

Demographic Growth and Development Prospects in Rwanda: Implications for the World Bank

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Sub-Saharan Africa Demographic Background

1. **With the exception of Southern Africa, sub-Saharan countries have only recently experienced a decline of their fertility levels.** This step, which started in the last decade of the twentieth century, is the final stage of the demographic transition or modernization process, namely the gradual shift from high crude birth rates and high crude death rates in equilibrium to low levels of fertility and mortality, reaching a new equilibrium. By contrast, most countries of Latin America, the Caribbean, and Asia, had completed their demographic transition 40 or 30 years ago. These countries have experienced high rates of population growth in the late 1960s (at about 2.5% per year), but they did experience this situation for 10 or 15 years only. Thereafter, they put in place effective population policies to reduce high levels of fertility and therefore curb rapid population growth (May and Guengant 2008).

2. **In sub-Saharan Africa, changes in fertility levels have been very slow or have not yet occurred in earnest in some countries whereas mortality levels have declined more rapidly despite the HIV/AIDS epidemic.** As a result of this delayed fertility transition, population growth in Sub-Saharan Africa (SSA) has been maintained at the level of 2.5% per year for the past half century, implying a doubling time of the population in 28 years. The large number of young Africans – 2 out of 3 people are under 25 – and persistent high fertility levels imply that population growth will continue. In mid-2008, sub-Saharan Africa had 809m people – 12 per cent of the world’s population. This share will increase to 18 per cent in 2050, or 1.8bn people. However, this assumes that African women would *then* have 2.5 children on average, against 5.4 today, according to the United Nations 2008 population projections (United Nations

2009). Therefore these projections imply rapid declines in fertility levels that are far from guaranteed, except again in southern Africa (which represents less than 7% of the total population of SSA). Higher SSA population figures, potentially reaching 2bn or more in 2050, are plausible if fertility declines more slowly (Population Reference Bureau 2008 and <http://www.un.org/esa/population>).

3. **Reducing high population growth was at the top of the international development agenda in the 1960s and 1970s but is no longer a priority today.** As mentioned, successful population programs were implemented in Latin America, the Caribbean and Asia. However, such proactive population policies were not implemented in SSA and benign neglect from African leaders and elites translated into late, weak, and ineffective programs. In part because of the success of the Latin American, Caribbean and Asian experiences, international attention has shifted to other urgent issues, such as the HIV/AIDS epidemic, humanitarian crises, and good governance. Recent concerns about climate change have further overshadowed the demographic dimensions of African development. Yet, unless the transition towards lower levels of fertility starts in earnest in the region, rapid population growth will jeopardize Africa's development efforts and its prospects for full integration into the world economy (May and Guengant 2008).

4. **There are four major and compelling reasons to accelerate the decline of fertility in sub-Saharan Africa, namely health improvement, human capital formation, poverty reduction, and environmental protection.** First and foremost, it is urgent to address high fertility levels from a gender and health perspective. Many African women, both urban and rural, are desperate to get contraceptives. However, they are prevented from doing so because of gender inequalities, cultural and religious barriers and inadequate family planning services. Addressing these unmet needs will greatly improve women's health outcomes by lowering maternal mortality and enabling them to realize their own economic potential. Second, growth rates in the order of 6 per cent per year (before the global economic crisis) translate into only half that level per capita because of the current pace of demographic growth. Rapid population growth prevents countries from achieving their "education for all" target, a prerequisite to economic development. Unless fertility declines, attainment of the Millennium Development Goals (MDG) will remain an ever-receding mirage. As the East Asia experience has shown, a slower rate of population growth leads to more favorable dependency ratios – limiting the number of child dependents on a comparatively larger, productive workforce. Third, high fertility levels jeopardize poverty reduction efforts, in particular among poor quintiles. The poor households suffer most because high fertility is an additional burden with regard to access to quality education and health services. Fourth, slower population growth will help reduce the pressures countries face with food security, land tenure, water supply, and environmental degradation. It will also ease the security problems that are often the result of conflicts over scarce resources, which are exacerbated by unsustainably high rates of population growth and widespread youth unemployment (May and Guengant 2008).

The Rwandan Context

5. **Rwanda, a small landlocked country of almost 10 million people in the Great Lakes region of Eastern Africa, has emerged from one of the worst civil war and genocide in the twentieth century.** The 1994 genocide made an estimated 850.000 victims in a span of only 100 days. The political upheaval and civil unrest was followed by massive migratory movements. Many people left Rwanda mostly to the Democratic Republic of Congo (Congo DR) but numerous Rwandans who lived in neighboring countries (mainly Uganda, Burundi, Kenya, Democratic Republic of Congo, and Tanzania) came back to settle in Rwanda. The country has since made a remarkable recovery and has become a beacon of developmental efficiency and good governance in the region. Economic growth has resumed and the Government of Rwanda has also implemented far reaching reforms, including a resettlement program to create villages in rural areas (*Umudugudu*), a performance-based financing (PBF) scheme in health along with almost universal health insurance (“*Mutuelle de santé*”), an effective administrative decentralization, and the introduction of a strong culture of accountability. The Government has adopted a key strategic document, the Vision 2020, which is anchored on six main pillars: good governance and an efficient state, skilled human capital, a vibrant private sector, world-class physical infrastructure, modern agriculture and livestock husbandry, and attracting national, regional, and global markets. Finally, although Rwanda is a member of the Economic Community of the Great Lakes Countries (CEPGL), along with Congo DR and Burundi, it has also become in 2007 a full member of the East African Community, strengthening its economic ties with Uganda, Tanzania, and Kenya.

6. **Although all these new development policies are bearing impressive results, one should not forget the huge challenges that remain.** Among these, one should list the high levels of poverty, the persistent high levels of maternal mortality and malnutrition, and the odds that Rwanda must face to foster its socio-economic development. In particular, Rwanda’s geographical situation and small size (26.338 square kilometers), the lack of abundant mineral resources, the rapid population growth, and the highest population density of the continent are all severe constraints and risks. In addition, the decentralization process must continue and foster a more effective integration of interventions and services at the periphery. The highest level of leadership is acutely aware of these challenges and is determined to address them squarely. It has also been able to communicate effectively with the population as to the need to bring further reforms. In addition, the Rwandan leadership has been able, through persuasion and consensus building, to mobilize the population around its overall vision for development.

7. **Rapid population growth and population issues at large have been a recurrent concern of Rwanda authorities.** Even before the Independence in 1962, Rwanda was deemed a small, overpopulated country with one of the highest fertility in the world. Prior to the genocide, the Government had attempted to put into place policies to curb high levels of fertility. These successive policies adopted four different approaches: emigration and resettlements (the “*paysannats*”); agricultural intensification; national family planning program; and national

population policy with the aim of fostering the demand for smaller families. These policies have been met with a limited amount of success, although some progress had been obtained in the area of family planning (May 1996). As a result, fertility had declined to a level of 6.2 children per woman in 1992, after reaching a peak of about 8.5 children per woman (the world record) in the late 1970s and early 1980s (May 1996; May et al. 1990). Rapid population growth has also put additional pressure on the environment (May 1995).

8. **The trauma caused by the 1994 genocide has put on hold for almost 10 years any meaningful discussion of the population issues in Rwanda.** As the population tried to cope with the aftermath of the 1994 events, the issues of rapid population growth, demographic pressure, and especially family planning became virtually taboo (Solo 2008) and discussions on the same issues were rendered sensitive in that context. The new Rwanda Government did not want to endorse the population policy of the previous regime. During the 10 years following the war, fertility levels remained in the vicinity of 6 children per woman and, after a peak of 13% in 1992, contraceptive prevalence (modern methods) stagnated at about 10%, with a drop to 4% in 2000 (there was no real family planning program at the time). It was only in 2003 that the Government revisited the demographic challenge and issued the new National Population Policy for Sustainable Development of Rwanda (The Republic of Rwanda 2003).

9. **The 2005 assessment of the first Poverty Reduction Strategy Paper (PRSP) brought back to the fore the need to curb the rapid rate of population growth as a prerequisite to poverty reduction.** Rwanda's first PRSP covered the years 2002-05. Despite rapid economic growth at the rate of 6% per year between 2000 and 2005, poverty levels had been reduced only slightly over this period, from 60 to 56%, and the absolute number of poor had even increased by about 600,000 people. This triggered a further reassessment of Government's policies toward demographic issues. As a result, the second generation poverty reduction strategy, named the Economic Development Poverty Reduction Strategy (EDPRS) covering the years 2008-12, addressed the population challenge head on (The Republic of Rwanda 2007). The change of Government's policy became even clearer during the Government's Management Retreat (*Umwihherero*) of 2007, where the Futures Group International's Resources for the Awareness of Population Impacts on Development (RAPID) model was presented and population and reproductive health issues were discussed extensively. The *Common Performance Assessment Framework* (CPAF) of the EDPRS has the contraceptive prevalence rate (CPR) as an indicator and the goal is to reach a CPR of 70% by 2012-13. The performance contracts between the Presidency and the district mayors (*Imihigo*) also include a family planning indicator (it is envisaged to extend the *Imihigo* system down to the level of the individual family). Moving forward, the Government of Rwanda has recognized and appreciated the fact that population growth remains one main constraint, among others, to the realization of desired growth levels. As such, the top leadership and the ministries concerned (especially ministries of health, finance and economic planning, local government, gender and family promotion) are not only aware of this challenge but have also undertaken to champion creation of awareness amongst the populace

as part of the development effort. Population issues are now a key ingredient of the Vision 2020 and EDPRS, the two main documents that present Rwanda's poverty reduction and growth vision and strategy both in the medium and long term.

Rwandan Demographic Data

10. **Rwanda benefits from a fairly robust system of demographic data collection and analysis, although there is room for improvement.** Rwanda's first National Population and Housing Census after the 1994 genocide was conducted in 2002 (The Republic of Rwanda 2004b). Several Demographic and Health Surveys (DHS) were also organized during the last decade, namely in 2000, 2005, and 2007, respectively (ONAPO and ORC Macro 2001; NISR and ORC Macro 2006; NIS, MINECOFIN and MEASURE DHS 2008). A DHS had also been conducted in 1992 (ONAPO and Macro International 1994). Finally, it is planned to improve the civil registration data. Better civil registration data could then be used to complete data from other sources, such as census and survey data. Rwanda has also an ambitious program to establish a national population register.

11. **Information on the age structure has to be extrapolated from the 2002 Census but mortality and fertility estimates are routinely provided by a string of Demographic and Health Surveys.** This information, in particular on the population movement, appears to be up to date and of good quality. The next DHS is scheduled to take place in 2010. Unfortunately, migratory movements are not well captured with the current system of demographic data collection. However, it is expected that the improvement in the civil registration and especially the creation of the national population register would provide better insights on internal and external migration movements.

Rwanda's Demographic Situation and Population Projections

12. **Rwanda's population was estimated at 9.6 million people in mid-2008 and is very young, with 44% of the Rwandans below age 15.** The population density was estimated in mid-2008 at 364 persons per square kilometer, the highest in the Africa Region (with the exception of one island in the Comoros). The current rate of population growth is estimated at 2.7% per year, leading to a doubling time of 26 years (Population Reference Bureau 2008). Even if fertility were to decline dramatically and reach right away the replacement level (i.e., a total fertility rate slightly above 2.1 children per woman, because of high mortality), Rwanda's population would continue to grow and would probably double during the next 70 years or so. This is due to the youthfulness of the age structure and the phenomenon of the population momentum, by which the very large number of people in the reproductive age groups fuels the population growth, even as fertility comes down rapidly.

13. **Mortality is decreasing fast and fertility is declining also, but more slowly.** Despite the HIV/AIDS epidemic, which appears now to be under control in Rwanda (HIV-1 prevalence of about 3% among the 15-49 group), mortality levels are decreasing very rapidly. The 2007-08

Interim DHS results indicate that the infant mortality rate has reached 62 deaths per 1,000 live births as compared to 86 in 2005. Similarly, the under-five mortality rate has also declined sharply, from 152 deaths per 1,000 live births in 2005 to 103 in 2007-08. Nevertheless, the maternal mortality ratio (MMR) remains very high and is currently estimated at about 750 deaths per 100,000 live births (however, it could have decreased in recent years). The total fertility rate (TFR) was estimated in 2007-08 at 5.5 children per woman, the first significant decline of the TFR in the last decade. In the same 2007-08 Interim DHS, the contraceptive prevalence rate (CPR) for modern methods was estimated at 27% of married women, a huge jump from the previous level of 10% (modern methods) as assessed in the 2005 DHS (NIS, MINECOFIN and MESASURE DHS 2008). This figure of 27% of contraceptive users for modern methods seems reliable and is coherent both with the numbers of family planning acceptors and users provided by the services statistics and with the numbers of commodities, for which the demand has skyrocketed over the past 3 to 4 years. Finally, impact assessments of health programs at the community level also point to a large increase in contraceptive use and yield quite similar figures for the CPR (modern methods).

14. **Population projections indicate that the population of Rwanda is bound to increase rapidly still during the next 40 years.** The National Institute of Statistics of Rwanda (NISR) has just prepared new population projections until 2022, but these have not yet been released. Therefore, the United Nations projections will be used instead, up to 2050. According to the Medium Variant of the *World Population Prospects: The 2008 Revision* (the population projections updated every two years by the UN Population Division), the population of Rwanda should reach 22.1 million people in 2050, assuming a total fertility rate (TFR) of 2.5 for the period 2045-50. The 2050 population would be 19.5 million should fertility decline to 2 children per woman in 2045-50, but almost 25 million should the TFR be at 3 children per woman in 2045-50. These UN projections assume significant improvements in the mortality levels: the expectancy of life at birth (both sexes combined) would increase from 49.9 years in 2005-10 to 65.3 years in 2045-50. Finally, net migration is assumed to be zero as of 2010 onward (United Nations 2009; see also <http://www.un.org/esa/population>). The Low Variant of the new NISR projections is very similar to the Low Variant of the UN 2008 projections. However, the NISR High Variant and Medium Variant yield higher populations (about half a million persons more in 2020) than the High Variant and Medium Variant of the UN 2008 projections, respectively.

Rwanda's Population Policy

15. **The Rwandan Government is currently preparing a new national population policy to supersede the one that was enacted in 2003.** A first National Population Policy has been prepared in 1990 and its aim was to increase the demand for smaller families (May 1996). In 2003, the Government prepared the National Population Policy for Sustainable Development of Rwanda. That policy appears to have been too broad and have embraced too many priorities to have had actually an effective impact (The Republic of Rwanda 2003). Following the policy shift that occurred in 2005-07, particularly after the assessment of the first PRSP, the

Government decided to prepare a new national population policy. The new policy has four priorities: to reduce the levels of infant, child, and maternal mortality; to promote education, especially for girls; to promote long-term family planning methods and make access universal; and to focus on the needs of the youth. The new policy addresses also the gender issues as they are linked to population and reproductive health outcomes. In many ways, it integrates the tenets of a previous gender policy that had been prepared in 2004 (The Republic of Rwanda 2004a). Currently, the Ministry of Finance and Economic Planning is preparing the costing of the new population policy before submitting it to the Cabinet for approval.

16. The responsibility for population and reproductive health issues is being shared between the Ministry of Finance and Economic Planning and the Ministry of Health. The National Office of Population (ONAPO), the institution previously in charge of population issues, has been abolished in 2005 (it was perceived as a legacy of the old regime). At that time, the Ministry of Health (MINISANTE) was put in charge of reproductive health and family planning programs, whereas the Ministry of Finance and Economic Planning (MINECOFIN) was given the responsibility for the population dimensions and their linkages to development. MINISANTE has a Coordinator of Maternal and Child Unit that supervises family planning activities nationwide. MINECOFIN has a Population Desk under the Director of Development Planning.

Accelerating the Rwandan Fertility Decline

17. The current strong political support to family planning programs appears to herald a new era that will be propitious to an acceleration of the fertility transition in Rwanda. Family planning is back in Rwanda and from “a taboo topic became priority number one” (Solo 2008). The nod of approval from the highest level of leadership in favor of it has made the climate most conducive for a rapid expansion of family planning services. Politicians at all levels mention routinely the need to limit the size of the family. Some family planning billboards and messages are to be seen in cities and rural areas and in the media (even in the Rwanda 2008 National Telephone Directory!) but they seem to be outnumbered by messages on HIV/AIDS and malaria. The *Imihigo*, the performance contracts between the Presidency and the mayors of districts, include a family planning indicator. Since the last few months, the *Umuganda* community mobilization activities conducted on the last Saturday of each month have also devoted time to family planning information, education and communication (IEC) and Behavioral Communication for Change (BCC) activities. However, the new population policy orientations of the Government need to be better communicated to the media and the general public. As the new policy calls for an ideal number of 3 children per family, a kind of motto today in Rwanda, the media and the general public have determined hastily that the target of 3 children had been passed into a new law (in all fairness, it should be mentioned that for a moment the Government considered a more strict policy). Such a misconception should be dispelled clearly as the new policy is persuasive but not coercive. Actually, the new policy does not deviate from the Plan of Action (PoA) adopted at the International Conference on Population

and Development (ICPD) held in Cairo in September 1994 that stresses the freedom and rights of couples.

Health Programs' Successes in Kamembe (formerly Cyangugu), West Province

A field visit to the city of Kamembe (formerly Cyangugu) in the West Province has shown that the District Hospital of Gihundwe and the Health Center of Rusizi I [close to the border with Congo DR and near the city of Bukavu] do function well.

The health insurance system ("*Mutuelle de santé*") has enabled Rwandans to have access to medical services and the Performance-based financing (PBF) scheme [which has been piloted initially in Butare and Cyangugu] allows health facilities to pay incentives to their personnel. The PBF contracts include also a series of indicators that are to be met for the next tranche of funds to be released. This in turn creates a culture of accountability that translates into better quality services. As a result, most health indicators have improved markedly. However, it should be stressed that the PBF system requires the health facilities to spend their subsidies strategically and wisely to grow their consumer base (Marrinan 2008).

The visit to the Health Center Rusizi I, which is run by the Catholic Church (it is a "*centre agréé*"), demonstrated that the Health Center does not supply modern family planning methods (in 2007, the Catholic Bishop of Cyangugu ordered the Health Center to discontinue the provision of such methods). However, the planned additional Health Post to be run by MINISANTE is not yet built. Therefore, modern contraceptive methods are not yet provided in the catchment area of the Rusizi I Health Center despite the desire to do so on the part of the Catholic nuns who work there (as nurses, they are very aware of the needs of the population).

18. **It is the strengthening of the health system that has made possible the huge gains in the supply of family planning services.** The performance-based financing, the health insurance ("*Mutuelle de santé*"), and the decentralization of the health system have all contributed to the improvements both in health coverage and health services. Contraceptive commodities stock-outs are now very rare, thanks to better management and strong support from the development partners (in particular, USAID and UNFPA). Women are encouraged to deliver in health centers and more than 50% do so already. All types of health personnel have been, or soon will be, trained in delivering all family planning services, including long-term methods (e.g., the injectables, used by more than half of the women using modern contraception; the hormonal pill represents a quarter of the contraceptive users in the contraceptive method mix; the IUD is less used but has potential for larger diffusion). All this has made possible to meet rapidly the pent-up demand for family planning services that probably has been accumulating and waiting for so long to be satisfied. In addition, the rapid progress in contraceptive prevalence might also be viewed as a homeostatic response to cope with extreme population pressure. Poor Rwandan

household may have no other response to their predicament than limit the number of their children.

19. **Future gains in family planning coverage are most likely although one should not underestimate the huge task at hand** (Solo 2008). At this stage, Rwanda has accomplished more than a third of what is required to reach the replacement level of fertility. The contraceptive prevalence rate (CPR) was estimated at 27% for modern methods in 2007-08 and is perhaps 30% today, whereas replacement fertility would ultimately require a CPR of 80 to 85% (modern methods). However, unmet needs for family planning remain high. In 2007-08, 49% of women declared that they did not want another child, a very large figure by any sub-Saharan standard. Another 36% of women want to postpone their next birth by at least 2 years. This indicates that further family planning gains are achievable although this will require major efforts during the next decade.

20. **The Government of Rwanda has started to use its own resources to buy contraceptives.** Traditionally, the donors would buy the commodities of the family planning program and USAID and UNFPA have been particularly active in this respect (USAID supports the family planning program in 23 districts and UNFPA in the 7 remaining districts). As the demand for family planning has skyrocketed, so have the requirements for contraceptives. New donors have joined the effort. The procurement and distribution of contraceptives and other products is one of the priorities of the budget support to the health sector provided by DFID, the German Cooperation, and the Belgian Cooperation. Recently, the Global Fund on AIDS, Tuberculosis and Malaria has also started to provide contraceptives. Moreover, the Government of Rwanda is also purchasing contraceptives with its own resources, to the tune of almost US\$1m per year (out of a total of about US\$6m per year for all commodities).

21. **To sustain the current progress and accelerate the demographic transition, the family planning program will need to address several critical issues and bottlenecks.** First, the health centers operated by the Catholic Church (the “*centres agréés*”) do provide only natural methods of family planning (i.e., methods based on symptoms and temperature). The patients of these “*centres agréés*” can only find the modern methods at additional health posts that need to be constructed nearby. Today, MINISANTE estimates that such 120 additional health posts are needed, at a global cost of about US\$5m. This will make possible to offer *all* contraceptive methods in *all* health facilities. Second, access to family planning methods needs to be fostered through strategies of proximity, such as the community-based distribution (CBD). Rwanda has today about 60,000 community health workers that need to be trained in the provision of family planning services, including some long-term methods such as the injectables [this has been experimented very successfully in Ethiopia]. A specific family planning training program to reach 60,000 health workers and cover 30 districts would entail a global cost of about US\$3m. Third, family planning programs will have to provide for the needs of the youth. Age at marriage is fairly late in Rwanda (fixed by law at 21 year). A large segment of the population (aged 15 to 21) needs to have access to services as well and anecdotal evidence suggests that the

age of sexual debut might even be lower than 15. The failure to address the needs of the youth will translate in high levels of induced abortion, a phenomenon that is occurring in Rwanda and might explain to a large extent the very high level of the maternal mortality ratio (which is completely out of line with the other health indicators of the country). The Government should envisage strategies to reduce the incidence of induced abortions. Fourth, better integration of family planning and other health services is also needed, in particular with HIV/AIDS. It is rather ironic that such integration had been advocated in *The Lancet* almost two decades ago, with specific reference to the situation of Rwanda (May et al. 1991). Family planning services should also be integrated with vaccination campaigns. Moreover, family planning services should be offered to women just after delivery, a trend that might take hold as more and more women deliver in health facilities.

The Role of the World Bank

22. **Key Bank documents do not address proactively the population and reproductive health issues of Rwanda.** The Government of Rwanda's policies on population, reproductive health, and family planning have evolved very rapidly in the last few years. However, the Bank Country Economic Memorandum (CEM) and the Bank Country Assistance Strategy (CAS) issued in 2007 and 2008, respectively, do not reflect these major changes (The World Bank 2007, 2008). Moreover, population and reproductive health issues are often treated as a Health, Nutrition, and Population (HNP) sector problem, as was the case in the 2008 CAS. In fact, population trends impact most development sectors and therefore should determine the very core of the Bank's strategy for Rwanda. However, some Bank's sector work and project appraisal documents do recognize the importance of the demographic challenge in specific sectors (e.g., agriculture, community development, health, etc.).

23. **Nevertheless, the Bank has several opportunities to support Government's efforts in the area of population and reproductive health.** A first entry point would be the strengthening of the statistical system in Rwanda, a task that the Bank has been doing successfully in the past. The preparation of the new 2012 Census would present an ideal opportunity to do more work in this area. A second entry point would be to use the IDA First Community Living Standards Grant (US\$6m) that was prepared with a Norwegian Trust Fund contribution, to address some of the bottlenecks identified in the family planning program (The World Bank 2009). The Grant has a strong component (Policy Area) on Community Health, Nutrition and Population Services, which goals are, *inter alia*, to provide incentives for women to deliver in health facilities as well as additional training and incentives for the community health workers (CHW) along with a rigorous Monitoring and Evaluation (M&E) mechanism. Some of the resources of the Grant could possibly be reallocated to address the specific issue of training the 60,000 health workers in the provision of long-term family planning methods. Alternatively, supplemental funding could be provided to address this issue and/or the Bank could consider preparing a new Grant.

Conclusions

24. **It could be argued that in addition to the national reconciliation Rwanda must in essence address two main developmental challenges, namely to reduce its population growth and to create jobs in the non-agricultural sector.** The acceleration of the demographic transition, in particular the decline of fertility, is a necessary but not sufficient condition that will predicate the development prospects of the country for the several decades to come. The decline of fertility will impact positively most development sectors. In particular, it will enhance the health of women and children, facilitate the formation of human capital (particularly in education), help reduce poverty levels, and mitigate the pressure on the environment.

25. **The Government of Rwanda has understood the demographic challenge to an extent that is truly impressive and that has seldom been seen in other sub-Saharan countries.** Moreover, the progress of the contraceptive prevalence rate (CPR) between 2005 and 2007-08 appears to be a unique feature in the modern history of family planning programs worldwide (the CPR for modern methods increases on average at only 0.5 percentage point per year in SSA; see Guengant and May 2002). As Rwanda appears to be at the tipping point with respect to the completion of its fertility transition, it needs all the support it can muster from its development partners, including the World Bank.

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