5th International Dialog
on Population and Sustainable Development

Demographic Dynamics and Socio-Economic Development

October 17, 2006

KfW Branch Berlin
Charlottenstraße 33
10117 Berlin, Germany

Editorial

It is my great pleasure and privilege to open the 5th International Dialog – Population and Sustainable Development. I believe this conference can now be said to have attained tradition status. Since 2001, together with experts and our partners, we have been discussing reproductive health and the way it impacts economic and social development, especially in poorer regions.
I am sure that we can look forward to a fruitful exchange of ideas here in the rooms of the KfW Entwicklungsbank (KfW development bank) – and at this point, I would like to thank the KfW, and especially Dr. Wolfgang Bichmann, for making it possible for all of us to be here as their guests.

This year our International Dialog explores the dynamics of demographic change.

While Western Europe is having to cope with the fear of a rapidly aging population in a shrinking society and the collapse of a tried and tested social system, African countries especially are facing limited resources and a population explosion.

The earth already has 6.6 billion people living on it – just a few decades ago, a figure that seemed inconceivable. Every year, that total increases by around 80 million, with 95 per cent born in the so-called developing countries.

It is a great blessing to have children and see them grow up. But the massive population growth in developing countries is marked, above all, by the instability of the conditions there. In „World Hunger, Ten Myths", the Alternative Nobel Prize Laureates, Frances Moore-Lappé and Joseph Collins give a very clear picture of how high birth rates are not simply a symptom of poverty but also reflect women's social powerlessness.

For more than 40 years, Schering's family planning programe has been making it viable for women in developing countries to determine for themselves the way they plan their families. Our commitment there aims at ensuring people have access to contraceptives, irrespective of their incomes.
According to the United Nations Population Fund (UNFPA), 120 – 150 million women worldwide want to use family planning methods but have no access to information or the requisite family planning services.

Women ought to be able to decide whether they use contraceptives and which contraceptives they use. Only when they have that choice, can they plan the size of their family to ensure their children can enjoy optimal conditions; only then are they able to invest more in their children's health and education. Ultimately, by reducing women's health risks and encouraging smaller families, family planning also reduces the risk of poverty.

As the market leader in hormonal contraception, we are taking on board our social responsibility in family planning by participating in a network with state and non-state organizations in public sector markets where we waive profit on our contraceptives and help carry out information and education campaigns. The UN Millennium Development Goals on reproductive health can only be achieved by 2015 if we work together – promoting women's empowerment, cutting child mortality rates, and improving maternal health.
In our talks and lectures, when we consider what influence demographic change has on socio-economic development, we also need to remember and discuss the link between poverty and family planning.

Demographics give us two challenges: in our mature industrial societies, we have to practice with the growing number of old people; in the developing countries we have to join forces and find a way to give a perspective to young families.

Only by joining forces, we will be able to make a change. This is why I am particularly pleased to open a forum with so many knowledgeable and influential professionals. I hope that the dialog will be fruitful and that it will contribute to positive change.

Dr. Ulrich Köstlin
Member of the Executive Board
Schering
Berlin

Contents

Evening Discussion: „Condoms, Demography and the Developing World“

Keynote Address

Evening Discussion

Dr. Thoraya Obaid, Executive Director, United Nations Population Fund (UNFPA), New York

Susan Rich, Senior Program Officer for Reproductive Health, Bill und Melinda Gates Foundation, Seattle, USA

John Skibiak, Director, Reproductive Health Supplies Coalition (RHSC), Seattle, USA

Prof. Dr. Klaus Töpfer, former Executive Director of the United Nations Environment Programme (UNEP), Member of DSW's Advisory Council, Hanover, Germany

Dr. Peter Wolff, German Development Institute (DIE), Bonn, Germany

Summary of discussion

Annexes:

Welcome Address

Dr. Claudia Radeke
First Vice President East and West Africa
KfW Entwicklungsbank
(KfW development bank)
Frankfurt, Germany

It is a particular pleasure for me to welcome you as your host to this year's dialog on "Demographic Dynamics and Socio-economic Development". This is the 5th International Dialog on Population and Sustainable Development in Berlin, jointly organized by German Foundation for World Population (DSW) , Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ), InWEnt- Internationale Entwicklung und Weiterbildung gGmbH, International Planned Parenthood Federation (IPPF) and KfW Entwicklungsbank (KfW development bank) in cooperation with the Federal Ministry of Economic Cooperation and Development (BMZ) and Schering AG.

German Development Cooperation attributes special emphasizes to the field of Sexual and Reproductive Health and Rights and KfW development bank is particularly interested in addressing the mutual relationship between socio-economic development, demographic dynamics, pro-poor growth and reproductive health. The results of your discussions will certainly add to our understanding of these relationships and guide German Development Cooperation in priority setting in development cooperation as well as development financing. Issues of good governance, gender and human rights are closely linked to the subject of this year's dialog. As Germany also firmly supports the Paris Declaration on

Aid Effectiveness, the issues of country ownership, coordination and harmonization in program-based financing will have to be addressed when we discuss socio-economic development in low income countries.

Let me welcome two special guests attending this dialog:

Dr. Thoraya Obaid, the Executive Director of the United Nations Population Fund (UNFPA) whose presence at this event is particularly helpful, as she represents – officially as well as in her long personal career – reproductive health and population politics and wisdom in a holistic manner. It is her second time already that she attends one of the dialog events in combination with an official visit to Germany.

Let me also welcome Dr. Gill Greer, the Director General of the International Planned Parenthood Federation (IPPF) who has taken up her new post and task in this year only. We are honoured that you have chosen to attend the dialog at your first visit to Germany in your new function, immediately. As you all know, IPPF as a co-sponsor of the dialog events, had been active contributor to the successful meetings over the last year. We do hope that this positive collaboration between German Development Cooperation and the world's biggest civil society organization in reproductive health may continue based on mutual trust.

Welcome Address by Claudia Radeke, KfW Entwicklungsbank

Session I Keynote Speeches

Keynote Speech

Dr. Thoraya Ahmed Obaid
Executive Director
United Nations Population Fund (UNFPA)
New York, USA

I think all of us in this room understand that demographic dynamics – such as population size and growth, fertility and mortality trends, age structure, population distribution, urbanization and migration-affect in a significant way every aspect of social and economic development. The main point that I would like to stress today is that greater investment is needed in population and reproductive health if we are to achieve international development goals.

We will not achieve the Millennium Development Goals (MDGs) to eradicate extreme poverty and hunger, advance gender equality, improve maternal health, reduce child mortality, ensure universal education, combat HIV/AIDS and protect the environment, unless more attention and resources are devoted to population and reproductive health. This is particularly true in the poorest nations, where there are high rates of fertility and mortality, rapid population growth, and high unmet need for family planning. The achievement of greater socio-economic development in the poorest countries depends to a large extent on success in addressing population and development issues. Poor sexual and reproductive health is a leading cause of death and disability in the developing world. It limits life expectancy, hinders educational attainment, diminishes personal capability and productivity, and thus

impacts directly on economic growth and poverty reduction. Every year, more than half a million women die during childbirth, over 95 per cent in Africa and Asia. Every minute, nearly 10 people are newly infected with HIV and almost three million die of AIDS each year. This is a double tragedy because we know how to prevent these needless deaths. Effective interventions exist. Poor people have the least access to education and health care, including reproductive health information and services, as well as family planning. And this keeps them trapped in a vicious cycle of poverty that runs from one generation to the next.

It is this poverty trap that must be broken if we are to achieve the Millennium Development Goals (MDGs) and investments in sexual and reproductive health play a significant role.

Benefits of Investing in Reproductive Health and Rights

Good reproductive health enables couples and individuals to lead healthier, more productive lives, and in turn to make greater contributions to their household incomes and to national savings. The health benefits of these investments are well known, well documented and substantial. It is estimated that ensuring access to voluntary family planning could reduce maternal deaths by 20 to 35 per cent, and child deaths by as much as 20 per cent.

The World Bank estimates that ensuring skilled care in delivery and, particularly, access to emergency obstetric care would reduce maternal deaths by about 74 per cent. These are significant benefits. But as striking as these numbers are, the personal, social and economic benefits of reproductive health services may be even more important. A study in Mexico found that for every peso the Mexican social security system spent on family planning services between 1972 and 1984, it saved nine pesos in expenses for treating complications of unsafe abortion and providing maternal and infant care. In Thailand, every Dollar invested in family planning programs saved the Government more than $16. Even more dramatic, an analysis in Egypt found that every Dollar invested in family planning saved the Government $31 in spending on education, food, health, housing and water and sewage services.

Studies also show that the benefits go beyond government savings. A study for Latin American countries showed that the relatively modest investments needed to meet women's needs for family planning in the poorest groups would result in a one per cent increase per year in the country's gross domestic product (GDP). In addition, reproductive health investments, in particular family planning, can produce what is called a "demographic bonus".

This is spurred by lower rates of fertility and mortality, and a large healthier working population with relatively fewer dependants to support. If jobs are generated for the working population, this bonus results in higher productivity, savings and economic growth. In East Asia, where poverty has dropped dramatically, the demographic bonus is

estimated to account for about one third of the region's unprecedented economic growth from 1965 to 1990.

Investing in sexual and reproductive health is also strategic for curbing the HIV/AIDS epidemic. With over 75 per cent of HIV cases due to sexual transmission, delivery and breastfeeding, it makes sense to link HIV/AIDS efforts with sexual and reproductive health, which would benefit women and young people who are being disproportionately affected.

We know what needs to be done. We know what works. What we need is the political will and action to make reproductive health and rights a reality. We need added urgency. Today, there is a great demographic divide between rich and poor nations. While nations such as Germany are concerned about low birth rates, population aging and population decline, the population of poor countries continues to grow and remains relatively young. The youngest populations are found in the least developed countries, where prospects for social services and employment remain limited. It is clear that the opportunities and choices young people have and the decisions they make will shape our common future.

Today, 95 per cent of all population growth takes place in the developing world and population in the poorest nations is expected to double by mid-century. In countries with rapid population growth, the achievement of goals such as universal education and improved health standards are made more difficult. Every few decades governments will have to double the number of teachers, equipment and classrooms and a similar strain is placed on health services and housing.

We also see more and more people on the move, migrants leaving their homes in search of better opportunities and lives. Last month, we issued our annual The State of World Population report, which focused on women and migration and we issued our first youth supplement, entitled Moving Young. Both reports call for greater attention to development, gender and human rights in the policies and debates on migration-and greater investment in population and development to reduce migration pressures.

As I alluded to earlier, this country, Germany, is among 51 nations in the world, including Italy, Japan, the Baltic States and most of the successor States of the former Soviet Union, where population is expected to be lower in 2050 than it is today. Women are having fewer children, which raises concerns among politicians of how to pay for increasing pensions with income from a shrinking workforce and how to ensure economic growth.
There was an interesting article about this in the magazine, The Economist, in April 2006. The headline read: Forget China, India and the Internet, economic growth is driven by women. It said that the increase in female employment in the rich world has been the main driving force of growth in the past couple of decades. The article said that while some people fear that if more women work, they will have fewer

children, the countries where more women do work, such as Sweden and the United States, actually have higher birth rates than Japan and Italy, where more women stay at home. The article concluded that, if female labour force participation rose to American levels in countries such as Germany, Japan and Italy, which are all troubled by the demographics of shrinking populations, it would give a helpful boost to these countries' growth rates.

The main point is that, if higher female labour force participation is supported by the right policies, it needs not reduce fertility. Europe's aging population was also recently addressed in the European Commission's new Communication on "The demographic future of Europe – from challenge to opportunity". The Communication highlights five areas for action, including helping people to balance work, family and private life. It also underlines the importance of valuing the contributions of both older and younger employees and to harness the positive impact of migration for the job market.

I am happy to report that progress is being made. Between 1960 and 2000, the percentage of married women in developing regions using contraception rose from less than 10 per cent to about 60 per cent and the average number of births per woman fell from 6 to about 3. Yet, while great progress has been made in Asia and Latin America, many of today's poorest countries, concentrated in sub-Saharan Africa, have a long way to go.

I recently participated in a meeting of Health Ministers of the African Union, in Maputo. All of us in this room should be encouraged that the participants adopted a Plan of Action to dramatically expand comprehensive sexual and reproductive health services in Africa. The plan recommends a number of measures, including:

Integrating HIV/AIDS and sexual and reproductive health and rights programe and services;
- Repositioning family planning as a crucial factor in attaining the health Millennium Development Goals;
- Addressing the sexual and reproductive health needs of adolescents and young people;
- Addressing unsafe abortion;
- Delivering quality and affordable services to improve maternal, newborn and child health;
- Strengthening reproductive health commodity security with an emphasis on family planning and emergency obstetric care;
- The Maputo Action Plan is a big step forward. It has targets, indicators, time lines and estimated costs to guide nations and they move forward.

We are making progress in Africa and I am optimistic, but I am also realistic. Yes, we have a long way to go. I am pleased to inform you that Member States have recently supported the Secretary-General's recommendation to establish a new target on

universal access to reproductive health by 2015 under MDG 5 (maternal health). We are now developing indicators for it to assist countries in their monitoring of progress made in this area. In view of that, political will and increased funding for sexual and reproductive health, including family planning, are essential in order to achieve our common goals.


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Dr. Thoraya Obaid
Dr. Gill Greer

Keynote Speech

Dr. Gill Greer
Director-General
International Planned
Parenthood Federation (IPPF)
London, UK

Thank you and good afternoon, your Excellencies, Members of Parliament, Government Representatives, Officials and Members of Civil Society. I'm delighted to be with you today in my new role as Director General of IPPF and it is a privilege to share a platform with such distinguished speakers.

This is the beginning of my 4th week in this role and I find it very encouraging to be taking up this post at a time when IPPF and its global family of 150 Member Associations are implementing a new strategic framework focused on improving sexual and reproductive health and rights for people around the world, particularly the poorest and most marginalized. I acknowledge the outstanding leadership of my predecessor, Dr. Steven Sinding in achieving this new energy and focus, and also the earlier leadership of Ingar Brueggemann whom I'm delighted to see here today.

Today I've been asked to discuss the importance of universal access to comprehensive sexual and reproductive health in relation to population issues, rights based and youth focused programming and the achievements and the lessons learned since ICPD.

In committing to a programe of action that would result in universal access to comprehensive sexual and

reproductive health services (including HIV/AIDS) by 2015, 179 countries and those working in the field of population made brave a paradism shift from demographic targets to a rights based approach centered on the needs and wishes of individuals, rather than top down policies and programs for population control. Although issues of population vary greatly around the world today, we know that this rights based approach remains absolutely critical. The ICPD was indeed a watershed event.

In 2002, Kofi Annan, highlighted the importance of family planning, and wider sexual and reproductive health and population issues, to the eradication of poverty: "the MDGs, particularly the eradication of extreme poverty cannot be achieved if questions of population and health are not squarely addressed. And that means stronger efforts to promote women's rights, and greater investment in education and health, including reproductive health and family planning."

Although most of us here today are similarly well aware that sexual and reproductive health is not only a health issue but a precondition of any effort for sustainable socio-economic development, it has all too often been 'the missing link'. Access to sexual and reproductive health impacts upon many areas, including education, productivity, the environment and, of course, the everyday lives, wishes and hopes of billions of people. Although fertility levels have dropped in many countries, and we have seen dramatic gains in development, there are still many of the least developed and poorest countries where the fertility rate is "not only the result of poverty, but one of the causes of poverty" and that becomes particularly true when we also consider the wider concept of poverty of opportunity.

We know, for example, that families with fewer children are more likely to be able to educate them, and those who are educated are less likely to suffer from poor health, and more likely to contribute fully to economic productivity. This has proved to be particularly true for women, but millions still do not have the opportunity to make these choices.

Most of the MDGs cannot be achieved with the high levels of population growth that are current in some of the least developed countries and regions (APPG Report 2006). These levels of population growth not only impact on vital resources, but that lack of resources, in turn, impacts on good sexual and reproductive health, including maternal and infant mortality and morbidity. How can we ensure safe childbirth, for example, without access to water? How can a country where the total fertility rate is 7 children per woman ensure that more than one in four families has access to safe drinking water or can access the universal right to health?

An estimated one third of women's ill health globally results from poor sexual and reproductive health. One quarter of the disease burden among men is similarly thought to be due to sexual and reproductive health issues. It is clear therefore, that without universal access to sexual and reproductive health services, individuals, families, communities and whole nations can be weighed down by a burden of ill health.

When we talk about universal access we are talking then about access to a comprehensive range of services. But inequalities in society are reflected in inequalities in health. Poorer, more marginalized and vulnerable people are least likely to be able to access the full life-cycle continuum of services as defined by ICPD and WHO, including sexual and reproductive health services and information related to family planning, STIs, cancer, antenatal and post natal care. This can be especially so in the case of hard-to-reach groups, such as internally displaced persons or migrants. Nor can they access the information that is vital to their health and well being.

To see a true and comprehensive improvement in sexual and reproductive health, and quality of life, there must be access for all. Programs and strategies also need to focus on the wider linkages to the MDGs, and development gains, and the critical linkages between sexual and reproductive health and rights and HIV/AIDS.

Together, HIV/AIDS and maternal and child death and illness are eroding hard won development gains and destroying communities.
A recent 'Guardian' article compared the risk of a woman dying in childbirth between one African country and Sweden, 1 in 7, compared with 1 in 29,800. This is an avoidable denial of social justice. The provision of family planning and sexual and reproductive health services is key to reducing maternal and infant mortality and poor health and HIV/AIDS.

Yet clearly then there are still high levels of unmet need for contraceptives and other reproductive health commodities. It is not surprising therefore, partially as a result of this unmet need, that globally, this year, 19 million women confronted with an unintended and unwanted pregnancy, will face the deadly consequences of unsafe abortion. As a result over half a million women will die due to unsafe abortion by 2015, and over 95 per cent will come from the world's poorest countries.

We live in an age of statistics – they threaten to become meaningless or paralyze us with their enormity, but behind each of these statistics is a complex story, the complex story of a woman entitled to a life of dignity and meaning.

And that is why the rights based approach of Cairo continues to be critical in relation to population and development. The empowerment and education of women, and the importance of women's rights, including the right to sexual and reproductive health is central to ICPD, the 2006 World Summit outcome document and the Beijing Platform for Action. There is no development tool that is more effective than the empowerment of women, or as likely to raise economic productivity, or to reduce infant and maternal mortality. In Kofi Annan's words "There is no other tool which is as sure to improve nutrition and promote health – including the prevention of HIV/AIDS."

But these are not easy rights to exercise:
We know, for example, that 'ABC'/Abstaining, being faithful, and using condoms' does not protect many of those who are most vulnerable to HIV infection – and have little power or choice – young married women die from AIDS, their only crime has been to be married to men they believed to be faithful. In one Pacific country women insert the female condom before they travel on the bus between two cities, because they know they are likely to be raped on the journey, and sex workers arrested for prostitution are raped while in custody.

Nevertheless there are some who remain opposed to a rights based approach to sexual and reproductive health because these issues are about the most intimate aspects of life and provoke intense emotions. Different world views on women's role in society, and on sexual morality, on dogma versus individual conscience, conflict, and so issues or morality and mortality can become tragically intertwined at the personal, community and policy levels, young people, women and men are denied access to the information and services that could enrich, or even save their lives.

IPPF is a rights based organization, a rights-based approach has been central to our work and we know it works. A rights-based approach increases access to services and improves the quality of care. A rights-based approach has:
- helped to turn service providers into credible advocates, who will call upon governments to deliver on their promises and turn clients into citizens aware of their rights
- contributed to the building of local, regional and global alliances, and in incremental steps toward social change
- opened doors so that we can address new areas of sexual health, such as epidemic levels of gender-based violence
- A rights-based approach encourages confidentiality and non-judgmental staff and services, this in turn increases the uptake of services by people and groups who might otherwise feel stigmatized, marginalized, or afraid.

One young person is infected with HIV every 14 seconds, yet young people's rights to access the critical information and services that can save their lives, can be particularly contentious and the thought that their lives might even be enhanced by such access is even more so. Frequently this is juxtaposed with parent's rights and responsibilities, resulting in polarized positions which then prevent meaningful dialogue.

But we ignore the realities of 21st century life at our peril. The largest ever generation of young people is about to enter their reproductive years. Many of them are also unemployed, out of school, lacking any hope of a meaningful future, or the vital information and decision-making skills that will enable them to make the decisions that will shape their lives, and the future of our planet. They need both the means and the motivation to exercise their rights responsibly. We know that

comprehensive sexuality education and high quality youth-friendly services can make an enormously positive contribution, and IPPF works in partnership with young people to ensure this. For example, in the Yemen an IPPF project funded by the German government has provided young people with a safe environment, a youth centre where they can learn computer skills and access information they need, school seminars and inter generational workshops.

What else have we learned since ICPD?

We have learned the critical importance of political leadership commitment and to the linkages between reproductive health and the MDGs. This has been recognized in numerous recent declarations and commitments including the European Consensus, the General Assembly and most recently at Maputo at a Special Session of the Conference of African Union Ministers of Health. Now we need to turn that rhetoric into reality, to ensure that these commitments are turned into the funding for sexual and reproductive health that is so urgently needed to ensure that family planning and sexual and reproductive health are incorporated into national plans for HIV/AIDS, including poverty reduction strategy papers, and are integral to health sector reforms. We cannot afford for family planning and reproductive health to continue to be the missing link.

We have learned about the importance of parliamentarians as the bridge between the people and their governments in championing these commitments. We know the importance of the role of civil society, of NGOs working together, in partnership with their communities and with the private sector in order to bring about change, and we know the importance of a respectful, strong and trusting relationship between government and NGOs and wider civil society cannot be overestimated.

We have found that linking sexual and reproductive health and HIV/AIDS makes good economic and programmatic sense. Projects such as the IPPF Models of Care project funded by the German government with IPPF Member Associations including those in Columbia, Kenya, Rwanda and the Dominican Republic, have shown that traditional family planning services can be expanded successfully to include wider sexual and reproductive health services, including the continuum of HIV/AIDS prevention and care. Not only can this prevent STIs including HIV, through education and services, but it will also contribute to the needs of the HIV-positive community and stigma reduction. Voluntary counselling and testing, prevention of mother-to-child transmission, and the treatment of HIV-positive pregnant women are important areas where services can be linked, particularly as we confront the feminization of HIV and AIDS. Combined sexual and reproductive health and HIV/AIDS services can reduce duplication of services, reduce administrative and overhead costs, and allow sharing of resources.

The 2006 UNGASS Declaration has reinforced the importance of these linkages and emphasizes the need to strengthen them, recognizing that HIV/AIDS is disproportionately affecting women and young people, and requires an “exceptional

and comprehensive global response." Next week, we will we will bring HIV/AIDS and reproductive health organizations together in Bangkok at a workshop to fully explore the potential of what can be achieved.

We have also learnt that comprehensive sexual and reproductive health strategies need to reach those who do not use traditional health services. Reaching vulnerable groups 'where they are' is essential, and recent IPPF initiatives have included mobile clinics for market traders, and peer educators for sex workers seeking contraception and protection for HIV and transient construction workers.

We also know increasingly that the high levels of unmet need for services are exacerbated by a lack of sustainable supplies of contraceptives and other sexual and reproductive health commodities. "Without supplies there are no programs" and so there is a need for accurate research, innovation, capacity-building, commitment and coordination if these problems are to be overcome. The forthcoming meeting of the Reproductive Health Supply Coalition here in Germany in the next few days is integral to this.

Thank you for your shared commitment in being here today. In my country the indigenous Maori people have a saying, Your Food basket, My food basket, Together we can feed the people. By acting on the basis of our shared knowledge and experience we can help to ensure that the shared vision of sustainable development becomes a reality.

Keynote Speech

Lena Sund
Deputy Head
Social and Human Development
European Commission (EC)
Brussels, Belgium

I have been invited to give a broad outline of the European Commission Sexual and reproductive health and rights policies set in a wider development context.

Sexual and reproductive health services and rights are key issues deserving strong political support from all. Governments, national parliaments, the European Parliament, the European Commission (EC) and the Council together with European civil society have to be fully involved and supportive to ensure the full implementation of the commitments made in Cairo 1994.

The International Conference on Population and Development (ICPD) was indeed a historic milestone when world leaders moved on from a preoccupation with population growth to new approaches centered on respect for human rights, gender equality and improved rights for men and women to decide on the number of their children. It was emphasized that reproductive health services, provided without any form of coercion and focused on care in pregnancy, childbirth and sexually transmitted infections, are key to preventing disability and death as well as to improving health and reducing poverty. Since 1994 the ICPD agenda and its full implementation has been the policy of EC and its Member States on sexual and reproductive health and rights.

A lot has been achieved politically at European level. At the Cairo +10 anniversary celebrations in 2004 the Dutch presidency of the Union presented a paper which clearly re-stated the strong commitments of the EU and that sexual and reproductive health and rights are critical determinants to poverty reduction and for attaining the Millennium Development Goals. The Council's conclusions from November 2004 recognize that additional financial resources to enable prompt implementation of the ICPD agenda are needed and the Council strongly encouraged the EC and the Member States to provide financing through geographical and thematic instruments, sector and/or budget support.

The Council's conclusions also specifically pin-point that the EC and the Member States shall provide additional resources through United Nations Population Fund (UNFPA) to fill the reproductive health commodities gap as a short term measure to respond to urgent needs. Member States responded promptly by pledging 75 million Euros for this purpose and the European Commission secured a 15 million Euros contribution to UNFPA's commodity programe. These funds are coming from the 9th European Development Fund (EDF) in agreement with the African Caribbean and Pacific countries (ACP). This contribution comes on top of 32 million Euros to UNFPA and International Planned Parenthood Federation (IPPF) for the implementation of the ICPD Programe of Action released subsequently to the US administration decision in 2002 to stop funding organizations that counsel on or carry out abortions (The Mexico City Policy).

For the budget years 2003 to 2006, the EC budget line on aid for policies and actions on reproductive and sexual health and rights in developing countries has enabled us to finance a number of important NGO-driven (Nongovernmental Organization) projects in the poorest countries. About 55 million Euros have been allocated to projects on maternal health and projects addressing youth and their special sexual and reproductive health problems and needs. One remaining call for proposals under this budget line totaling 18.4 million Euros is still under discussions, targeting how to improve sexual and reproductive health in refugees' and displaced population settings. For the financial perspectives 2007-2013 a new regulation named the Development Cooperation Instrument – DCI – is just to be voted for in the Parliament and the Council of Member States. In that instrument all human development issues are addressed on a thematic basis including health and sexual and reproductive health. The budgets and numbers are not yet known but Directorate General for Development is presently programming for the years 2007 until 2010.

However, sexual and reproductive health needs and rights have to be addressed in countries and by countries on a long term basis. The bulk of European aid is therefore channeled on a bilateral basis. The Country Strategy Papers made up under the 9th European Development Fund shows that only 14 ACP countries – covering four per cent of the total EDF – put priority on health. Hopefully we will see many more countries prioritizing health under the new programming that starts running 2008 to 2013. ACP countries will receive their aid for this period from the 10th EDF

which is record high – 23 billion Euros! Other developing countries are covered by a new separate budget line. The starting point for the new programming is the new European Development policy named the European Consensus where the principle of local ownership in partner countries is the main principle. It is satisfactory to note that there are several references to the importance of sexual and reproductive health and rights in this document including a statement saying "The Millennium Development Goals (MDGs) cannot be attained without progress in achieving the goal of universal sexual and reproductive health as set out in the ICPD Cairo Agenda".

In the European Consensus it is clearly set out that budget support or sector budget support is the preferred tool for future aid. Clearly this must be linked to strong national policies and commitments on part of the recipients. Another issue that feature strongly in the Consensus is the need for donors to coordinate better in order to make aid more effective. In some countries we already see the difference in that the European Commission and the Member States jointly negotiate Country Strategy Papers and subsequent programming documents.

Good governance is another key issue in the European development policy. In August 2006 the Commission adopted a new communication on democratic governance towards a harmonized approach within the European Union. It is clear that good governance means more than tackling corruption. Good governance is to be approached holistically taking into account all dimensions; political, economic, social, cultural, environmental etc. Strong sexual and reproductive health and rights policies and ownership is certainly part of the social dimension of good governance. For ACP countries an incentive-based approach is being created and almost 3 billion Euro have been set aside from the 10th EDF fund.

The importance of prevention and availability of contraceptives cannot be underestimated. The Reproductive Health Supplies Coalition is a partnership between many organizations and donors active in RH supplies security which plays a key role in coordination information and activities. The European Commission is bringing an EU perspective to the group which is chaired by the Netherlands and also hosted Germany in Bonn. In the context of the Coalition several studies have been carried out focusing on the situation on a national basis. Those studies and other research results will now be used in advising developing countries and plan for the future.

The link between sexual and reproductive health and HIV/AIDS is obvious. It is appelling that three million people died from AIDS last year and that yet another five million became newly infected. What is even scarier is that not even 20 per cent of people at risk of infection had access to means of prevention. Availability of affordable condoms has to be heavily increased. At the World AIDS Day 2005, Europe therefore made a strong commitment to link sexual and reproductive health and HIV and integrate prevention supplies.

Safer motherhood is still a key issue, an issue where also UNFPA is very active. We see some progress being made but still more than 500.000 women die yearly from pregnancy and childbirth complications. This is of course unacceptable and we are far from living up to the MDG on safe motherhood. Skilled attendance at birth and access to emergency obstetric care should be available to each pregnant woman. Strong support goes to UNFPA for their global Campaign to End Fistula!

Gender equality and sexual and reproductive health are inseparable and key to achieve the MDG on gender equality. With regard to strengthening women's position also new prevention tools are necessary. Therefore the Commission and many Member States are supportive towards research and development of microbicide that will eventually enable women worldwide to protect themselves on their own initiative.

Women's exposure to violence and sexual violence is yet another horror to be addressed seriously. The European Commission together with UNFPA and the Belgian government hosted a high level symposium on 'Sexual Violence in conflicts and beyond' in June 2006. A strong call for action was adopted at that event in which conflict and post-conflict countries have a key role to play.

It is time to ensure that sexual and reproductive health and rights issues become a priority worldwide. The African Union meeting in Maputo in September and the adoption of an Action Plan to implement sexual and reproductive health and rights measures is certainly an important step in that direction.

Keynote Speech

Prof. John Cleland
Professor of Medical Demography
at the London School of Hygiene
and Tropical Medicine
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It is a huge privilege for an academic to talk in a room with so many powerful people. Academics don't have any power, but they do have the advantage of being able to speak the truth as they see it, because they are not encumbered by considerations of political consensus and correctness. I am going to abuse that freedom. Luckily, being the fourth speaker means that I can tear up most of my notes, because many of the important points have already been made.

As a demographer, let me start with a demographic perspective. We have already heard that the population of the world is set to increase from six and a half billion to a little over nine billion by the middle of the century. That's a 40 per cent increase, much less than in the past 45 years, but, in absolute terms, still huge – 2.6 billion compared with 3.5 billion over the last 45 years. For things like the environment, numbers matter, not percentage increases and it is still a huge increase that we are facing. These numbers are based on 'medium variant UN projections' – and they assume that fertility in Asia and Latin America, indeed in most developing countries, is going to come down in the coming decades to under two births per woman, to 1.8. That is a hugely controversial assumption and I'm skeptical that it will actually be

achieved. In Africa, they assume that fertility will come down from about five births per woman, to 2.5. That's a fairly steep decrease.

Those population projections are highly sensitive to what happens to fertility. If fertility is a mere half a birth higher than the medium variant UN projection, the world's population won't be nine billion by the middle of the century, it'll be 10.6 billion. Conversely, if fertility is half a birth lower than assumed by the UN in its medium variant, the world's population will be 7.7 billion in 2050. Now, that's a huge difference – 10.6 versus 7.7. It's fertility, not mortality, that drives the future trajectory of world population. There's a huge amount at stake. Quite colossal, and it depends on minor trends, minor differences in what happens to fertility.

It's misleading to think of all poor regions as the same. In Asia, the projected population increase is 35 per cent and, in absolute terms, it's a mammoth one. Nevertheless, the problems of high fertility and rapid population growth in Asia are yesterday's problem. There is an important exception to that – North India, where fertility remains high, as opposed to South India where it's low. Pakistan and Afghanistan are also big exceptions and Laos is a smaller exception. Population growth problems and high fertility problems are no longer a dominant concern in Asia. Nor are they in Central and South America, which is expected to have a 40 per cent increase in population. But, as in Asia, much of this future increase is an almost inevitable consequence of the age structure of population. It's what demographers call population momentum and it reflects the fact that a disproportionately large fraction of the population is in the reproductive age range. That type of population pyramid sustains a high birth rate, even while the level of child bearing at the individual woman level is really quite low. There's not much we can do in most Latin American or Asian countries to bring about a more rapid stabilization of the population. Though I would stress that the family planning needs of the poor still remain only partially addressed throughout much of Latin America and Asia.

In the Arab states of North Africa and the Middle East, the increase is rather higher – a 60 per cent increase. There are a number of critically important countries where fertility and population growth does remain high – Jordan, Syria, Yemen, in particular, Sudan and Iraq. The Arab states lie towards the high growth end of the continuum. But, of course, it's really sub-Saharan Africa, as speakers have already alluded to, where fertility remains high and continued substantial population increase remains certain. The projected increase for sub-Saharan Africa is 125 per cent – that's over a doubling in the next 45 years. Many countries are going to treble in population size in that period.

But, even within Africa, there's huge diversity. Eight countries in the south have horrendous HIV epidemics. Levels of infection are 15 per cent or more. And six of those eight countries already have quite moderate fertility. So, for them, population growth and high fertility is not a big problem. But in West and Central Africa, HIV epidemics remain at a fairly low level, and there's no sign that they are going to take

off in the dramatic and horrible way that they have in the south. Fertility remains high and population growth remains high. It is true that fertility is gently declining in many West and Central African countries, but it is not being driven by increased uptake of contraception. Almost certainly, it is being driven by increased resort to illegal and often unsafe abortion – which, of course, is going to fuel maternal mortality rates.

East Africa lies somewhat between the south – where population growth is by and large not a problem – and the west and central parts of Africa. It is a region of moderate HIV epidemics and much higher levels of contraceptive practice than in West or Central Africa. But even there, I would claim that population growth and the moderate to high fertility levels represent a bigger threat to poverty reduction than HIV. Take the case of Uganda, which we are going to hear more about. Uganda, despite its long-standing, moderately severe HIV epidemic is projected to grow in the next 45 years from about 30 million to 127 million when it will far bigger than any European country. President Yoweri Kaguta Museveni seems to welcome that and nobody outside of Uganda challenges him enough.

Kenya, now 35 million, is projected to grow to 80 million by the middle of the century. That's a huge increase on the projection made two years ago, which suggested a population of 44 million in 2050. What happened in Kenya, is that – unexpectedly – fertility stabilized at a little under five births per woman in the mid-nineties instead of continuing its downward descent. One reason for that plateau is that USAID reduced its family-planning funds and put them into HIV control. In retrospect, a disastrous decision. The percentage of unwanted pregnancies has shot up, unmet need has shot up and fertility has actually risen amongst the poor.

Anybody who thinks that the world's population growth problem is over might consult this sheet (see. page 29).

In the 75 low income and lower middle income countries in the world with a population of over five million, 32 of them – nearly half – have a population growth rate of two per cent or more per annum. That means a doubling every 25-35 years. Luckily, 25 of those 32 countries also have high unmet need for contraception. Therefore, the humanitarian health rationale for investment in family planning coincides with the economic imperative to reduce rates of population growth. Half of the low and low middle income countries in the world today, the larger ones, are still doubling in population size every 25-35 years. I believe that poses a threat to development.

Now, we have heard a lot already about investment in family planning and reproductive health and their link to the Millennium Development Goals (MDGs) and I'm not going to repeat most of that. But the big two are environment and poverty. Because unless you can effectively link population stabilization and lower fertility through investment in family planning to either environmental considerations or poverty considerations, the big

Classification of 75 low and lower-middle income countries by population growth (2005-2010) an unmet need for contraception

Population Growth Rate (2005 – 2010)	Low (<10%)	Medium (10%-19%) Unmet Need	High (20%+)
High (2%+ pa)		Nigeria [24] Niger [25] Paraguay [21] Nicaragua [26] Honduras Jordan [34] **Mean CP 39% Mean TFR 4.3**	Yemen [37] Rwanda [24] Ethiopia [20] Uganda [28] Pakistan [40] Togo [14] Senegal [18] Burkina Faso [13] Mali [22] Laos Malawi [17] Sierra Leone Dem Rep Congo Angola Benin [16] Iraq Burundi [22] Sudan [29] Kenya [23] Somalia Madagascar [24] Chad [26] Guatemala [32] Afghanistan Syria Guinea [17] **Mean CP 17.3% Mean TFR 5.4**
Medium (1& - 1.9% pa)	Eypt [24] Indonesia [13] Iran Brazil [30] Columbia [20] Vietnam [16] **Mean CP 60% Mean TFR 2.3**	Tunisia [37] Mozambique [16] Philippines [33] El Salvador India [28] Algeria Ecuador [16] Uzbekistan [30] Kyrgyz Republic [30] Bangladesh [16] Dominican Republic [28] Morocco [17] Peru [20] **Mean CP 47% Mean TFR 2.8**	Haiti [27] Ghana [14] Nepal [23] Cambodia [21] Cote d'Ivoire [16] Zambia [16] Papua New Guinea Bolivia [28] Tajikistan Tanzania [17] Cameroon [22] **Mean CP 27% Mean TFR 3.9**
Low (<1% pa)	Korea Dem Rep Kazakhstan [32] Tailand [24] Cuba Romania China **Mean CP 71% Mean TFR 1.6**	Ukraine Belarus Zimbabwe [11] Sri Lanka [29] Azerbaijan **Mean CP 59% Mean TFR 1.9**	Myanmar Serbia Bulgaria **Mean CP 46% Mean TFR 1.6**

Note:

(a) Countries are color coded based on abortion policy (Center for Reproductive Rights, 2005).
RED = Abortion prohibited altogether or only to save the women's life.
ORANGE = Abortion allowable under restricted circumstances (e.g. in cases of fetal abnormality).
BLUE = Abortion on demand or liberally available.

(b) The number in brackets represents the percentage of second and higher order births occuring last than 24 months since previous birth, according to DHS data.

(c) Unmet need imputed for 12 countries without a direct estimate based on contraceptive use and level of unmet need in adjacent countries.

(d) CP is the unweighted mean contraceptive prevalance in married women for each cell; TFR is the unweighted mean total fertillity rate for each cell.

(e) Within each cell the countries are listed in order of decreasing unmet need.

KEY MESSAGES

- Family-planning promotion is unique among medical interventions in the breadth of its potential benefits: reduction of poverty, and maternal and child mortality; empowerment of women by lightening the burden of excessive childbearing; and enhancement environmental sustainability by stabilising the population of the planet.
- National family-planning programmes have proved effective in reducing fertility and making progress towards population stabilisation in most of Asia and Latin America, although the needs of the poor populations remain only partially addressed.
- Many of today's poorest countries, mainly in sub-Saharan Africa, still have high fertility and high unmet need for family planning, and their populations are projected to double in the next few decades.
- In most African countries, contrary to the impressions presented by numerous pronouncements from eminent leaders and current funding patterns, high fertility and rapid population growth represent a bigger threat to achievement of the Millennium Development Goals than HIV/AIDS.
- In the past decade, family planning has dropped down the list of international development priorities, with the result that demographic issues in poor countries have been severly neglected.
- The family-planning agenda must be revitalised but, for once, leadership might need to come from Europe rather than the US administration.
- Most governments in poor countries have appropriate population and family-planning policies but are receiving little encouragement and insufficient funds from international and bilateral donors to implement them with conviction.
- The keys to effective and sustainable family-planning programmes are well established: high-level political commitment; a broad coalition of support from elite groups; adequate funding; legitimisation of the idea of smaller families and modern contraceptives through mass media etc; and making a range of methods available through medical facilities, social marketing and outreach services.
- No contradiction needs exist between respect for reproductive rights and strong advocacy for smaller families and for mass adoption of effective contraceptive methods.

Source: Cleland, J. et al. Family Planning: the Unfinished Agenda, Lancet (2006)

boys are not going to listen. The World Bank will not care. You have to convince the economists that reductions in fertility are essential for poverty reduction and environmental sustainability.

Family planning and poverty reduction

One of the tragedies of the International Conference on Population and Development (ICPD) – and there are many very good things that it did – is that it gave up that link between family planning and poverty reduction. Who moved in to grab that arena? The HIV people. There's a quote from Peter Piot. I'll read it to you. "I ask myself about what political leaders really care about. The truth is, it's not health, it's economics and security...I decided to position HIV in that new arena." And everybody has followed the line. Tony Blair and Kofi Annan mimic in a slavish way Piot's claim that AIDS is the biggest economic disaster since the great flood. Of course, the evidence base for saying that is extremely slender. But that is why HIV/AIDS programs have been so hugely successful in raising funds while the family planning people see their funds and their influence slowly slide away.

Now, it just so happens that, since Cairo, the evidence base for asserting that population growth does pose a real threat to poverty reduction has grown much more convincing. The work of nearly all the economists active in this field – David Bloom (Harvard School of Public Health), David Canning (Harvard School of Public Health), Allen Kelly (Duke University), Michael Lipton (Sussex University, UK) – have reached a sort of consensus that reductions in fertility and subsequent changes in the age structure of populations offer a unique but transient opportunity for countries to escape from poverty. Put another way – as long as countries have high fertility, where half the population or thereabouts is under age 15, the possibilities of escaping from poverty are much diminished.

Similarly, at the household level, and panellists have said this already, we know that households with large numbers of children are more likely to get into poverty, and when they do, they are much less likely to escape from poverty. The evidence base is sufficient to convince anything but the most bigoted economist. But economists are quite bigoted and, for much of the last 30 years, they have been unable to prove to their own satisfaction that high fertility and rapid population growth really matter for poverty reduction.

One reason for that is the very poor quality of their research, which has improved in the last decade. The other reason is that poverty reduction is influenced by many factors, not just demographic dynamics. Therefore, it has always been difficult to discern the role of demographic change and separate it from governance and fiscal policy and all the other things that influence in the short term, quite dramatically, the welfare of a nation.

Population growth and environment

On environment, I'd like to make three points:
First of all, population growth is the main driver of water demand. Agriculture consumes about 80 per cent of our need for water and a growing population means that more food has to be grown. Water is destined to become one of the critical constraints on human welfare in the next few decades. UN documents show this quite clearly.

The second point, continued growth of rural populations in Africa is going to put huge pressure on marginal land and there's a real danger of overgrazing and loss of vegetation and increasing desertification and degradation of local environments. That's already happening and it's almost bound to get worse.

The third point is that, while we the rich countries are the villains of carbon dioxide emission, it is to be hoped the poor countries will become rich, and therefore their potential to emit carbon dioxide and other pollutants will grow correspondingly. Indeed, the biggest growth in carbon dioxide emissions is coming not from North America, but from China and India, because their economies are growing so rapidly. I put it to you that, in a world of 12 billion, the steps necessary to stabilize the world's environment will have to be much more draconian than in the world of, say, eight billion. Anybody who claims that population is irrelevant to the environment is deluding themselves.

Example of Niger

Some of the arguments in favour of family planning could have been put a lot more forcibly. I am going to use a country in Africa to demonstrate how serious the problem is. I am going to use the example of Niger. It's lost half its arable land through desertification. It can barely feed its own population of 14 million. In 2005, if you remember, there was a terrible famine and the western world was very reluctant and very slow to offer support. Niger has a fertility rate of over seven births and even if that comes down to three and a half births in the next few decades, its population is projected to be 50 million by 2050. I see absolutely no hope that Niger could feed anything like that number. No prospect that decent employment could be offered and yet it's possible that this country will end up with a population almost as big as the UK's or Germany's. They are marching towards catastrophe. Nobody seems to care very much about it. A rights-based approach is far too feeble, much as I support it in principle. There's no sense of urgency. Although the World Bank demographers are doing a little bit, I don't hear anybody in Europe pointing out the catastrophe that awaits a country like Niger.

Twenty years ago, we would have been alerted to it. Today we just turn our eyes away and pretend that an unfocussed sexually reproductive health approach is going to solve it. It's not! It needs a huge campaign to promote family planning such as

Kenya launched in the early eighties to have any prospect of a decent future for Niger. Niger is not alone. The situation is almost as bad in neighbouring countries. It's really severe. That's the point of urgency I wanted to get across.

Challenges and opportunities

We've got to reinforce the link between family planning and poverty reduction. Without that nothing is going to happen. Nothing will change. Our influence and funds will continue to dwindle. The evidence base, I repeat, justifies such an approach. We've got to convince the economists, we've got to convince the EC, we've got to convince the World Bank, Department for International Development (DFID), the German Development Bank and so on. Unless we do that, they're not going to speak out; they're not going to raise the profile.

Secondly, we've got to use straightforward robust language. It does this cause no service at all to continue to shroud family planning in the obfuscating phrase "sexual and reproductive health". People don't really know what it means. If we mean family planning or contraception, we must say it. If we are worried about population growth, we must say it. We must use proper, straightforward language. I am fed up with the political correctness that daren't say the name population stabilization, hardly dares to mention family planning or contraception out of fear that somebody is going to get offended. It is pathetic! Now this is not an attack on the holistic vision of ICPD and it is not an attack on the realization that women have other needs than contraception. It's not an attack on integrated services. It's just a plea for plain language and to say what we mean. No more shrouding our statements in code. Because code just confuses people.

We should emphasize that there need to be no contradiction between reproductive rights and a revitalization of the family planning agenda. Nobody is arguing for a coercive approach or anything of that nature. What many of us are arguing for is that governments and donor agencies begin to 'talk the talk' and to stir things up, because the success of family planning programs in poor countries is largely a matter of winning hearts and minds – not just services – it's winning hearts and minds. You do that through incessant publicity, through marches, through getting school teachers together and explaining to them how the future of the country will be severely damaged if people don't begin to reduce their family size. A myriad of ways. Many developing countries have learned how to do it with huge ingenuity and creativity.

Role of donors and leadership

Lastly, we need champions of the cause. Outside the UN system as well as inside it. Now United Nations Population Fund (UNFPA) is obviously the champion inside, but UNFPA, while not being powerless by any means, doesn't control the huge sums of money that the World Bank does or the bilateral donors do.

Historically, the American government has been the main champion of international family planning. More than half of all international aid for family planning still comes from America. But, for reasons that you are well aware of, the present US administration is not going to be a champion for the revitalization of the family planning agenda. Simply because they are too scared that contraceptives will get into the wrong hands i.e. people who aren't happily married. Who is going to take the lead? Who's going to really talk the talk? Walk the walk? Is it the World Bank? Well, my understanding is that their economists are still pretty wishy-washy on the subject. Is it going to be the European Commission – I didn't hear anything that inspired me. Is it going to be the Gates Foundation? They've got the clout; they've got a bigger budget than most rich countries do. They're a possibility, but I think the best bet are the European bilateral donors. I see a change in mood. I gave a talk at the Dutch Ministry of Foreign Affairs a couple of weeks ago where there seemed to be a lot of people concerned, as I have been concerned, that population stabilization and family planning have slipped off the agenda and they think it's time to get things going again. I don't see why it shouldn't be the German development agencies. I know, in my own country, DFID are under huge pressure from parliamentarians to stop this terrible neglect.

Anyway, if you donor agencies don't get your act together and look at this problem honestly and talk about it openly, history will judge you very harshly.


Prof. John
Cleland


Demographic Dynamics and
Socio-Economic Development

Keynote Speech

Dr. Jacques Baudouy
Director for Health,
Nutrition and Population
World Bank
Washington, DC, USA

Power point presentation

The economic impact of demographic trends and population growth: A look at the World Bank's approach

Fifth International Dialogue
Population and Sustainable Development
Demographic Dynamics
and Socio-economic Development

Berlin, Germany

Dr. Jacques Baudouy, Director
Health, Nutrition and Population
Human Development Network
The World Bank

October 17, 2006

Overview

- Theories on population growth and economic development
- Recent economic research on population growth
- Three emerging demographic trends
- The World Bank and its comparative advantages
- Bank activities to address client countries' demographic needs
- Conclusions

Theories on economic consequences of population growth

Time	+/-	Theory on Population Growth
First view	-	Malthus believed growth would exhaust resources
Early 1960s	+	Aids economic development by spurring technological and institutional innovations
Late 1960s	-	Neo-Malthusians warned of dangers due to resource depletion
1980s & 1990s		"Neutralism"– net impact on economic growth is negligible
Recently	+/-	Effect can be positive or negative, depending on certain determinants

Population growth matters

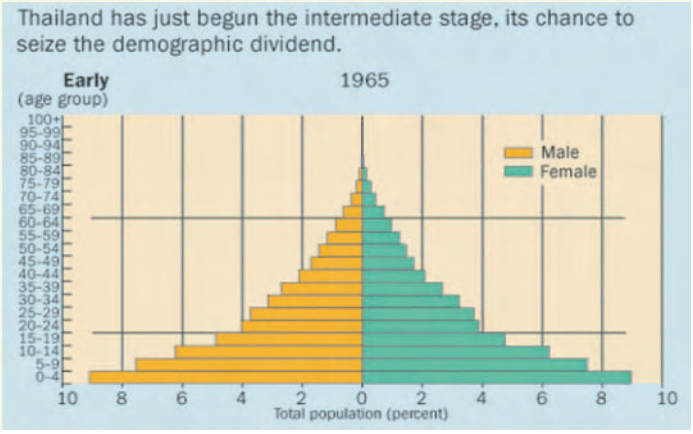
- Recent economic research shows trends:
  - **Accelerated economic growth or "demographic dividend"** only realized when appropriate investments in education, employment, and health services are made
  - **Economic challenges** face countries with large ageing groups and shrinking population size due to social security and health expenditures
  - **Negative impacts on economic development** with rapid population growth in low income countries

Defining the "demographic dividend" and its potential benefits

- With sharp declines in fertility, the labor force grows faster than the dependent population
- Benefits may include:
  - Lower dependency ratios
  - Still small ageing population
  - Larger labor force (more productivity)
  - Higher savings rate
  - More available resources for investment in social and economic development

Demographic transition in Thailand

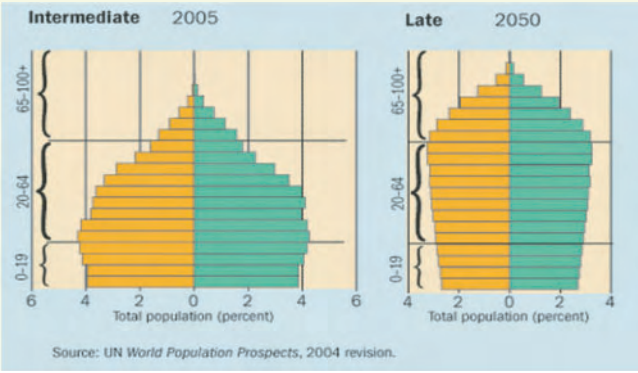
Early stage: fertility rates rapidly increase; mortality rates decrease



Demographic transition in Thailand

Intermediate stage: "demographic dividend" – fertility begins to decline, share of working age population increases

Late stage: low fertility and mortality increase share of ageing group



"Window of opportunity"

- Declines in fertility and mortality and increases in working age population are necessary, but not sufficient to realize potential of the "demographic dividend"
- A "window of opportunity" needs:
  - Good policies and institutions are essential
  - *E.g.,* East Asia harnessed potential of the demographic dividend, attributing 45 per cent of its economic growth to the dividend
  - Latin America missed the opportunity, despite similar demographic pattern

What is needed to open the "window"?

- Key policies and institutions need to focus on:
  - Health and nutrition
    - Ensure children develop to their fullest potential with good nutrition and care
    - Ensure healthy population to maximize productivity
  - Education
    - Essential for developing future labor force
  - Labor market opportunities
  - Social systems
    - Social security systems
    - Financial protection to reduce "shocks"

Second "demographic dividend"

- Second "dividend" occurs about 5 decades after the first
  - Population is concentrated at older working ages
  - Facing a long retirement, older population has strong incentive to accumulate assets
  - Additional assets are later invested in economy
  - 2nd may be more beneficial than the 1st:
    - Benefit is larger
    - May last indefinitely

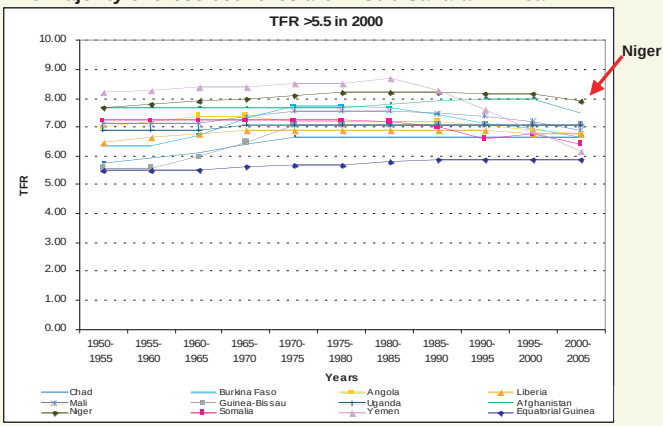
Source: IMF, Finance & Development Report, September 2006

Negative impacts on development with rapid population growth

- Some countries, particularly in Sub-Saharan Africa, are experiencing rapid population growth and extreme poverty
- 95 per cent of the worldís population growth currently occurs in developing countries
- Family planning programs need to be scaled up

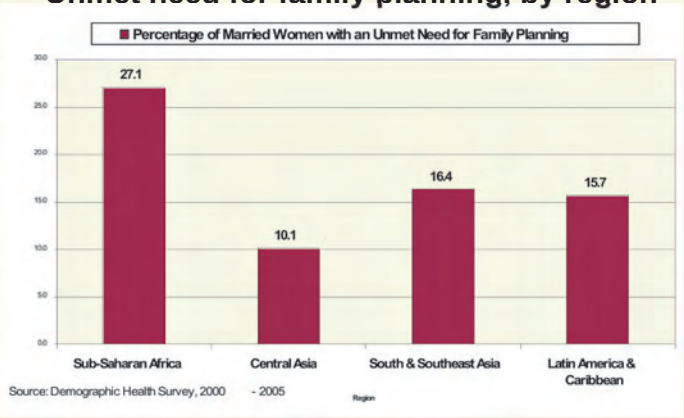
Countries with total fertility rates greater than 5.5 in year 2000

The majority of these countries are in Sub-Saharan Africa



Sub-Saharan Africa has greatest unmet need for family planning

Unmet need for family planning, by region



World Bank's priorities

- The World Bank Group's mission is to alleviate poverty through economic growth and addressing inequities
- In the health sector, this means:
  - Improving health outcomes for poor and vulnerable groups
  - Making health systems more effective
  - Improving financial protection

Bank's comparative advantages

- Given the technical expertise of other agencies (*e.g.,* UNFPA, WHO), the Bank's focus is on:
  - A macro-economic and fiscal context
  - Multisectoral orientation
  - Financial resources targeted to address key priorities
  - Convening power with various partners
  - Economic research to inform operations and government policies

Current Bank products

- Importance of population and demography issues is reflected in current World Bank products:
  - **World Development Report 2007: Development and the Next Generation**
  - Population Sector Strategy Update for the health sector strategically outlines a plan to mainstream population and demography into overall health programs at the Bank

Demographic analysis of populations of the Bank's client countries

- High fertility countries with low socio-economic indicators
- Others have reduced fertility rates, but are experiencing population momentum
- Many countries have vast inequities and weak institutions
- A small, but growing number have shrinking population sizes and low fertility (*e.g.,* Russia, Poland, Ukraine)

World Bank programs that address client countries' needs (1)

- The Bank's work program consists of strategies tailored to demographic trends in countries:
  - **Client countries with high fertility rates**
    - Analytical work serves to underpin policy dialogue to develop a focused national strategy to urgently address demographic issues
    - *E.g.,* population strategy for Ethiopia and similar work planned for Mali and Niger

World Bank programs that address client countrie's needs (2)

- **Clients with reduced fertility rates and population momentum**
  - Address inequities
  - Strengthen policies and programs
  - Multisectoral approach (*e.g.,* importance of secondary education and labor)
  - *E.g.,* India's Reproductive and Child Health Project reflects the Bank's continued engagement on reproductive health issues, beyond fertility reduction

World Bank programs that address client countries' needs (3)

- **Clients with ageing populations and low fertility**
  - Develop social pension and financial protection plans
  - Strengthen health systems to respond to non-communicable disease burden
  - Engage with other partners on reach and analytical work to understand better:
    - Dynamics of sustained low fertility
    - Other emerging issues, such as migration and its affects on economic development

Poverty Reduction Strategy Papers

- PRSPs have been useful in keeping population on countrie's poverty and development agenda
- Recent analysis indicates that a significant number of PRSPs discuss population and reproductive health issues
- However, much remains to be done to link this discussion to policy actions and indicators to measure results
- Overall, we have made some progress in utilizing mechanisms like the MDGs and PRSPs but much more needs to be done to capitalize on these opportunities. We are working on it.

Conclusions

- Demographic trends have a large impact on economic development.
- Whether this impact is negative or positive depends largely on the demographic trend itself as well as sound policies and programs.
- Even potentially positive demographic trends such as the “demographic dividend”, require capacity and resources to take advantage of the “window of opportunity”.
- The World Bank is committed to tailoring analysis and programs to client countries’ various demographic needs and challenges.

Case Study Kenya

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I. Country Profile

Kenya is situated in the eastern part of the African continent. The country lies between five degrees north and five degrees south latitude and between 24 and 31 degrees east longitude. It is almost bisected by the equator. Tanzania borders it to the south, Uganda to the west, Ethiopia and Sudan to the north, Somalia to the northeast, and the Indian Ocean to the southeast. The coastline and the port in Mombasa enable the country to trade easily with other countries.

The country is divided into eight provinces and 72 districts. It has a total area of 582,646 square kilometers of which 571,466 square kilometers form the land area. Approximately 80 per cent of the land area of the country is arid or semiarid, and only 20 per cent is arable. The country has diverse physical features, including the Great Rift Valley, which runs from north to south; Mount Kenya, the second highest mountain in Africa; Lake Victoria, the largest freshwater lake on the continent; Lake Nakuru, a major tourist attraction because of its flamingos; Lake Magadi, famous for its soda ash; and a number of rivers, including Tana, Athi, Yala, Nzoia, and Mara.

The country falls into two regions: lowlands, including coastal and Lake Basin lowlands, and highlands,

which extend on both sides of the Great Rift Valley. Rainfall and temperatures are influenced by altitude and proximity to lakes or the ocean. There are four seasons in a year: a dry period from January to March, the long rainy season from March to May, followed by a long dry spell from May to October, and then the short rains between October and December.

Population pattern and trend

According to the 1999 census, the total population of Kenya was estimated at 28.7 million with the following population age group proportions: under five years, 15.8 per cent; under 15 years, 44 per cent, 15-64 years, 52 per cent; and over 64 years, four per cent. Of the total population, 34 per cent live in urban areas. The urban population has increased from 3.8 million in 1989 to 9.9 million in 1999 and is projected to grow to 16 million in 2005 (MoPND, 2002). Disparities in population growth rate per annum among provinces range from 1.7 per cent in Central Province to 9.5 per cent in North Eastern Province. Kenya's inter-censual population growth rate declined from 3.9 per cent per annum during 1969-79 to 2.5 per cent during 1989-2000.

Although the 1999 population figures showed an increase of 34 per cent over the 1989 population census, there was a significant decline in the intercensal growth rate as compared to the previous decade. The decline in population growth rate is associated with declining total fertility rate among women 15 – 49 years of age: 8.1 in 1977/78 and 4.7 in 1998.

However, the previously documented decline in fertility rates has been erased with surprising increases in fertility. The 2003 Kenya Demographic and Health Survey (KDHS) estimates show that fertility rate has increased to 5.0 from 4.7 reported in 1998 (Republic of Kenya, 2003). This shows that gains made through sustained family planning campaigns are currently giving way to unplanned parenthood. The desire to have more children, partly a response to HIV/AIDS pandemic, is taking centre stage among the adult population. This is despite increased knowledge and use of contraceptives.

Trends in demographic indicators for Kenya, 1948 -99

	1948	1962	1969	1979	1989	1999
Population (million)	5.4	8.6	10.9	16.1	21.4	27
Total fertility rate (per woman)	6.0	6.8	7.6	7.9	6.8	5.4
Crude Birth rate (per 1,000)	50	50	50	52	48	50
Crude death rate (per 1,000)	25	20	17	14	10	12
Population growth rate (per cent per year)	2.5	3.0	3.3	3.8	3.4	2.5
Infant mortality rate (per 1,000)	184	NA	118	104	66	74
Life expectancy (years)	35	44	49	54	57	54

Source: Censuses various, KDHS various

Morbidity and mortality

Compared with other countries in the region, the health status of Kenyans is not only below that of most sub-Saharan countries but has shown signs of stagnation in the last ten years (KDHS, 1993, 1998 and 2003). The life expectancy for instance, is on the decline, currently estimated to be about 48 years for females and 47 for males. This is expected to fall further due to the rising incidence of AIDS.

Overall, morbidity and mortality remain high in Kenya, particularly among women and children. The infant mortality rate (IMR) of 62 per 1,000 achieved in 1985 fell by 12 per cent to 74 per 1,000 in 1998, a short period when the reverse should have taken place. This fell further to 77 deaths per 1,000 in year 2003. Under-five mortality, which stood at 122 per 1,000 in 1998 has only improved by a small margin and currently stands at 115 per 1,000 in 2003. This indicates that one in every nine children die before his or her fifth birthday. The maternal mortality rate estimated to be 590 per 100,000 in 1998 has now gone down to 414 per 100,000. Abortion (which is illegal) accounts for up to 40 per cent of maternal deaths (KDHS 2003).

Migration and urbanization

People naturally move from environment, which are of low carrying capacity to those perceived to be potential and thus offering great opportunity for livelihood. The direction of internal migration has been from the high densely populated provinces of Central, Nyanza and Western and low potential land in Northern Eastern and Eastern province to Rift valley, Coast and Nairobi Provinces. In a period of ten years preceding 1989 population census in Rift valley increased by close to seven million due to migration.

Population movement to urban centres has made the number of urban centres to increase from 15 per cent in 1979 to 139 in 1989 and to about 249 in 1999. The rate of urbanization has increased from 15 per cent in 1979 to 18 and 19 per cent in 1989 and 1999 respectively. Urban population size increased from 2.3 million in 1979 to 3.9 million in 1989 reflecting a growth rate of 5.2 per cent per annum. The process of urbanization in Kenya is determined by rural-urban as well as the government policy to accelerate and create an enabling environment for growth of smaller urban centres. Rural migration is due to demand for arable and to some extent due to displacement of persons for various reasons.

The high population growth is also reflected in the rapid growth of urban areas with their attendants problems. The environmental conditions of most urban centres in Kenya are unsatisfactory and the magnitude of poverty is growing. The majority of the population lives in poor sanitary conditions with inadequate shelter.

Population and family planning policies and programs

Kenya was the first country in the sub-Saharan Africa to launch an official National Family Planning Programe in 1967. The Government of Kenya launched the National Population Policy for Sustainable Development (National Council for Population and Development, 2000) in year 2000. This policy paper builds on the strength of Sessional Paper No. 4 of 1984. The policy outlines ways of implementing the programe of action developed at the 1994 International Conference on Population and Development in Cairo. The implementation of this policy is being guided by the national and district plans of action formulated by the National Coordinating Agency for Population and Development (NCAPD).

The policy also addresses the issues of environment, gender, and poverty, as well as problems facing certain segments of the Kenyan population, such as adolescents and the youth. The goals and objectives include full integration of population concerns into the development process; motivating and encouraging Kenyans to adhere to responsible parenthood; empowerment of women; and integration of the youth, elderly, and persons with disabilities into mainstream and national development.

The overriding concern of the policy is the implementation of appropriate policies, strategies, and programs that will shape the population growth to fit the available national resources over time, in order to improve the well-being and quality of life of individuals, the family, and the nation as a whole. Current policies and strategies emphasis is on creation of awareness on impact of high population growth, promotion of activities which lead to lowering of fertility and integration of population concerns into development planning at all levels.

II. Impact of Demographic Dynamics on Specific Sectors in Kenya

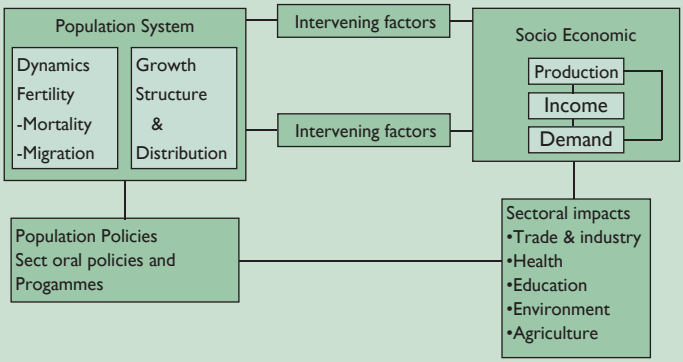
As indicated in the diagram (Figure I), population system is simplified to consist of two main sub-systems namely: population dynamics experiencing the interplay of fertility, mortality and migration; population size, growth, structure and distribution. The sub-system of population dynamics determines the population size, growth, structure and distribution.

The socio-economic as a system can be simplified to consist of three main sub-systems namely: production; income; and demand. The dynamic of the socio-economic system is such that demand leads to production, production in turn leads to income and income in turn leads to demand. The two sub-systems interlink through intervening factors which include population size and growth; population density; pre-school age population; school age population; labour force; rural urban distribution and the elderly population.

These intervening factors have implications on sectoral development in Kenya particularly in trade and industry, health, education, environment and agriculture.

Demographic dynamics and socio-economic development

Figure1. Schematic diagram representing population and socio-economic



Demographic dynamics and trade and industry

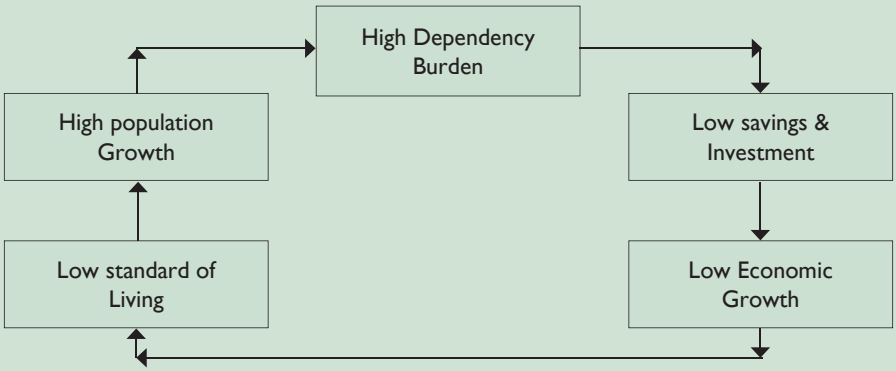
The high rate of population growth in Kenya has led to high dependency burden of 100:117 (ratio of persons who are in dependent status because of their age, too young or too old to work to persons eligible for productive work). This dependency burden reduces the levels of savings since at any given output per worker the greater the number of dependents causes rise in consumption resulting in a fall in the savings per capita.

As long as about 45 per cent of the population of the country is below the age of 15 years, that country would have to use almost all its resources in providing all the services including food, education, health. Hence, that country would not be able to invest in order to promote rapid economic growth. Consequently, economic development stagnates with deterioration in standard of living.

To substantiate this, the population development interrelationship exists in a form of what is described as the "Cycle of Rapid Population Growth". In this cycle, rapid population growth results in a high dependency burden, which in turn creates a situation of low savings and investments. Economic growth stagnates or slows downs and eventually standard of living of the population deteriorates.
This implies that very limited resources can be saved for further investments in trade and industry. This is further compounded by widespread poverty which is estimated at 56 per cent due to large family sizes among other factors.

Demographic Dynamics and Trade and Industry

Figure 2. Cycle of Rapid Population Growth



Demographic dynamics and health

The objective of Kenya's health policy includes the reduction of morbidity and mortality, reduction of fertility through provision of health services. However population growth continues to pose a major challenge to the health sector. This has led to an overburdened health sector. Achievement of good health for the population is critical in enhancing human development. Rapid population growth, fuelled by both in-migration and natural population increase due to high fertility rates, is outstripping capacity to provide health care services. Young women are increasingly migrating from rural to urban areas, seeking among other things for better health care, and increasing the pressure on reproductive health services in particular.

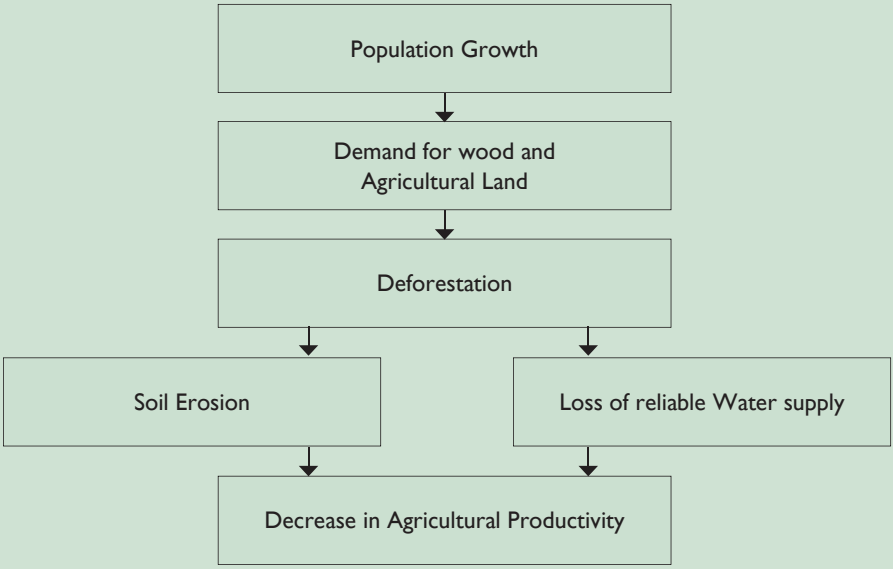
Although in Kenya the allocation to the health sector has increased from seven per cent of the total national budget for health services in 2003/04 to 8.4 per cent in 2005/06, rapid population growth has caused the per capita government expenditure on health to remain low at 6.5$ in 2003/04 and 7.5 $ in 2004/05. This is still below the 33 $ per capital expenditures recommended by World Health Organization. As a share of GDP, expenditure on health remained at about 1.41 and 1.55 per cent between 2002/03 and 2004/05.

Demographic dynamics and the environment

The impact of population growth on environment can be illustrated by the following model: Technology currently used does not allow sustainable exploitation of the resources. Instead, they continue to cause environmental degradation which includes

soil erosion; pollution from excessive use of fertilizers and pesticides; deteriorating soil conditions; surface and ground water pollution; deforestation; loss of indigenous plants and animal species; and destruction of water catchments areas (see figure below for illustration).

Figure 3. Interrelationships between population dynamics and the environment



Population pressure due to increasing population size has caused serious injury to the environment especially in low dry marginal lands where poor farming techniques are used. Squatter migrants to various parts in Kenya are promoting land degradation by destroying forests and using inappropriate farming methods in the marginal areas.

Moreover, the concentration of population has depleted valuable water catchments thus upsetting the equilibrium between land use and land capacity in many parts of Kenya particularly in Rift Valley and Mount Kenya regions. Environmental degradation in terms of deforestation, invasion of Semi-Arid areas and soil erosion have compounded the problem in the agriculture sector due to reduction soil fertility and rain. Rapid urbanization due to increasing population creates overcrowding, development of informal settlements, inadequate water supply and sanitation, poor wastes disposal crime and violence.

Demographic dynamics and agriculture

The increasing population size in Kenya has led to scarcity of agricultural land since 80 per cent of the country's total land surface which support only 25 per cent of the total population is arid and semi arid.

During the 1982-1992 period for example, the average size of the land holdings in the rural areas declined from 2.0 hectares to 1.6 hectares due to population pressure in those areas. Rapid growth has outstripped increases in food production, and population pressure has led to the overuse of arable land and its destruction.

Demographic dynamics and education

High fertility in Kenya has led to an increase in school age population. This implies that if standards have to be improved quantitatively and qualitatively more national savings have to be generated or curtail investments in other sectors for example in power and transport.

Reduced allocation in education with the introduction of free primary education in Kenya has resulted in the reduction of the quality of education in the country. Moreover, the increasing population size has increased demand for education while the capacities of the central government, urban and rural authorities to provide education services have been exceeded.

III. Measures Being Taken By Government

Achieving Millennium Development Goals (MDGs) in Kenya

Kenya subscribed to the Millennium Declaration with a strong conviction that the future of our societies will be more promising if strong partnerships are built around mobilizing resources and instituting policy measures to implement the MDGs. Nationally, regionally and globally, efforts are being made to provide an MDGs-friendly policy framework because nations have realized that the MDGs are too important to be allowed to fail anywhere in the world.

Evidence arising from the Needs Assessment Study in Kenya indicates that Kenya has great potential to meet these goals. Significant progress has been made towards achieving MDG goal 2 (Achieve Universal Primary Education) and 6 (Combat HIV/AIDS, Malaria and other Diseases). As for the rest of the goals, the government will need to scale-up efforts in order to implement the goals beyond the current pace. This means that the government will have to meet a number of challenges by 2015 before realizing these goals. These challenges vary from goal to goal and range from policy and institutional reforms to increased funding towards the goals.

With the current government's commitment to the course of pursuing MDGs-based development agenda, and with the implementation of innovative measures to address MDGs at all levels, for example through such funds as Local Authority Transfer Funds (LATF), Constituency Development Fund (CDF) and other constituency-based funds and the emerging fiscal discipline, there is all the hope that if this is sustained, the government will meet most, if not all, of these goals by 2015.

The National Coordinating Agency for Population and Development (NCAPD) was recently re-launched to respond quickly in addressing declining demographic and health indicators, which would translate into improved welfare of the people. NCAPD draws its mandate from the Sessional Paper No. 1 of 2000, which incorporates principles from the Programe of Action that was adopted at the Cairo International Conference on Population and Development (ICPD) in 1994. The national population policy addresses various concerns that determine the wellbeing of the people. Like any other government policy, population policy seeks to influence social, economic and political behavior in certain ways for the benefit of all Kenyans.

Kenya's population policy is anchored on the premise of human development; hence the goal is to achieve a balanced population growth that is propelled by smaller, healthy families. This will be achieved through voluntary family planning, ensuring all mothers deliver at health facilities to minimize chances of death to mother and child and that youth and people with disabilities access reproductive health and information services. Population policy is categorical that abortion will not be allowed as a contraceptive method. Unless two Doctors share opinion life of mother in danger.

The principle role of NCAPD is to aggregate efforts by various players into national achievement by catalyzing actions to improve the quality of life of Kenyans – where these actions may be by other government agencies, communities, Faith Based Organizations, NGOs and development partners by providing the institutional set up for the implementation of the policy. This placement makes it imperative for the agency to create partnerships and various networks coalescing on different population issues – this is a multi-sectoral approach to population management.

The government of Kenya through the land settlement and irrigation schemes has helped to ease population pressure in high population density areas by influencing rural-rural migration.

Since 2003, the government of Kenya has been implementing free and universal primary education with a view to reducing the levels of poverty and creating an enabling environment for positive demographic behavior among the population.

The government of Kenya has developed a strategy for the decentralization of economic and social infrastructure from Nairobi and Mombasa to scheduled growth

centres. This strategy is aimed at curbing out migration from rural areas and re-directs migration streams to small towns.

To improve the health of all Kenyans the government of Kenya has initiated health sector reforms. These reforms are expected to have positive influence on demographic and health indicators in Kenya.

Slum upgrading programs have been initiated in Nairobi and other major towns in Kenya to improve sanitation and reduce environmental pollution in the informal settlement in the country. This is being done alongside the provision of low cost housing with a view to improving the living standard of the Kenyan people.

To reduce economic disequilibrium between the rural and urban areas and make rural areas more attractive for investments, the government of Kenya has established social action funds (Constituency Development Funds, LATF, Fuel Levy e.t.c).

Priorities for actions

- Advocate for positive population issues

The government of Kenya through the National Co-ordinating Agency for Population and Development should sustain the already initiated high policy advocacy via the Parliamentary Network on Population and Development directed to policy makers, planners and programe managers to ensure directed action for maximum impact on population issues in the country.

This should be done by ensuring that population concerns are taken into account when planning and implementing development projects and programs. Consequently, this is expected to ensure socio-economic development catalyzes improvement of key demographic and health indicators in Kenya

- Improvement of the economic well-being of all Kenyans

The government of Kenya recognizes that in a situation of high unemployment, a high population growth rate has adverse economic effects such as low income per capita, lack of resources for investment, high dependency ratios and low productivity.

The government should therefore put in place mechanisms to ensure sustained utilization of the social action funds such as Constituency Development funds, Local Authority Transfer Funds among others in order to create and sustain higher GDP than population growth rate while encouraging people to freely choose having the number of children they can adequately provide for.

There is a need to promote and sustain the current initiatives of National Coordinating Agency for Population and Development together with its key

collaborators which include Central Bureau of Statistics, Ministry of Health and several development partners to generate evidence through research analyses and repackages policy briefs.

This is expected to inform policy and programs and convince individuals and community to take appropriate action to improve individual welfare and not merely seeking to achieve demographic targets.

The existing initiatives already established by the government of Kenya on gender issues need to be promoted further and sustained through the establishment of mechanisms that would ensure equal participation and representation of men and women at all levels in decision-making including planning and implementation of population programs.

This should be carried out through advocacy at policy and community levels for non-discrimination on basis of gender or age. The Policy recognizes that advancing gender equity and equality, empowerment of women, elimination of all forms of violence against women and the ability to control their own fertility are cornerstones of population and development programs. When societies invest less in girls and underestimate the economic contribution of women and when few women are in decision-making positions, it should be no surprise that maternal mortality increases. The situation is even worse in resource-poor settings since saving the lives of mothers is given low priority.

- Repositioning Family Planning and Reproductive Health

In a nutshell the population programe in Kenya seeks to achieve a balanced population growth propelled by smaller, healthy families. This could be achieved through voluntary family planning, ensuring all mothers deliver at health facilities and that youth and people with disabilities access reproductive health and information services.

- Reproductive Health Output Based Approach Project (RH-OBA)

The RH-OBA Project aims to bring the quality reproductive health services to those who can least afford them.

The Reproductive Health Output Based Approach Project is a joint venture between the Governments of Kenya and the Federal Republic of Germany that will be implemented on a pilot basis over duration of three years in three rural districts and two urban slums in Kenya. The rural districts identified for the project are Kisumu, Kiambu, and Kitui while the urban slums that will participate in the project are Korogocho and Viwandani. The total population of the project sites is about three million people.

The main objective of this project is to provide quality health care services for economically disadvantaged sections of the population in the pilot sites through a voucher system. Economically disadvantaged people will be able to access safe motherhood, family planning, and gender violence recovery services from qualified and approved service providers by purchasing vouchers at a low cost and presenting the same to the facilities of their choice. Once a facility provides a service to the holder of a voucher, the facility will be entitled to a payment from the project for the service offered.

The RH-OBA Project is very important because it is expected to contribute to a reduction of both the maternal and infant mortality rates that currently stand at 414 per 100,000 live births and 77 per 1,000 live births respectively. In addition, the lessons that will be learnt from the project are expected to contribute towards the finalization and implementation of the National Social Health Insurance Scheme.

The Voucher scheme has improved access by the poor to quality reproductive health services. This is demonstrated by the high number of poor women going for safe motherhood services in the accredited facilities. Clients empowered by the vouchers are going for services providers known for quality service provision. Competition between the accredited facilities has stimulated an improvement in the quality of service provision in a bid to attract voucher clients. Family planning vouchers are moving much slower than was anticipated during the project design.

Institutionalize children and youth concerns in all sectors

There is a need for the government of Kenya to ensure that children and youth concerns are institutionalized in all sectors in order to prepare them for adulthood. The newly created ministry of Youth Development should ensure that population, reproductive health and development issues are fully integrated in their development frameworks in order to encourage.

Case Study Uganda

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Uganda's High Population Growth Rate: A Challenge to Poverty Eradication

Over the past 10 years, Uganda experienced an unprecedented increase in its rate of population growth. At an average population growth rate of 3.4 per cent per annum between 1991 and 2002, Uganda has become one of the fastest growing countries in the world. By implication, the current total fertility rate is the second highest in Sub-Saharan Africa, and the third highest in the world.

Empirical studies have typically found important linkages between population growth and economic development. Moreover, a debate has raged over population growth and its links with development. The Uganda Participatory Poverty Assessment (UPPAP, 2002) identified "large families as a cause of poverty", and it linked large families to limited access to land or asset shortages. It is our growing concern that high fertility rates and fast population growth are threatening to wipe out the benefits from improved social spending that Uganda has enjoyed over the last decade.

Both theory and evidence clearly show that there are significant payoffs to Uganda if its fertility rate is reduced and population growth consequently