal health programmes; ensuring availability, accessibility and utilisation of quality maternal and newborn health

services; strengthening human resource capacity; advocating for increased allocation and distribution of resources; strengthening coordination and management of maternal and newborn care services; and empowering communities to participate in care, as well as strengthening monitoring and evaluation mechanisms for better decision making and service delivery.

The National Population Policy

The National Population Policy (NPP) 2008 is in harmony with the former Uganda's over-arching development framework, the Poverty Eradication Action Plan (PEAP). It defines the critical issues that must be tackled in order to ensure a quality population that enhances the country's development goals and objectives. The National Population Policy takes into account Uganda's past and present, and remains cognisant of Uganda's commitments to international and regional conventions, declarations and covenants such as the "International Conference on Population and Development programme of Action (ICPD-PoA)", "4th World Women's Conference, Millennium Development Goals (MDGs)" and "New Partnership for African Development (NEPAD)".

The National Population Policy (2008) recognises that all couples and individuals have the basic right to decide freely and responsibly the number and the spacing of their children, and to have access to information and education in order to make an informed choice; and the means to do so. It stipulates the promotion and expansion of comprehensive family planning services, facilitating individuals and couples wishing to practise family planning with the means to do so, and enhancing the role of men in the promotion and utilisation of family planning. The policy underlines empowerment of women, provision of higher education and capacity to make informed decisions as crucial in positively influencing women's reproductive health. It recognises that health, in particular, reproductive health, is a basic human right, and specifically points out the importance of RH commodity security and increased budgetary allocation for reproductive health.

The National Population Policy Action Plan

The purpose of the NPPAP is to coordinate the implementation of the NPP and contribute to the realisation of Uganda's vision on sustainable human development by:

- Identifying and integrating programmes and actions addressing population issues into national, sectoral and departmental plans.
- Facilitating the implementation of the policy at national, district and community levels by making the national policy objectives operational.
- Serving as a tool that will guide the implementation and coordination of the National Population Policy.

The NPPAP links population issues with broader development concerns, like poverty eradication, health (including Reproductive Health and HIV/AIDS), education, housing, agriculture, environment, gender, labour and employment, among other social issues

which should be explicitly addressed by public policy so as to positively impact on the quality of life.

The NPPAP translates the goal, objectives and strategies of the NPP into focused and measurable intervention programmes and activities, where stakeholders identify easily with activities relevant to their sectors. The national population agenda is articulated in five thematic areas, namely:

- Population and development.
- Sexual and reproductive health.
- Gender and family welfare.
- Advocacy and communication.
- Institutional framework and coordination.

In each thematic area, crosscutting issues namely research, gender, advocacy, and poverty are identified so that they are not compromised in the course of implementing the policy at all levels.

The National Population Action Plan is prepared within the framework of the NDP in addressing issues of limited human development and disempowerment: Actions to improve human development focus on improving the quality and retention at primary and post primary education levels, reducing infant, child and maternal mortality rates and increasing peoples control over the size of their families by ensuring that family planning services are accessible to all, and ensuring households responsibly participate in increasing protection against HIV/AIDS.

NPP Implementation Framework

There is a well established policy implementation mechanism with the Population Secretariat taking the lead role and responsibility for ensuring a quality population. Population Secretariat collaborates with several stakeholders, including sectoral ministries, government agencies, development partners, CSOs, religious and cultural institutions on policy development, advocacy and awareness creation on the population issues outlined in the NPP and NPPAP. For effective implementation and coordination of the NPP, the specific roles of major stakeholders such as: line ministries, local governments, civil society institutions, as well as individuals and households, have been identified within their mandates.

The National Population Council, in collaboration with the Prime Minister's Office and the National Planning Authority, will be responsible for ensuring that stakeholders comply with the Action Plan through relevant and timely interventions. The Council will organise quarterly review meetings of the forum to monitor the progress and adherence to the sector plans. It will also sanction a mid-term and final (end of five years) evaluation of the NPP implementation by an independent body or as will be deemed appropriate. This will guide the future direction of the implementation process of the Policy.

The Joint Population Programme (JPP)

The Joint Programme on Population (JPP) is a four year partnership between the Government of Uganda, CSOs and 10 UN agencies which include; World Health Organization (WHO), International Labour Organization (ILO), United Nations World Food Programme (UNWFP), International Organization for Migration (IOM), United Nations Joint Programme on AIDS (UNAIDS), United Nations Women (UN WOMEN), United Nations Populations Fund (UNFPA), United Nations Children's Fund (UNICEF), United Nations Human Settlements Programme (UN-HABITAT), and United Nations High Commissioner for Refugees (UNHCR).

The JPP is referred to as "investing in population" aiming to accelerate efforts towards turning Uganda's youth population into a skilled and motivated labour force capable of propelling the nation into a prosperous economy. The programme will help tap opportunities presented by Uganda's currently youthful population, where 69.3 per cent are under the age of 24 years while aiming at placing necessary conditions to enable the country benefit from the potential young people.

As discussed in earlier, Uganda's Population is mostly made up of children who have to depend on fewer working adults. This means that a large proportion of the national income is spent on social services like education, health, and housing leaving a small fraction for families to save and invest. The JPP believes that with family planning, good education, especially for the girl-child, the country will be able to transform high fertility and mortality rates into low fertility and mortality rates, a process referred to as "demographic transition" hence resulting in a population with a larger group of people working thus deducing to economic growth, a phenomenon known as "demographic bonus", where everyone should benefit.

Do Population Policy Commitments translate into quality population?

While there are a number of policies, guidelines and service standards to address the high fertility in the country, the apparent weak implementation and limited coverage of these policies has led to persistent high fertility, morbidity and increasing poverty. The 1995 NPP which by far offered the most comprehensive discussion on the causes of high fertility and infant and maternal mortality and morbidity, did not articulate concrete actions to address gender related barriers to better quality of life. Male involvement is now highlighted in the 2008 NPP as a cause of poor social status of women resulting in failure to fully exercise their reproductive rights. Thus high fertility and increased maternal deaths; yet no particular attention is paid to it as a priority area of focus.

The discussion on reproductive health has largely focused on gender as a "women-only-issue" with no comprehensive focus on men and their involvement in maternal and reproductive health, given the fact that men are central in household decision making, particularly on issues of access to, control and distribution of resources, movement outside the home, as well as control over one's sexual life. The 1995 NPP also offered little

discussion on the role of the community in population issues; yet population challenges are rampant in poor and rural communities. Community mobilisation and empowerment are pertinent to improved quality of the population. The year 2008 has wide focus on male involvement in reproductive health issues and the NPPA clearly demonstrates the urgent need for the Population Secretariat to liaise closely with the MOGLSD in community mobilisation and empowerment.

Uganda's RH commodities have been relentlessly starved of funding. Direct contraceptive funding from UNFPA and USAID represented about two-thirds of the total government budget for contraceptives, with the government covering only 14 per cent of the national contraceptive need. What is worse is that even this small government contribution was not fully forthcoming. For instance, the government had allocated Uganda Shillings 1.5 billion per year for reproductive health commodities since 2005/06, but much of this money was either not disbursed or diverted (Madesen, et al (2009). For instance, spending on contraceptives has been between 2–6 per cent of allocated funds. The MoH had estimated a 30 per cent gap between contraceptive need and actual availability, raising the question of whether policy implementation depends too much on the interests or commitment of stakeholders. It was not until 2009/2010 that the government funding for RHCS was prioritised, with increasing funding in financial year 2010/2011 (Table 9.4).

Table 9.4: Government funds available for RH Commodities

Item	Funds
MOH Funds Under Letter of Credit (From 2008/09 FY)	454,882,539 (UGX)
MOH Funds FY 2009/10	1,498,798,489 (UGX)
MOH funds FY 2010/2011	1.5 billion (UGX)
MOH funds FY 2010/2011 (Mobilized by NMS)	900,000,000 (UGX)
Total Available funds Now (MOH Funds)	4,353,681,028 (UGX) **=1.917,921 USD**
Funds Anticipated from MOH in the next 4 financial Years	6 Billion (UGX) **=2,643,171 USD**
World Bank Loan for 5 years	18,949,654.74 (USD)
Total Available for 5 years	23,510,746 (USD)

Financing the Population programmes

Budgeting in Uganda has been guided by the PEAP, Uganda's National Development Framework and Medium-Term Planning Tool since 1997 to 2009 and currently, the NDP. The sources of financing for the Population Secretariat and the Population Programme include the national budget (central government budget) that includes GoU and donor budget support and project funding.

The government budget includes both government funds and donor budget support and is the most preferred mode of funding because it is flexible and the government has the control to allocate resources to agreed priorities. There is a well-established finance management and monitoring mechanism which reinforces a similarly well established accounting system in ensuring expenditure is made against agreed work plans and outputs. While there are a number of donors supporting the population programme, UNFPA is the main development partner. Inadequate budgetary allocation has been and is a major obstacle to improving the quality of Uganda's population.

CONCLUSION

What needs to be done?

Most sectors, especially health and education still argue their planning and budgeting proposals from a needs/cost perspective and therefore do not factor in, the investment case: returns on every dollar spent on reproductive health, savings accruing and potential lost earnings that could be saved which weaken the case during budget negotiations. There is need to empower health and education sectors to make the case for investment in reproductive health and create a mechanism during planning and budgeting process for this dialogue with the Ministry of Finance officials. The Ministry of Finance should appreciate that budget allocation for sexual and reproductive health is not a cost, but an investment. With a total fertility rate of 6.7 children per woman and an average economic growth rate of 7 per cent over the last decade, there should be an ideal balance between the two that can allow a balanced investment in economic and social sectors to meet the needs of a growing population.

Investing in Reproductive Health

Potentials for investing in reproductive health exist within each country in the planning and budgeting processes. Over the last 2 years, Uganda went through the process of developing a five-year National Development Plan (2009/10–2014/15), a successor document to the Poverty Eradication Action Plan I & II (2000/1–2008/9). Sexual and reproductive health has been integrated within this document, with clear set targets. For instance, the NDP targets to increase the CPR from 24 per cent to 50 per cent within 5 years and reduce Total Fertility Rate from 6.7 to 6.0. There are other sexual and reproductive health indicators included in this document as well as in sectoral policies and strategic plans.

Recognising the role of reproductive health to national development, in the Financial Year 2008/9, the Parliament of Uganda refused to approve the Ministry of Health budget until the Ministry could clearly show the proportion of the budget earmarked/allocated for sexual and reproductive health. Similarly, the Parliament also refused to approve a World Bank loan amounting to US$130 million for health systems strengthening, until there was specific allocation for sexual and reproductive health component. The loan was approved with reproductive health taking US$30 million, the balance going for health systems strengthening.

The development of Medium Term Expenditure Framework presents another opportunity for integrating SRH in the national planning and budgeting process. However, these instruments not withstanding, there are challenges in planning for, budgeting and utilising resources allocated for sexual and reproductive health. Often times there are competing priorities/needs in a developing country with very limited income and resource base. The questions that policy makers, planners and economist have to battle with are:

- Do we focus our budget on drivers of economic transformation such as investment in infrastructure that creates jobs and investment, and then in turn raise the income that can be invested into other sectors?
- Should we invest in social sectors before we can do the infrastructure investment or should we do both? Which of these options make sound economic decision? Countries like China focused on infrastructure for a long time and then only recently moved to social investment when their economies have grown. Is this the way forward or what is the right balance?
- Sometimes even when the budget allocation is made for sexual and reproductive health, absorption capacity is limited and at the end of the year funds are returned to the treasury due to non absorption. There are also cases of fungibility in some instances.

The Ministry of Health underscores the critical role of RHCS in attaining better reproductive health status and sustaining services, as stated in the Strategy to Improve Reproductive Health in Uganda (2005–10), and the National Family Planning Advocacy Strategy. The second Health Sector Strategic Plan (HSSP II) targets an increase in contraceptive prevalence rate (CPR) to 40 per cent from the current 23 per cent; full availability of condoms (100%); eliminate drug stock-outs, including RH commodities in 80 per cent of health units; and provide emergency contraceptives in 60 per cent of health units. In spite of these and other policy commitments and promises, stock-outs of all drugs, including RH commodities occur regularly.

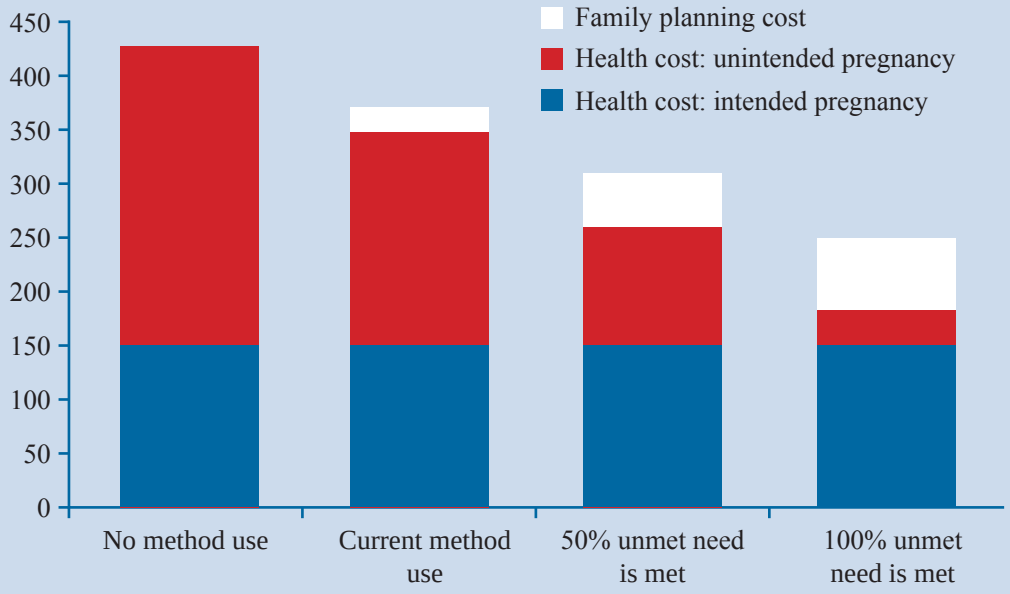
Making the Economic Case for investing in RH

In general, there is paucity of evidence that links SRH with investments. However, in Uganda there are currently a few studies that have shown potentials for investing in sexual and reproductive health, in particular, family planning. These are:

1. "Adding It Up Study" done by the Economic Policy Research Centre which shows that investing by addressing the current 41 per cent unmet need for family planning as one of the reproductive health elements reduces maternal death by 33 per cent. We also know it has potential to reduce infant mortality by two times if birth were spaced for more than 2 years with significant returns to the children, household, community and nation. For every US$1 invested in family planning, there would be US$3 return. So if Uganda invested US$108 in the family planning commodity procurement (which is the estimated cost) and therefore addresses the current unmet need for family planning, Uganda would save US$112 million dollars annually in health care

costs associated with management of complications of unintended pregnancies. This would add to earnings by saving potential earnings that would be lost through lives lost and lives lived with disability, equivalent to UGX 120 billion or 0.4 per cent of GDP. These savings could be invested back into health care to achieve the Abuja target for health sector budget allocation of 15 per cent or even get re-invested in other economic sectors.

Graph: 9.9 **Fulfilling the unmet need for FP would save women's lives and contribute to economic investment**



2. Resources for Awareness in Population & Development (RAPID) Projections – this projection has been done for Uganda, jointly with the National Population Secretariat and it examines the link between fertility, population growth rate and its impact on different sectors and the overall national economy. Assuming a slower population growth rate scenario (which can be achieved by a combination of strategic investment in economic and social sectors (e.g., addressing unmet need for family planning & girl child education) and assuming economic growth rates at constants of 7 per cent or 10 per cent, the projection gives Uganda options for attaining middle income status within a single generation (30 years time frame).

Accountability

What also could be done is holding the relevant ministries accountable so that they contribute towards the outcomes. Advocacy targeted towards opinion leaders since they seem to be responsible for influencing people's decisions about practising safe sex. Interventions targeted towards young people are required since they make half of the Ugandan population and are at the reproductive age.

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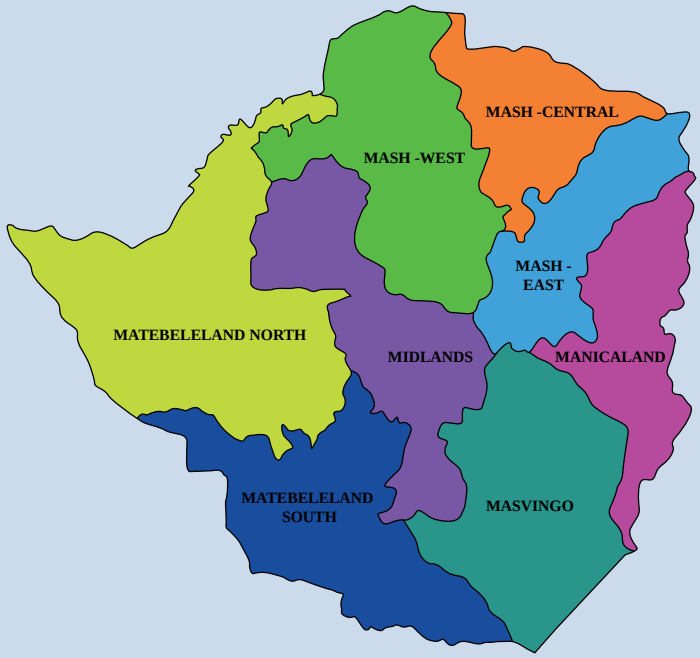
CHAPTER 10

ZIMBABWE POPULATION STABILISATION REPORT

Munyaradzi Murwira

Map of Zimbabwe



INTRODUCTION AND BACKGROUND

Zimbabwe bordered by Zambia on its north, South Africa on the south, Mozambique on the east and Botswana on the West is a land locked country situated in Southern Africa with a total land area of 390757 sq. km. The country is made up of 10 Administrative Provinces (8 rural provinces – Mashonaland Central, Mashonaland East, Mashonaland West, Midlands, Manicaland, Masvingo, Matebeleland North and Matebeleland South; and 2 metropolitan Provinces – Harare and Bulawayo. The rural provinces are made up of Districts, with a total of 62 rural districts in the country.

Policies on Population & Development in Zimbabwe

Post-1994 Cairo conference, Zimbabwe developed an enabling environment by developing strategies, guidelines and policies in order to meet the expectations of the ICPD Plan of Action. The Population Policy was developed in 1998. It is the primary

document guiding the population agenda in Zimbabwe. The Policy was developed in order to address the socio-economic and environmental challenges related to population issues, in a holistic way. In addition, there are many policy documents and statutory instruments supporting the population agenda in Zimbabwe. These include among others; National Reproductive Health Policy 2003 (including RH and FP Service Delivery Guidelines), National Gender Policy 2003, National HIV/AIDS Policy 1999 and 2002 (including STI & HIV/AIDS Strategic Plans), National Health Strategy 2010–2015, Zimbabwe Maternal and Neonatal Health Road Map, Educational Policy (life skills), National Youth Policy, Zimbabwe National Family Planning Council Act 1984, Child Survival Strategy, Poverty Reduction Strategies, Economic Development Plans (Medium Term Plan 2011–2015, being the latest).

ICPD and MDGs Context

Zimbabwe is one of the countries that took part in the negotiations that culminated in the adoption of a 20-year Programme of Action (PoA) at the International Conference on Population and Development (ICPD) in Cairo, Egypt in 1994. The main objective of the PoA is to raise the quality of life of human beings and to promote human development in the next 20 years from 1994. This is through focusing on achievement of sustained economic growth, eradication of poverty, increasing access to education, especially for girls, promoting gender equity and equality, and provision of universal access to comprehensive reproductive health services including family planning, and HIV prevention, mitigation and support(ICPD, 1994). In 2004, the Ministry of Finance and Economic Development with support from UNFPA commissioned the ICPD +10 report (ICPD, 2004). The report was a review of the implementation of the ICPD PoA put together by the National ICPD Steering Committee, through the contribution of various government departments, NGOs and Civil Society.

The government of Zimbabwe is proud to be one of the successful implementers of the Millennium Declaration adopted by the Heads of State and Government at the 55th Session of the United Nations General Assembly in September 2000. The government then developed national targets to serve as benchmarks for all development policies and interventions. They identified 3 Goals on: Poverty; Empowerment of Women; and HIV/AIDS as main priorities which would underlie the achievement of MDGs in Zimbabwe, due to their strong linkages. With the support of UNDP, the government produced an MDG progress report in 2004, providing an analytical summary of the development progress, challenging priority areas for intervention and the expected cost in meeting the national targets.

SITUATIONAL ANALYSIS: Population & Development in Zimbabwe

Population Policy

With the support of UNFPA, Zimbabwe developed a comprehensive Population Policy in 1998 under the auspices of the then National Economic Planning Commission (NEPC).

1 The overall aim of the policy is to achieve higher standards of living for the people through influencing population variables and development trends in order to achieve economic and social goals of the nation. However, in 2002 the NEPC was merged with the Ministry of Finance, Economic Planning and Development. This resulted in population matters being marginalised by more pressing issues. Towards the end of 2004, the population agenda regained its momentum as the ICPD+10 became a global issue, with all countries reporting the progress on the ICPD 1994 PoA. This led to the Ministry of Finance, Economic Planning and Development to actively participate in population issues locally, regionally and internationally.

Population Evolution (Distribution, Growth Rates and Traits)

Population Size and Growth Rate

The total population was estimated at 12.1 million people – 6.2 million females and 5.9 million males (Projected figures, CSO, 2008). The population of Zimbabwe has grown more than tenfold from 713000 in 1901. The first doubling of the 1901 population occurred in 1931 (within 30 years). Thereafter the doubling time has been around 20 years. A steep increase in population was observed between 1969 and 1992. This was largely due to the attainment of Independence in April 1980 from Britain, which saw an influx of people into the country. The 1997 Inter-censal Demographic Survey (ICDS) reported a population of 11. 8 million, which was slightly higher than the 2002 Census. This decline in population between 1997 and 2002 could be partly explained by exodus of people from the country to seek greener pastures due to prevailing economic hardships.

Population growth rate has increased since 1901, from 2, 4 per cent per annum between 1901 and 1911, stabilizing at 3.5 per cent between 1951 and 1961. The 2002 Census indicate that the average population growth rate was 1.1 per cent per annum between 1992 (10.4 million) and 2002 (11.6 million). The decline in population growth rate between 1992 and 2002 to 1.1 per cent is due to many factors including HIV/AIDS related mortality, success of the family planning programme, improvements in female education, decline in fertility, and migration of people out of the country(ICPD, 2004) and (Census, 2004).

Table 10.1: Population in Millions 1901–2002

1901	1911	1921	1931	1941	1951	1961	1969	1982	1992	2002
0.713	1.0	1.2	1.6	2.1	3.6	4.1	5.7	7.8	11.1	11.7

Age and Sex Structure

The sex composition of the population indicates that there are more females than men, 52 per cent and 48 per cent respectively. The 2002 census indicates that the population of Zimbabwe is relatively young with 40. 1 per cent aged below 15 years, the age group 15–64 constituted about 53 per cent of the population between 1982 and 2002 and is critical for economic development and providing for the children and elderly and 4 per

cent aged above 65 years. This is largely due to relatively high fertility and increased mortality in adult population aged 15–49 years due to HIV/AIDS. The youthful population implies future population growth as the young enter into the reproductive age group.

Population Distribution and Density

The 2002 Census showed that the population density is 29 persons per sq. km, indicating a rise from 27 persons per sq. km in 1992. The population density has more than doubled since 1969 from 13 persons per sq. km. More people in Zimbabwe reside in rural areas 65 per cent (Census, 2002). The proportion of people residing in urban areas has increased since independence from 26 per cent in 1982 to 35 per cent in 2002, with the Capital City (Harare province) the most populous with 16 per cent of the country's population. This continued growth in urban population is associated with strain in provision of basic social amenities (infrastructure, housing, transport, health, education, water and sanitation). The rural to urban migration is mainly by young people, especially men, as they seek better economic opportunities in towns and cities. As a result there are more women than men in Zimbabwe rural areas. In an effort to regulate and minimise rural to urban migration, the government established Growth Points (Wekwete, 2008) in rural areas to create employment.

Fertility

The crude birth rate (CBR) in 2002 was estimated at 30 births per 1000 population. The CBR has been declining from 48 births per 1000 population in 1969, 39.5 births in 1982 and 34.5 births in 1992. DHS (2006), on Age specific fertility rate (ASFR) indicates that child-bearing peaks at 20–24 years and then drops sharply after 30–34 years.

Table 10.2: Age Specific Fertility Rates 2006

Age	15–19	20–24	25–29	30–34	35–39	40–44	44–49
Rural	120	248	198	164	111	59	17
Urban	70	147	130	112	51	6	0

There has been a decline in fertility across all age groups since 1988. The biggest decline in fertility was observed among young women between age groups 25 to 34 years.

The total fertility rate (TFR) was 3.8 children in 2006, with rural women more likely to have more children (4.6 children) compared to urban women (2.6 children). Women with no education have the highest fertility (6.1 children per woman). Women in the lowest wealth quintile have higher fertility (5.5 children) compared to 2.3 children in women from the highest wealth quintile. Men generally prefer slightly larger families than women do.

Table 10.3: Total Fertility Trends 1988–2006

1988	1994	1999	2006
5.5	4.3	4.0	3.8

The median age at first live birth is higher in urban areas (20.7 years) than in rural areas (19.6 years). The median age at first live birth is also related to education and economic status, with better educated and wealthier women having a higher age at first live birth and preferring fewer children.

Mortality

This general decline in mortality in the early years after Independence can be attributed to massive investment in Primary Health Care (PHC) resulting in increased access to health care services throughout the country. This led to decline in maternal and child mortality. However, with the advent of the structural adjustment programme and reforms there was removal of consumer subsidies and reduction in government investing in welfare system. This reversed the social gains of the first decade after independence. This scenario was worsened by the emergence of the HIV/AIDS epidemic. Mortality in the country has been increasing since the early 1990s, with higher mortality rates among men than females. This is true in all the other measures of mortality, including infant and child mortality. The average life expectancy decreased from 58 to 53 years (males) and from 62 to 57 years, from 1992 to 1997. The life expectancy has further declined to 49.9 years in 2010 (Wekwete, 2008) However, it has increased from 45 years from year 2002 so the past eight years have been crucial.

Migration

Historically, prior to Independence, the movement of Black people was restricted in Zimbabwe. This resulted in selective migration of young men from rural areas to urban areas leaving the women, children and the elderly behind. After Independence the restrictions were removed resulting in influx of people into urban areas. Rural to urban migration is dominant in Zimbabwe (78 per cent). This is mainly due to limited economic opportunities and poor living conditions in rural areas. The 2002 land reform programme also resulted in some people moving from urban areas to the commercial farming areas. (Wekwete, 2008) However, to reduce the rural to urban migration in Zimbabwe, the government set up Growth Points and Vocational Training Centres to create employment. In addition the Rural Electrification Programme and the 'Give a Dam Project', were launched to provide reliable energy and water sources in the rural areas.

However, this is yet to make an economic impact. A large population has migrated to neighbouring countries and abroad due to economic hardships. This has resulted in acute shortage of professionals and skilled personnel, particularly in the health and education sectors. It is estimated that around 2 million Zimbabweans are in the diaspora, with the largest percentage in South Africa (Wekwete, 2008).

The Elderly

Data on the elderly is very limited in Zimbabwe. The 2002 Census indicates that 5.6 per cent of the population is over 65 years – 2.5 per cent males and 2.8 per cent females. The HIV/AIDS epidemic is a major challenge, with the elderly now left to take care of a large

number of orphans. In addition, the old are faced with a serious problem of food security, since they require special diet and are not able to work to provide for themselves and the orphans in their care. (Census, 2004) and (Wekwete, 2008). While there are projects to support the elderly initated by HelpAge Zimbabwe, the Social Dimensions Fund provides social welfare support to elderly. However, resources are scarce and inadequate.

Persons with Disabilities

The Poverty Assessment Study (PASS) of 2003 showed that 3 per cent of the population is living with disabilities. Rural areas were reported to have slightly higher numbers of persons with disability (3.3 per cent) than urban areas (2.3 per cent). Of all people with disability, only 10 per cent had received assistance. In 2006, 0.7 per cent of primary school pupils were disabled.

Economic Development and Poverty Reduction

Independence in 1980 saw Zimbabwe inherit a dual economy characterised by a relatively well developed modern sector and a largely poor informal sector. Employment levels were about 80 per cent of the labour force. The manufacturing sector and agriculture have been the major drivers of the economy since 1980, contributing 20 per cent and 16 per cent of the Gross Domestic Product (GDP) respectively. In the decade after Independence a number of initiatives were developed which led to the expansion of education, health and rural infrastructure (Zimbabwe Population Policy, 1998) The real Gross Domestic Product averaged 3–4 per cent per annum between 1988 and 1998.

However, between 1991–1995 the GDP was now averaging only 1.5 per cent with an annual inflation of 23 per cent compared to single digit inflation in the 1980s. This was mainly a result of persistent droughts and the Economic (ESAP) of 1991. From 1997 the GDP registered negative growth up to 2008. Between 1999 and 2003 Zimbabwe witnessed a dramatic decline in the flows of Official Development Assistance (ODA) and Foreign Direct Investment (FDI). During this period the economy was faced with a number of challenges, some of which are: MTP (2011)

- Severe macro-economic instability, characterised by hyper-inflation and high unemployment of over 80 per cent.
- Low national savings as a percentage of GDP.
- Low international investment.
- Severe shortage of basic utilities including, electricity, fuel and water as well as basic commodities and drugs.
- Real Gross Domestic Product declined by over 50 per cent.
- Massive decline in agricultural production.
- Manufacturing and service sectors were hampered by foreign currency shortages, loss of skilled labour and unreliable energy and water supplies.
- Price controls and an over-valued exchange rate regime.

- Low capacity utlisation.
- Negative trends in mining and the tourism sector.

Table 10.4: GDP Growth Rate 1990–2007										
1990	1995	1996	1997	1998	1999	2000	2002	2003	2005	2007
7.0	0.2	10	1.6	0.1	-4.0	-8.2	-14.0	-13.9	-4.0	-4.3

Current trends indicate that poverty is on the increase in both rural and urban areas. Poverty is more common in female-headed households at 78 per cent than in male-headed households at 58 per cent. The Poverty Assessment Survey of 1995 indicated that 57 per cent of the population lived below the Food Poverty line (FPL), rising to 69 per cent in 2002. This led to the country adopting the Poverty Alleviation Action Plan (PAAP) in 1995, with targeted social expenditure and decentralised decision making for greater involvement of poor people. However, the withdrawal of support by World Bank and IMF resulted in failure to fully implement the PAAP. The 2003 Poverty Assessment Study (PAS) indicated that the total consumption poverty increased from 42 per cent in 1995 to 63 per cent in 2003. This is a 51 per cent increase in poverty incidence. During the same period food poverty increased from 20 per cent to 48 per cent. As a result more people moved into the 'very poor' category instead of 'out of poverty'. The poverty incidence was worse in rural areas (63 per cent) compared to urban areas (53 per cent), but poverty increased more rapidly in urban areas than in rural areas. Thus households in urban areas are most affected by the deteriorating macro-economic environment, especially unemployment. The Human Poverty Index (HPI) increased from 23.9 per cent in 1995 to 33.1 per cent in 2003(ICPD, 2004), (Zimbabwe MDG, 2005) and (Wekwete, 2008).

The formal sector employment growth has declined from 2.7 per cent before 1990 to (-1.7) by 2002, mainly due to massive retrenchments under ESAP and closure of companies due to macro-economic instability. Currently unemployment is estimated around 80 per cent. This has led to informalisation of the economy, and therefore a need to support small to medium enterprises in order to create employment and wealth. The government established the Ministry of Small to Medium Enterprises (SMEs) in 2001, to support upcoming entrepreneurs at grassroots with resources and set up income generation projects. In 2003 the government launched the National Economic Revival Programme (NERP) to address the effects of ESAP and address the prevailing socio-economic challenges (Zimbabwe MDG, 2005) and (Wekwete, 2008).

With the formation of the inclusive government in 2008, Zimbabwe launched the Short Term Economic Revival Plan (STERP). This led to stabilisation of the economy and reduction of inflation. Benefits of STERP in the social sector included: re-opening of schools and hospitals and increased drug availability among others. Support to the health sector has been emphasised in the Short Term Emergency Plan (STEP) and the Mid-Term Plan (MTP) of 2011–2015. The inclusive Government has indicated its commitment to reach the Abuja target of 15 per cent of total government expenditures going towards the health sector (MTP, 2011).

In 2011 the government launched MTP 2011–2015 with the theme, "Towards Sustainable Inclusive Growth, Human Centred Development, Transformation and Poverty Reduction". The MTP is the premier economic and social policy document of Zimbabwe. One of the focus areas of the MTP is improving social indicators including education, health, and population issues as they are fundamental for sustainable development of Zimbabwe (MTP, 2011).

Education

The literacy rate in Zimbabwe is at 97 per cent, the second highest in Africa after Mauritius. Adult literacy rate has been increasing from 62 per cent in 1982, 80 per cent in 1992 and 97 per cent in 2002. This was a result of the Adult Literacy Campaign launched soon after independence to enable those disadvantaged during the colonial era to get education. Literacy rates are higher in men than women in all age groups.(Wekwete, 2008)

The post-Independence era witnessed the massive expansion in the educational system especially basic education, with almost universal primary education for all. However women are still generally disadvantaged compared to men in terms of access to education. Net enrolment for primary education increased from 81.9 per cent in 1994, to 92 per cent in 2003 then 97 in 2006, with the country almost achieving universal primary education. However it should be noted that net enrolment does not translate to effective access, as actual attendance is lower than enrolment due to absenteeism, poverty, illness and hunger, given the current economic challenges and the HIV/AIDS epidemic. This is compounded by lack of adequate teachers in schools. The gender gap in primary schools has generally been closing since Independence. Secondary school enrolment ratios are lower than those at primary school, with an evident gender gap. Primary school completion rates have declined from 73.2 per cent in 1995 to 67.6 per cent by 2004. The secondary school completion rates are generally higher, with an overall peak of 87.6 per cent in 2006. Females have lower completion rates than males in secondary school, 83 per cent and 92 per cent respectively. There is a higher drop-out rate among girls compared to boys from primary to secondary school, with fewer girls than boys proceeding to secondary school from primary school. At tertiary education level female enrolment is generally about 30 per cent, with exception of teacher training colleges and nursing colleges where female enrolment has been over 50 per cent. The drop in the number of teaching staff has had an impact on the pupil to teacher ratio and ultimately the quality of education (Zimbabwe MDG, 2005) and (Wekwete, 2008).

Policies and programmes have been put in place by the government to promote universal quality education for children in Zimbabwe. These include the National Strategic Plan for Education and Vulnerable Children of 2006, the Girl Child Education Policy and Early Childhood Development (ECD). Social Safety Nets in Education, including Basic Education Assistance Module (BEAM) of 2001 were established to provide education assistance to orphans and vulnerable children. Introduction of School Development Committees/Associations was meant to involve parents in the running of schools and to improve standards ICPD (2004), (Zimbabwe MDG, 2005) and (Wekwete, 2008).

Population and Environment

Agriculture and Land Reform Programme

Agriculture is the mainstay of the Zimbabwe economy contributing almost 20 per cent of GDP. In addition, agriculture is interlinked to other key sectors of the economy especially the manufacturing and processing industries. The agricultural sector declined by an average of 2.4 per cent between 2000 and 2007, mainly due to combination of poor rainfall and inadequate inputs. This has resulted in shortage of basic foodstuffs leading to poor food security and malnutrition in the country ICPD (2004), (Zimbabwe MDG, 2005) and (Wekwete, 2008).

Increasing agricultural production depends on ensuring more land is under irrigation. Currently the country has a total of 174000 ha under irrigation, with 139000 ha in the former large scale commercial agricultural sector. The total irrigation potential for Zimbabwe is estimated at 240000 ha which is targeted by 2015. (Wekwete, 2008)

Before and immediately after Independence there was imbalance in the ownership of land in Zimbabwe, with 6000 white commercial farmers owning 15.5 million ha, whilst the black majority community farmers had 16.4 million ha of land. To ensure equity and sustainable growth, the government embarked on a land reform programme in 1983. However this initial initiative was slow with very few people allocated land. In 2002, the government then launched the Fast Track Land Reform Programme which led to over 135000 families being beneficiaries of land, with a total of 6.4 million ha allocated. Long term leases were given for tenure security to indigenous commercial farmers. To support the new farmers and to increase productivity the government provided input schemes and equipment for mechanization through the national budget (Wekwete, 2008).

Environment

The total land area covered by forest has been falling significantly, signifying massive deforestation of around 100 000 to 340 000 hectares per year (MDG Report 2007). The total land area covered by forest decreased from 58 per cent in 1990 to 45 per cent by 2003. This deterioration of forests is mainly due to economic hardships and high population density in some communal areas. Poor forest management, increasing use of firewood in urban areas and opening up of land for agriculture being the major causes of deforestation. Use of firewood is increasing due to electricity shortages and the lack of alternative fuels such as coal and paraffin. The country introduced a programme of afforestration but this is not able to keep pace with rate of deforestation. Over the years it is estimated that 17 million trees have been planted in the country (Zimbabwe MDG, 2004) and (Wekwete, 2008).

The Environment Management Act 2002, the National Environmental Policy, and the Environmental Strategic Plan of 2003 provide a comprehensive framework for mainstreaming environmental issues into national policies and programmes to ensure sustainable land use and protection of the environment. Other institutions mandated to manage the environment include the Parks and Wild Life Management Authority,

Zimbabwe National Water Authority, Forestry Commission and the Rural Electrification Agency (Zimbabwe MDG, 2004) and (Wekwete, 2008).

Energy Sources

In Zimbabwe the main sources of energy include wood, electricity, petroleum fuels and coal. The 2006 DHS indicates that 37 per cent of households in the country have electricity supply (91% in urban areas and 9% in rural areas). The most commonly used fuel for cooking is firewood (66%), followed by electricity (33%). The use of wood fuel as an energy source is not sustainable as the rate of use exceeds natural annual yield. There is generally shortage of electricity in the country and the shortfall in generation capacity is met by importing power from neighbouring countries (Mozambique, Zambia, Congo and South Africa). In addition Zimbabwe imports all of its petroleum and this constitutes large foreign currency expenditure annually (Wekwete, 2008) and (DHS, 2006).

Water and Sanitation

The majority of households (78%) have access to safe water, with urban areas having 99 per cent of the households accessing safe water compared to 67 per cent in rural areas. In recent years households in urban areas have been experiencing erratic water supplies, compromising access to safe water. The shortage of water in urban areas is primarily due to inadequate infrastructure; old equipment; shortage of water treatment chemicals; power cuts at water treatment plants; and the rapid expansion of residential areas. This has led to outbreaks of diseases like cholera in some cities and towns in last few years. In rural areas siltation of rivers due to deforestation and poor agricultural activities have significantly reduced of water sources. Through the drilling of boreholes and construction of deep wells, the access of safe water in rural areas increased from Independence to about 75 per cent in 1999. However, this has decreased to about 67 per cent in 2003 due to inadequate investments and poor maintenance of water infrastructure (Zimbabwe MDG, 2004) and (Wekwete, 2008).

In 2006, 40.1 per cent of the population had access to improved sanitation facilities. The proportion of households with access to improved sanitation is higher in urban areas (58.5%) compared to rural areas (30.5%). There has been a general decline of access to improved sanitation in both urban and rural areas between 1999 and 2006 (DHS, 2006).

Housing

The demand for housing has been growing since Independence, outstripping the capacity of government and Local Authorities to provide adequate and affordable accommodation. The annual target of 250000 housing units per year has not been achieved. In rural areas the challenges is to improve the quality of housing. This led to the government setting up the Ministry of Rural Housing and Social Amenities to embark on a Rural Housing Programme (Zimbabwe MDG, 2004) and (Wekwete, 2008).

Health and Development

The Zimbabwean health system has been in decline for more than a decade and the result is a systematic decrease in coverage of most basic services and a rising maternal and child mortality rate. This is most noticeable in key areas of maternal and child health, such as the Expanded Programme on Immunisation and obstetric care for pregnant women, once high-performing core elements of Zimbabwe's Primary Health Care System. The disparities between urban and rural access to health care continue to grow. An ambitious National Health Strategy is now in place that covers the period 2009–2013 (MHCW, 2008). The main priorities in the health strategy is the reduction of HIV/AIDS, improving maternal and child health services, ensuring adequate human resources for health and strengthening institutional capacity in the health sector. The Health Sector Investment Case, 2010–2012, outlines the key package of health services, the key health system bottlenecks to be overcome, the desired coverage targets, the incremental costs and the expected achievements in relation to the health MDGs MHCW (2010).

The investment case validates the historical focus of the Ministry of Health and Child Welfare on Primary Health Care, with a strong focus on community-based approaches, complemented by robust referral systems and facilities. Under the most ambitious scenario in the investment case, an additional investment of 700 million USD over 3 years or around 19 USD per capita is required to achieve a reduction in under-5 and maternal mortality of 38 per cent and 17 per cent respectively. The Ministry is currently undertaking a mapping exercise to determine the current resources available, mostly through the support of bilateral and multilateral partners, in order to determine the precise financing gap. Concerted efforts will then need to be made in order to expand the fiscal space available for the health sector through internal and external sources.

Further efforts will now be made to ensure that both government resources and external aid are focused on the national health packages and priorities outlined in the investment case. While it is clear that more aid is required, it is also clear that there are risks of fragmentation of the assistance for the health sector, unless the health system is supported more broadly to deliver on the health MDGs in Zimbabwe.

Reproductive Health and Maternal Health

Maternal mortality remains a cause for concern, as most maternal deaths are preventable through increased access to antenatal, delivery and post natal care. The DHS (2005–2006) showed that maternal mortality ratio has been rising from 283 per 100,000 live births in 1994 to 578 and 555 per 100,000 live births in 1999 and 2005/6 respectively. This sharp rise in maternal mortality is largely explained by the rapid spread of the HIV and AIDS epidemic. The Maternal & Perinatal Mortality Study of 2007 shows that the maternal mortality has risen further to 725 per 100000 live birth, with HIV&AIDS related deaths accounting for 25.5 per cent of all maternal deaths (MHCW/DFID, 2007).

Table 10.5: Maternal Mortality Trends 1994–2007			
1994	1999	2006	2007
283	578	555	725

The 2004 Maternal and Neonatal Health Services Assessment found out that maternal deaths were due to three delays. The Time Lost in:

- Recognising the seriousness of the situation and deciding whether or not to seek medical attention.
- Reaching a health facility or a trained service provider, once a decision was taken to seek care.
- Receiving expeditious and effective care, once the challenge of referral was overcome.

Appropriate care during prenatal pregnancy, delivery and postnatal care, are important for the health of both the mother and baby. In 2006 there has been an increase to 94 per cent women attending at least one antenatal care visit from 81 per cent in 1999 (ZDHS) and 93 per cent in 2009 (Multiple Indicator Monitoring Survey – Census, 2010). Coverage of antenatal care is slightly higher in urban areas than in rural areas. Skilled attendance at delivery, declined from 73 per cent in 1999 to 69 per cent in 2006 (DHS), and then fell to 60 per cent in 2009 (MIMS). Institutional deliveries declined from 72 per cent to 68 per cent over the same period (DHS 1999, 2006), and subsequently to 61 per cent in 2009 (MIMS) (DHS, 2006), (Census, 2010)

Perhaps the most important intervention to reduce maternal and neonatal morbidity and mortality is to develop and sustain a strong national Family Planning programme, designed to prevent unwanted pregnancies, and to encourage child spacing

Family Planning

The Contraceptive Prevalence Rate or the percentage of currently married women, using a family planning method in Zimbabwe, has increased steadily from 35 per cent in 1984 to 60 per cent in 2006; the CPR was reported as 65 per cent in 2009 (MIMS, 2009). This is now one of the highest rates in Sub-Saharan Africa. This is in sharp contrast to the knowledge level of modern methods of family planning, which is almost universal at 99 per cent. This may imply that knowledge levels of family planning are not necessarily translating to actual use of contraception. The fact that even though a lot of the people are aware they may not be using contraception for various reasons, such as of cost, access, religion, cultural issues, etc. The Total Fertility Rate has declined from 5.5 in 1988 through 3.8 in 2006 (ZDHS, 2005–6) to 3.7 per cent (MIMS, 2009) (DHS, 2006) and (MHCW, 2008).

According to the ZDHS 2005/6, the unmet need of family planning stands at 13 per cent, which signifies an increase of 2 per cent from the previous ZDHS. This presents an anomaly, as generally, the rise of CPR should conversely signify the decrease in the unmet

need. The family planning method most commonly used is the pill (43%), followed by injectables at 10 per cent. These commonly used methods in Zimbabwe do not protect against the transmission of STIs including HIV/AIDS. The Behavioural Change Strategy also outlines that condom use in regular and marriage relationships remains low (about 1%), despite the fact that being in long term relationships is not necessarily a protective factor against STIs and HIV/AIDS(DHS, 2006).

After Independence, the ZNFPC made significant strides in ensuring a wide coverage in FP service provision. However, these gains have been seriously negatively impacted in the recent past mainly by macro-economic challenges affecting the nation. The declining number of Community Based Distributors (CBDs), due to natural attrition or retirement has drastically reduced the coverage of family planning services at the community level (Zimbabwe National Family Planning Council, 2004). Service delivery, through the clinics has been affected by shortage of fully qualified staff and this has affected the provision of comprehensive and quality services, particularly long-term and permanent family planning methods.

Children and Child Health

The child mortality rate reflects the level and burden of poverty and is consequently a sensitive indicator of socio-economic development (Zimbabwe Child Survival Strategy, 2010-2015). The under five mortality rate (<5MR) has been rising from 77 per 1000 live births in 1994 to 102 per 1000 live births in 1999 (ZDHS). The rate then decreased to 97 per 1000 live births in 2009 (MIMS). The infant mortality (IMR) also followed the same trend and is currently at 67 per 1000 live births (MIMS, 2009). The rise in mortality between 1994 and 1999 was mainly attributed to the direct and indirect impact of the HIV and AIDS epidemic, declining coverage of immunisation against childhood illness, malnutrition and the concomitant rise in poverty levels. The proportion of children 12–23 months fully immunised has dropped from 67 per cent in 1997 to 49 per cent in 2009 (MIMS) (DHS, 2006), (Census, 2010) and (Zimbabwe Child Survival Strategy, 2010–2015).

According to a recent Child Health Situation Analysis Study (2006), the recent decline in child mortality rates could be linked to the overall decrease in HIV incidence and prevalence and greater access to opportunistic infection treatment for children using cotrimoxazole. The Integrated Management of Childhood Illnesses (IMCI) is a broad strategy which was adopted by the Ministry of Health and Child Welfare in 1999 in order to address child health problems and ensuring maximum development of the child. The overall objective of the strategy is to contribute towards the reduction of child morbidity and mortality.

The Ministry of Health & Child Welfare reports indicated that under-nourishment in children below 5 years rose from 13 per cent in 1999 to 20 per cent in 2002. The 2002 National Nutritional Assessment Study estimated that 11 per cent of the children in urban areas and 26.5 per cent of the children in rural areas were malnourished. The Poverty

Assessment Survey of 1995 showed that 61 per cent of children under-five years were taking 3 meals a day, leaving a big proportion under risk of malnutrition (ICPD, 2004), (Zimbabwe Millenium Development Goals, 2004) and (Wekwete, 2008).

A number of programmes to improve the status of child health have been put in place in Zimbabwe. These include: Child Supplementary Feeding Programme; Vitamin A Supplementary programme, Expanded Programme of Immunisation (EPI); PMTCT Programme; Village Health Worker programme. In addition there is a Zimbabwe Children Act that protects children from abuse, and neglect. Zimbabwe is a signatory to the UN Convention on the Rights of the Child and is a State Party to the African Charter on the Rights of the Child (ICPD, 2004) and (Zimbabwe Millenium Development Goals, 2004).

Adolescents and Youth

The ICPD (1994 Cairo) embraced the new broader concept of RH and Rights that include ASRH. Prior to the ICPD, Zimbabwe health programmes were mainly targeting the needs of women of child bearing age and children under 5 years. Adolescents were being left out on the assumption that they were the healthiest segment of the population. Since then the MOH&CW has remained committed to the improvement of the reproductive status of young people

(10–24yrs), who constitute 36.4 per cent of the population (Census, 2002). Young people in Zimbabwe face considerable challenges as they grow up which threaten their individual and collective survival, yet they are the future generation. However, there has only been limited coverage of services in a few districts in the country. Sexual and reproductive health issues affecting the youth include, HIV/AIDS epidemic exposing young women to extraordinary high rates of new infections, high level of teenage pregnancies and limited access to sexual and reproductive health rights. Of particular concern is the vulnerability of young women to maternal mortality, due to gender inequality, low access to education, early marriage, adolescent pregnancy and low access to sexual and reproductive health services (ICPD, 2004), (Census, 2004) and (Wekwete, 2008).

Over the past decade Zimbabwe has developed a number of policies and strategies to facilitate ASRH service provision. These include the National RH Policy, National RH Service Guidelines, the Zimbabwe National HIV/AIDS Strategic Plan (2006–2010) and the Zimbabwe Maternal and Noeonatal Road Map (2007–2015). A number of ASRH programmes have therefore been developed within this context by the Ministry of Health & Child Welfare, Zimbabwe National Family Planning Council, National AIDS Council, other ministries (Youth & Gender, Education), and several NGOs. The ASRH Strategy (2010–2015) reaffirms this commitment through refocusing and realigning its priorities with regard to sexual and reproductive health for young people for the period, in line with the MDGs.

The MOHCW has the primary responsibility for providing and coordinating the provision of ASRH services in Zimbabwe in collaboration with ZNFPC and NAC. It

works closely with the ZNFPC, especially in the provision of FP, IEC and Youth Centres services. The components of the ASRH programme in Zimbabwe include; training of service providers and Peer Educators; establishment of Youth Centres and Youth Friendly Corners; procurement of commodities (contraceptives, STI drugs, HIV test kits and condoms); production and distribution of IEC materials and BCC. To ensure a holistic and comprehensive programme the MOHCW uses a multi-sectoral approach by engaging other government departments, ministries, and NGOs. However the information dissemination and programme coverage is not adequate. Through the ASRH Strategy 2011–2015 the MOHCW has ensured a standard package for comprehensive services for young people. Service provided for young people include FP, MCH, STI, HIV, Post Abortion Care, Emergency Contraception but these are not universally available in all areas in the country. In addition, the accessibility and utilisation of services by young people is limited due to restrictive operating hours, transport costs and lack of privacy.

UN agencies have been supporting national efforts to improve sexual and reproductive health education and services for young people in Zimbabwe. Areas of support by the UN family include: sexual and reproductive rights, sexual and reproductive health research, promotion and scaling up evidence based interventions, multi-sectoral approach in young people interventions, and the provision of norms and standards in programming for young people.

The Ministries of Education Sports & Culture; and Higher & Tertiary Education espouses and promotes abstinence and it endeavours to provide life skills, HIV/AIDS information, SRH information, BCC to in-school young people. The education ministries provide gender sensitive learning and teaching materials for the empowerment of both girls and boys.

The Ministry of Youth Development, Indigenisation and Empowerment has the primary responsibility for overall youth development and empowerment issues to ensure poverty reduction and better economic prospects. This is through skills development and entrepreneurship programmes. Through vocational training centres (a total 42 in the country) the ministry offers a range of trainings to empower young people with skills to be self sustainable and start their own businesses and projects in areas like horticulture, agriculture, catering, metal work, carpentry etc. To support young people establish their businesses the government set up a Youth Development Fund in 2006. In addition there is a Zimbabwe Youth Council to ensure efficient and effective youth participation in the social and economic development of the country (Wekwete, 2008).

About 8 per cent and 18 per cent of single female and male adolescents (15–19 years) respectively had sex in the last 12 months preceding the 2006 DHS. In those aged between 20–24, 27 per cent of females and 46 per cent of the males had had sex in the year preceding the 2006 DHS. The majority (75 per cent) of the female adolescents who had had sex indicated that their first heterosexual encounter was wanted, but not planned.

However, the younger the age, the more likely they were to have been forced using mild insistence to physical force,[26] into sexual intercourse, and mostly by people they knew (partner or boyfriend) (DHS, 2006).

Age at first sex was reported to be below 15 years by 4.9 per cent and 5.2 per cent of females and males respectively by those aged 15–19 years during the 2006 DHS. The median age at first sexual intercourse was about 19 years for both females and males in the 20–24 year age group. Young females in rural areas were noted to have experienced sexual intercourse earlier than their urban counterparts, for example 23 per cent of urban female adolescence (15–19 years) had experienced sex (protected and unprotected) compared to 35 per cent in rural areas.

About 24 per cent and 97 per cent of sexually active female and male adolescents (15–19 years), respectively and about 13 per cent and 70 per cent of sexually active female and male young people (20–24 years), respectively had had high-risk sexual intercourse, in the past 12 months before the 2006 DHS. However, 43 per cent and 68 per cent of sexually active female and male young people who had had high risk sexual intercourse, in the year preceding the DHS had used a condom. The 2007 DHS also showed that 5 per cent of adolescent girls (15–19) who had higher risk sex had intercourse with a man 10 or more years older than themselves. About 3.3 per cent of young men of 15–24 years had paid for sex in the year before the 2006 DHS.

About 6 per cent of the 15–19 year old adolescents and 9 per cent of those aged 20–24 years were pregnant at the time of the DHS in 2006, (majority of these were in rural areas), whilst 72 per cent of the female young people (15–24 years) who had begun child bearing were aged 15–19 when they first gave birth. About 4 per cent of young females who were interviewed in the DHS reported ever had a terminated pregnancy, with a higher proportion in rural areas. About 43 per cent of female young people managed to attend ANC and the majority of young women had delivered within a health facility (94% in urban areas and 66% in rural areas). Over 95 per cent of young people knew a modern method of contraception, 34 per cent and 40 per cent of young male and female, respectively had even used a modern contraceptive method (DHS, 2006).

The HIV prevalence for young people (15–19 years) in 2006, was 6.2 per cent in females and 3.1 per cent in males; and for the age group 20–24 years the HIV prevalence was, 16.3 per cent in females and 5.8 per cent in males. Urban young people were slightly more likely to be infected with HIV. The level of education has an inverse relationship with HIV prevalence. Use of condoms in unmarried sexually active young women is lower compared to their male counterparts (40% and 67% respectively). This is despite 66 per cent of young people had known of at least one source of condoms (DHS, 2006).

[26] Also see "Mahendru, R (2010), Young People's Perceptions of Gender, Risk and AIDS: a comparative analysis of India and the UK. Saarbrücken: VDM Verlag Dr Müller" on casual heterosexual sexual encounters to understand the gender dynamics in a sexual relationship

HIV and AIDS

Zimbabwe is experiencing one of the worst HIV epidemics in Southern Africa which threatens the socio-economic landscape of the country, and places a tremendous strain on the capacity of the health sector to respond to the health needs of the population. Zimbabwe responded to the epidemic by setting up the National AIDS Council to coordinate the national response and declaring HIV/AIDS a national emergency. To raise resources to scale up interventions to control HIV/AIDS, the government established the AIDS Trust Fund or AIDS levy (3% of taxable income) in 1999.

The National HIV/AIDS Policy and the Zimbabwe National HIV and AIDS Strategic Plan (2006–2010) (ZNASP) the Health Sector HIV Prevention Strategic Framework were developed to guide the national response towards HIV. According to the National HIV and AIDS Estimates of 2007, HIV prevalence in Zimbabwe peaked at 29.3 per cent around 1997, before gradually declining to 26.5 per cent in 2001, 23.2 per cent in 2003, 19.4 per cent in 2005 and 15.6 per cent in 2007. Although the country has reported a decline, HIV prevalence still remains high. The declining HIV prevalence was first observed in the late 1990s and was supported by data from Antenatal Clinic surveillance (ANC) 2002, HIV and AIDS estimates from Modelling and the Population based survey, Demography and Health Survey of 2005/06. With increase in availability of antiretroviral therapy (ART), it is expected that prevalence will stabilise and then begin to increase once again as a reflection of survival on ART. The estimated number of adults and children living with HIV and AIDS is 1,189,279 (1,078,758–1,312,981) in 2009 (2009 HIV Estimates – April 2010). The HIV prevalence among pregnant women 15–49 years has declined from 17.7 per cent in 2006 to 16.1 per cent in 2009 ($p<0.001$). A similar trend was observed in the 15–24 age group where HIV declined from 12.5 per cent in 2006 to 11.6 per cent in 2009 ($p<0.001$). High HIV infection rates were observed among women 30–34 (24.9%) and 35–39 (24.6%) years of age (2009 ANC Surveillance Report).

The DHS of 2006 reported an HIV prevalence rate of 18.1 per cent among adults 15–49 years, with HIV prevalence being higher in women (21.1%) compared to men (14.5%). Of the estimated 1.1 million people living with HIV, 60 per cent are women who are more vulnerable to HIV infection than men due to physiological as well as socio-cultural factors such as gender inequality (DHS, 2006).

Table 10.6: HIV Prevalence 2001–2009

	2001	2002	2003	2004	2006	2007	2009
Adult Prevalence	26.5		23.1		18.1	15.6	14.3
ANC Prevalence		25.7		21.3	17.7		16.1

The ZNASP and the Health Sector HIV Prevention Strategic Framework have both identified HIV Testing and Counseling (HTC) as an important component of the national response. Given the importance of HTC as a gateway to HIV and AIDS prevention, treatment and care interventions, the MOHCW has developed this strategic plan to guide the scale-up of HTC towards Universal Access by 2010. The goals described in the national HTC Strategic Plan 2007–2011 aim to:

- Reach universal access to HTC by 2010 with 85 per cent of the Zimbabwean population, children and adults, knowing their HIV status and to increase the coverage of HIV testing and counselling services enabling access within a 10 km radius in all districts by 2010.
- Create awareness and demand creation for HTC through a comprehensive integrated communication strategy which should inform client initiated testing and counselling (CITC) as well as provider initiated testing and counselling (PITC) are important to ensure uptake of the services provided among the different target groups.
- Emphasise on further expansion of CITC services in rural areas and to most-at-risk populations through expansion of mobile services and community and home based counselling and testing.
- Strengthen the integration of PITC at all levels of health care in the private and public sector.

PMTCT is a key strategy in Zimbabwe's National HIV/AIDS strategy, and has been given prominence in Zimbabwe's National Health Strategy, as being recognised as a tool to improve maternal health, reducing maternal morbidity and mortality towards attainment of MDG 5, as well as significantly reducing new paediatric HIV/AIDS cases (Zimbabwe Maternal and Neonatal Health Roadmap, 2007–2015). Zimbabwe has recently launched the campaign to Accelerate Reduction in Maternal Morbidity and Mortality (CARMMA), during which the contribution of HIV/AIDS to maternal and child morbidity and mortality has been highlighted. The rights of women to focus on ANC, together with access to a skilled birth attendant is an area of emphasis for the CARMMA, as well as strengthening comprehensive PMTCT that takes into account the sexual and reproductive health needs of all women, including those that are HIV positive; using a human rights based approach. The current challenges in the PMTCT programme include a low percentage of 66 per cent women counselled for HIV, and those tested for HIV during ANC visit for the last pregnancy is 58% (MIMS, 2009).

Zimbabwe has adopted the United Nations "4 pronged" approach towards the prevention of mother-to-child transmission of HIV:

- Primary prevention of HIV infection in women and girls.
- Prevention of unintended pregnancy in women living with HIV
- Prevention of vertical transmission in pregnant women living with HIV

- Provision of comprehensive care, treatment and support to women with HIV and their families.

It can be understood that these four prongs together encompass many aspects of an entire HIV response. The extremely cross-cutting nature of PMTCT services means strategic actions related to all four prongs are also found in many other strategy documents, including HIV Testing and Counseling, Antiretroviral Treatment, the National Behaviour Change Strategy, Maternal & Neonatal Health Roadmap and the Child Survival Strategy.

In addition to the HTC and PMTC components of the HIV programme, the country is also increasing access to ART, care and support to HIV+ people. The goal of scaling-up ART is to reduce morbidity and mortality due to HIV and AIDS, and to improve the quality of life of people living with HIV and AIDS in Zimbabwe in the context of comprehensive care. However the coverage of treatment and care services remains low relative to the burden of HIV/AIDS, with only 54 per cent and 57 per cent coverage of ART for adults and children respectively. To achieve better coverage, the country adopted strategies including, expanding the provision of ART services in all sectors through decentralisation with special attention to pregnant mothers; development of human capacity, through OI/ART training and mentorship, to provide ART; ensuring availability of quality AIDS medicines, diagnostics and supplies; strengthening community involvement in the provision of ART through Community Empowerment and Mobilisation for Improved Access to Care, Support and Treatment (CMEIAST); strengthening of systems for ART programme monitoring, including patient tracking, HIV drug resistance surveillance, evaluation and research; resource mobilisation for increasing access to ART; strengthening ART programme management, coordination and supervision; strengthening public-private-partnership; strengthening TB/HIV collaborative activities and advocacy for a supportive environment (including policies and legislation) to ensure a sustained environment for scaling up ART; and community and home based care.

Gender Equality, Equity and Women Empowerment

Women constitute over 50 per cent of the population and produce 80 per cent of the agricultural output in Zimbabwe. The National Gender Policy was adopted in 2003 in order to address the gender disparities existing in the country. In addition there is also the Public Sector Gender Policy 2004, the Sexual Offences Act, Domestic Violence Act 2007, Women Parliamentary Caucus, and the University Affirmative Action Policy to increase women enrolment. Zimbabwe is a signatory to several regional and international conventions, protocols and declarations that promote gender equality and human rights. These include the Convention on Elimination of all Forms of Discriminations against Women (CEDAW) 1991, the Beijing Platform of 2005, and the SADC Declaration on Gender and Development. The country is also committed to the attainment of Millennium Development Goals on "Universal Access to Primary Education" and "Promote Gender Equality and Empower Women". This has resulted in an improvement in the collection, dissemination and utilization of gender-disaggregated data in many sectors.

The marginalisation of women regarding inheritance and property sharing at divorce or death of the spouse is a common problem in the country, with women denied the right to inherit or share property equitably. The death of the man frequently results in complicated inheritance issues, which can lead to the impoverishment of women and girls, if customary inheritance practices are followed as these continue to favour male heirs over women and girls. As long as these cultural practices continue to be practised they will act as barriers to universal access as they predispose women and girls due to HIV.

Although the literacy rates are almost identical between males (97%) and females (96%), there are gender imbalances that exist in access to higher and tertiary education, with female enrolment at Universities being 32 per cent in 2002. This translates to gender inequity in areas of employment, health status, poverty and decision making. Women are more likely to be found in the informal sector economy which in most cases is non-value producing activities. Women in the informal sector are poor due to the fact that their work is poorly recognised and poorly paid. The informal sector receives very little national resources, as most national policies support the formal sector. The percentage of women in the informal sector increased from 64 per cent in 1984 to 75 per cent in 2000. There are gender disparities in access to land, with very few women (15%) having benefited from the land reform programme, compared to the government target of 20 per cent (Zimbabwe Millenium Development Goals, 2004), (Census, 2004) and (Wekwete, 2008).

The proportion of women in decision making positions is very low. In 2008 elections, only 29 women (26%) were elected into Parliament, below the SADC quota of 30 per cent women representation in top positions. This was however a significant increase compared to 16 per cent representation in the previous Parliament of 2005–2008, and at Independence when women constituted only 9 per cent of the legislature. At ministerial level there were only 4 women out of 32 Ministers (13%) in 2005. A decline from 14 per cent in 2000 and 19 per cent in 1998. The 2006 Human Development Report noted that out of 10 Governors in 2005, there were only 2 women. The proportion of women councillors in Local Authorities increased from 2.7 per cent in 1998, 4.3 per cent in 2003 and 18.6 per cent in 2006, but is way below the SADC benchmark of 30 per cent (ICPD, 2004), (Zimbabwe Millenium Development Goals, 2004) and (Wekwete, 2008).

Zimbabwe is a patriarchal society, largely characterised by male dominance and thereby, exposing females to reproductive health problems more than their male counterparts. Gender inequality and widespread negative cultural practices such as polygamy, wife inheritance, multiple and concurrent sexual relationships and cross-generational sex are some of the factors which fuel Zimbabwe's HIV epidemic, particularly among women and girls. Stigma and discrimination associated with HIV and AIDS are also preventing many from knowing their sero-status. The inability of many to talk about HIV status or sexual relations also creates barriers to behaviour change. The practice of polygamy is

discriminatory against women as it allows men to enter into multiple relationships which impose various pressures on family resources (ICPD, 2004) and (Wekwete, 2008).

Gender-based violence (GBV) is a key factor in women's vulnerability to HIV as forced sex does not allow negotiation for condom use. The risk of HIV transmission is greater when sex is forced and therefore the need to address the inter-linkages between sexual violence and HIV and AIDS in national programming. Sexual violence crimes are under-reported as they evoke shame and blame, social stigma, and often rejection by the survivor's family and community. Statistics on rape survivors provided by the Adult Rape Clinic provide telling evidence of the linkages between GBV and HIV. Most rape survivors come forward much later due to lack of knowledge of services available for survivors, the complexities of accessing services and in certain instances, cases being dealt with at family level. The statistics revealed (35.5 per cent) survivors were raped by strangers while (64.5%) were raped by persons known to them. These include boyfriends, religious sect leaders and relatives. There is need to increase public awareness on the consequences of not presenting to the clinic within 72 hours of rape, both on the part of the public and the police (ICPD, 2004) Zimbabwe Millenium Development Goals, 2004) and (Wekwete, 2008).

Emerging Issues on Population and Development

Despite social, gender and economic challenges faced in the past decade, Zimbabwe has made some notable achievements:

- HIV/AIDS prevalence declined from 29 per cent to 14 per cent over the last two decades, becoming the first country in Southern Africa (and second in Africa) to achieve that feat. This has been due to "multi-sectoral collaboration" and government commitment. The challenge now is to sustain the trend and maintain behaviour change.
- Great strides have been made in the family planning area with a rising CPR which has surpassed the target of 52 per cent by 2002, set by the National Population Policy. The current CPR of 60 per cent is one of the best in Sub-Saharan Africa.
- A decline in fertility has been realised. The TFR of 3.8 in 2006, was close to the Population Policy target of 3.5 by 2002.
- There has been an improvement in the collection, dissemination and utilisation of gender-disaggregated data in all sectors.
- High literacy rate has been achieved due to high enrolment into primary school education and the Adult Education Programme.

However challenges still exist and these include:

- Population growth exceeded the economic growth over the last 2 decades due to declining GDP. Negative GDP growth was registered between 2000 and 2008, whilst the population growth rate was 1.1 per cent in the same period

- The eradication of poverty still remains a major obstacle as poverty levels have been rising over the past 10 years. The standard of living has been falling over the last decade. The target of the Population Policy was to reduce poverty from 45 per cent in 1995 to 20 per cent by 2005. Poverty levels have been increasing due to poor economic performance, low productivity in agriculture, declining industrial activity, and the impact of HIV/AIDS
- To reduce rural to urban migration, the government set up Growth Points, started the Rural Electrification programme, and built community dams to create employment opportunities and income generation activities.
- There is limited application of gender analysis in the formulation of policies and strategies at all levels. In addition, the involvement and participation of women in decision making is limited, mainly due to existing socio-cultural attitudes, beliefs, practices and norms.
- The Zimbabwe Constitution has a dual legal system allowing Customary Law to co-exist with General Law. Thus section 23 of the Constitution allows discrimination against women in the application of Customary Law in matters relating to adoption, marriage, divorce, inheritance of property, etc.
- The socio-economic challenges continue to hinder the attainment of universal education for children, due to non-attendance and children dropping out of school. The quality of education has also been declining due to inadequate staff and learning materials
- The HIV/AIDS epidemic still remains a big concern despite declining prevalence. Zimbabwe still remains one of the high burden HIV/AIDS countries in the world. The disease has resulted in high morbidity and mortality in adults and children, with stigma still a major issue. Inadequate resources have resulted in many people failing to access treatment and care for HIV/AIDS.
- High maternal mortality due to lack of skilled humanpower, poor transport and communication systems, poor community awareness, inadequate equipment and drugs. This is compounded by declining skilled attendance at delivery and a high number of adolescent pregnancies.
- The unmet need for family planning is relatively high (13%), and is coupled with the low uptake of long acting and permanent family planning methods.
- Poor method mix for family planning methods and a high unmet need of family planning remain an obstacle to better quality of service.
- The target of the Population Policy was to have immunisation coverage in children of all vaccines of over 90 per cent by 2005. However, the coverage of immunisation had dropped to 53 per cent by 2006. In addition, levels of malnutrition have increased among children under-5 years.
- Children's health and welfare are greatly compromised due to poor food security, poverty and hunger, HIV/AIDS, poor access to safe water and sanitation and low levels of immunisation.

- Due to deaths of adults in the productive age groups, there is an increasing number of orphans which is now under the care of the elderly (especially grandparents).
- The proportion of people residing in urban areas has increased from 31 per cent in 1992 to 35 per cent in 2002. This has resulted in urban areas failing to cope with the provision of basic services and amenities, including housing, health, and water and sanitation. The current infrastructure cannot sustain increasing population.
- Young people, especially women are facing serious challenges in accessing reproductive health services and thereby exposing them to unintended pregnancies, unsafe abortion, HIV/AIDS and physical/emotional abuse. The economic challenges and poverty has worsened the plight of young people threatening their livelihoods.
- The Population Policy of 1998 is outdated and needs to be reviewed in line with current trends in population and development.
- The exodus of Zimbabweans to other countries has created new kinds of families in which a single parent is left alone looking after the children, or both parents go abroad leaving many child-headed families.
- There is limited data on elderly people and the disabled friendly programming for this vulnerable group.
- Provision of safe water and sanitation remains a challenge in both urban and rural areas.
- Implementation of the provisions of the Environment Management Act is key to ensure sustainable development, but this has not been done to the full extent. There is need for a comprehensive energy policy to address current energy problems, with focus on alternative sources and renewable energy. There is need to strengthen the re-forestation programme, land reclamation and natural conservation programmes for environmental sustainability.
- Provision of decent accommodation in urban areas and improving quality of houses in rural areas is a priority.

CONCLUSION AND WAY FORWARD

The key challenge to the implementation of the Population Policy is putting in place an appropriate and effective coordinating and monitoring institutional framework. The following strategies are critical to further strengthen the population and development agenda in Zimbabwe:

1. Macroeconomic Stability

   - Maintaining the economic recovery momentum and consolidate gains of the inclusive government.
   - Resource mobilisation – internal and external – to support the Population and Development Agenda.
   - Reviewing the Population Policy of 1998.

2. Improving Access to Comprehensive RH Services (including FP)
   - Provision of services to marginalised populations (including new settlements).
   - Increasing coverage of ASRH services.

3. HIV/AIDS
   - Reducing incidence and prevalence of HIV/AIDS.
   - Providing care and support for people living with HIV/AIDS.
   - Scaling up PMTCT programme to eliminate parent to child transmission of HIV/AIDS.

4. LEGAL
   - Constitution amendments to promote gender equality.

5. SOCIO-CULTURAL
   - Promoting gender equality and equity through research and advocacy.
   - Addressing negative socio-cultural beliefs and practices.

6. MONITORING AND EVALAUTION
   - Mechanism for timely and accurate data for monitoring implementation of ICPD-Plan of Action and MDGs.

Table 10.7: Key Development Indicators Table

INDICATORS	1990	1995	2000	2002 Census	2005 DHS	2009 MIMS	2011 DHS[16]	MDG TARGET 2015
Real GDP Growth	7,0	0,2	-8,2	-14,5		6,3		5
Population Growth Rate	2,5		2,5	1,1				
Population Below the Food Poverty Line (%)		57		69			35	
Population Below the Total Consumption Poverty Line (%)		74		80			40	
Human Poverty Index (%)			36					18
Net Enrolment Ratio, Primary Education (%)		82		93				100

Completion Rates – Primary Education (%)	83	75	75					100
Literacy Rates, 15-24 yrs (%)	95	98						100
HIV Prevalence (15-49 yrs)		28		18.1	13.7	15.2	16	
Crude Death Rate		17.2			20	11.5		
Maternal Mortality Ratio		283	578		555	725 (MIMS)	960	174
Skilled Attendance at Delivery (%)		72.5		68	60 (MIMS)	66.2	100	
Under 5 Mortality Rate		102		82	86 (MIMS)	84	34	
Infant Mortality Rate		65		60	60 (MIMS)	57	22	
Stunting in Children under 5 year (%)		27		35	29	32	7	
Children 12-23 Months Fully Immunised	74	67		53	49 (MIMS)	67.8	90	
Life Expectancy		45		43	43			
University Enrolment, Women (%)	30	32					50	
Women in Senior Government Position (%)	22		30					50
Unemployment Rate (%)		50			80		10	
Safe Water Access, Rural Areas (%)		73	75					100
Safe Sanitation Access, Rural Areas (%)	48	56	58					100

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