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PUBLIC HEALTH

Return of the Population Growth Factor

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Academic analysts, the news media, and the international community have frequently engaged in divisive debates over population and international family planning, with periods of attention and funding followed by years of neglect, particularly in the last decade. On 31 January, the All Party Parliamentary Group on Population, Development, and Reproductive Health of the U.K. Parliament (the group) issued a report, *Return of the Population Growth Factor: Its Impact upon the Millennium Development Goals* (MDGs) (1). The report, the product of extensive hearings and analysis of written and verbal testimony, cited overwhelming evidence that “the MDGs are difficult or impossible to achieve with current levels of population growth in the least developed countries and regions.” It recommends a substantial increase in support for international family planning, particularly for the 2 billion people currently living on less than \$2 per day. The report does not argue that population is the only, or even the leading, factor in achievement of the MDGs. Instead, it presents a compelling case that continued neglect of family planning in developing countries will severely undermine crucially important goals.

The Population Pendulum

In the 1960s and '70s, many developing countries adopted national population policies and family planning services. Although some Asian policy initiatives incorporated coercive elements, most family planning efforts were entirely voluntary and proved remarkably successful. Initiatives relied on both public and private sectors to provide modern methods from voluntary sterilization to condoms, with appropriate information. Between 1960 and 2000, the percentage of married women in developing countries using contraceptives jumped from <10% to 60%, and total fertility rates fell from six to about three (2).

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Despite these successes, surveys continued to indicate that many women in developing countries wanted to space their children or limit childbearing altogether, but still did not have access to the most effective contraceptive methods. When the world's scientific academies, including the American Academy of Sciences and the Royal Society of London, gathered in New Delhi in 1993, they concluded that “humanity is approaching a crisis point with respect to the interlocking issues of population, environment, and development.” The academies agreed, “the goal should be to reach zero population growth within the lifetime of our children.” (3).

The United Nations 1994 International Conference on Population and Development (ICPD), held in Cairo, noted the need to slow population growth in developing countries, but the political emphasis of their Programme of Action (PoA) was on holistic approaches to reproductive health. Many women's advocates at the ICPD criticized promotion of family planning to reduce population growth as inherently coercive. The PoA estimated that by 2005 the cost of meeting the broad agenda set out at Cairo would be \$25 billion annually (adjusted for inflation), with one-third to be provided by international donors. It was a bold agenda, but it lacked sufficient political traction.

Many of its goals proved unattainable in resource-poor settings, whereas attention to family planning was largely ignored. By 2004, the investment by developed countries in international family planning had fallen to 13% of the target set by the ICPD (4).

Population Growth and MDG Goals

The evidence provided and analyzed in (1) included the following points.

MDG 1: Eradicate extreme poverty and hunger. It will be almost impossible to reach the target of halving the number of people living on less than \$1 a day by 2015 without a large-scale recommitment to family planning. In sub-Saharan Africa, partly as a result of rapid population growth, the number of peo-

The Millennium Development Goals set by the United Nations cannot be achieved unless family planning is made easily available in the lowest-income countries.



The crisis in Niger. “Niger’s population is set to increase from 14 million to 80 million in 2050 if current fertility remains the same—an unimaginable scenario in a country already unable to feed itself, facing widespread destruction of local ecosystems through over-grazing, continued mass poverty, underemployment and massive dependence on international aid....so, without massive investment in family planning programmes, the outlook is bleak.” (6).

ple living in extreme poverty rose from 231 million in 1990 to 318 million in 2001. The U.N. Population Fund (UNFPA) pointed out that almost 1.5 billion young men and women will enter the 20-to-24-years age cohort between 2000 and 2015, and if they don't find jobs “they will fuel political instability.” (5).

MDG 2: Achieve universal primary education. Voluntary limitation of family size is also essential for developing countries striving to meet the MDG of eliminating gender disparities in primary and secondary education by 2015. Children in large families, especially girls, are less likely to enter school, more likely to drop out, and are sick and hungry more often than children from small families in the same community. In the poorest coun-

tries as a whole, two million additional schoolteachers are required each year to keep up with population growth and to maintain the current, inadequate levels of primary education. Uneducated girls marry earlier and tend to have more unintended pregnancies, setting up a pernicious cycle of sexual inequality and high fertility (6).

MDG 3: Promote gender equality and empower women. The ability to choose if and when to have a child is central to the autonomy of women. Sir David King, the Science Adviser to the U.K. government, told the group that with respect to fertility decline, "There is little doubt in my mind that female empowerment to control fertility is a key part of that equation." (7).

MDG 4: Reduce child mortality. Given the same level of health care, a child born less than 18 months after an older sibling has a death rate two to four times that of a baby born after a 36-month interval (8). An estimated one million infant deaths a year could be prevented if all births were spaced a minimum of 2 years apart.

MDG 5: Improve maternal health. The expansion of the health infrastructure to meet the needs of women in childbirth cannot keep up with the growth of the population as long as fertility is high. Family planning saves women's lives by reducing unintended pregnancies and unsafe abortions, and it is estimated that improved access to family planning could prevent 150,000 maternal deaths each year (9). The proportion of potentially fertile women who want no more children or wish to postpone the next birth for at least 2 years, but are not using contraception, exceeds 20% in 24 sub-Saharan nations and 30% in nine of these countries (10).

MDG 6: Combat HIV/AIDS, malaria, and other diseases. Family planning, by preventing unintended pregnancies in the first place, is the most cost-effective way of reducing mother-to-child transmission of AIDS. In 1 year, even the low use of contraception in sub-Saharan Africa prevents over twice as many cases of maternal-to-child transmission of HIV than the cumulative total of cases prevented by antiretroviral therapies (170,000 cases versus 65,100) (11). Condoms are now the most popular method of contraception among sexually active single women in Africa and Latin America (2). However, the difference between the number of condoms needed in Africa and the supply is roughly 1.9 billion a year (12).

MDG 7: Ensure environmental sustainability. The roots of environmental degradation are found in consumption patterns among the world's economic powerhouses and rising

demands of growing local populations. For example, burgeoning demand for goods in North America, Europe, and China leads to deforestation in Brazil and Africa, but so do the needs of subsistence farmers to feed their large families. In oral evidence, Sir David King noted that, "the massive growth in the human population through the 20th century has had more impact on biodiversity than any other single factor." (7).

Population Momentum

The loss of attention to population has created formidable problems for the future. Some countries are undergoing explosive and possibly unsustainable population growth: Niger with 15 million today could hit 80 million in 2050, and Afghanistan could grow from 30 million to 82 million. In 1950, Sri Lanka had the same population as Afghanistan, but it implemented a realistic set of fertility regulation choices, and as a result, it will have one-quarter the population of Afghanistan a century later (13). In 1970, there were 5 million more people in Bangladesh than Pakistan, but Bangladesh focused on making family planning available in culturally acceptable ways, while Pakistan did not. As a result, by 2050 Pakistan will have 62 million more people than Bangladesh (13).

Next Steps

Much is known about ways to support government, nongovernmental organization, and private sector initiatives to make family planning widely accessible at low cost (14, 15). Perhaps the most urgent need is to remove the barriers to access that are not based on any evidence and that so often prevent the adoption of modern methods of family planning (16). In Ethiopia, only physicians and nurses are allowed to provide injectable contraceptives, making them inaccessible to the very large number of women who prefer this method above all others. Injectables are the second most commonly used contraceptive method in Africa, after the pill. They are not as cost-effective as IUDs, but IUDs are unpopular. Of course, strict control of needle contamination is needed. In some parts of Africa, women who do manage to get to a family planning clinic are turned back unless they are menstruating that day (16). Family planning clinics in northern Pakistan refuse Afghan refugees contraception unless their husband gives permission, even though women with economic means can buy the same products in the local bazaar without any intrusive questions asked (16).

The most-needed contraceptives are off-patent and low-cost, but even so, supplies often dry up. In Ghana, 10% of service delivery points were out of contraceptive pills or

condoms at least once each year in the late 1990s, and in Tanzania it was 27% (17). More than \$1 billion per year is needed in support of contraceptive supplies for low-income countries, but actual support from donors is in the \$200 million per year range (4). One possibility that was brought up in the hearings is that China, with its high-volume manufacturing capacity, might supply an increasing proportion of the pills, condoms, and injectable contraceptives for the developing world.

Between 2005 and 2050, the world population is projected to grow by 2.6 billion—a number roughly equal to the total global population in 1950 (2.5 billion) (13). Decisions made now can influence the growth rate. If the rates are not altered, hundreds of millions of families will suffer from poverty, hunger, inadequate education, and lack of employment opportunities, all of which might otherwise have been avoided.

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