A SAVOIR
09

How Can We Capitalize on the Demographic Dividend?

Demographics at the Heart of Development Pathways
Synthesis of studies conducted in WAEMU countries
and in Ghana, Guinea, Mauritania and Nigeria.

Jean-Pierre GUENGANT
Emeritus Research Director, IRD

with the collaboration of Yarri KAMARA, Economist at ICI
All studies coordinated by ICI - Initiatives Conseil International - Burkina Faso

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About *À Savoir*

The A Savoir *collection was created in 2010 by AFD's Research Department and gathers either literature reviews or existing knowledge on issues that present an operational interest.*

Publications in this collection contain contributions based on research and feedback from researchers and field operators from AFD or its partners and are designed to be working tools. They target a public of professionals that are either specialists on the topic or the geographical area concerned.

All our publications are available at http://recherche.afd.fr

[Acknowledgements]

[Foreword]

Foreword

Contrary to popular belief, the demographic future of sub-Saharan Africa has not been written. According to the 2010 population projections from the United Nations Population Division published in May 2011 (United Nations, 2011), the population of sub-Saharan Africa, estimated at 860 million in 2010, may be somewhere between 1.7 and 2.2 billion by 2050, depending on whether the fertility rate of 5 children per woman in 2010 declines to 2.4 or 3.4 in 2050. However, these assumptions imply a yearly increase in contraceptive use by 1 to 1.5 percentage points each year for the next 15 to 20 years. But in West and Central Africa, which account for more than half the population of sub-Saharan Africa, annual growth over the past 20 years has been only 0.3 points and 0.2 points per year respectively.

The social, economic and political stakes associated with the different demographic paths that can be modeled from proper analysis of the available data are enormous. In a nutshell, it comes down to the capacity of a country to satisfy the basic needs of its population in terms of health and education. It is also a question of whether it is possible or not for African agrarian systems to reduce the food and nutrition insecurity that affects many countries, both in urban and rural settings. And finally, it is a matter of the ability of the state and local authorities to create and implement effective policies that target sustainable development (protect the environment, prevent conflicts, assure the safety of goods and persons, provide for and manage a growing number of urban settings of various sizes and support the emergence of dynamic urban economies).

To provide a clearer overview of the situation in each of the WAEMU countries, a series of 12 country analyses were prepared for the conference "Population, Development, and Family Planning in Francophone West Africa: The Urgency for Action" (Ouagadougou, February 8-11, 2011), organized jointly by the French Ministry of Foreign and European Affairs, USAID, AFD, The Gates Foundation and The Hewlett Foundation, with the support of the French NGO Equilibres et Populations. These analyses should be seen as a contribution to deliberations that are ongoing in each country, and to the development of policies and programs that will reinforce and accelerate economic growth and reduce poverty. This document is a synthesis of these country analyses.[1]

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[1] A non-final version of this regional summary was published by AFD for the conference.

Several timeframes were used in preparing these contributions. Firstly, whenever possible, the goal was to reconstruct using several indicators the economic and social demographic trends since 1960, the year of independence for most of the countries in this subregion. The results allowed us to measure the extent of efforts made by each country, especially in the areas of education and health, two essential elements of human capital. But these analyses also allowed us to better grasp the level of effort that is still needed. In addition, population projections were prepared using different assumptions for the period 2010-2050. The results for the 2050 timeframe are only intended to outline the range of possible futures within a 40-year term (the "relatively distant future"), and to spark a debate on the subject. But the results for 2020 and 2030 (the "near future"), reveal trends that are both serious and cannot be ignored, and to which we must adapt; they also reveal potential margins of change for influencing population dynamics and more or less satisfying the needs of these populations, especially in terms of health and education. The analysis of various policies and several programs (public and private), both in the past or in progress, completes this picture and aims at maximizing their impact.

Various sources were used to prepare these analyses. They include data published by national institutions, in particular statistics offices or their equivalent, and data available in international databases. Whenever possible, preference was given to national data, particularly to those available on statistical office websites. References from international databases used are provided in each report: the most commonly used are from the United Nations Population Division, the World Bank and Measure DHS (for demographic and health surveys). These references are included in the bibliography. For strategies, policies, plans and programs dealing with population, health, reproductive health, poverty reduction and other sector-focused policies (education, food security, provision of drinking water, access to sanitation systems, land use planning and other sectors), original documents produced by ministries and other official national services were used. Depending on their availability, these documents have been obtained directly from these services or from their websites. Likewise, documents relating to international and private partners who are active in population and reproductive health were either provided by national consultants or were downloaded from their websites. Exact sources and references are also provided for these documents.

In order to not clutter these contributions, we have attempted to limit ourselves to the most recent documents. However, every recent document available on population, health, reproductive health, etc., has not necessarily been cited. In addition, certain areas that bear some relationship to population, such as the

environment, were not dealt with. We apologize for these limitations, but it was challenging to claim to be exhaustive in an area as complex as the relationship between population growth and development. Finally, in most cases, the data and documents used were those available during the third quarter of 2010. For some countries and for some subjects covered, publication of new data and/or the adoption of new strategies, policies, plans or programs after the countries reports were finalized might have an effect on the analyses, commentaries and interpretations of those sections that were based on data and documents that may not have been the most recent at the end of 2010. We hope readers will excuse us for this constraint, which is usual for this type of work.

The purpose of this synthesis is to put the primary results and issues identified in these country analyses into perspective, looking ahead as far as 2030. We focused on both the similarities and differences between countries in terms of their initial conditions and possible future developments. Although the data and documents used are the same as those used to prepare the 12 country analyses, this synthesis is not a summary. Readers interested in a particular country or countries or a given theme should refer to the country-specific analyses.[2]

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[2] The twelve country monographs (Benin, Burkina Faso, Côte d'Ivoire, Ghana, Guinea, Guinea-Bissau, Mali, Mauritania, Niger, Nigeria, Senegal and Togo) can be downloaded from the AFD website at http://recherche.afd.fr and from the IRD at http://www.ird.fr/la-mediatheque/archives-et-bases-de-donnees/dossiers

Contents

Summary

West African countries, such as Burkina Faso, Mali and Ghana, have experienced a renewal of the economic growth of the mid-1990s, with rates of 4 to 6% per year. However, due to the high rate of population growth, this economic growth remains insufficient to meet the health and education needs of the population, improve food and nutrition security and reduce poverty, which still affects between one and two thirds of their inhabitants. West African countries will not emerge economically unless they seize a "demographic window of opportunity" by reducing their fertility, as countries now considered emerging did in the 1970s.

With strong population growth, the large numbers of young people entering West African labor markets (from six million in 2010 to nearly 10 million in 2030) may be disastrous if growth and jobs are not coordinated. But it can become an advantage if the number of dependents (children and the elderly) per worker (aged 15 to 64 years) is reduced through a decline in fertility. With a decline of this ratio, also called the "dependency ratio", the working population will be able to decrease their spending on children (their primary expense) and devote a larger share of their income to savings and productive investment. In turn, this will help stimulate economic growth.

Reducing fertility to accelerate demographic transition and reduce the dependency ratio is an essential process for sustainable economic growth. Between 1970 and 2000, most of the developing regions, such as East and Southeast Asia where demographic transition was quick, benefited from this "demographic dividend". Most regions, but not sub-Saharan Africa, precisely because the birth rate remained high, averaged more than five children per woman. In West Africa today, the ratio is still close to one unemployed person for every employed person, or a dependency ratio of nearly 100%. By allocating an average of 3 to 5 times more resources to family planning than they do currently, countries in the region could halve this ratio within 20 years, and reach dependency levels close to those observed in emerging countries today.

Until now, financial and human resources allocated to controlling population have been lacking in Africa. Faced with major public health problems, the policies, plans, programs and strategies implemented over the past 20 years have had to focus on prevention and caring for people with HIV/AIDS, as well as on managing pregnancies, deliveries and obstetric and neonatal emergencies. In parallel with these interventions, access to family planning services and the promotion of contraceptive use have not

been sufficiently encouraged. Today, only 10 to 20% of West African women in union use contraceptives. Yet, the demand for family planning is quite high: between 30% and 60% of these women desire access to contraceptives..

Development does not depend solely on controlling the birth rate, but accelerating the demographic transition through increased contraceptive use (which responds to the needs expressed by women) is one of the major levers that would help West Africa meet the social and economic challenges it faces now and in the future. We would do well to remember that almost half of the strong economic growth in East and Southeast Asia between 1970 and 2000 can be attributed to demographic changes brought about by governments. Like the latter, West African countries should multiply the resources allocated to family planning by 3 to 5 times over the next 10 years to stabilize the number of births by 2030 and be able to capitalize on the demographic dividend.

Introduction

Economic growth has returned to Africa. Many countries in West Africa and WAEMU (West African Economic and Monetary Union) have reported significant economic growth since the mid-1990s. This has restored them back to life, with an increase in their per capita GDP after decades of stagnation or even decline. Consequently, many governments of the 12 countries[3] analyzed in this synthesis now articulate a desire to become emerging countries.[4] This legitimate goal should enable them to accelerate the reduction of poverty that still affects between 30% and 60% of their populations. It should also help them meet some of the challenges they face, particularly high rates of population growth resulting from some of the highest fertility levels in the world.

The sharp increase in this area raises a number of questions for the subregion. Will the renewed economic development and growth of these countries automatically lead to a decline in fertility and, as a result, a relaxation of demographic constraints? Is betting on continuing strong economic growth realistic?

Until recently, existing econometric studies maintained that the relationship between economic growth and population growth was very weak. However, a basic demographic variable seems to have been ignored: age structure. Newer analyses have recently demonstrated the importance of modifying age structures to accelerate economic growth in emerging countries, particularly in Eastern Asia. A significant increase in productive investment, which is an engine of strong sustained growth, was possible in these countries because the number of dependents per worker had been reduced. This reduction in the dependency ratio was made possible by a rapid decline in fertility. It was accelerating the demographic transition (a decline in mortality combined with a decline in fertility) that provided these emerging countries with an

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[3] This study focuses on eight WAEMU countries, namely Benin, Burkina Faso, Côte d'Ivoire, Guinea Bissau, Mali, Niger, Senegal and Togo, as well as Ghana, Guinea, Mauritania and Nigeria.

[4] Emerging countries, once called "developing" or "underdeveloped", are characterized by a per capita GDP lower than in developed countries, rapid economic growth and living standards and economic structures approaching those of developed countries Among these countries, in Africa we can count Egypt, Mauritius, Morocco, South Africa and Tunisia; China, India, Indonesia, Malaysia, Singapore, South Korea, Thailand and Turkey in Asia and Brazil and Mexico in Latin America. The list of emerging countries varies depending on sources and authors. For example, Singapore and South Korea are often no longer considered emerging but developed countries.

opportunity to enter the "demographic window of opportunity" and to capitalize on the "demographic dividend".

So, is the concept of a demographic dividend relevant for countries in the West African subregion? Can they hope to reinforce and accelerate economic growth through an age structure that is more favorable to development? Is it possible to reduce their mortality and fertility levels rapidly to access the window of opportunity that would accompany their demographic transition, and allow them to capitalize on the demographic dividend in the same way as emerging countries?

This regional synthesis attempts to answer these questions by examining the relationships between population and development, the role of policies implemented and the feasibility of accelerating the demographic transition in the 12 countries studied. We will also cover:

- The challenge of economic growth;
- The benefits associated with rapid demographic transitions;
- The importance attached to population concerns in development policies and the sectoral policies of the countries;
- Finally, the feasibility of accelerating the decline in fertility, which is indispensible for quick entry into the demographic window of opportunity.

We will conclude with comments about the obstacles that, up until now, have prevented population policies from achieving their objectives, and with observations about the issues associated with a faster demographic transition and with several recommendations.

1. The Challenge of Economic Growth in West African and WAEMU Countries

1.1. From low growth to renewed growth

Over the last 50 years, the countries of West Africa have seen modest economic growth, but too low to allow for any substantial increase in per capita income levels. Many countries in the region have even experienced levels of economic growth that are insufficient to offset the weight of population growth, resulting in deterioration in living standards.[5] Various factors explain the disappointing performance, including the adoption of inappropriate economic policies, structural adjustment programs with significant consequences, erratic and unfavorable prices for products exported to international markets or political turbulence. In this context, the best performance reported by the 12 countries studied is that of Burkina Faso, whose real GDP increased by a factor of seven from 1960–2008, and the real per capita GDP doubled (Graph 1).

During the same time period, many emerging countries (Egypt, India, Indonesia, Tunisia and Turkey) saw their real GDP increase at least 10-fold, and several Asian countries (China, Malaysia, Singapore, South Korea and Thailand) saw an increase by a factor of 20 to 40.[6]

In comparison, the growth of per capita GDP for countries in the West African subregion remained moderate. Expressed in "PPP dollars" (Purchasing Power Parity) or "International dollars", the 2008 GDP ranged between 2100 PPP dollars for Nigeria,

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[5]   The data used are from the World Development Indicators database from the World Bank, available on the completion of the 12 studies, or between mid-2010 and early 2011 (World Bank, 2010a), which used national data, data compiled by the World Bank and data from other databases (UNESCO, UNICEF, WHO, FAO, OECD, etc.).

[6]   These impressive growth rates, associated with levels of population growth reduced by half, started an increase of between 4 and 14 times the per capita GDP of these countries between 1960 and 2008 (20 times in China) and a sharp reduction in poverty levels.

Graph 1 *Growth of real per capita GDP, from 1960 to 2008 (in constant US$ in 2000)*

Source: World Bank, 2010a.

Graph 2 *Per capita GDP (in PPP dollars) in 2008*
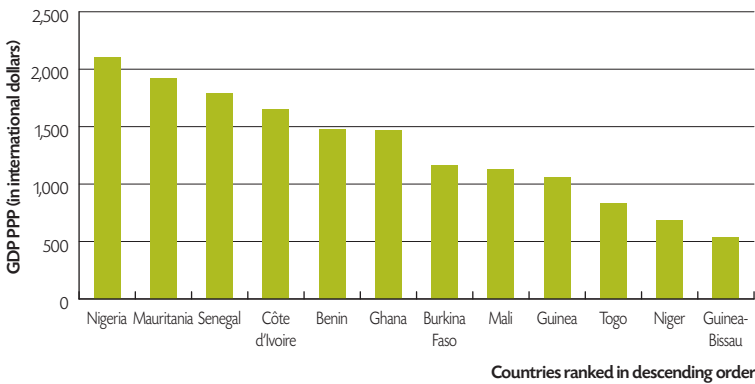
Source: World Bank, 2010a.

700 for Niger and 540 for Guinea-Bissau (Graph 2). The per capita GDP PPP for Nigeria, the highest of the 12 countries studied,[7] was only 15% to 20% of the per capita GDP estimated for Brazil, Malaysia, Mauritius and South Africa. In WAEMU in 2008, the highest per capita GDP (expressed in CFA francs), were those for Côte d'Ivoire and Senegal and the lowest was for Guinea-Bissau (Table 1).

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[7] The highest per capita GDP of the subregion in 2008 was for Cape Verde with 3,200 PPP dollars.

Table 1 *Per capita GDP (in CFA francs) in 2008 (WAEMU countries)*

Country	Rounded figures	In Euros
Côte d'Ivoire	510,000	€776
Senegal	490,000	€741
Bénin	345,000	€526
Mali	310,000	€469
Burkina Faso	235,000	€356
Togo	200,000	€306
Niger	165,000	€248
Guinée-Bissau	130,000	€199

Source: World Bank, 2010a.

The renewed and accelerated economic growth in the 1990s has been attributed to several factors, especially:

- improved macroeconomic and fiscal frameworks in most countries, positive "delayed" consequences from structural adjustment plans;
- price increases for products exported by countries, raw materials (oil, uranium, gold, iron ore, phosphates and bauxite, etc.) and agricultural products (cocoa and coffee, etc.);
- an end to the debt crisis; and
- stability and political normality, in some countries (Severino and Ray, 2010).

1.2. Variable economic growth

Average annual economic growth rates for the entire period 1995 to 2009 were very unbalanced. They varied as follows (in descending order):

- From 5% to 6% for Burkina Faso (5.8%), Mali (5.4%) and Ghana (5%);
- From 4% to 5% for Nigeria (4.8%), Benin (4.5%), Senegal and Mauritania (4%);
- From 3% to 4% for Niger (3.7%), Togo (3.5%) and Guinea (3.4%);
- And less than 3% for Côte d'Ivoire (2.1%) and Guinea-Bissau (1%).

At the same time, strong population growth in the area (between 2% and 3.5% per year) slowed the increase in per capita GDP over the entire period. In four countries, Burkina Faso, Ghana, Mali and Nigeria, the average per capita GDP increase was between 2% and 3% per year. In the other countries, it was between 1% and less than 1% per year.[8]

Moreover, the average five-year rates of economic growth for the three periods 1995–1999, 2000–2004 and 2005–2009 indicate that the renewed growth since the mid-1990s is still not regular (Graph 3). Among the seven countries that reported average growth exceeding 4% per year between 1995 and 2009, only Ghana had increases from one period to the next. Benin, Burkina Faso, Mali and Senegal experienced declines in growth rates between 1995–1999 and 2005–2009.

Graph 3 *Average annual economic growth rates (1995–2009)*
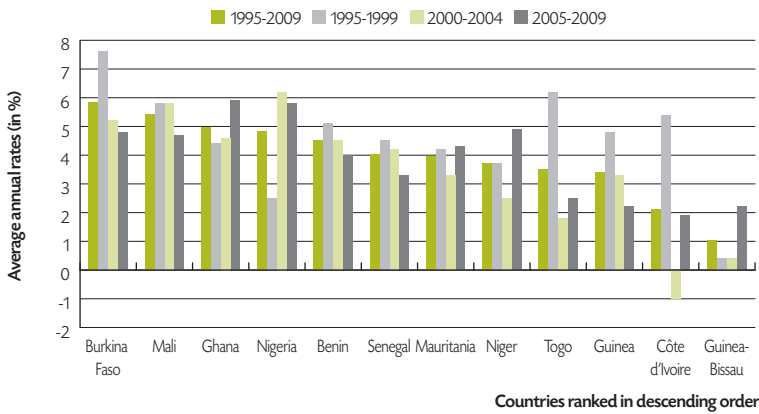
Source: World Bank 2010a and b.

In the late 2000s, the slowdown in economic growth in many countries' economies can be attributed to the impact of the global economic crisis. This factor, which certainly came into play, also contributed to the difficult political crises and transitions in the area.

[8] The increase was approximately 1% per year in four countries, Benin, Guinea, Mauritania and Senegal, 0.6% per year in Togo, close to zero in Niger, and negative in Côte d'Ivoire and Guinea-Bissau.

However, there are good reasons for thinking today that the significant economic growth from 4 to 6% per year observed in recent years and in most of the 12 countries studied will continue and increase, especially due to the upward trend in price increases for raw materials and agricultural products. Other factors may work in favor of this economic growth, including investments and gains in productivity, improved macroeconomic and budgetary frameworks, institutions strengthened by improved governance, an economic climate more conducive to investor confidence, the urbanization and densification of rural areas and the influx of better educated young people on labor markets.

At the same time, certain phenomena may put the brakes on accelerating economic growth. Indeed, economies of the subregion's countries remain vulnerable to internal and external forces, and their irregular growth depends on a few products, their global price variations and weather conditions. In recent years, growth has also depended on revenues from extractive industries (oil, uranium, etc.) that create few jobs and are disconnected from social issues related to access to employment for significant numbers of young people.[9] The inability of the modern sector to create a sufficient number of jobs over the past 30 years has led to a strong "informality", social destabilization and has weakened the economies of countries in the subregion. The informal sector's contribution to the GDP of several countries in Francophone West Africa has reached major proportions (in 1999/2000, this sector contributed 70% to the GDP of Benin, Niger and Togo, 60% of Mali's GDP, 50% of the GDP for Burkina Faso and Senegal and 44% to Côte d'Ivoire's GDP).[10] Moreover, on average, agriculture still employs more than half of the working population of West Africa. In its 2007–2008 report on West Africa, the OECD concluded that the informal sector has, since 1980, become "*the primary source of urban employment and this will probably remain the case in the future, although modern businesses as a whole represent 80% of non-agricultural added value.*" (OECD, 2008). This is significant because the majority of the population in most countries will probably be living in urban areas in the next 20 years.

In this context, the question arises as to whether the anticipated strong economic growth in coming years will actually allow for rapid increases in per capita GDP of countries in the sub region.

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[9] Between 2010 and 2030, there will be between 50% and 100% more arrivals on the labor market of different countries in sub-Saharan Africa. The total of these arrivals is expected to increase from 17 million in 2010 to 27 million in 2030 for all countries (Beaujeu *et al*., 2011).

[10] OECD, 2008.

1.3. Economic and population growth: are they related?

It is difficult to know what the growth rates of various economies in the subregion will be in the next 10, 20 or 30 years. To enable poverty reduction, we generally assume that an economic growth of at least 7% per year is needed. As we have just seen, this rate has never been achieved in the region in the last 15 years. Nevertheless, positive factors that indicate good economic prospects led most countries to retain an economic growth rate of 7% per year in their most recent Poverty Reduction Strategy Papers (PRSP). Mauritania[11] and Burkina Faso[12] go so far as to target 10% growth.

Can these targets accelerate the increase of per capita income and reduce poverty in the subregion if the current strong population growth is maintained? We have tried to answer this question by combining several assumptions of constant GDP growth rates (10%, 7%, 5% and 4%), and population growth (3%, 2.5% and 2%). The results give us a rough estimate of the mechanical effect of the interaction between these rates, in terms of number of years required to double per capita GDP, using different combinations of assumptions (Graph 4).

Graph 4 *Number of years required to double per capita GDP for different annual economic and population growth rates*
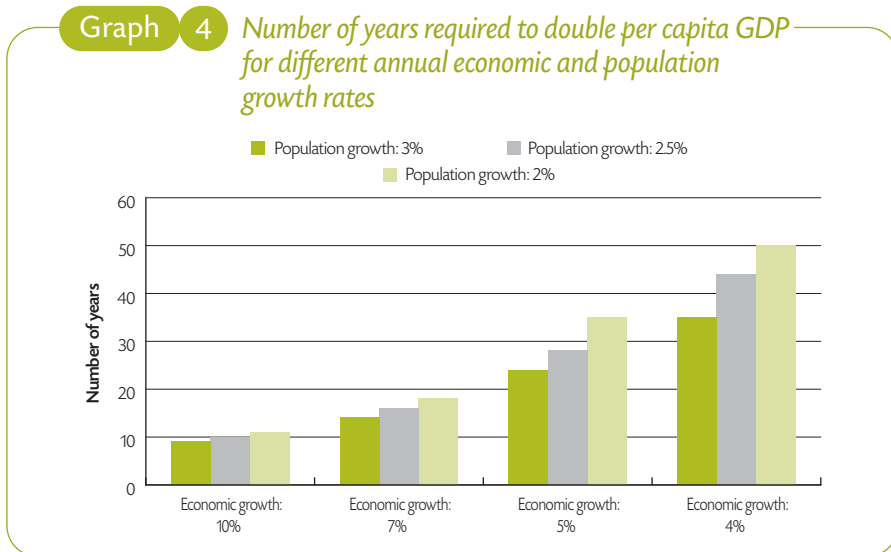
Source: Author's calculations.

[11] In Mauritania, the 2006-2010 PRSP targets economic growth of 10.7%, based on the assumption of very strong growth in the oil sector.

[12] In Burkina Faso, the Strategy for Accelerated Growth and Sustainable Development (SCADD) covering the period 2010-2015 aims to achieve an average growth rate of real GDP of 10% per year.

It is clear that very strong and sustained economic growth of 10% per year would make it possible to quickly double per capita GDP in a decade. If economic growth fell to 5% (which would be considered good performance), it would take 24 years to double per capita GDP with sustained population growth of 2% per year, but 35 years with sustained population growth of 3% per year. With economic growth of 4%, which would still be considered significant, it would take 35 or 50 years respectively to double per capita GDP with "medium" population growth of 2% per year or "strong" population growth of 3% per year.

Slower population growth would decrease the time needed to double per capita GDP, especially if the rate of economic growth is low. The approach used here is schematic, and could be called neo-Malthusian because it does not take into account possible positive effects that population growth could have on economic demand, and therefore on growth. Note that on this topic, sub-Saharan Africa policymakers still widely regard rapid population growth as a factor for prosperity because it contributes to market expansion and the country's strength. Indeed, until the end of the 1990s, most of the econometric studies on the relationships between population growth and economic growth were inconclusive. However, these studies ignored a fundamental demographic variable: age structure (Birsdsall *et al.*, 2001).

1.4. Demographic transition, age structure and demographic dividend

Many recent works demonstrate the importance of changing age structures in accelerating economic growth for emerging countries, particularly in Eastern Asia. One attempt at explaining the disparity between growth rates in sub-Saharan Africa and estimated growth rates in a sampling of other countries concluded that the bulk of this disparity is explained by demographic factors (Ndulu, 2007). In fact, in Africa, dependency ratios[13] remained high because of high fertility (although they declined rapidly elsewhere due to rapid declines in fertility), and life expectancy at birth was still low and improving more slowly than elsewhere.

These new approaches integrate the concept of age structures, and they are based on the recognition of the intergenerational solidarity that exists in every society, and on the recognition of changing age structures that go along with the demographic transition. In the early stages, declining mortality, especially among children, leads to

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[13] Traditionally, the relationship between the number of dependents under 15 years of age or 65 years of age or higher, and the number of workers from 15 to 64 years of age.

marked increases in births and the number of youths. Then, as fertility starts to decline, the number of births either rises more slowly, stabilizes or decreases, but the working-age population (ages 15–64) continues to grow. Dependency ratios decline, and governments and the greater number of people in the labor force are able to reduce their spending on children and devote a greater part of their income to savings and productive investments. By doing this, they help stimulate economic growth. This period of continued decline in dependency ratios opens a first window of opportunity. This makes it possible, under certain conditions, to take advantage of the first "demographic dividend". This period might last approximately fifty years, until the generations with an ever-increasing labor force near retirement age. Toward the end of the first period, widespread aging of the labor force opens what some authors refer to as the "second demographic dividend". In effect, these newly-minted "senior citizens", who have a good chance of living many years in retirement, have strong incentives to save and accumulate property and assets. If they invest these assets, they are likely to contribute to a sustainable increase in national revenue.

Between 1970 and 2000, most developing regions, such as East and Southeast Asia, where demographic transition was rapid, took advantage of this demographic dividend, except Sub-Saharan Africa, where dependency ratios remained very high. The experiences in East Asian countries (Mason, 2003) underline the importance of three factors for benefiting from the demographic dividend:

- The quality of human capital (education and health);
- The country's ability to create a sufficient number of jobs and increase workplace productivity (and therefore worker pay);
- The role of savings and investments.

2. The Benefits Associated with Demographic Transition

Will the countries of the West African subregion ever be able to capitalize on the demographic dividend? To answer this question, we need to examine their current stage of demographic transition and then formulate some future assumptions.

2.1. Slow and irregular transitions in mortality and fertility rates in comparison with emerging countries

The countries of West Africa currently have life expectancies at birth generally between 50 and 60 years (*versus* 35 to 40 years in the 1960s) and levels of fertility per woman between 4 and 6 more children. We can safely say that the first phase of demographic transition (lower mortality) is well advanced, although significant work remains to be done. However, the second phase of the transition, characterized by declining fertility, is still largely in its infancy and remains very slow.

The current and future levels of mortality and fertility in the subregion depend on two types of variables:

- Socioeconomic, cultural, institutional and political variables;
- "Intermediate" variables (also called proximate determinants) that directly affect the phenomena.

National contexts are thus more or less favorable and depend on the policies and programs implemented that promote or, conversely, slow down cultural and socioeconomic changes that lead to decreasing mortality and fertility.

In terms of high mortality in children,[14] recent studies have focused on these two types of variables that significantly affect life expectancy at birth. On this basis, two types of interventions to lower child mortality have been proposed:

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[14] Currently, deaths in children under age five generally represent half of all deaths in each country.

- Programs directed at intermediate variables (exposure to risk, resistance and therapy) and intended to quickly change levels of morbidity or mortality;
- Longer-term strategies targeting real improvement in health by implementing interventions in social, economic and political structures (Mosley and Chen, 1984; Barbieri, 1991).

For all West African countries, life expectancy at birth should continue to increase in coming years, reaching an average of between 65 and 70 years toward 2050, due to the success of infant and adult mortality reduction programs, and of programs to contain the HIV/AIDS epidemic (United Nations, 2011; UNAIDS, 2010).[15]

As for fertility, its proximate determinants are also defined as variables which directly affect fertility, in contexts where policies and programs implemented promote or, conversely, slow cultural and socioeconomic changes and changes in attitude and behavior regarding reproduction (status of women, ideal number of children, etc.). Bongaarts (Bongaarts, 1978), who formalized the relationship between the level of fertility and the values of these basic fertility determinants selects the five main ones:

- Marriage or being in a union;
- Postpartum insusceptibility;[16]
- Abortion;
- Contraceptive use;
- Sterility.

Bongaarts' model makes it possible to forecast changes in the fertility rate using values for proximate determinants. The trends for these values (for example, the decrease in the percentage of women in union and the duration of breastfeeding, and increased contraceptive use) are related to the socioeconomic, cultural, institutional and political changes the countries experience during their demographic transitions. These include primary and secondary school enrollment for girls, urbanization and

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[15] Contrary to what happened in the countries of Southern Africa, where there were significant decreases in life expectancy at birth, in West Africa, HIV/AIDS did not have a major impact on mortality trends due to the lower levels of infection and the success of prevention programs. The increase in life expectancy at birth only halted between 1980 and 1990 in two countries (Côte d'Ivoire and Nigeria) where the prevalence of disease in people aged 15 to 49 exceeded 3%. Life expectancy at birth recently started increasing again in these two countries.

[16] Postpartum insusceptibility is the period after birth during which the mother is not at risk of pregnancy either because her menstrual cycle has not resumed (often because she is breastfeeding) or because she does not have sexual intercourse for a period after giving birth (post partum abstinence).

improving the status of women in society. These changes are not explicitly included in the Bongaarts model. Trends in these areas, as for mortality, point to long-term strategies.

With five or more children per woman, most countries in the subregion are part of the twenty countries with the highest fertility levels in the world. Only Ghana, Mauritania and Togo now have "intermediate" fertility levels with four children per woman. These high levels of fertility at the regional level are largely explained by low levels of contraceptive use, at around 10 to 20% of married women. This low rate is the result of very slow growth in contraceptive prevalence, at about 0.5 percentage points per year over the last 20 years. However, there is significant unmet demand for family planning that affects 20 to 30% of women in different countries.

If we add the met demand (composed of the 10 to 20% of contraceptive users) and expressed unmet demand, the result is the total demand for family planning, which ranges between 30 and 50% of married women. This relatively low demand can be attributed to the ideal number of children, which is still quite high at four to six children per woman, as revealed by the surveys. The ideal number of children also remains high among young women and educated women.

In contrast, fertility levels in emerging countries are now two to three children per woman, and 60% to 85% of married women use contraceptives (United Nations, 2011, 2010*a* and *b*). In the 1960s, the fertility level in these countries was six or more children per woman, and only 10% to 20% of women in union used any contraceptive method. Emerging economies thus completed their demographic transition (marked by bringing mortality and fertility levels under control) and their "contraceptive revolution" (made possible by making contraception accessible to all women who wanted it) in about forty years. The average number of children per woman has decreased by one child per decade overall, and this decrease was associated with average increases in contraceptive use (or contraceptive prevalence) of approximately 1.5 percentage points per year.[17] Note also that, in developing countries, more educated women now specify an average ideal number of children that ranges from less than two children (Brazil, India, Turkey, Vietnam and also Bangladesh) to 2.5–3 children (Egypt, Indonesia, Morocco, Philippines, Tunisia and also Haiti).

[17] The increase in prevalence of approximately 60 points (from 10-20% to 70-80%) in 40 years represents an average increase of 1.5 percentage points per year (Guengant and Rafalimanana, 2005).

These rapid declines in mortality and fertility in emerging countries are not a coincidence. They are the result of policies or programs conducted simultaneously to diversify their economies, increase levels of education and the health of their populations and control their population growth. Population policies have specifically targeted legitimizing family planning where it was not widely accepted, through informational, educational and communications campaigns calling on people to change their reproductive behavior. These policies have also contributed to providing sufficient accessible and high-quality reproductive health services. Transforming these developing countries into emerging countries can be attributed as much to economic and social policies (education and health) as to population policies. Similarly, the rapid demographic transitions observed owe as much or more to the population policies and economic and social progress that result from them.

2.2. Future scenarios

Given these elements, what are the imaginable scenarios for future population changes for the subregion's countries?

In countries with high or intermediate fertility rates, as is the case in the subregion, changes in the population and the population's characteristics depend primarily on changes in the fertility rate. The impact of changes on other variables, even if not negligible, is nonetheless much less important. Demographic projections are therefore generally based on several assumptions for fertility rate trends and on a single assumption for life expectancy at birth and international migration.

In the framework of this study, we have elaborated projections for the period 2010 to 2050 for each of the 12 countries studied using the Spectrum model (Futures Group, 2011).[18] We used the 2010 estimated population as the starting population, an assumption for trends in life expectancy at birth, an assumption for international migration, an assumption for trends in urbanization and three assumptions for

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[18] Spectrum is a software application that combines several applications developed in the 1980s and 1990s that used to operate independently. Specifically, it includes *DemProj: Demography* software for demographic projections by component (by sex and by age starting with a base population and assumptions for changes in fertility, mortality and international migration, as well as assumptions for urbanization); *FamPlan: Family Planning,* which is used to calculate the fertility level associated with various assumptions for changes in fertility determinants, making fertility a variable that depends on the proximate determinants of fertility; *AIM: AIDS Impact Model* which, based on assumptions, projects the impact of the HIV/AIDS epidemic, such as the number of people infected, new infections and deaths due to the disease by sex and age. Version 3.46 from 16 March 2010 was used for the assumptions.

fertility[19] using the proximate determinants of the Bongaarts model as enabled in Spectrum.

Given the national and regional data available, we used the following for each country:

- An assumption with a slight decline in the percentage of women in union;
- An assumption with a slight reduction in the duration of postpartum insusceptibility;
- A negligible abortion rate and a constant permanent sterility rate;
- Three assumptions for trends in contraceptive use (all methods combined) based on the level estimated in 2010. As a result, we selected:
  - A "high" or "*laissez-faire* assumption" with a +0.5 percentage point increase per year, termed as such because it results in the highest population numbers, and because it corresponds to a trend of weak growth in contraceptive use observed in the countries studied for the last 10 to 20 years;
  - An "intermediate" assumption with a +1 percentage point increase per year;
  - A "low" or "accelerated" assumption with a +1.5 percentage point increase per year, termed as such because it results in the least elevated population numbers and has the highest increases in contraceptive use, close to those observed in emerging countries, presuming more commitment and significant resources than those applied in recent years.

For these three assumptions and as suggested by the data, we presumed a decrease in the use of traditional less effective contraceptive methods in favor of modern methods. We assumed that the 2010 level of traditional contraceptive method use (between 15% and 60% depending on the country) would increase to 10% in 2030. These increases in contraceptive prevalence, either slow (0.5 percentage points per year), average (1 point) or rapid (1.5 points), correspond to the range of trends observed in developing countries between 1970 and 2000, for long periods of at least 10 years (Guengant and Rafalimanana, 2005). These are realistic.

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[19] Whenever possible, we used (or adjusted for 2010) the latest available national estimates for total population (by sex and age), life expectancy at birth and total fertility rate (TFR). In the absence of national estimates, we used the estimates from the United Nations Population Division available during preparation of the 12 studies, or those from 2008 (United Nations, 2009a). For 2010-2050 we followed the trends for life expectancy at birth used by the United Nations Population Division, and used its annual estimates on international migration. For urbanization trends, we used estimates of urban and rural populations provided in the 2009 revision of urbanization projections from the United Nations Population Division (United Nations, 2010c).

Moreover, when unmet needs for family planning are at least 30%, as is the case in seven countries,[20] an increase of 1.5 percentage points per year means that these needs would be met in 20 years (2030). For the five countries where unmet needs are lower (from 15 to 25%),[21] an increase of 1.5 percentage points per year means that these needs will be met in 10 to 16 years (2020–2026). These data illustrate the inability of these countries to reach target 5B of the Millennium Development Goals (MDGs), to provide universal access to reproductive health by 2015.

These projections and assumptions are not intended as substitutes for national projections and assumptions, nor do they present the results of the medium assumption (supposedly probable). They are intended only as decision-making tools. A comparison of data from the high/*laissez-faire* assumption and the low/accelerated assumption should shed light on policy choices. The results of the two assumptions for 2030 appear starkly contrasted depending on the variables considered (Graphs 5 and 6). It seems that the decline in fertility levels varies not only based on assumptions, but also on the country, depending on differences between initial levels (fertility levels and contraceptive prevalence) and the numbers moving from traditional to modern contraceptive methods.[22]

Under the high/*laissez-faire* assumption (0.5 percentage point increase in contraceptive prevalence per year), the total fertility rate (TFR) decreases by an average of 0.4 children per decade and by 0.8 children between 2010 and 2030 for five of the countries with a high 2010 TFR (five children or more per woman): Benin, Burkina Faso, Mali, Niger, Nigeria, as well as Ghana. In the six remaining countries, the decline is more modest between 2010 and 2030; on average between 0.2 and 0.3 children per decade. These results are in line with the trend of a slow decline in fertility in the countries studied.

Using the low/accelerated assumption (+1.5 percentage point increase in prevalence per year), declines in TFR are approximately three times higher. The three countries with the highest 2010 TFR, Burkina Faso, Mali and Niger, as well as Benin, show declines of approximately one child per decade and two children between 2010 and 2030. But in 2030, Mali and Niger will still have TFRs higher than four children per

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[20] Benin (30%), Burkina Faso (31%), Côte d'Ivoire (29%), Ghana (35%), Mali (31%), Senegal (32%) and Togo (41%).

[21] Guinea (21%), Guinea-Bissau (25%), Mauritania (25%), Niger (16%) and Nigeria (20%).

[22] The higher the percentage of traditional methods used in 2010, the more rapid the transition to more efficient modern methods will be in 2030, which, in turn, will contribute to accelerate the fertility decline.

Graph 5 — *TFR (2010–2030), high assumption/laissez-faire (+0.5 points/year)*

Legend: 2010 2020 2030

Countries ranked in descending order by 2010 TFR
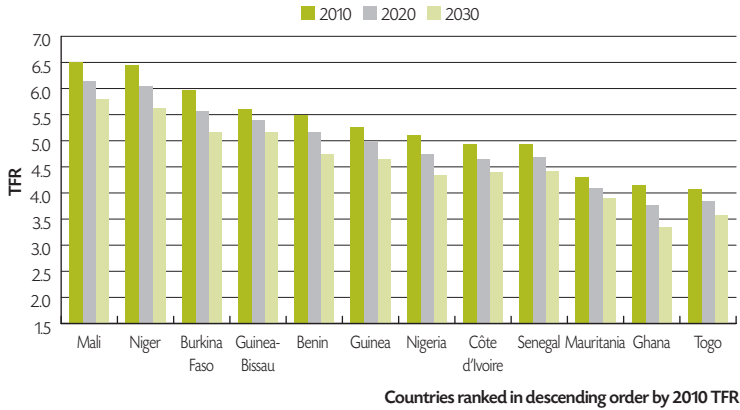
Source: Projections made within the framework of the study.

Graph 6 — *TFR (2010–2030), low/accelerated assumption (+1.5 points/year)*

Legend: 2010 2020 2030

Countries ranked in descending order by 2010 TFR
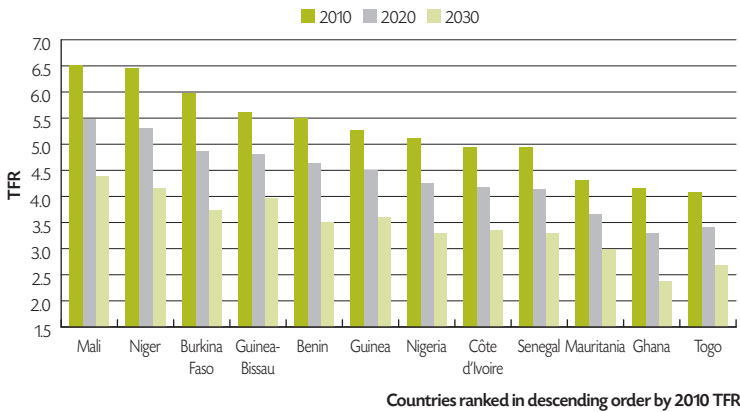
Source: Projections made within the framework of the study.

woman (the current levels for Ghana, Mauritania and Togo). For the remaining countries (excluding Mauritania and Togo), the decline is between 0.8 and 0.9 children per decade and between 1.6 and 1.8 children for the period between 2010 and 2030. Mauritania and Togo, which have the lowest TFR in 2010, show declines from 1.3 to 1.4 children between 2010 and 2030.

The results of the low/accelerated assumption are in line with observations made in emerging countries in the early 1960s and the 2000s. Compared to recent trends, this is an assumption showing the acceleration of the fertility declines already noted at various levels in the 12 countries studied. It should be noted that if this assumption were to come true, the average number of children per woman in 2030 would remain relatively high in most of these countries, which would then maintain the potential for a significant population growth after 2030. Under the low/accelerated assumption, all of the countries would have at least three children per woman, except Togo and Ghana, with 2.7 and 2.4 children per woman, respectively.

## 2.3. Rapid increase in population and tripling of urban populations by 2030

What will the impact on total population be for each country for each of these two assumptions that combine declining fertility with an assumption of increased life expectancy at birth? What changes will be seen in urban and rural populations given the increased urbanization in the assumptions?

Paradoxically, even under the low/accelerated assumption, the projected decline in fertility will not prevent the total populations of the countries in the subregion from increasing dramatically (from 50% to 100%), both initially and over the next 20 years (Graphs 7 and 8). In reality, this paradox is only apparent, and its explanation is simple. Due to high population growth in the past, half of the population in the countries studied is under 20 years of age. Depending on more or less recent declines in fertility, the number of women of childbearing age will double or increase by at least 50% in 20 years. Thus, even if the projected declines in fertility are rapid, they cannot offset the strong and inevitable increase in the number of women of childbearing age, because these women have already been born. As a result, countries that still have high fertility levels in 2010 can expect a near doubling of their total population by 2030, with only minor differences between assumptions.

For countries with intermediate levels of fertility, increases in total population of approximately 50% can be expected.

Given the expected increase in urbanization levels, a large proportion of the overall projected population growth will affect cities. It is difficult to pin down urban and future urbanization growth estimates as well as the number and size of cities by country (Chatel *et al.*, 2008). Our data are based on information from the United

Graph **7** *Increase in total population (2010–2030), high/laissez-faire assumption (+0.5 points/year)*

■ 2010 ■ 2020 ■ 2030
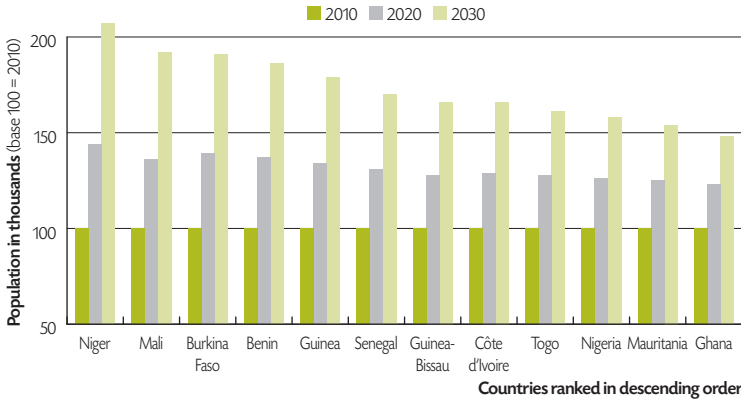
Source: Projections made within the framework of the study.

Graph **8** *Increase in total population (2010–2030), low/accelerated assumption (+1.5 points/year)*

■ 2010 ■ 2020 ■ 2030
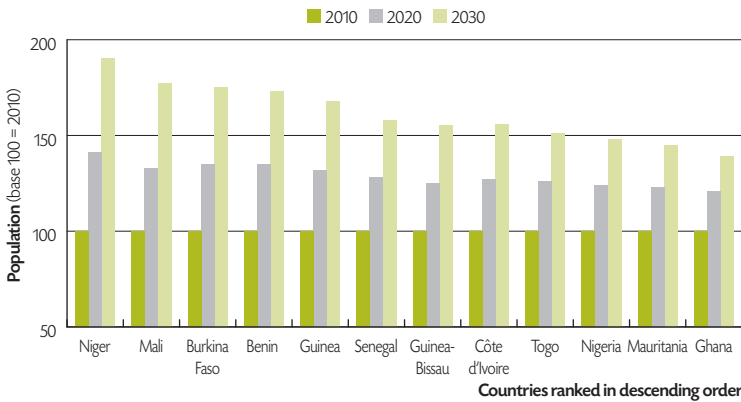
Source: Projections made within the framework of the study.

Nations Population Division (2010*c*). It appears that countries with high fertility levels and relatively low urbanization rates (between 20% and 40%) could see their urban populations increased by a factor of 2.5 to 3 in the next 20 years. The remaining countries, where growth should be lower, should still expect to double their urban populations by 2030. Three of these countries will be overwhelmingly urban in 2030.

By that date, two-thirds of the population of Côte d'Ivoire, Ghana and Nigeria will live in urban areas. In the remaining countries, with two or three exceptions, half of the population will live in urban areas in 2030.

The growth of rural populations will depend on their natural growth rates and the impact of rural-urban migration. The projection model used here is not perfect, but helps to highlight the fact that countries with high fertility are also those whose rural populations will continue to grow fairly strongly (approximately 50% by 2030 and 100% in the case of Niger). In the remaining countries, increases will be more moderate, and in countries with intermediate fertility and those with already high rates of urbanization, we can expect a quasi-stabilization of rural populations under the low/accelerated assumption (Graphs 11 and 12).

The challenge associated with these developments is daunting. The high expected growth in urban population means that the majority of new jobs created for young people should be in cities. Since the 1980s, the main provider of urban employment in West Africa is the informal sector. Will this sector be able to absorb 2.5 to 3 times more newcomers than today? Can some of this sector's activities be transformed into modern activities and contribute significantly to the countries' economic development and the states' tax revenues? These represent questions that are difficult to answer today. Moreover, growing food requirements for increasing numbers of urbanites and slower – or even stagnated – rural population growth will pose problems in several countries, which will need to rapidly transform their low-productivity subsistence farming into modern agriculture focused on domestic markets and export.

2.4. Growth contrasted by number of births, population growth rates and dependency ratios

Twenty years down the road, the ultimately insignificant impact on total population growth in the various assumptions that can be made about fertility can generally be attributed to what is called the inertia of demographic phenomena. We forget that fertility is the main determinant of population growth and that the impact of these assumptions is seen first and fairly quickly in changes in the number of births, and in population growth rates and dependency ratios.

The first consequence of the contrasting trends in fertility described above (*laissez-faire* assumption/slow and accelerated/rapid) is in the number of births. For the high/*laissez-faire* assumption, modest increase in contraceptive use and slow decline

in fertility that accompanies it do not compensate for the significant expected increase in the number of women of childbearing age. Consequently, the annual number of births continues to rise quite sharply. It should almost double between 2010 and 2030 in Mali and Niger. It will increase from 50% to 66% in half of the 12 countries studied and from 20% to 40% in the remaining four countries (Graphs 9 and 10). In contrast, in the low/accelerated assumption, the more rapid decline in fertility would limit the increase in the number of births in 2030 to approximately 40% of their 2010 level in Mali and Niger, and in the remaining 10 countries, the annual number of births would tend to stabilize, with a maximum increase of 20% by 2030. In Ghana, the number of births in 2030 could be 15% lower than its 2010 level.

The second consequence of the contrasting trends in fertility and changes in the number of births involve annual population growth rates.

Using the high/*laissez-faire* assumption, these rates will remain above 2.5% in 2030 in eight countries and decline slightly in the remaining countries, staying above 2% per year, except in Ghana (Graph 11).

In contrast, in the low/accelerated assumption, only two countries, Mali and Niger, have population growth rates over 2.5% in 2030. Six other countries have rates of approximately 2% (between 1.9% and 2.3%), three countries have rates of 1.5% and Ghana has a rate of 1.1% (Graph 12).

Graph 9 — *Number of annual births (2010–2030), high/laissez-faire assumption (+0.5 points/year)*
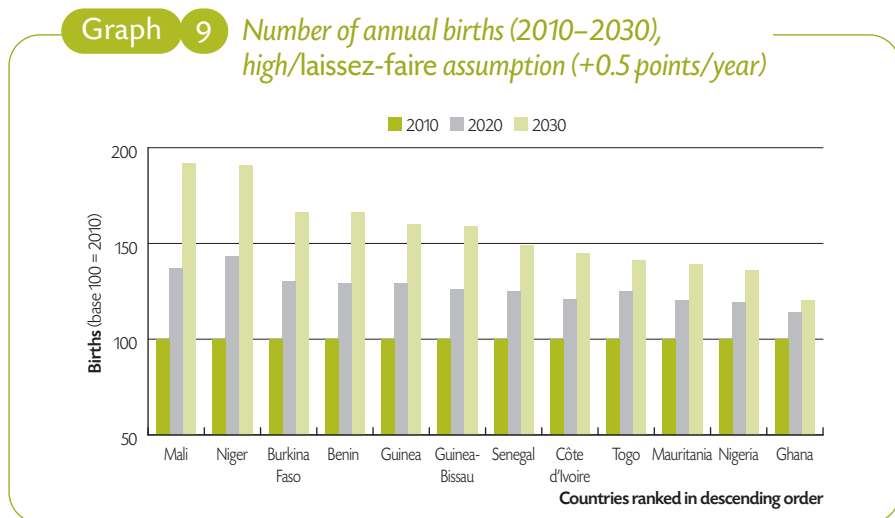
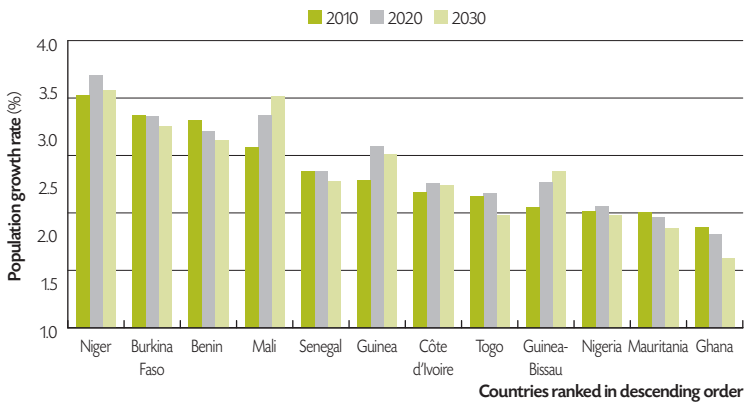*Source: Projections made within the framework of the study.*

Graph **10** *Number of annual births (2010–2030), low/accelerated assumption (+1.5 points/year)*
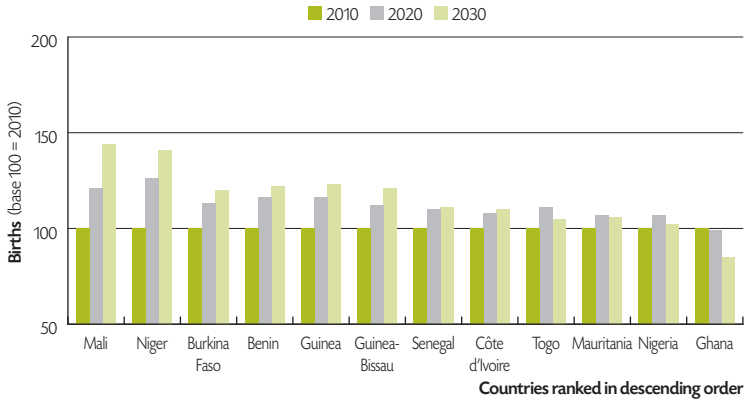
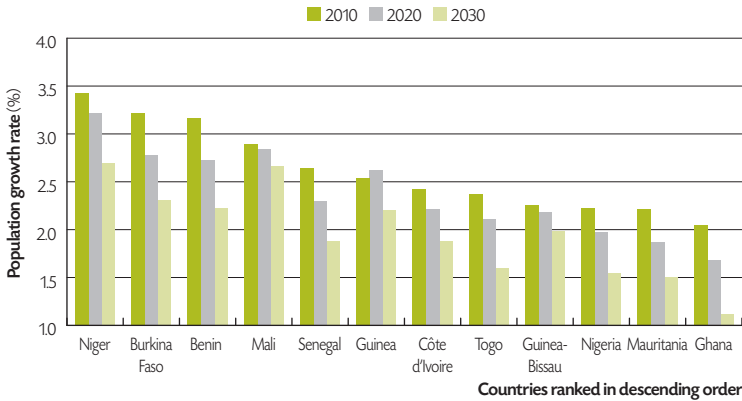*Source: Projections made within the framework of the study.*

Graph **11** *Average annual population growth rate (2010–2030), high/laissez-faire assumption (+0.5 points/year)*

Source: Projections made within the framework of the study.

Using the high/*laissez-faire* assumption, population growth rates in 2030 are in many cases higher than in 2010, and are only slightly lower in other cases. In contrast, using the low/accelerated assumption, population growth rates are below their 2010 levels by about 1 point in three countries (Benin, Burkina Faso and Ghana), by 0.5 to 0.8 points in six countries and by 0.2 to 0.3 points in the three remaining countries.

Graph 12 *Average annual population growth rate (2010–2030), low/accelerated assumption (+1.5 points/year)*

Source: Projections made within the framework of the study.

The third consequence of contrasting trends in fertility and in the number of births involves the change in dependency ratios and their inverse, the number of employed/unemployed. The quasi-stabilized annual number of births from the low/accelerated assumption gradually adds to the bottom of the population pyramid, resulting in a faster (in comparison with the high/*laissez-faire* assumption) decline in the percentage of those under age 15 in the total population in the countries studied (Graphs 13 and 14). This change leads to different trends for dependency ratios and for the number of employed/unemployed depending on the assumption used. Dependency ratios[23] in 2010 were relatively high in the countries studied: above 0.8, which translates into slightly more than one potentially employed person (aged 15 to 64) per unemployed person (under age 15 and age 65 or over).

Under the high/*laissez-faire* assumption, the modest decrease in the percentage of under age 15 combined with slow declines in fertility leads to a ratio of employed/unemployed on the order of 1.3 by 2030 in most countries, which is only slightly better than in 2010 (Graph 15).

However, under the low/accelerated assumption, the quasi-stabilization in the number of births means that the number of employed/unemployed in 2030 is

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[23] Traditionally, the ratio between the number of dependents under age 15 or 65 years old or higher and the number of workers aged 15 to 64.

between 1.6 and 1.9 in half the countries. This is close to the levels seen today in emerging countries (Graph 16).

Graph 13 *Dependency ratio (under age 15 and 65 or over/age 15 to 64), high/laissez-faire assumption (+0.5 points/year)*
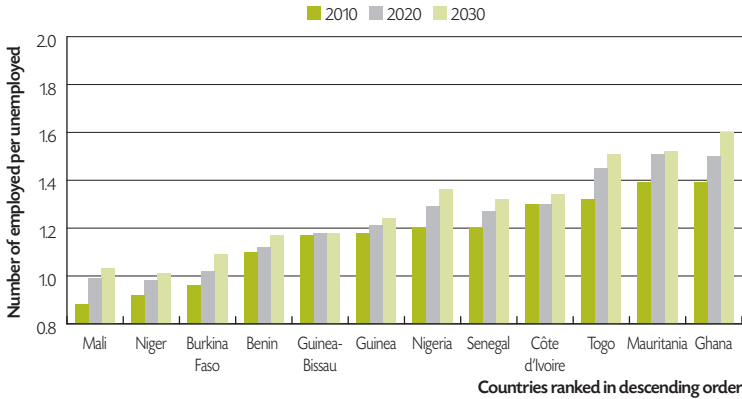
■ 2010 ■ 2020 ■ 2030

Dependency ratio (%)

Countries ranked in descending order
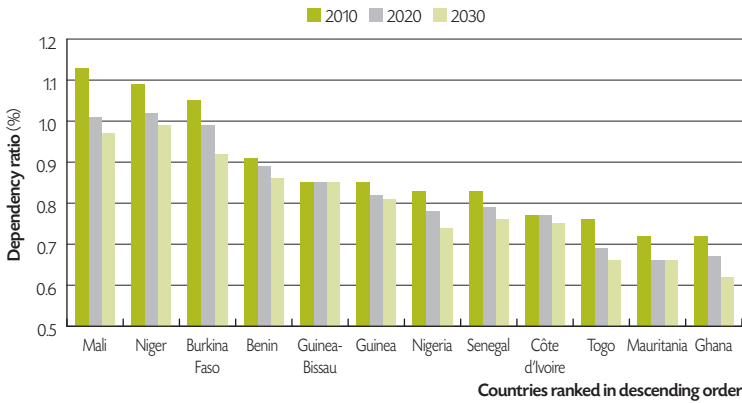
Source: Projections made within the framework of the study.

Graph 14 *Dependency ratio (under age 15 and 65 or over/age 15 to 64), low/accelerated assumption (+1.5 points/year)*

■ 2010 ■ 2020 ■ 2030

Dependency ratio (%)

Countries ranked in descending order
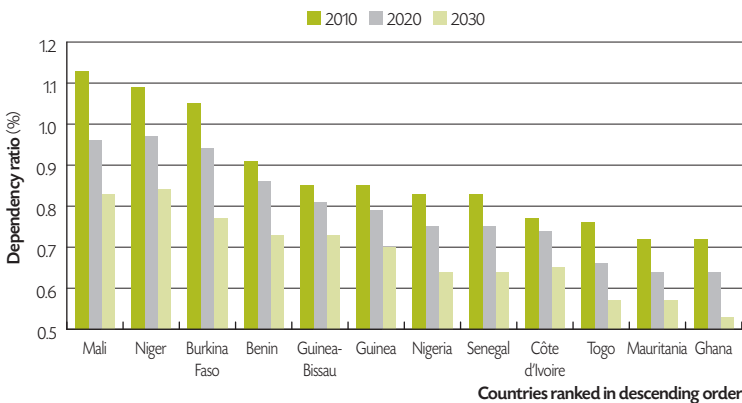
Source: Projections made within the framework of the study.

Graph 15 *Number of employed/unemployed (age 15 to 64/under age 15 and 65 or over), low/accelerated assumption (0.5 points/year)*

Source: Projections made within the framework of the study.

Graph 16 *Number of employed/unemployed (age 15 to 64/under age 15 and 65 or over), low/accelerated assumption (1.5 points/year)*
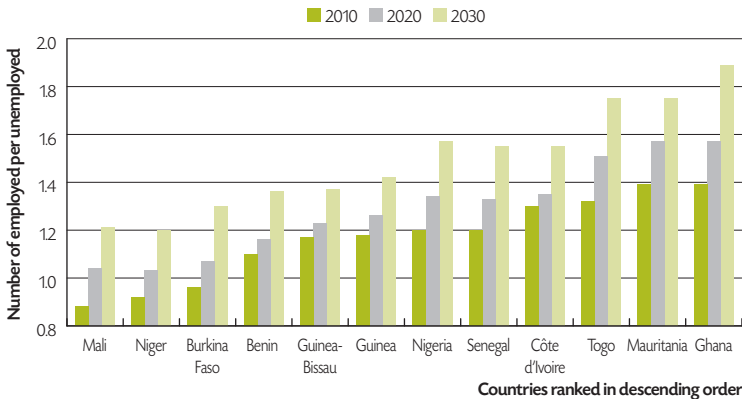
Source: Projections made within the framework of the study.

2.5. The three major advantages in accelerating fertility decline

The contrasting trends for population growth rates, number of births and dependency ratios for the different assumptions (*laissez-faire* assumption/slow and accelerated/rapid) are likely to have particularly significant consequences for the economic and social development of the countries studied.

First, as already noted, a decline in population growth should reduce the time needed to double the GDP per capita, which is still low in the countries studied. This time is less significant whenever the economic growth rate is very high. Nevertheless, it remains at approximately 25 years of economic growth at 5% per year, which matches the best rates observed in the subregion in recent years.

Moreover, the quasi-stabilization in the number of births, achieved by accelerating the decline in fertility (using the low/accelerated assumption) is likely to benefit all of the countries regardless of their rate of economic growth. Over the next 20 years, the countries studied will face three challenges in the areas of education and health (key factors in the quality of human capital):

- Catching up with insufficient coverage rates;
- Continued population growth;
- Improving the quality of care and services provided to the population.

In terms of health, we can use the example of a country where one quarter of pregnant women take advantage of the recommended four prenatal visits, and where only half of them have qualified attendants at the time of delivery. If we take as a goal that all pregnant women have four prenatal visits and assistance from qualified personnel at the time of delivery by 2030, the coverage rate for prenatal visits would have to be multiplied by four and the rate of attended delivery by two. In terms of education, a net enrollment rate of 66% would need to be multiplied by 1.5 to achieve universal enrollment.

These delays must be combined with the demographic factor, especially with eventual increases in the number of births.[24] They involve an increase in financial resources and personnel (without taking into consideration the quality improvement

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[24] By 2030, these figures will likely double in Mali and Niger, and increase by an average of 50% in most other countries.

factor), by a factor of 1.5 to 8, depending on the delay and population growth in question (Graph 17). For example, increasing prenatal visits by a factor of eight in 20 years is equivalent to a sustained annual increase in resources of 10.5% per year. Increasing attended deliveries by a factor of four is equivalent to a sustained annual increase in resources of 7% per year, whereas doubling it is equivalent to an increase of 3.5% per year.

Graph 17 **Increase in resources needed over 20 years, based on the need to catch up and on population growth**
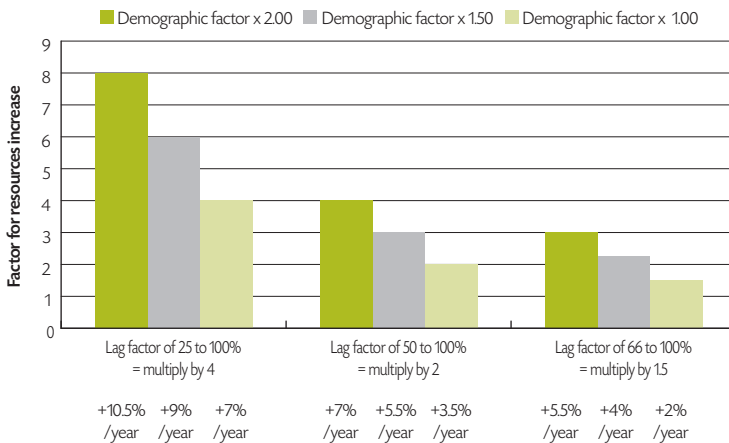
Source: Author's calculations.

The lack of quasi-stabilization (or strong reduction) in the number of births and young children means that more time and resources will be required to catch up on delays in coverage. Similarly, a significant portion of the profits from economic growth will continue to be invested to meet the increase in the number of pregnant women and young children, to the detriment of improving the quality of services and care provided.

Conversely, in the event of quasi-stabilization (or strong reduction in the increase) of the number of births, a significant portion of the profits from economic growth could be allocated not only to productive investments, but also to improving the quality of human capital (increased enrollment in secondary, technical and higher education, for example). These profits could also be used to improve services and care provided to the population (lower student/teacher ratios, increase the numbers of doctors and nurses, etc.).

This brings us to the third major benefit likely to be reaped by accelerating declines in fertility – the possibility of capitalizing on the demographic dividend. Given the recent trend toward declining fertility and development delays in the countries of sub-Saharan Africa, some authors wondered whether these countries are even in a position to capitalize on it (Bloom *et al*., 2007). Their research covers 32 countries in sub-Saharan Africa, including 10 of the 12 West African countries studied here,[25] and leads to a favorable response to this question. The authors examined the projected growth for those aged 15 to 64, the change in dependency ratios according to projections from the United Nations Population Division and the indicators for the institutional environment; in 2007, they concluded that, among the 32 countries selected for their research, five were in a position to benefit from the demographic dividend over the next 20 years (Côte d'Ivoire, Ghana, Malawi, Mozambique and Namibia). Four other countries (Cameroon, Senegal, Tanzania and Togo) could benefit from increases in their workforce and levels of education, but still need to significantly increase their institutional environments to be able to fully benefit from the demographic dividend. Mauritania, whose dependency ratios should improve significantly over the next 20 years, could be added to these countries. According to the authors, the persistence of high dependency ratios and a continued deficient institutional environment seemed to exclude the remaining countries studied, at least for now.

The opportunity to capitalize on the first demographic dividend and create conditions for stronger and sustainable growth depends primarily on the speed of the demographic transition and the reduction in dependency ratios that accompany it, as noted in Section 2.4. It also depends on other factors, such as the quality of human capital (education and health), the creation of a sufficient number of paying jobs, the existence of significant savings and investments and the maintenance of an adequate political and institutional environment. The few countries in the subregion where the demographic transition is relatively well under way are well placed to benefit quickly from the demographic dividend if their political and institutional environments remain satisfactory, if their human capital is good and if their declines in fertility continue. The other countries that are less advanced in their demographic transition and are having more difficulties in improving their human capital must first create the conditions for a more rapid decline in fertility and meet the other requirements before they can benefit from the demographic dividend.

We will presently examine the efforts made in recent years by the various countries in the subregion to control their strong population growth.

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[25] Burkina Faso, Côte d'Ivoire, Ghana, Guinea, Guinea-Bissau, Mali, Niger, Nigeria, Senegal and Togo. The two countries not studied are Benin and Mauritania.

3. Public Policy and Population Issues

Up to the 1980s, most of the governments in the subregion's countries considered their population growth and levels of fertility satisfactory and did not find they required any specific intervention (United Nations, 2009*b*). In addition to this regional trend, Ghana adopted a National Population Policy in 1969 (Republic of Ghana, 1969; Caldwell and Sai, 2007). And, although Senegal already considered its population growth too rapid in the 1970s, in 1988 it became the first Francophone country in the subregion to adopt a population policy.

3.1. Population policies

In the 1990s, the 12 countries studied already had or were on the verge of adopting population policies to support governmental development efforts. These policies favor a very general approach to population issues, stating as primary goals integrating and taking into consideration demographic variables in development plans, controlling population growth and increasing contraceptive prevalence.

With the adoption of an approach that focuses on reproductive rights at the International Conference on Population in Cairo in 1994, these countries are also implementing policies, plans and programs for health, reproductive health and securing reproductive health products. The adoption of the MDGs in 2000 pushed them to develop Poverty Reduction Strategy Papers (PRSPs), which has led to revisions of their initial population policies.

The "developmental" approach of the first population policies covered many areas. The order in which these areas and their corresponding objectives appear vary from one country to the next, but they most often include health (reducing morbidity and mortality), education (access to education and promoting human resources), population growth control, population distribution, international migration, inclusion of women, improvements in living conditions for vulnerable populations (children, young people, women, rural populations and disabled persons), meeting food requirements, preserving natural resources and improving socio-demographic knowledge. The general objectives retained are generally broken down into specific

targets and overall or specific strategies, without necessarily providing quantitative objectives.

The implementation of the first population policies, some of which were evaluated, ran up against several difficulties. The first was the lack of financial and human resources. In theory, these policies should be implemented in "Action Plans and Population Assistance Investment Programs" (or PAIP: *Plans d'action et d'investissements prioritaires en matière de population*). However, those first population policies were not always finalized or were poorly financed (as financing was primarily expected from international donors). Another difficulty laid in the lack of commitment and support from governments and civil society for population policies and programs and their objectives. This limited commitment was demonstrated by the lack of national resources assigned to them and restricted support from lenders. In addition, political turmoil, including coups d'état, that have affected several countries in the subregion led to interruptions of external development assistance for fairly long periods. Assessments of population policies in Mali and Burkina Faso highlight other problems. In Mali (Republic of Mali, 2002), the evaluation highlighted the overly broad definition of the field "population" (which amounted to it handling all essential development problems), lack of quantification for some objectives, non-integration of the population policy into development policies and strategies, and partner disinterest. The assessment in Burkina Faso (Badjeck, 2009) revealed that adopting the PRSP as the sole orientation for the country's development policy contributed to disqualifying the planned activities and expected funding in the field of population. These analyses also apply to the other countries.

Revised or new population policies adopted in the 2000s attempted to integrate these difficulties. They also tried to simultaneously take into account the "reproductive rights" approach adopted in Cairo in 1994, the MDGs adopted in 2000 and the PRSPs for the countries. Since much more data (from censuses and surveys) were available, these new policies have a certain number of quantitative objectives. However, they still cover a wide range of areas.

The Declaration of the Government's Population Policy (or DGPP: *Déclaration du gouvernement en matière de politique de population*), adopted in Niger in 2007 (Republic of Niger, 2007*a*), is an exception to this. Of course, it states an intention to *"contribute to poverty reduction"* but does so *"through reproductive attitudes and behavior likely to lead populations to significantly increase contraceptive use and reduce the number of early marriages"*. The objectives are therefore limited to

increasing the modern contraceptive prevalence rate and decreasing the proportion of early marriages, breastfeeding, fertility levels and the rate of population growth. These objectives were set based on the results of national population projections, intended as "decision-making tools" published in 2005 (Republic of Niger, 2005*a*). Niger's 2007 population policy focuses exclusively on issues related to reproductive behavior, contrary to the policies of other countries in the subregion, whose approaches are more "developmental".

3.2. Policies, plans and programs for health, reproductive health and securing reproductive health products

All countries also adopted plans and programs for health, reproductive health and securing reproductive health products in the 2000s. These health development plans or programs usually cover periods of 5 to 10 years. Their names vary by country. For example, in Burkina Faso, it is called the *Plan national de développement sanitaire* (National Health Development Plan or PNDS), adopted for 2001–2010 (Republic of Burkina Faso, 2000), in Mali, it is the *Plan décennal de développement sanitaire et social* (PDDSS), adopted for 1998 -2007 (Republic of Mali, 1997) and in Niger, the *Plan de développement sanitaire* (National Health Development Plan or PDS), for 2005–2009 (Republic of Niger, 2005*b*). These plans and programs are important because they are intended to encompass all activities and actions in the health sector, particularly those relating to reproductive health.

In terms of reproductive health, all of the countries also have plans or strategic plans. Depending on the country, we have, for example in Mali, a *Plan stratégique de santé de la reproduction* (Strategic Plan for Reproductive Health or PSSR), supplemented by a *Plan d'action pour la contraception sécurisée* (Action Plan for Securing Access to Contraception). Today however, the trend is toward adopting a *Plan stratégique de sécurisation des produits de santé de la reproduction* or PSSPSR (Reproductive Health Commodity Security Plan or RHCS) that is not limited to contraceptive products.

Referring to the MDGs of the 2000s, the countries have also adopted roadmaps to accelerate the reduction of maternal and neonatal mortality. In some cases, increasing contraceptive prevalence is added to these objectives.

Finally, note that, at the end of 2010, eight of the studied countries (Benin, Burkina Faso, Guinea, Guinea-Bissau, Mali, Niger, Senegal and Togo) had each adopted a law on reproductive health. These laws recognize the rights of individuals and/or couples

to decide freely and carefully how many children they want and how to space them. They also recognize the right of couples to have the information necessary to do this. However, there are differences from one country to another. The law adopted in Niger stipulates that *"legally married couples may decide freely and judge how far apart their children should be born"*. It seems to only take married couples into consideration and apply only to spacing between births.

Despite the diversity of situations in different countries, a number of general observations can be made on the contents and coherence of policies, plans, programs or strategies.

First of all, it seems that the objectives of the population policy are not always mentioned in these various documents, although policies on health and reproductive health are also concerned with mortality trends, fertility and their determinants.

Next, it is not always easy to know how the stated goals were set, other than when MDGs are used. In this case, targets for reducing neonatal (and infant) mortality and maternal mortality do not differ greatly from one document to another in the same country. This is not the case for all of the objectives stated for contraceptive prevalence, which may vary in the same country by a factor of one to two for similar or closely related periods, according to the plans and strategies analyzed. These discrepancies in the objectives to be achieved and the effort required will not help mobilize action on population issues or meeting family planning needs. Moreover, the recently adopted PSSPSRs are justifiably focused on continuing to secure financing for products. However, they often appear more like plans to secure products, participation from the private sector or improvements to LIMS (Logistics Information Management Systems) rather than plans to (also) finance the purchase of reproductive health products. In fact, elements in these plans (strategic axes, objectives and budget forecasts) only rarely provide information on the increase in contraceptive prevalence and how many women using contraceptive are targeted in the requested budgets. Finally, the most important part of the budget goes primarily to increasing access to safer delivery (delivery with the help of a trained attendant) and to emergency obstetric services. The *Programme national 2005-2009 de santé de la reproduction* (2005–2009 National Program of Reproductive Health or PNSR) for Niger (Republic of Niger, 2005*c*) planned to spend 72% of its budget on reducing high-risk pregnancies and only 19% on planning family, whereas increased use of contraception could have reduced the current high proportion of high-risk pregnancies.

3.3. Population treatment in the Poverty Reduction Strategy Papers (PRSP)

Integrating the population variable into the development plans of the subregion's countries has been set as an objective in virtually all the plans and programs implemented with the support of the UNFPA (United Nations Population Fund) over the last 30 years. Yet, the MDGs did not mention population and fertility issues. Accordingly, the dominant "reproductive health" approach has governed their development, and plans initially only dealt with reducing maternal and infant mortality. It was not until 2005 that universal access to reproductive health became an objective (target 5B in the MDGs). Given this context, it is not surprising that the first PRSPs barely considered demographic issues.

Virtually all new PRSPs (second or third generation depending on the country) adopted in recent years include population growth as a constraint (due to strong social demand) and as an obstacle to the countries' development efforts. Despite this, they barely go beyond this recognition. Indeed, almost all PRSPs have become strategy documents for accelerating growth and poverty reduction. They also count on strong economic growth to reach the status of an emerging country which, according to their scenario, will "automatically" lead to a slowdown in population growth (see 2.3).

For example, the Poverty Reduction and Growth Strategy (PRGS), adopted in Benin for the 2007–2009 period (Benin, 2007), assumes that taking into account the considerable social demand that will be expressed in terms of nutrition, health and education – a result of high population growth in the country – involves action in both economic and social sectors that will help achieve the objective of slowing population growth over the long term.

The *Stratégie de croissance accélérée et de développement durable* (Accelerated Growth and Sustainable Development Strategy, SCADD), drafted in Burkina Faso for the 2010–2015 period (Republic of Burkina Faso, 2010) also clearly referred to population issues in two of its four strategic orientations. It states that *"the issue of population will be discussed in terms of controlling population growth [and] building the capacity of actors to take account of demographic data in development policies, plans and programs."* However, the approach adopted is very broad and the current document states that *"the major themes that form the logic of population and development are migration, urbanization, education and training, environment,*

drinking water, employment, health, gender, AIDS and other topics subject to international commitments."

In Niger, however, the second *Stratégie de développement accéléré et de réduction de la pauvreté* (Accelerated Development and Poverty Reduction Strategy, SDRP), adopted for the 2008–2012 period (Republic of Niger, 2007*b*), clearly expresses political will to control the population growth of the country. It draws not only on the 2005 national population projections, but it also takes into account the 2007 Declaration of the Government's Population Policy which sets a clear objective of accelerating the use of contraception.

Overall, population issues are now usually referred to in PRSPs. But, in general, PSRPs do not include priority actions to be carried out. In the best scenarios, PRSPs refer readers to the last population policy, or to the ongoing process of developing a new population policy.

3.4. The place of population variables in sectoral policies

Taking population variables into account in other sectoral policies (health, education, food security, land use planning, etc.) varies depending on the country. But, again, some general trends can be identified.

First of all, the latest population policies are rarely mentioned in sectoral policies, plans, programs or strategies that were adopted in the countries.

Next, these policies, plans and programs often state their goals as percentages, or coverage rates, regardless of the increase in numbers involved. This is particularly unfortunate for 10–15 year plans. If we take a given population into account (to be vaccinated, school age or entering the labor market) that grows 3% per year, this population will be 35% higher than its starting level 10 years later, and 55% 15 years down the road. At a growth rate of 3.5% per year, the population will be higher than 41% of its starting level 10 years down the road and 68% 15 years later.

When a demographic variable is included in these plans, it most often uses the average annual growth rate of the total existing population for the last intercensal period. This method is not very accurate, on the one hand because real population growth varies over time and, on the other hand, because the populations in question have trends and growth rates that differ from total population growth rates. In fact, population projections by sex and age (national projections and those of the United

Nations) have not been used much or at all in the past, leading various departments to at best prepare their own estimates or projections, or at worst, to simply ignore the demographic variable altogether.

However, population projections are a crucial tool for measuring coverage rates, estimating needs and setting goals. Niger prepared these types of projections in 2005, as did Burkina Faso in 2009 (INSD, 2009). In Niger, the results of these projections were included in the population policy of 2007, and were used to set goals. These results also allowed the authors of the 2008–2012 ADPRS (Accelerated Development and Poverty Reduction Strategy) to conduct an analysis of the "potential effects of population growth" on various sectors (agriculture and food security, education and health). In Burkina Faso, the results of the national demographic projections were included in the draft population policy in 2007, and they were also used to set goals. However, the results of these projections were not included in the December 2010 version of the 2010–2015 SCADD, which was supposed to be finalized in late 2010.

The development and use of "decision-making" types of national population projections (see 3.2, 3.3 and 3.4) are the first essential step in actually considering the population variable in sectoral policies. This is why all countries should have such projections, and they should be widely distributed, and then accepted, recognized and used by all of the stakeholders and sectors. They are in fact intended to serve as a single base of reference for estimates and projections and for setting goals for all sectors, including those identified in strategies for accelerating growth and fighting poverty, many of which are due for revision soon.

4. The Feasibility of an Increased Use of Contraception

Given the economic, demographic and political contexts of the countries studied, can we expect a rapid increase in contraceptive use, which would allow these countries to look at an acceleration in the decline of fertility and to enter the demographic window of opportunity soon? What could the role of technical and financial partners be in achieving this objective? What are the obstacles? What are the costs?

4.1. The role of technical and financial partners

The policies, plans, programs and strategies on population, health and reproductive health receive support from many technical and financial partners (between 10 and 15 per country) in all of the countries. Among them, we must identify:

- Partners within the United Nations system (UNFPA, UNICEF, WHO, UNAIDS, WFP, UNDP, World Bank);
- The European Commission and bilateral partners (in particular USAID for the United States, KfW from Germany and AFD from France);
- Private partners (usually from international NGOs such as IPPF (International Planned Parenthood Federation) and PSI (Population Services International).

The operating procedures of these partners vary. The agencies of the United Nations system and multilateral and bilateral cooperation agencies mainly provide financial support to the public institutions (financial support of projects and/or budgetary support). Private partners, who receive international funds from bilateral or private sources, are usually directly involved in providing services and benefits.

The scope of involvement of these partners varies. However, most of them operate in the fields of reducing maternal mortality, improving child survival or preventing or combating HIV/AIDS.

In addition, there are partners (approximately one third) that support family planning programs or activities as one of their priorities. Finally, some partners are involved in programs to fight violence against women.

The three most important partners in the field of family planning, namely UNFPA, IPPF and PSI, have currently adopted a "reproductive health" approach. Their family planning activities are therefore "diluted" throughout all their activities.

UNFPA, the United Nations agency specialized in population issues, began intervening in the 12 countries studied in the 1970s, beginning with providing support to improve demographic knowledge.[26] Starting in the 1980s, UNFPA activities in each country became part of collaborative country programs of about five years, and to date, four or five programs have already been implemented in the said countries. The current programs are now part of the United Nations Development Assistance Framework (UNDAF) in each country. They all include three subprograms or components: reproductive health, population and development and gender issues. The reproductive health component, which includes family planning, aims to improve the provision and use of reproductive health services in general, but only in certain "priority regions" of the UNFPA. However, this component also provides support at the national level by supplying contraceptives to countries, and by assisting the countries in defining policies and strategies for reproductive health. The population and development component generally supports implementing population policies, and includes population, gender and human rights issues in the policies, plans and programs, and particularly in the PRSPs. Finally, by improving institutional mechanisms and helping to change socio-cultural practices, the gender issues component aims at promoting the rights of girls and women and contributes to gender equality and equity.

The IPPF, which was originally a federation of autonomous national family planning associations, currently has the goal of promoting the right to reproductive and sexual health, sex education for young people, the empowerment of women, the fight against STDs and fertility control. Today it has some 180 associations around the world, including those of the 12 countries studied (MFPF, 2011; IPPF, 2011). The oldest is that in Ghana, established in 1967, two years before the adoption of the country's population declaration. Associations were subsequently created in Mali (1972), Senegal (1974), Togo (1975) and Côte d'Ivoire (1979). The most recent are those in Niger (1996),

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[26] Refer to the UNFPA websites for each country, for example for Benin, go to http://benin.unfpa.org/, for Burkina Faso, visit http://burkinafaso.unfpa.org/ and for Nigeria, the address is http://nigeria.unfpa.org/.

Guinea-Bissau (1993) and Mauritania (1990). The oldest were, for a long time, the only ones to offer family planning services and promote them in their country. Today, all of these associations with a "reproductive and sexual health" approach provide benefits and services to vulnerable groups, including prenatal and postnatal and post-abortion care and counseling, HIV/AIDS counseling and testing, infertility treatment, counseling before marriage and more. The data available about these activities apply to all Associations' benefits (for example, they served nearly 400,000 people in Togo and 100,000 in Senegal in 2006), except in two cases for which we have specific data on family planning services. The association in Ghana also indicated that it provided nearly 90,000 couple years of protection (CYP) in 2006,[27] which represents approximately 15% of users of modern methods in the country. The Nigerian association estimates that it has provided contraceptives to 10% of users of modern methods in the country. It is still difficult today to know the reach of family planning activities for other associations.

PSI began its activities in West Africa in the 1990s by promoting condom use using social marketing techniques to prevent the transmission of STIs (sexually transmitted infections) and HIV/AIDS. Its current goal is to *"empower women and couples to lead healthier lives by providing them access to innovative family planning and maternal health products and services"* (PSI, 2011). PSI operates in thirty countries in sub-Saharan Africa (including eight in West Africa: Benin, Burkina Faso, Côte d'Ivoire, Guinea, Liberia, Mali, Nigeria and Togo). Today, the national branches of PSI, as well as some national organizations that PSI has promoted (PROMACO, *Projet de marketing social des condoms* (Project for Social Marketing of Condoms) in Burkina Faso and AIMAS, *Agence ivoirienne de marketing social* (Agency for Social Marketing in Côte d'Ivoire) have expanded their range of activities. While they distribute the pill in some countries, their interventions also include reproductive health in general, and, in many countries, the fight against malaria and waterborne diseases. We must also mention the existence of national organizations, such as the Ghana Social Marketing Foundation (GSMF) and *Animas Sutura* in Niger, who use the same type of social marketing approach, based on a balance between communication and awareness building and selling subsidized health products through traditional marketing structures. Local entities that receive financial support and technical advice promote the sustainability of these services through social marketing in the countries in

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[27] Couple years of protection (CYP) measures the total number of years of contraceptive protection provided to a couple (IPPF, 2010) according to the various modern contraceptive methods used (13 cycles of oral contraceptives and four injections protect a couple for a year, and the insertion of one IUD protects an average couple for three and a half years).

question, even though these activities do not presently provide any financial independence.

Generally, this wide range of partners in the countries and their varying statuses, activities and coverage of population and reproductive health makes it complicated to analyze all the activities conducted and to evaluate their impacts. The wide range of fields are derived from many components of reproductive health, including maternal and infant health, sexually transmitted diseases, AIDS, sterility, post-abortion care, cancer related to reproduction, and family planning. In countries where fertility and mortality remain high, there is now competition in defining priorities between these various reproductive health components. Finally, implicit or explicit priority has often been given to protected maternity and childcare, as these are the most pressing needs. But this is most often done at the expense of family planning, as indicated in an evaluation conducted by the United Nations on the subject in 2004 (United Nations, 2004). This evaluation reminds us that integrating reproductive health services and family planning in the public health system remains the reference, because it helps reduce the cost of these services and increases their geographic coverage. However, it also points to several obstacles to this integration: a vertical structural organization of care, a lack of suitable financial and human resources and also a low absorptive capacity for aid; in addition, the quality of care provided by public services goes down, which leads to the discouragement of staff to provide women who come in for prenatal or postnatal visits with even the most basic information about family planning. This is what is indicated in the results of surveys conducted on relationships between caregivers and those receiving care in five Western Africa capitals, Abidjan, Bamako, Conakry, Dakar and Niamey (Jaffré and Olivier de Sardan, 2003).

Should a vertical approach to family planning be prioritized? It is difficult to answer this question. For example, in Togo, in the 1970s, family planning promotion conducted by the sole IPPF member association appears to be partly responsible for the faster decline in fertility in the country. But nothing like this happened in Mali. Surprisingly, in Ghana, the combination of promoting family planning starting in 1967 by the IPPF member association, adopting a population policy declaration in 1969, and implementing a national family planning program in 1970 did not provide better results than in Togo.[28]

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[28] The reasons for the modest performance in Ghana, despite very favorable conditions, are detailed in an analysis by Caldwell and Sai (2007).

All in all, it is not easy to answer any of the three following issues: integration of family planning services into public health systems; extent of technical and financial support to be provided to authorities; and reserving a place for private providers. The results of recent Demographic and Health Surveys (DHS, 2011*a*) conducted in the countries studied show that more than half of the women usually obtain their modern contraceptive methods from the public sector. This proportion varies from one method to another, but it often remains very high for the pill and sometimes for condoms. Under these circumstances, expanding the role of the public sector could help increase the supply of oral contraceptives and condoms, freeing up public health centers that are currently meeting a significant portion of demand. As a result, we could expect them to increase their provision for longer term methods (such as IUDs and implants), which require the intervention of a qualified personnel.

Expanding the use of modern contraceptives requires a careful examination of the capacities of each provider (public and private), the distribution of methods used and the choices that can be considered with regard to future changes in contraceptive mix. Studies such as those conducted in Niger in 2008 (Guengant and Metz, 2008) may shed light on the possible choices in this matter.

## 4.2. Are rapid increases in contraceptive use possible?

The levels of contraceptive use in the countries studied are among the lowest in the world (see Section 3.1). Overall, between 5% and 20% of women in union used some method of contraception at the end of the 2000s (Graph 18). The highest figure is reported in Ghana (23% in 2008). The rates for the use of traditional methods, considered less effective,[29] remain highly variable but very high in several countries: 65% in Benin, nearly 50% in Guinea and over 40% in Nigeria. However, they range between 10% and 15% in Guinea-Bissau, Mauritania, Niger and Senegal. The use of modern methods only applies to 5% to 15% of women in union.

Despite these very low levels of contraceptive use, the surveys reveal significant unmet needs for a large proportion of women who are not using any contraceptive methods, although they would like to delay their next birth or not have any more children. In the late 2000s (Graph 18), these unmet needs affect an average of 30% of women in union, with significant variations by country (from 16% in Niger to 40% in

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[29] Traditional methods, whose effectiveness is lower than that of modern methods, are the reason for many failures (unwanted pregnancies). For more information on the effectiveness of various contraceptive methods, see Futures Group, 2011 and USAID, 2011.

Graph **18** *Proportion of women in union using a contraceptive method with unmet needs in family planning*
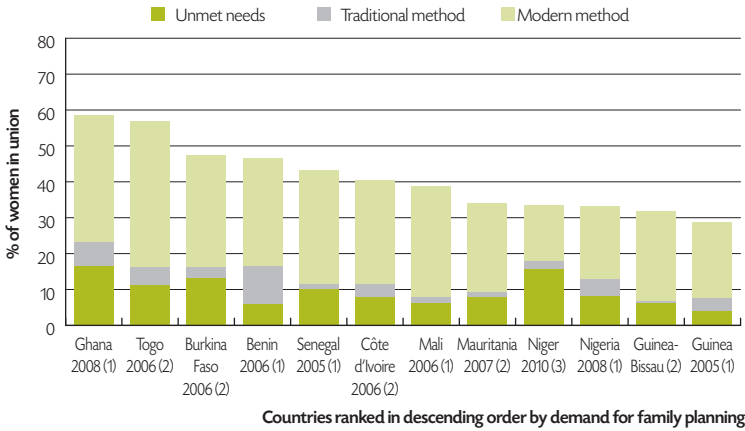
Source: DHS, 2011a; UNICEF, 2007; IDEACONSULT International, 2010.

Togo). Unmet needs are generally two to three times higher than met needs, in other words, the percentage of women using a contraceptive method. Nevertheless, paradoxically, total demand for family planning (the sum of met needs and unmet needs) remains low in most countries. The total demand for family planning by women in union is actually below 50% everywhere except in Ghana and Togo, which is low compared to the demand of 70 to 85% observed in emerging countries. Total demand is between 40 and 50% in four countries and below 40% in six countries (a level two times lower than that those observed in emerging countries).

One often attributes the low levels of contraceptive use in sub-Saharan Africa to a lack of easily accessible family planning services. This factor certainly plays a role and may explain the high number of unmet needs in comparison with met needs. The low level of contraceptive use is also often attributed to the population's low level of education and poverty. The data available in the DHS surveys on the subject only partially confirms this interpretation. The use of contraceptives by the most educated women and those who are better off is generally at least three times higher than for uneducated women and for the poorest women. However, contraception use remains low even among the most privileged women. For many women, it is certainly difficult to access safe reproductive health and family planning services that are effective and affordable, which explains the scale of unmet needs. However, many

women are clearly not even fully aware that they can space or limit births, or that they can express an opinion on this matter (which may differ from that of her husband, family or in-laws). In this case, denying expression or knowledge can explain the low demand for family planning.

However, low demand may also be explained by social norms, particularly the pro-birth tradition and the promotion of multiple births, and by what some term "socio-cultural pressures". The results of DHS surveys on this topic actually indicate an average ideal number of children raised in most of the countries studied, including for young women (Graph 19). In fact, the average ideal number of children for all women aged 15 to 49 remains higher than six in four countries (it is nine in Niger). This figure is between five and six children in other countries, except in Togo where it is 4.5, which remains high compared to the average ideal number of children observed in emerging countries. In a fairly predictable manner, the ideal number is lower in young women (age 15–24) than in older women (age 40–49). However, the 25 years separating the two age groups does not lead to a significant decrease (more than two children) except in Côte d'Ivoire and Mauritania. In the remaining countries, the decrease in the ideal number of children desired by women generally ranges from 1 to 1.5. This means that the number remains very high among young women – close to or higher than five children in most countries (eight in Niger) and between four and five children in remaining countries.

Are increasing education levels, particularly among the young, likely to lead to a faster decline in fertility over time, thanks to these more educated young women adopting new standards that are less pro-birth? Certainly, but not as much as we might expect. It should first be noted that the 20% to 30% of young girls currently enrolled in secondary education in most countries will only end their reproductive lives in thirty years. In addition, the average ideal number of children for young women with at least a secondary level of education is actually less than that indicated for uneducated young women (Graph 20). Although the difference is approximately three children in two countries, Niger and Nigeria (who start with higher levels), the difference is 1.5 to 2 children for the other countries. The average ideal number of children for most educated young women remains higher than four for half of the countries, and is between three and four in the remaining countries.

From these results, an average ideal number of children emerges that is probably quite different from the number of children that the young women respondents would actually have. However, they underscore that in most of the countries, progress in education and "the youth effect" will not be enough to accelerate a decline in fertility.

We must also take into consideration the fact that raising the level of education for the entire population is a slow process.

However, accelerating the use of contraceptives, which would lead to faster declines in fertility, could be undertaken in most of the countries on the basis of unmet needs. It will not occur "all by itself" and will not be the mechanical consequence of economic and social development in the countries.
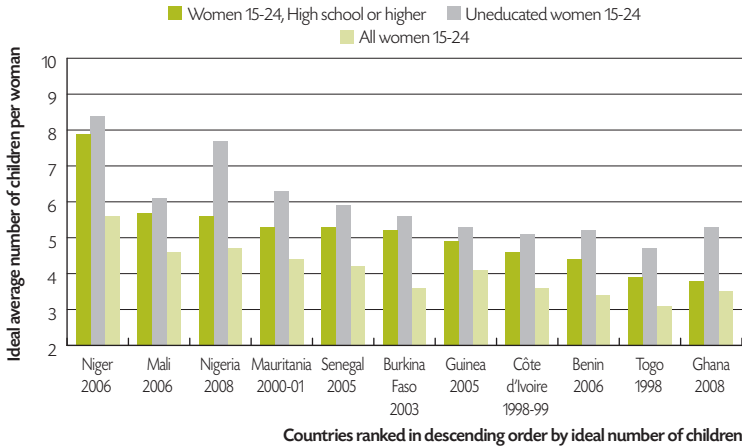
We can learn lessons from the experiences in emerging countries, where an acceleration of economic growth occurred at the same time as an acceleration of the demographic transition, which itself was triggered by specific policies and programs. Therefore, it seems necessary to convince the countries' leadership that in order to scale up and sustainably increase their economic growth, they also need to accelerate their demographic transition by continuing efforts to not only reduce mortality levels, but also to accelerate the decline in fertility.

The low levels of modern contraceptive use, their very slow increase and the still high average ideal number of children, including among educated young women, raise several issues. The first involves the almost exclusive focus most countries have placed on spacing births, to the detriment of freedom of choice in matters of reproduction. The second is the acceptance of maintaining reproductive norms from

Graph 19 *Average ideal number of children per woman (by major age groups)*
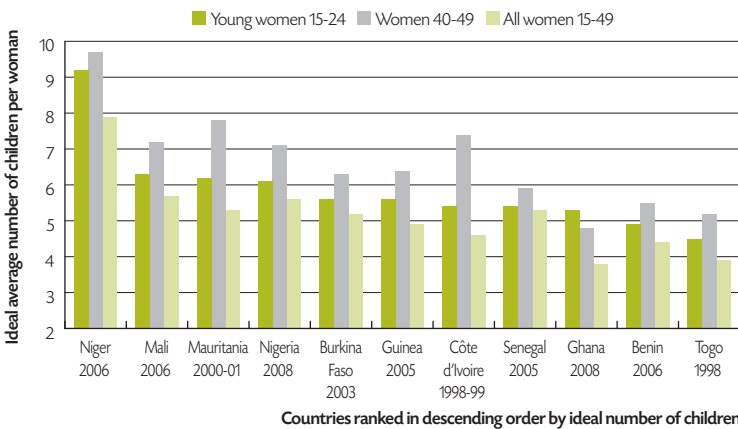
Source: DHS, 2011b.

Graph 20 *Average ideal number of children for young women (by level of education)*

■ Women 15-24, High school or higher   ■ Uneducated women 15-24
■ All women 15-24

Countries ranked in descending order by ideal number of children

Source: DHS, 2011b.

overwhelmingly rural societies without debate, with the inherent high mortality and low levels of education, which were in effect when these countries became independent. The third focuses on the unmet needs for family planning. Meeting these needs would help reduce the number of high-risk pregnancies as well as the remaining very high levels of maternal and infant mortality.

Promoting free choice and changes in procreation norms as well as satisfying unmet needs for family planning will occur by re-examining policies and programs targeting population, health and reproductive health. This re-examination should be seen as an opportunity to give family planning the standing it deserves among the many elements that make up reproductive health. In addition, it seems necessary to launch genuine, sustained family planning campaigns. And finally, vigilance about women's rights still appears to be needed, in particular regarding their economic and social rights as well as their reproductive rights, which are not always respected.

4.3. Costs associated with a rapid increase in the use of modern contraception

Estimating costs associated with family planning programs and increasing contraceptive prevalence is a difficult exercise. First of all, family planning services in

the public sector are often included in health care services and it is complicated to isolate specific costs. The respective shares of the public and private sectors and the extent of social marketing also vary from one country to another. Finally, the rate of urbanization and the wages paid in each country also have an impact on program costs.

The primary cost associated with programs for family planning and increasing contraceptive prevalence is the purchase price of the contraceptives themselves. However, they also include employee compensation (based on the time they spend on family planning if it is part of health services), increasing healthcare workers' awareness of the importance of family planning, their training (especially for supplying long-term methods), recruiting new staff in case of increased contraceptive use and recruiting community agents. They also include costs linked to infrastructure: maintenance, electricity, upgrading, construction of new healthcare centers, setting up mobile teams, etc. Increased contraceptive use also requires stimulating demand, which means significant budgets for communication such as annual national family planning campaigns. Finally, in most countries of sub-Saharan Africa, it would appear necessary to strengthen and sometimes reorganize the supply logistics chain for contraceptives and other reproductive healthcare products, which comes at a cost.

For all of these reasons, three types of approaches, or methods, are generally used to estimate the costs associated with family planning programs. The first and simplest approach consists of estimating only the purchase costs of contraceptives. The second approach consists of evaluating program costs based on "couple year of protection" figures by integrating the cost of purchasing contraceptive products and the costs associated with distributing them to users. The third approach consists of taking the total cost associated with providing family planning services and dividing these costs by the number of users to be able to evaluate the "cost per user". This last approach includes the purchase cost of contraceptive products and total operating costs for the program, but excludes the expenditures needed for program outreach.

We have tried to put a figure to the costs for contraceptive products for the next ten years for each of the three assumptions for increased prevalence (see 2.2):

- High, *laissez-faire* assumption: +0.5 percentage point increase per year;
- Intermediate assumption: +1 point increase per year;
- Low, accelerated assumption: +1.5 point increase.

The purchase costs of contraceptives and changes in these costs depend on four factors:

- The cost of each method adopted during the year and price increases over time;
- Changes in the number of women of childbearing age (and in union);
- Changes in the distribution of methods used (costs varying from one method to another);
- Assumptions about an increase in the prevalence of the form of contraception chosen.

For each method, we estimated a reference price in US dollars for the 2010 base year (price registered in the capital or main city, excluding taxes and customs), based on the elements contained in the Reproductive Health Supplies Coalition database.[30] The data for the other factors were obtained from the demographic projections and assumptions prepared for each country in this study. We thus arrive at an estimate of the average cost per user of US$4-6.

Between 2010 and 2020, the number of women of childbearing age will increase by 30% to nearly 50% depending on the country, and the cost of products will increase by 35% (assuming an annual price increase of 3% per year for all contraceptives). Combining these factors with the assumptions for increased total prevalence (associated with a decrease in the use of traditional methods) results in an estimated purchase cost in 2020 that is significantly higher than in 2010:

- 2 to 3 times higher with the *laissez-faire* assumption of +0.5 points per year;
- 2.5 to 4 times higher with the intermediate assumption of +1 point per year;
- And 3 to 5 times higher with the accelerated assumption of +1.5 points per year.

In countries where the percentage of traditional methods was very high in 2010, the assumption that moves rapidly toward using modern contraceptive methods increases the need for modern methods. The increase in the number of women of childbearing age and projected increases in prevalence are headed in the same direction. It seems then, that regardless of the assumption used, the need for contraceptive funding will be considerable in coming years. For the next five years, the average annual increase is at least 10% with the assumption for increased

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[30] Estimated costs based on the average cost (2005-2010), see RHI, 2011.

Table 2 — Number of women (thousands) of reproductive age 15 to 49 (2010–2020)

Country	2010	2015	2020
Benin	2,031	2,371	2,780
Burkina Faso	3,686	4,378	5,215
Côte d'Ivoire	5,197	5,932	6,753
Guinea-Bissau	380	434	501
Mali	3,177	3,818	4,575
Niger	3,279	3,973	4,796
Senegal	3,027	3,509	4,003
Togo	1,689	1,954	2,230
WAEMU	22,466	26,367	30,853
Ghana	6,057	6,797	7,541
Guinea	2,373	2,765	3,222
Mauritania	838	944	1,053
Nigeria	37,425	42,712	48,619

Source: Projections and estimates made within the framework of the study.

Table 3 — Number of women (thousands) using modern methods of contraception (excluding sterilization)

Country	2010	2015	2020
Benin	86	196	375
Burkina Faso	435	705	1,065
Côte d'Ivoire	245	478	789
Guinea-Bissau	16	36	60
Mali	202	433	752
Niger	245	478	789
Senegal	225	400	613
Togo	120	214	337
WAEMU	1,574	2,941	4,781
Ghana	517	785	1,107
Guinea	79	199	382
Mauritania	41	80	128
Nigeria	2,016	3,945	6,599

Source: Projections and estimates made within the framework of the study.

Table 4 · *Cost of purchasing contraceptives (US$ thousands)*

Country	2010	2015	2020
Benin	450	1,187	2,628
Burkina Faso	2,560	4,813	8,423
Côte d'Ivoire	1,222	2,768	5,299
Guinea-Bissau	51	130	255
Mali	848	2,115	4,255
Niger	1,222	2,768	5,299
Senegal	982	2,019	3,589
Togo	545	1,124	2,053
WAEMU	7,881	16,924	31,801
Ghana	2,311	4,072	6,656
Guinea	327	956	2,126
Mauritania	245	560	1,035
Nigeria	29,725	51,043	84,239

Source: Projections and estimates made within the framework of the study.

prevalence of +0.5 points per year, and approximately 15% with the assumption for a rapid increase of +1.5 points per year.

The results for this accelerated assumption are presented in Tables 2 through 4. They involve multiplying the annual purchase costs of contraceptives by four for the eight WAEMU countries: estimated at US$8 million in 2010, they will increase to US$32 million in 2020.

However, the purchase costs for contraceptive products only represent a small fraction of the total cost of family planning programs in each country. A 2006 study on the contribution of family planning to the MDGs, which uses the "costs per CYP" approach, estimates the average cost per CYP at US$11.20 for sub-Saharan Africa (Moreland and Talbird, 2006), which is 2 to 3 times more than the purchase cost of contraceptives per user of US$4–6 mentioned above. This study also provided "cost per user" estimates while underscoring that costs diminish with an increase in contraceptive prevalence, resulting in economies of scale. The average cost per user in sub-Saharan Africa has been estimated at US$28 in 2005 and US$26.20 in 2010. A more recent study for 2010 indicates an average cost per user in Africa of US$27.60

(Moreland *et al*., 2010), or between five and seven times more than the average purchase price of contraceptives per user.

However, this study also provides an estimate of the "cost/benefit ratio" that can be expected from the implementation of family planning programs in the 16 sub-Saharan African countries (7 of the 12 studied).[31] For each of these countries, it first estimated the costs associated with meeting their unmet needs in family planning by 2020 for the 2005–2015 period. For most countries, this assumption matches the increase in contraceptive prevalence of approximately 1.5 percentage points per year, or an increase close to that used in the accelerated assumption for a rapid increase of contraceptive use. This assumption, based on satisfying unmet needs, is then compared for each country with an assumption for not meeting these needs (that is, maintaining them at their base level), which in 10 years (between 2005 and 2015) results in fewer children. The study then estimates for each country, on the one hand, the cost for family planning programs based on the assumption of meeting the unmet needs, on the basis of an average cost per CYP of US$11.20 and, on the other hand, the "lower expenses," or savings resulting from a decrease in the number of children under age 10. These "lower expense" figures are calculated for education, vaccinations, water supply, maternal health and malaria control. In 10 years, they are on average three times higher than the additional expense incurred by increasing contraceptive prevalence. More than three quarters of these savings come from education, maternal health and vaccinations.

Therefore, an additional investment in family planning would have very significant returns both over the short and long term; it would also help to improve the living conditions of the human capital of children. In fact, the savings could be invested to accelerate coverage and improve the quality of care and services provided in health and education. In total, an increase in contraceptive prevalence of +1.5 percentage points per year would imply a very sharp increase in contraceptive requirements in the next 10 years. It would also imply significant additional resources, both financial and human, likely to represent between five and seven times the average purchase costs for contraceptives per user. However, these costs should be assessed based on "lower expenses," that is, based on much higher savings than are made possible by family planning expenditures. In addition, above and beyond the cost benefit aspect, the stakes associated with increasing contraceptive prevalence are considerable (see 3.4) in terms of the change in the number of births, population growth rates and dependency ratios.

[31] Burkina Faso, Ghana, Guinea, Mali, Niger, Nigeria and Senegal.

Conclusion

The demographic transitions observed in the 12 countries studied[32] on which this synthesis was based are slow and recent. A number of factors explain the trends, notably the late recognition by the authorities, and by certain development partners, of problems related to population growth and high levels of fertility. Moreover, the policies, plans, programs and strategies defined and implemented over the last 20 years have not helped control the high increase in population in countries of the subregion.

These mixed results can be explained by the weakness of political, financial and human resources allocated to this area as well as by the lack of data, which hindered the formulation of objective diagnostics. They can also be explained by two major paradigm shifts that occurred at the international level as a result of adopting an approach promoting reproductive rights and health in Cairo in 1994, and the MDGs in 2000. They have overshadowed the demographic dimension of development in Africa for two main reasons: rapid demographic transitions observed elsewhere in the world, and fear of the magnitude of the deadly consequences of the HIV/AIDS epidemic. It is in this climate that countries and their partners have worked to make the most immediate challenges to the population a priority. This approach favored managing pregnancies, births, obstetric and neonatal emergencies as well as prevention and care for people with HIV/AIDS. These priority interventions were executed at the expense of a long-term vision of the impact of rapid population growth: they have had a negative impact on the prevention of high-risk pregnancies, reproductive rights and, in the end, on access to family planning services and on the promotion of contraceptive use.

The detailed analyses carried out have, however, shown signs of progress: the constraining effects of strong population growth making it more difficult to meet social demands and the acceleration in the increase of per capita GDP are now widely recognized. Nevertheless, the ability and legitimacy of acting in the short term on the "population" variable are not yet accepted by all. The need to reduce the high

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[32] The eight WAEMU countries (Benin, Burkina Faso, Côte d'Ivoire, Guinea-Bissau, Mali, Niger, Senegal and Togo), as well as Ghana, Guinea, Mauritania and Nigeria.

levels of morbidity and mortality is most certainly acknowledged. However, everything related to the field of fertility is often still subject to passion and polemics because it is at the crossroads between tradition and power issues between genders and generations.

Nevertheless, together with pursuing efforts to reduce mortality, interventions to reduce fertility will have the greatest impact on population dynamics and changes in age structure, allowing countries to generate what they need to accelerate economic growth and improve their human capital. The slow and recent demographic transitions of the 12 countries studied have major negative consequences.

The extreme youth of their populations creates particularly strong social demand for education, employment, health and housing that few countries in the world could meet on this scale of growth. Considerable efforts in all these areas have been made by the countries in question with support from their development partners, with the objective of achieving the MDGs by 2015. We must hope that these efforts will be supported at the same pace for the next 20 years.

The financial crisis that has struck OECD countries offers no guarantees over the medium term, especially in a context of increasing needs in some of the developing areas. The extreme youth of the population (two out of three West Africans are now under 25) will automatically result in high increases in populations by 2030. For the 2010–2030 period, the total population of the eight WAEMU countries is expected to increase from about 100 million to 165–180 million people. New annual arrivals on the labor market in these eight countries will increase dramatically at an impressive rate, from 1.8 million young men and women in 2010 to 3.4 million in 2030.

Given this limited and uncertain context, and since tomorrow's adults have already been born, it will be necessary to reflect and take action about the unmet needs for family planning (involving approximately 30% of women in union). Accelerating the use of contraception meets these expressed needs and can lead to a faster decline in fertility and population growth rates. This acceleration is one of the major levers that can enable countries to meet the social and economic challenges they face.

Meeting unmet family planning needs and accelerating the use of contraception will help countries reduce the time required to double their per capita GDP. With population growth reduced to 2% per year, the time required to double per capita GDP varies based on the strength of economic growth between 14 years (7% economic growth per year) and 24 years (5% economic growth per year). With

population growth maintained at 3% per year, the time required extends to between 18 years (7% economic growth per year) and 35 years (5% economic growth per year).

Accelerating the use of contraception will make the quasi-stabilization of the number of annual births possible, giving countries the opportunity to invest significant amounts previously spent on this important area of intervention differently. In 2010, nearly 4 million births were recorded in the eight WAEMU countries. This figure may stabilize at around 5 million in 2030, subject to acceleration in the use of contraception. However, a continuation of current demographic trends would mean nearly 7 million births in 2030.

Finally, this would allow for changing their age structures more rapidly and for capitalizing, under certain conditions, on the demographic dividend that results from reducing the number of inactive dependents per worker.

In contrast, continuing current trends will make it more difficult to reduce the percentage of high-risk pregnancies (between 50 and 65%), reduce the high percentages of children who have low height for age (between 25 and 50%), achieve universal primary school enrollment as well as food and nutritional security for urban and rural populations.

The analysis and forecasting work conducted in the context of this study allowed us to present an "accelerated" assumption for accelerating contraceptive use for the 2010–2030 period. These projections are realistic and do not question the demographic dynamism of the countries nor their youth. Trends related to accelerating contraceptive use that do not involve coercive actions meet the actual expressed needs for family planning that are currently unmet. Under this assumption, all the countries studied would maintain an annual growth rate of at least 1.5% (1.1% in Ghana). In 2030, youths under age 15 will still represent 30% to 40% of the total population of the countries (*versus* 40 to 50% in 2010), and will remain between 6 and 10 times more numerous than those aged 65 or over (compared to 15% of the total population of Western Europe).

For this "accelerated" pro-development assumption to become a reality, it is essential that each country be committed to programs and that these be financed by governments, civil societies and development partners. This could include a commitment to reduce expressed unmet needs for family planning by half by 2020, or similarly increase contraceptive use by 1.5 percentage points. Implementing this commitment would involve assessing the capacities of each stakeholder, defining the

respective roles of the public sector and private sector and the financial support for each. It also requires increasing the provision of contraceptive methods and estimating the number of users to be served. Depending on the country, this would require three to five times more resources than those currently allocated to family planning. For the eight WAEMU countries, the annual cost for purchasing contraceptives should increase by a factor of four in 10 years: Estimated at US$8 million in 2010, they will increase to US$32 million in 2002, with the purchase costs for the next five years approximately US$60 million, or over CFA30 billion. However, these costs should be assessed based on "lower expenses," *i.e.* on potential savings that are, on average, three times higher than would be made possible by family planning expenditures.

Naturally, development is not only about controlling fertility, but not taking demographic changes into account or limiting the number of observations would be a mistake. The 12 countries studied can benefit from the demographic dividend, as have other developing countries that are now classified as emerging countries before them. It is time for these 12 countries to enjoy the return on the significant investments they have made to improve their human capital. It is also time for these countries to use the flexibility of their economic investments to bring their human capital to the current levels observed in emerging countries. These countries, which became emerging countries over a period of about forty years, have invested heavily in the productive and social sectors while reducing their fertility levels, population growth and dependency ratios, factors that are often omitted from analyses. Almost half of the strong economic growth observed in East and Southeast Asia between 1970 and 2000 can be attributed to these demographic changes.

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List of Acronyms and Abbreviations

ADPRS   Accelerated Development and Poverty Reduction Strategy
(*Stratégie de développement accéléré et de réduction de la pauvreté* [Niger])

AFD   *Agence Française de Développement*

CYP   Couple year of protection

DGPP   *Déclaration du gouvernement en matière de politique de population*
(Declaration of the Government's Population Policy)

DHS   Demographic and Health Surveys

INSD   *Institut national de la statistique et de la démographie* (Burkina Faso)

IPPF   International Planned Parenthood Federation

LIMS   Logistics Information Management Systems

MDG   Millennium Development Goals

PAIP   *Plan d'action et d'investissements prioritaires en matière de population*
(Action Plans and Population Assistance Investment Programs)

PDDSS   *Plan décennal de développement sanitaire et social*
(Ten-year Health and Social Development Plan)

PNDS   *Plan national de développement sanitaire*
(National Health Development Plan)

PPP   Purchasing Power Parity

PRGS   Poverty Reduction and Growth Strategy

PRSP   Poverty Reduction Strategy Paper

PSI   *Population Services International*

PSSPSR   *Plan stratégique de sécurisation des produits de santé de la reproduction*
(Reproductive Health Commodity Security Plan)

SCADD   *Stratégie de croissance accélérée et de développement durable*
(Accelerated Growth and Sustainable Development Strategy [Burkina Faso])

SDRP   *Stratégie de développement accéléré et de réduction de la pauvreté*
(Accelerated Development and Poverty Reduction Strategy [Niger])

TFR   Total Fertility Rate

UNFPA   United Nations Population Fund

UNDAF   United Nations Development Assistance Framework

USAID   United States Agency for International Development

**UNAIDS/
ONUSIDA**   United Nations Programme on HIV/AIDS

WAEMU   West African Economic and Monetary Union

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How Can We Capitalize on the Demographic Dividend?

In the coming decades, West African countries could benefit from a "demographic window of opportunity" in order to reduce their poverty. The entry of 160 million young people into the labor market between 2010 and 2030 can accelerate economic growth. However, these countries will only benefit from this "demographic dividend" – which the now emerging countries have been doing for the past 40 years – if they lower their fertility rates. This in turn will reduce the number of inactive dependents per worker. Yet with an average of over five children per woman, these rates continue to be the highest in the world.

But how should this major demographic turning point be addressed? This publication provides a synthesis of an extensive study conducted in 12 West African countries. It seeks to identify the public policies and levers for action (family planning and promotion of contraception in particular) that are likely to meet this challenge. To achieve this, the countries in question will need to allocate three to five times more resources to this policy than they do today.

This regional synthesis is completed by 12 country studies (Benin, Burkina Faso, Côte d'Ivoire, Ghana, Guinea, Guinea-Bissau, Mali, Mauritania, Niger, Nigeria, Senegal and Togo), which can be consulted and downloaded on the websites of AFD and IRD, the co-publishers of this publication.

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