

Fertility Issues in Developing Countries

Claus C Pörtner

Department of Economics

Albers School of Business and Economics

Seattle University, P.O. Box 222000

Seattle, WA 98122

cportner@seattleu.edu

www.clausportner.com

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Center for Studies in Demography and Ecology

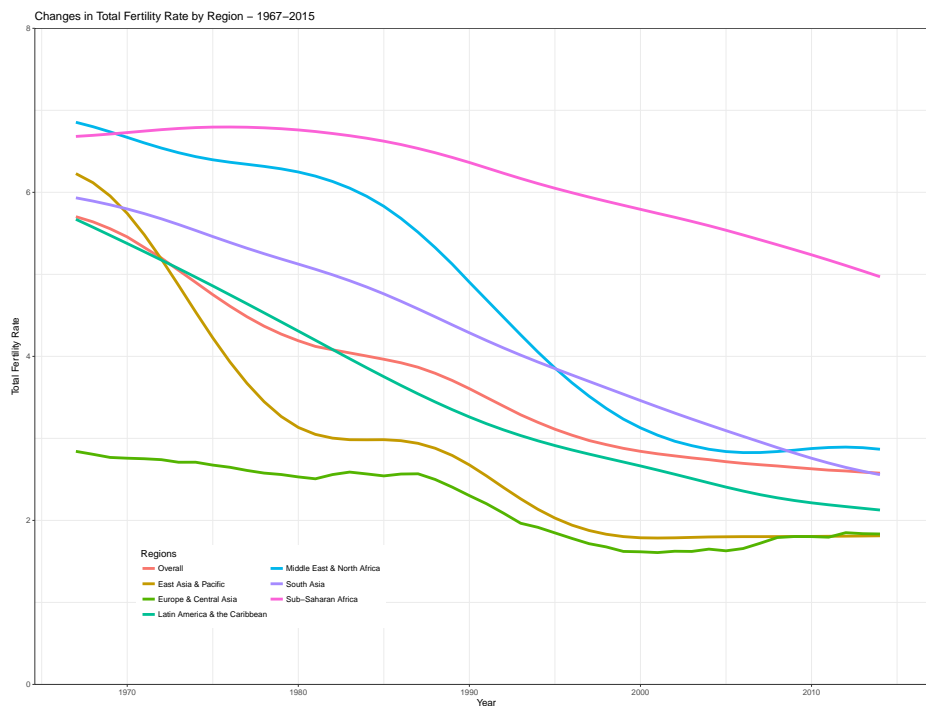
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1 Introduction

Despite a common perception that fertility is very high in developing countries, the truth is substantially more complicated. Figure 1 shows that there has been an astonishing decline in most developing countries' total fertility rate (TFR) over the last half century.¹ Half a decade ago, TFR was around 7 children, with the exception of TK. The most recent data show, however, that, with the exception of Sub-Saharan African, TFR is now either below or only slightly above the replacement level of 2.1. Despite this rapid decline in fertility population size is still growing in many of these regions because there are still many more young people than older people and these young people either have not entered reproductive age or are just starting out.

Figure 1: Total Fertility Rates by Region from 1967 to 2015



If fertility levels are close to identical across developing and developed countries and there is rapid urbanization and increasing labor force participation among women do

¹ TFR is the number of children a women entering her reproductive life would have if she had children following the age-specific fertility rates observed at that point in time. Hence, it is composite or snapshot measure of current fertility behavior.

we even need a developing country version of this chapter?² The goal of this chapter is to highlight the areas in which a separate focus on developing countries is still relevant, what the recent developments in research has been, and most importantly, what I consider to be the main outstanding issues.

[still need policy discussion; this seems kind of a rambling list] Furthermore, we still know relatively little about determinants of timing of births in developing countries. People in most developing countries are also still subject to higher risk of shocks, be that from weather, health, or political, but we still have little idea of how people respond to the level of risk and the occurrence of shocks. Finally, both in developed and developing countries we have mostly treated fertility decisions as separate from other household decision and preferences [ehh, Becker theory!]. We still need to know more about how husband and wife decides on fertility if they are have different preferences and how allocation decisions across all household member are related to fertility decisions. A prime example that I will treat separately is the role of son preferences in fertility decisions.

2 Sub-Saharan Africa

The outlier in the figure above is Sub-Saharan Africa. Sub-Saharan Africa now has an average TFR that is about twice as large as the other regions. Most of the projected future increase in world population is therefore likely to come from Sub-Saharan Africa (Gerland, Raftery, Ševčíková, Li, Gu, Spoorenberg, Alkema, Fosdick, Chunn, Lalic, Bay, Buettner, Heilig and Wilmoth, 2014).³ The most important issues from a policy standpoint is why the fertility decline in Sub-Saharan Africa have moved at a much slower pace than the other regions and even appears to have stalled in some countries (Ainsworth, 1996; Singh, Bankole and Darroch, Forthcoming). The purpose of this section is not to provide

² TK references on urbanization and labor force participation.

³ Currently Africa is home to about 1 billion people, but this will increase to between 3.1 and 5.7 billion by the end of the century.

the final answer, but instead to highlight both how we can think about fertility decisions and suggest possible answers.

Broadly speaking there are two competing approaches to explaining fertility decisions.⁴ One sees fertility preferences as the main driver of fertility and considers preferences malleable and mainly determined by cultural factors and transmission of ideas of ideal family size across groups. Under this approach the main constraints on reaching desired fertility is the level of access to family planning and contraceptives.

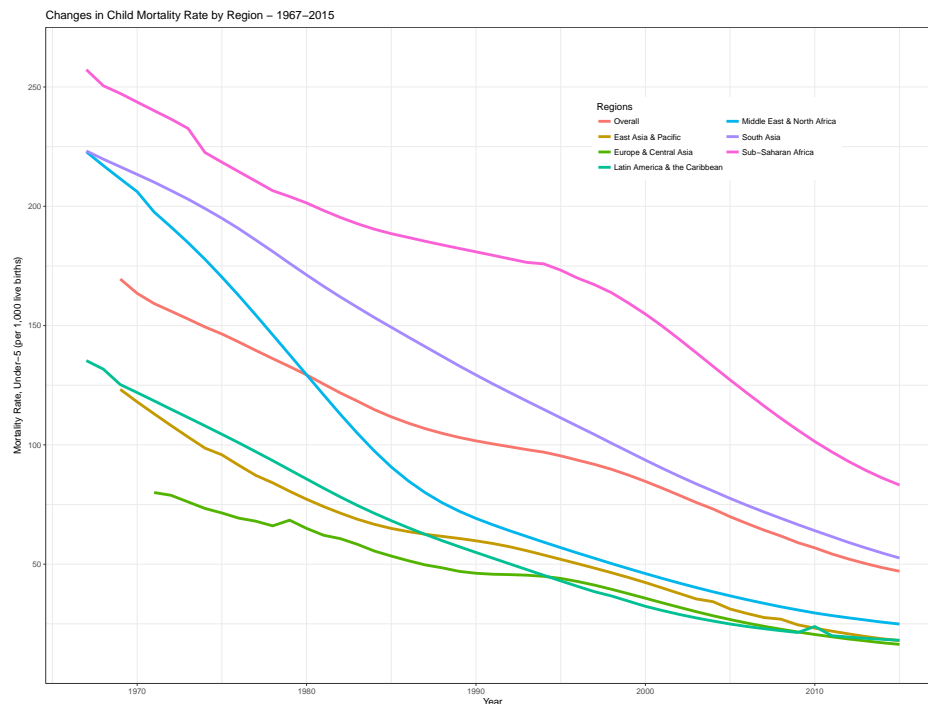
The other sees the decision on fertility as driven by the trade-off between the cost of children and the return to children, which can either be monetary or the utility of having offspring. In this approach parents are assumed to be able to control fertility even in the absence of modern contraceptives. Hence, although lower cost of preventing births—for example easier access to modern contraceptive—will still lower fertility in this approach the decline in fertility is assumed to be much smaller than the first theory.

Both theories consider the surviving number of children as the main outcome that people are interested in. One possible explanation for the slow decline in fertility could therefore be that mortality in Sub-Saharan Africa is higher than in the other regions. Figure 2 shows the development over time in under-5 mortality across the same regions as above. The improvements in mortality risk over time are truly astonishing. Over the last half-decade under-5 mortality in developing countries has fallen from close to 175 to below 50 per 1,000 live births. Sub-Saharan Africa, however, lacks substantially behind other regions. Despite a massive improvement from a situation where more than a quarter of all children born did not live to see their fifth birthday to about 80 deaths per 1,000 births, the current mortality rate is still more than three times larger than that of the other regions (with the exception of Middle East and North Africa). Although mortality is likely part of the explanation it cannot be the full explanation. Mortality in Sub-Saharan Africa is at the same level as it was in South Asia around the turn of the century, but fertility is

⁴ This is clearly a simplification but it serves to illustrate the differences in approaches.

about 1.5 child higher in Sub-Saharan Africa than it was in South Asia at the turn of the century (and therefore at the same level of mortality).

Figure 2: Under-5 Mortality Rates by Region from 1967 to 2015



If mortality is not the explanation, what might lead to the higher fertility in Sub-Saharan Africa? Demographers, following the first approach described above, have argued that the two main reasons for the slow decline in fertility in Sub-Saharan Africa are the high ideal family size still in place and a substantial “unmet need” for contraception (Bongaarts and Casterline, 2013; Singh et al., Forthcoming). Contraceptive use is, indeed, lower in Sub-Saharan Africa than the other regions, but other regions managed to reduced fertility even in the absence of access to modern contraceptives [TK add reference on Europe]. Furthermore, one difference in fertility behavior between Sub-Saharan Africa and the other regions are that the longer birth intervals even in the absence of access to modern contraception, which are the result of postpartum sexual abstinence and extended periods of breastfeeding (Caldwell, Orubuloye and Caldwell, 1992). To the extend that the longer birth intervals are the result of conscious decisions it shows that people are

able to control fertility.⁵

There are three alternative explanation that may explain the slow decline. First, the relative abundance of land compared to other regions. Second, low levels of education; or at least low levels of quality in education. Finally, the role of urbanization across regions.

The effect of land access on fertility works in a couple of different way. First, there is more land per capita in Sub-Saharan Africa than in the other regions. At the median projected population growth for Sub-Saharan Africa—which is 4.2 billion people by 2100—the population density will only be roughly equal to that of China today (Gerland et al., 2014, p 235). The low density means that there is little pressure to restrain fertility for fear of running out of land. In fact, it is likely that there is a higher return to children in Sub-Saharan Africa than in the other regions—or, at least, a substantially lower cost—because the return to children working on the family farm is higher (Caldwell et al., 1992). Similarly, there are substantially higher return to having wives work on agricultural land (Jacoby, 1995). The associated polygyny also appeared to have resulted in a situation where the cost of the children were born by the individual wives, but the decision on fertility was made by the husband. I return to this point below.

A second characteristics of land in Sub-Saharan Africa that also can lead to higher fertility is that—despite its abundance—access to land rights are controlled at the local level by chiefs and other local institutions rather than through market based buying and selling of land. This is important because the main way to maintain land fertility in many places in Sub-Saharan Africa is through fallowing and with less secure land rights farmers may fallow their land for shorter periods than those with more secure rights (Goldstein and Udry, 2008).⁶ The reason unsecure land rights can lead to other fertility is that land is often allocated based on the number of household members. Hence, more children,

⁵ It is still possible that fertility is higher than desired because the higher cost of preventing “accidental” conceptions. This would explain why the estimated effect of access to family planning in Ethiopia shows a reduction in fertility of about one birth, which is equivalent to an approximate 20% reduction in fertility Pörtner, Beegle and Christiaensen (2014).

⁶ See also Besley (1995), who discuss other investments in land that can secure property rights.

everything else equal, will increase your claim on land access. The irony here is, of course, that if everybody else follows the same strategy the result will be much higher fertility and little change in the allocation of land. For both of these potential effects of land access on fertility we, however, have little direct information on their effects and this is one area that calls out for future research.

My second suggestion for a major factor impacting fertility in Sub-Saharan Africa is education. The standard economic model of fertility considers the opportunity cost of women's time to be the main factor affecting the number of children (Becker, 1991). As women gain more education the cost of their time, and therefore of childbearing and childrearing, increases reducing fertility and leads to better health outcomes for both women and children.⁷ The better health outcomes lead to lower child mortality, which in turn further decreases fertility because fewer births are required to reach a desired number of surviving children (Ainsworth, Beegle and Nyamete, 1996). The effect of education on fertility is essentially universal, making it the main recommended way to decrease fertility (Schultz, 2002).

Fertility, however, begins to decline at higher levels of education in Sub-Saharan Africa than in other regions and the relationship between fertility and education may even be positive for low levels of education (Ainsworth et al., 1996; ?; Thomas and Maluccio, 1996). Part of the problem may be the quality of education in Sub-Saharan Africa. In other words, the stated number of years of education may be worse predictor of actual human capital accumulation in Sub-Saharan Africa than other regions.

A good example of this problem is Tanzania (Galabawa, 2001; Wedgwood, 2005). Taken at face value, Tanzania has a very high reported education level. This is most likely the result of the 1974 Universal Primary Education Movement, which increased accessibility of primary education and enrollment rates. The problem is that the quality of education reportedly was very low. In addition, the crisis Tanzania experienced in

⁷ It is, however, not completely clear why there is such a strong association between education and health (Thomas, Strauss and Henriques, 1991; Glewwe, 1999; Kovsted, Pörtner and Tarp, 2002)

the 1980s further lowered the quality and enrollments declined significantly. Hence, it is unclear to what extent reported education levels reflect women's actual human capital. The result is that education does not appear to have as a substantial effect on fertility in Tanzania as other found elsewhere Alam and Pörtner (2016).

The final explanation for differences in TFRs across regions is the role of urbanization. When talking about fertility and its determinants in Sub-Saharan Africa one discussion seems to be essentially absent and that is the difference between urban and rural areas. As a rule all regions have had and have higher fertility in rural areas than in urban areas. This is directly in line with what we expect. The cost of children is clearly higher in urban areas than in rural areas, even for women with the same amount of education—and therefore the same opportunity cost of time. Sub-Saharan Africa is no difference. An example is Ethiopia in 2011, where the overall TRF is 4.8, but that covers a TFR of 5.5 in rural areas and only 2.6 in urban areas (?). Part of the explanation for the lower fertility is the higher average education level of women in urban areas than in rural areas. But, even for women with the same education level fertility is lower in urban areas than in rural areas (Ainsworth et al., 1996).

There has, however, not been a systematic examination of how fertility varies with education in urban areas across different regions. If predicted fertility is similar across regions for the same level of education that would suggest that Sub-Saharan Africa is not inherently different. A lower "return" to education could either be an indication that the quality of education is lower, that the opportunity cost increases with higher education is not as high in Sub-Saharan Africa as in other areas (either because of the lower quality or because of lower levels of development), or it could suggest that there is something inherently different in what determines fertility in Sub-Saharan Africa than in other regions.

3 Timing of Fertility

How couple time their births is interesting both because it provides us with an idea of how good people are at controlling their fertility and because timing of births may impact the health of both mother and children. We know, however, surprisingly little about what determines the timing of births in developing countries. Especially with more and more women entering the labor force in developing countries, understanding how timing decisions are made will be important for the design of suitable policies. The lack of research is partly because of data limitations and partly because of the difficulty in identifying the causal relationship between timing and other decisions, such as labor supply.

The three sub-areas where we do have some information is the timing of first birth, how births respond to shocks, and how the sex of the last child affect timing of the next birth. This section covers the timing of first birth and leaves the two other areas for the sections below.

Having your first birth earlier in life is generally associated with lower educational attainment, higher completed fertility, and worse health and labor outcomes. This is, however, not necessarily indicative of a causal relationship between earlier first birth and the other outcomes. A woman who, for example, has a lower expected return to education may decide that using contraceptive is not worth the cost and therefore would be more likely to conceive and subsequently drop out of school. Furthermore, as long as fertility is well below natural fertility levels having an earlier birth will not, in itself, increase your fertility.⁸

For this reason most of the literature has focused mainly on what determines the timing of first births—and to some extent on whether women are more likely to drop out of school after their first birth. In the relatively small literature on timing of first births there are two main approaches to trying to identify whether a causal relationship exists between timing of first birth and other outcomes. One is to look for variables that can be

⁸ TK Need to describe natural fertility.

argued to only affect one of the other, with no direct effect on the other outcomes, and jointly estimate the various decisions.⁹

Marchetta and Sahn (2016): number of completed grades among young women is important in delaying marriage and first birth, with the latter mainly through the delay in marriage. More education also leads to earlier entrance into the labor market. [cannot tell us anything about end fertility]

The other approach is experimental where researchers randomly access to a program that is believe to influence one of decisions and then examine whether the timing of births and the other outcomes are affected by the program.

Duflo, Dupas and Kremer (2015)

Dupas, Huillery and Seban (2017)

Ozler work on Malawi

The downside of both approaches is that we cannot learn much about what completed fertility is going to look like. Even experiments that follow people for an extended period, like the seven years in Duflo et al. (2015), only gets to the beginning of the prime child-bearing years, 20 to 30.

4 Risk and Insurance

[should I treat mortality in general as a shock here?]

One of the defining characteristics of developing countries is that risk to life and livelihood are most more prevalent and less well insured against compared to developed countries. We can split the fertility response to this fact into two categories: how people respond to the shocks and how people respond to the underlying risk of experiencing a shock. This distinction is important because it is possible that the responses run in opposite directions, which may result in no apparent response to shocks if the underlying

⁹ This approach is often combined with restrictions on the correlation of error terms across decisions

risk is not controlled for, or a focus on treating the shock rather than the underlying risk if both move in the same direction.

[shock response]

(?) on fertility response to the tsunami.

(Alam and Pörtner, 2016)

[response to the underlying risk]

Gone with the wind?

(?)

(?)

5 Intrahousehold Allocation

Sub-Saharan Africa as a special case. The father bears less of the cost of children than in other places because of the family structure. This is especially the case for West Africa (Caldwell et al., 1992).

Ashraf, Field and Lee (2014)

Merli and Raftery (2000) on missing girls in China

Imran Rasul paper

(Field, Molitor, Schoonbroodt and Tertilt, 2016)

my sex selection paper on India

Absence of sex selection in Turkey ?

6 Policies

(Singh and Darroch, 2012)

Schultz papers on Matlab and improvements in women's lives.

Disruption in access: Dumas and Lefranc (Forthcoming)

Ian Salas's paper
Jones on gag rule
Our Ethiopia paper

7 Conclusion

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