

DEMOGRAPHIC DYNAMICS OF THE POPULATION IN OIC MEMBER COUNTRIES

By
Esat BAKIMLI

The developing world including the OIC member countries suffers from relatively poor living conditions (environmental, economic, and social) and low quality health care. This situation is reflected in many vital demographic indicators, showing that the developing countries are undergoing unfavorable conditions relative to the developed countries. This study aims to shed light on a few of these indicators such as infant mortality rate, life expectancy at birth, total fertility rate, and crude growth rate of population in order to present a picture of the demographic dynamics in OIC member countries with comparison to the world.

INFANT MORTALITY RATE

Infant mortality, corresponding to deaths within the first year of life, is one of the major health and socioeconomic problems of our time. Although it may be linked to a number of factors, the primary causes of high infant mortality are generally listed as diarrhea, infectious diseases, malnutrition, neglect, maternal stress, and unsafe water, all of which can in many ways be attributed to a bad environment and poverty. In addition, low birth-weights, preterm births, and very low or high maternal age may also contribute to high death rates because of their higher risk of infant mortality.

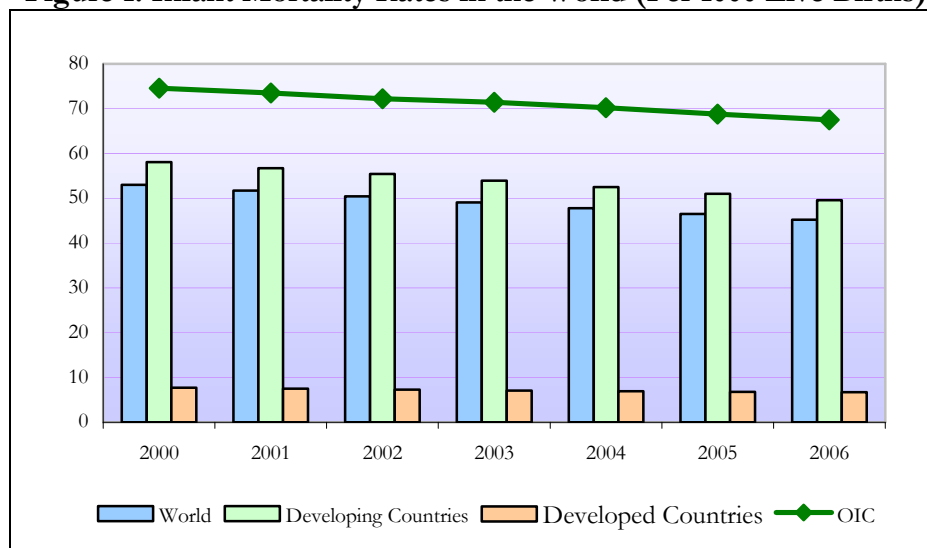
“A nation may waste its forests, its water power, its mines and, to some degree, even its land, but if it is to hold its own in its struggle for supremacy its children must be conserved at any cost. On the physical, intellectual and moral strength of the children of today the future depends... Unless the infants are saved there will be no children to educate.” L. Emmett Holt, 1913¹

Under these aspects, infant mortality rate (IMR), which is defined as the number of live newborns dying under a year of age per 1,000 live births², is an important indicator of a country’s level of health or development, reflecting, to an appreciable extent, the standard of living in that country. In this respect, it is not surprising that, though infant deaths are a rare event in all developed countries, developing countries including the OIC members, –particularly the least developed African members– continue to experience high rates of infant mortality.

¹ “Infant Mortality, Ancient and Modern, An Historical Sketch”, presidential address before the American Association for the Study and Prevention of Infant Mortality, at the Fourth Annual Meeting, held at Washington, D.C., November 14-17, 1913. Published in *Archives of Pediatrics*, 30: 885-915, 1913.

² US Census Bureau, International Data Base/Glossary.

Figure 1: Infant Mortality Rates in the World (Per 1000 Live Births)

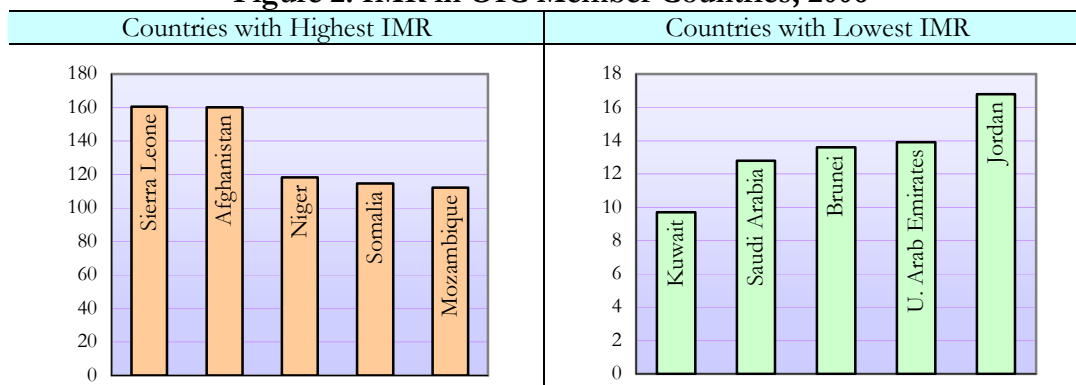


Data Source: US Census Bureau, International Data Base.

Figure 1 presents the infant mortality rates in the world during the period from 2000 to 2006. Accordingly, the IMR slightly decreased in all over the world from 53.0 to 45.2 infant deaths per 1000 live births. This development was mostly resulted from the improvement in the developing countries, where the IMR in this period declined from 58.1 to 49.6, while in the developed countries, where the IMR was already at a very low level, it decreased 1 point in this period to reach 6.7 in 2006. Although the average rate in the OIC member countries during this period was always higher compared to the world and developing countries, it showed a parallel downward trend, from 74.6 to 67.5, implying that there is still long way ahead to go in order to close the gap with the world.

At country level, the IMR was more than one hundred in 9 of the member countries in 2006, Sierra Leone and Afghanistan taking the lead with 160 deaths per thousand (Figure 2). At the opposite end of the spectrum, the lowest IMR among the member countries was recorded for Kuwait as 9.7, the only member country below a rate of ten³.

Figure 2: IMR in OIC Member Countries, 2006

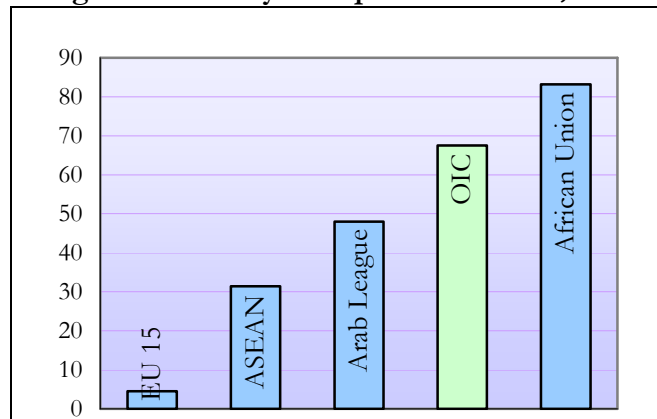


Data Source: US Census Bureau, International Data Base.

³ See Appendix 1 for data on all OIC member countries.

On the other hand, while the average IMR in OIC member countries is lower than that of the African Union, which suffers the highest IMR in the world (83.2), it is still far above that of the European Union as well as the ASEAN group and the Arab League. In 2006, almost 68 of every 1000 babies died during their first year of life in the OIC region while this figure was only about 5 for the EU 15 (Figure 3). These differences among the groups of countries obviously reflect the negative relationship between the IMR and development level.

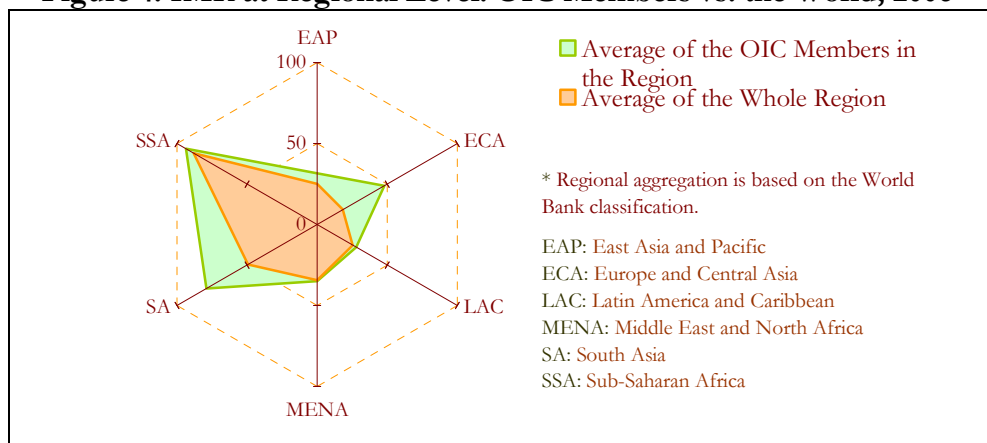
Figure 3: IMR by Groups of Countries, 2006



Data Source: US Census Bureau, International Data Base.

Consequently, considering that the countries constituting the OIC are spread up around the world with a wide spectrum of development levels, it is evident that the IMR may differ at the regional level. As presented by Figure 4, in all of the regions, the average of the OIC members in the region is higher than the average of the whole region. In addition, similar to the overall picture presented on the basis of the whole regions, the average of the OIC members as well is highest in Sub-Saharan Africa (SSA) and then in South Asia (SA). OIC members in SSA experienced, on average, the highest IMR rates of all the regions with almost 94 deaths per thousand, followed by the members in SA with an average of 79 deaths per thousand. On the other hand, the highest difference between the average of the OIC members and that of the whole region –the relative worst case– was recorded in SA and ECA, OIC members outweighing with 30 deaths per thousand in both regions⁴.

Figure 4: IMR at Regional Level: OIC Members vs. the World, 2006*

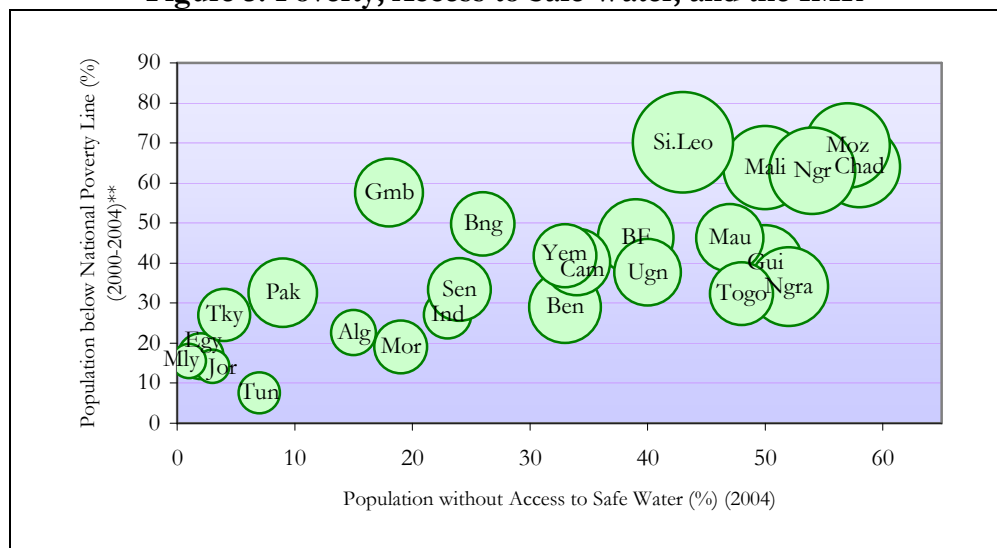


Data Source: US Census Bureau, International Data Base.

⁴ Since all of the MENA countries except Israel and Malta are OIC members, the average of the OIC members in this region does not differ much from the average of the whole region.

As stated above, unsafe water and poverty are among the main factors behind high IMRs. Figure 5 presents an immediate comparison among these three variables regarding OIC member countries for which data is available. It is clear that poverty and access to safe water are in close relationship, and the higher the rate of population below national poverty line and the higher the rate of population without access to safe water, the higher the IMR. As shown in Figure 5, Sierra Leone, Mali, Niger, Mozambique, and Chad –the countries with a significant proportion of their population suffering from poverty and unavailability of safe water– have the highest IMR while, on the other hand, Jordan, Malaysia, Tunisia, and Egypt –the countries with a small rate of their population below poverty line and without access to safe water– have the lowest IMR. This situation obviously indicates that improvement in these fields will no doubt help decrease the IMR in the suffering countries.

Figure 5: Poverty, Access to Safe Water, and the IMR*



Data Sources: **IMR:** US Census Bureau, International Data Base; **Poverty:** UNDP, *Human Development Report 2007/2008*; **Access to Safe Water:** WHO/UNICEF, *Meeting the MDG Drinking Water and Sanitation Target: The Urban and Rural Challenge of the Decade*, 2006.

* The size of the bubbles indicates the intensity of IMR: 2000-2006 average.

** Latest year available.

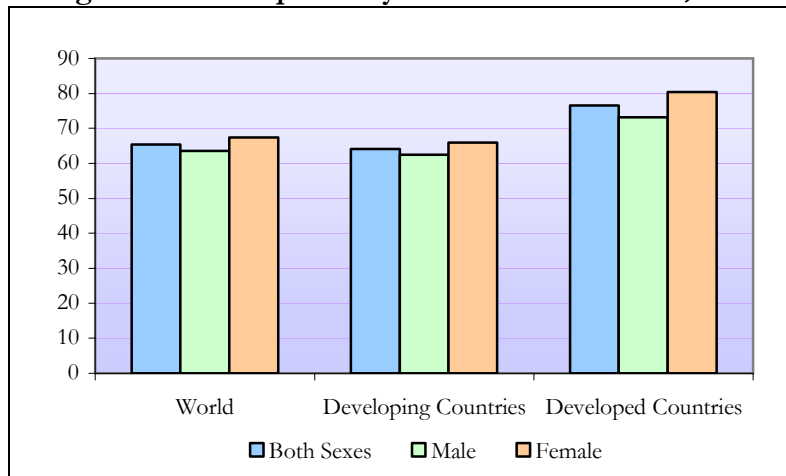
LIFE EXPECTANCY AT BIRTH

Life expectancy is generally defined as the average number of years a person or a given group of population is expected to live before death. Traditionally, it is calculated from the time of birth, but also can be calculated from any specified age. Life expectancy at birth (LEAB) is described by the UNDP⁵ as the number of years a newborn infant would live if prevailing patterns of age-specific mortality rates at the time of birth were to stay the same throughout the child's life. Accordingly, it is a measure of the average life span of the newborns given the health and living conditions at the time of their birth. In this respect, the state of food security and access to primary health care –including safe water, sanitation, medicines, and immunization– explains much of the factors influencing the life expectancy in a given country.

⁵ UNDP, Human Development Report 2003.

The mean length of life for the newborns in the world today is 65 years –63 years for males and 67 years for females. Not surprisingly, newborn babies in the developed countries are expected to live more than those in the developing world –76 years vs. 64 years, respectively– and this difference is even larger for females. Under the current conditions, female babies in the developed countries are likely to live up to 80 years compared to 66 years in the developing countries, while these figures for male babies are 73 and 63, respectively (Figure 6).

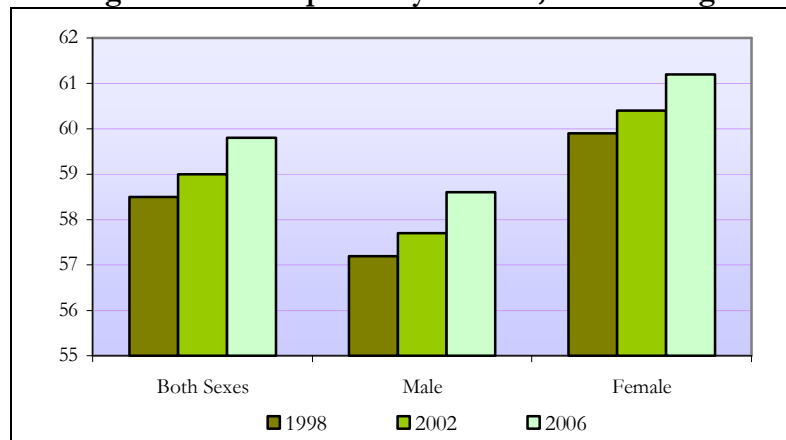
Figure 6: Life Expectancy at Birth in the World, 2006



Data Source: US Census Bureau, International Data Base.

As for the OIC region, the situation is even worse, yet it seems to improve slightly over time (see Figure 7). As of 2006, the average life expectancy at birth in the OIC region was 60 years, with females having a two-year advantage (61 years) over males (59 years). Figure 7 indicates that though the average LEAB for both sexes increased 1.3 year in the period from 1998 to 2006, the difference between males and females remained at the same level of 2.3 years.

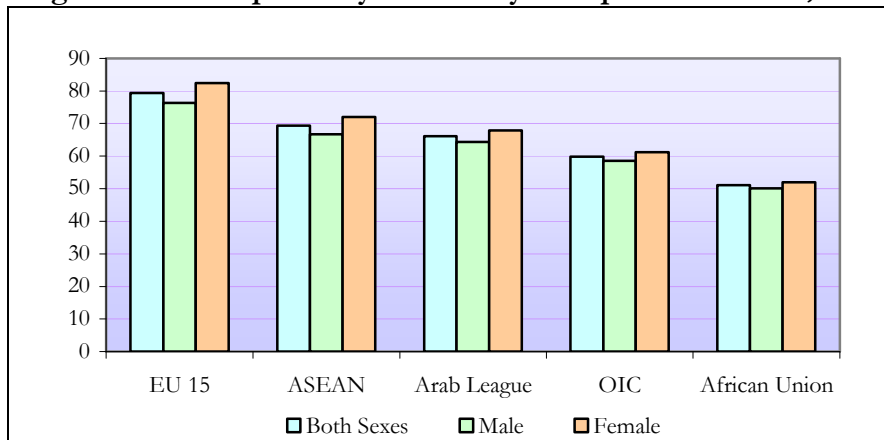
Figure 7: Life Expectancy at Birth, OIC Average



Data Source: US Census Bureau, International Data Base.

Under the present conditions, the average LEAB in the OIC region is well below of those in the world and even in the developing countries. On the other hand, as in the case of the IMR, life expectancy at birth in the OIC region is better than that in the African Union, where the newborn babies are expected to live up to only 51 years, yet again worse than that in the European Union (79 years) as well as the ASEAN group (69 years) and the Arab League (66 years) (see Figure 8).

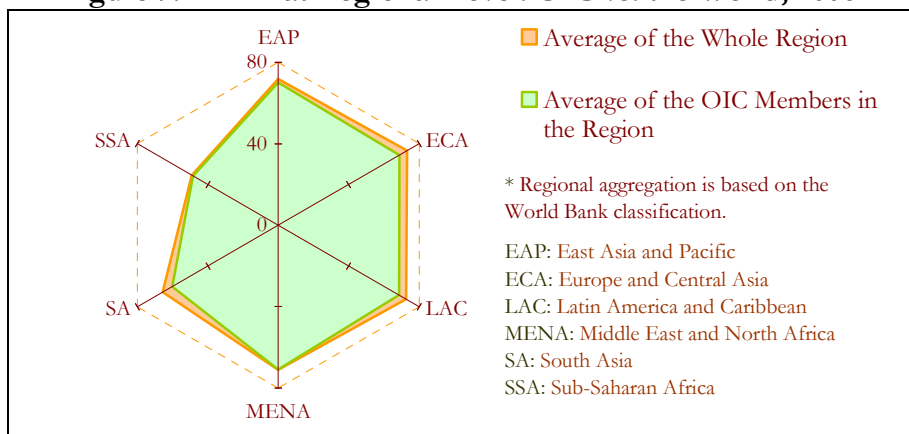
Figure 8: Life Expectancy at Birth by Groups of Countries, 2006



Data Source: US Census Bureau, International Data Base.

To better understand the relative status of the LEAB in the OIC members compared to the world, it is useful to compare them within their regions. As presented by Figure 9, the highest regional averages were recorded for ECA and LAC in 2006 while the average of OIC members was highest for MENA and EAP. As expected, the lowest average LEAB –both for the OIC members and the whole regions– was recorded for SSA due to unfavorable conditions prevailing in the region, particularly in food security and access to primary health care. Consequently, the average LEAB in OIC members in MENA (see footnote 4), EAP, and SSA is not so different from the regional averages –up to 1.6 year–, implying that the case is not specific to the OIC members but to the whole regions. On the other hand, the OIC member countries in the other regions, namely LAC, SA, and ECA, lag behind the regional averages with 4-5 years.

Figure 9: LEAB at Regional Level: OIC vs. the World, 2006*



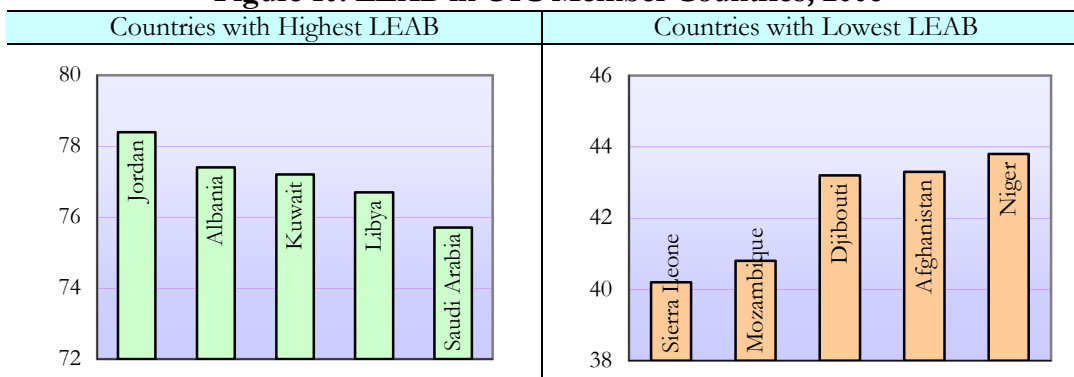
Data Source: US Census Bureau, International Data Base.

At regional level, it is obvious that the OIC region lags slightly behind the rest of the world in achieving improvements in life expectancy. However, large differences exist among the member countries within the OIC. At one end, there are countries where the newborn babies are expected to live more than 77 years, such as Jordan and Albania, while at the other end, there are countries where these babies are expected to live no more than 42 years, such as Sierra Leone and Mozambique (see Figure 10)⁶. This situation once more emphasizes the need to take action especially in member countries in Sub-Saharan Africa, which in many ways lag behind the world, which are usually unable

⁶ See Appendix 1 for data on all OIC member countries.

to overcome their problems on their own with limited resources, and which therefore need help and assistance at least to provide their people with secure living conditions.

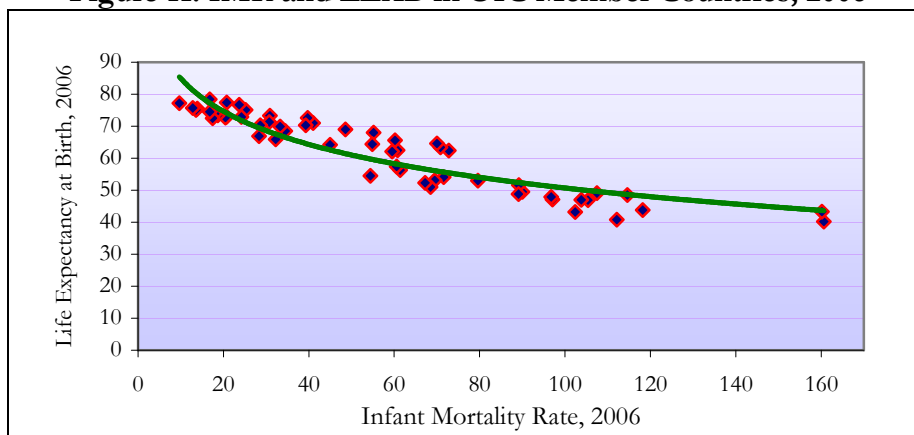
Figure 10: LEAB in OIC Member Countries, 2006



Data Source: US Census Bureau, International Data Base.

It should be mentioned here that since life expectancy at birth is highly affected by the infant mortality rate, any measure or attempt to decrease infant mortality will ultimately contribute to higher life expectancies. This is fairly clear from Figure 11, which presents the existence of high correlation between IMR and LEAB in the OIC member countries, implying that the higher the IMR, the lower the LEAB. However, the life expectancy at birth becomes less sensitive to IMR as IMR rises, which implies that in countries with high IMRs, the life expectancy at birth depend not only on the characteristics of infant mortality but also on the characteristics of the mortality rates of other age groups. This situation obviously reflects the severe living conditions in these countries that affect the life expectancies of people from all age groups.

Figure 11: IMR and LEAB in OIC Member Countries, 2006



Data Source: US Census Bureau, International Data Base.

FERTILITY, MORTALITY, AND POPULATION GROWTH

The Crude Birth Rate (CBR) and the Total Fertility Rate (TFR), though with different dimensions, are frequently used measures of the rate of population growth. The CBR represents the average annual number of births during a year per 1,000 persons in the population at midyear⁷. It is called “crude” because it does not take into account the age-sex structure of the population, which should

⁷ US Census Bureau, International Data Base/Glossary.

be kept in mind while interpreting it. For example, the birth rates will actually be higher in a population with more women of childbearing age but the calculation of the CBR sticks to per 1000 persons regardless of male-female decomposition and age specific fertility rates. Therefore, the Total Fertility Rate (TFR) is generally accepted as a more direct measure of fertility than the CBR as it represents births per woman. Technically, the TFR is described as the average number of children that would be born per woman if all women lived to the end of their childbearing years and bore children according to a given set of age-specific fertility rates⁸. From this definition, however, it is clear that the TFR, unlike the CBR, shows the “potential” for population growth in the country under the present conditions rather than measuring the actual births.

In addition to age-sex structure of the population, there are a number of factors which directly or indirectly affect birth rate in a country, such as access to contraceptive measures and abortion, lifestyle preferences, social and religious beliefs including attitudes towards family size, female literacy levels, participation of women in the labor force, and economic welfare which also includes “the need for children as labor force”. Moreover, high IMRs may also have an effect on birth rates; a family may tend to have more children for fear that some of these children may suffer death at early ages. Under these conditions, it is understandable and expectable for the CBR and the TFR to be higher in economically less developed parts of the world.

As for mortality, the Crude Death Rate (CDR) is a commonly used measure that represents the average annual number of deaths during a year per 1,000 persons in the population at midyear⁹. The determinants of death rates, though they differ between developed and developing countries, range from the age structure of the population and the prevalence of diseases (infectious diseases, AIDS, cancer etc.) to the quality of health standards –including the sanitary conditions, food security & malnutrition, and access to primary health care and medical technology– to the frequency of accidents, violent crimes, armed conflicts, and also wars.

With these in mind, statistics presented by Figure 12 show that, as of 2006, the CBR for the world was 20.2 per 1000 population, corresponding to 131 million babies in a year for a world population of 6.5 billion. This rate in the developing countries was twice as high as the rate in the developed countries –22.3 and 11.0, respectively. On the other hand, the average CBR in the OIC region was even higher with 28.6 live births per 1000 people, which, for a total OIC population of 1.35 billion, comes to 38.6 million babies in a year. These birth rates reflect themselves almost in the same manner in the TFR as well. As presented by Figure 12, the TFR for the world was 2.6 per woman while it was again higher for the developing countries (2.8) than the developed countries (1.6)¹⁰. The TFR in the OIC region (2.8 children per woman) was again higher than that of the developing countries, ranging at country level from 1.7 in Iran and Kazakhstan to 7.4 in Niger and Mali¹¹.

Unlike birth rates, death rates do not differ much at high aggregation levels. The CDR was 8.4 per 1000 people for the world, 10.3 for the developed countries, 8.0 for the developing countries, and 9.2 for the OIC region. However, it should be noted here that the CDR applied to a whole population can give a misleading impression. That the number of deaths per 1000 people is higher

⁸ US Census Bureau, International Data Base/Glossary.

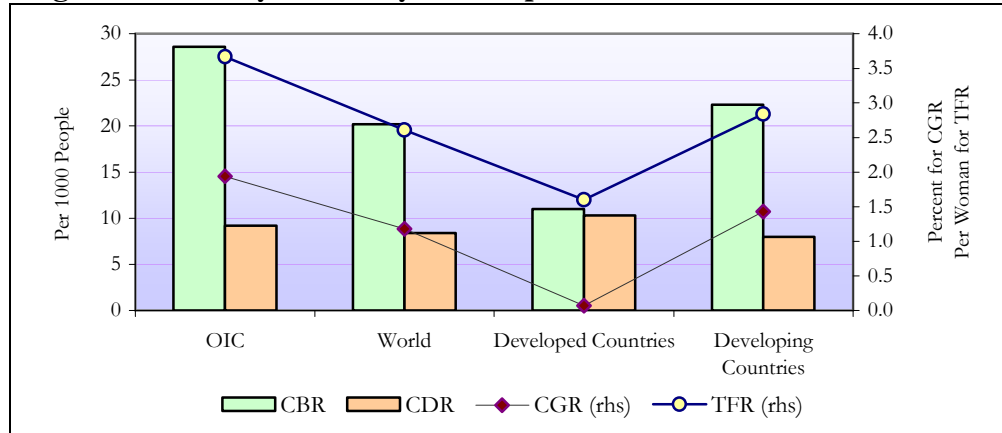
⁹ US Census Bureau, International Data Base/Glossary.

¹⁰ A total fertility rate of less than 2 indicates that the population cannot reproduce itself. This is because a woman needs to have, on average, at least two children –the replacement rate– to compensate for herself and her partner so as to maintain the current level of population (zero growth). Considering the possibility of death before having children or those who do not want or unable to have children, this replacement rate, in practice, is slightly higher than two and a bit more for the developing countries due to high mortality rates at early ages.

¹¹ See Appendix 1 for data on all OIC member countries.

for the developed countries should not be interpreted such that these countries are suffering from the bad conditions described above, while they obviously have quite better standards of health. The reason is that the developed countries have relatively more old population, which implies that the overall mortality rate can be higher while the mortality rate for any age group is lower.

Figure 12: Fertility, Mortality, and Population Growth in the World, 2006



Data Source: US Census Bureau, International Data Base.

Taking CBR and CDR together, the crude growth rate of population (CGR) can be easily measured¹². Since the CDR is almost the same for both the developed and developing countries as well as the OIC, it is the CBR that determines the difference in CGR among these groups¹³. Accordingly, the world population grew %1.18 in 2006 while this rate was quite higher in the developing countries (%1.43) than in the developed countries (%0.07)¹⁴, indicating that the developing countries accounted for almost %99 of the world population growth in 2006.

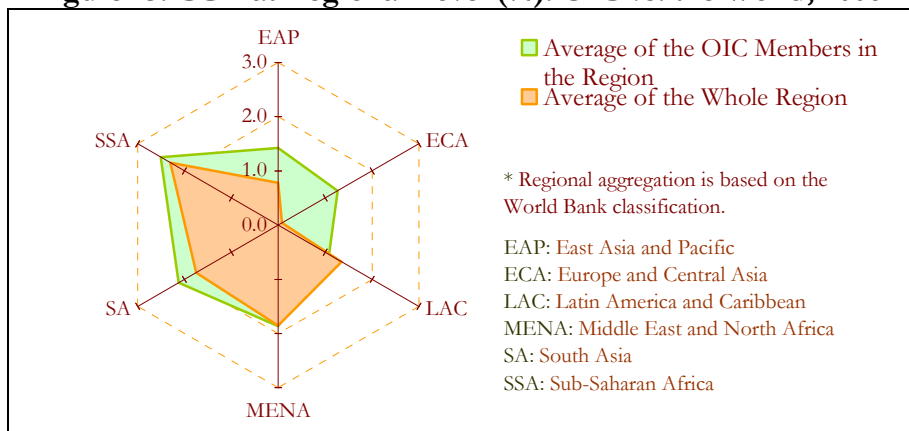
Population growth in the OIC group was even higher compared to developing countries (%1.94), corresponding to %36 percent of the increase in the world population in 2006. This implies that if the growth rate remains constant, the population of the OIC will double from its current 1.35 billion to 2.7 billion by 2042. Despite the young generation they will have, the OIC member countries, with such a high rate of growth in their population, may face the risk of worsening the hunger and poverty problems most of them already have unless they manage to achieve high rates of real economic growth so as to accommodate the new generations.

¹² $CGR = (CBR - CDR) / 10$

¹³ As seen from Figure 12, TFR is closely related to CBR and also CGR, rendering it a good indicator of population growth rate.

¹⁴ Such a low rate of population growth in the developed countries is often interpreted such that the population growth will come to a stop in the near future due to low share of reproductive population –but high rate of aged population– in addition to the low fertility rates.

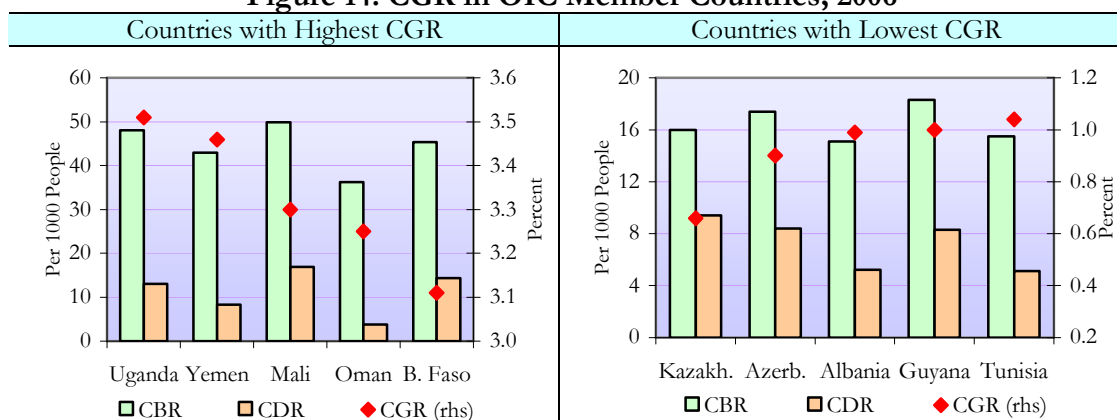
Figure 13: CGR at Regional Level (%): OIC vs. the World, 2006*



Data Source: US Census Bureau, International Data Base.

Regional decomposition of the world growth rate of population, as presented by Figure 13, reveals that the regional average CGR is highest in SSA (%2.30) followed by MENA (%1.85), and SA (%1.75). Though slightly higher, the OIC members in these regions have almost the same growth rates; %2.50, %1.86, and %2.12, respectively. The lowest regional averages are recorded for ECA (%0.08), as expected, and EAP (%0.78), where, on the contrary, the highest differences exist with the average of the OIC members. On the other hand, OIC members only in LAC recorded a lower rate than the regional average.

Figure 14: CGR in OIC Member Countries, 2006



Data Source: US Census Bureau, International Data Base.

Further details at country level in the OIC region indicate that Uganda, Yemen, Mali, Oman, and Burkina Faso –each with more than 3.1 percent– are the top five countries with highest CGR while Kazakhstan, Azerbaijan, Albania, Guyana, and Tunisia –each with less than 1.1 percent– are the bottom five countries with lowest CGR (see Figure 14)¹⁵. Assuming that these growth rates will be constant, the top five countries will double their population in 20-23 years whereas the bottom five countries will achieve this in more than 64 years.

¹⁵ See Appendix 1 for data on all OIC member countries.

EVALUATION AND POLICY IMPLICATIONS

Most of the OIC member countries, especially the 22 LDCs, suffer from high rates of infant mortality and low life expectancy at birth compared to the developed and even developing world due to unfavorable living conditions. Given that health is indispensable for every human being, however, any possible measure should be taken by every country to guarantee a healthy population. Indeed, this intention today has evolved into a global effort with the Millennium Summit, from which the Millennium Declaration and, subsequently, the Millennium Development Goals (MDGs) emerged, focusing on human development and poverty reduction with health at the center.

It is true that most of the member countries experience persistent poverty and do not have strong economies to implement every kind of measures in the health sector, especially which impose financial burden on the governments. There are certain ways, however, through which countries can save lives and improve the quality of life, though their benefits are obtained more comprehensively in the long term but their costs are thus outweighed.

First of all, ex ante measures focusing on eliminating the causes of infant mortality are crucial in reducing the risk of infant deaths. In this respect, education and training materials and programs or campaigns can be provided for expectant and new parents, health and human service professionals, and child care providers to create awareness against infant mortality. Mothers and particularly the expectant ones should be encouraged towards good nutrition and healthy lifestyles, reducing the use of harmful substances associated with high risk births. Nevertheless, it is important to note that while most interventions focus on women, the role of male partners is also critical in supporting the health of women and their infants since today's world is still patriarchal.

Moreover, since food security and unsafe water or –to sum up to a single factor– poverty is the main factor behind high infant mortality rates, any improvement in these fields and any poverty reduction policy will undoubtedly help decrease infant mortalities in the suffering countries.

Other efforts to promote infant health and prevent infant illness and mortality may include programs to improve access to prenatal and newborn care to safeguard the health of the mothers and infants. Nevertheless, it should not be ignored that access to health insurance is a critical component of assuring healthy births through public health services in many countries. What about the poor and unemployed people who are uninsured? A lack of health insurance often results in late or no entry into prenatal care, which may bring about various pregnancy complications and late diagnosis of treatable cases.

On the other hand, since the infant mortality rate correlates very strongly with life expectancy at birth, reducing infant mortality rate will inevitably contribute to longer life expectancies. However, when it comes to countries with quite high infant mortality rates, it seems that life expectancy at birth is heavily dependant on the mortality characteristics of the other age groups as well since over all mortality rates are already high in these countries. Therefore, given the fact that improvement in the living standard through enhancements in nutrition, sanitation, medical knowledge along with scientific and technological progress, and access to basic health care has brought about significant changes in life expectancy throughout the world, initiatives to support and further improve these aspects are of crucial importance. Of course, countries which suffer from HIV/AIDS, especially in Sub-Saharan Africa, need additional special treatment to increase life expectancy.

As for the higher birth and fertility rates and thereby higher growth rates of population in the OIC region, any population policy should take into account the major factors behind these phenomena as mentioned above. High growth rates may lead to difficulties for poor families to feed and educate their children and for women to participate in the labor force. In other words, the OIC member

countries with high rates of growth in their population may face the risk of worsening the hunger and poverty problems most of them already have unless they take the necessary measures or manage to achieve high rates of real economic growth so as to accommodate the new generations. On top of all, fertility is more or less a *preference* –of parents, society/culture, or governments– and therefore it has to do with family planning initiatives.

Spread up around the world with a wide range of development levels, the OIC member countries present vast differences in the demographic aspects analyzed in this study. It is therefore critical to focus on countries that suffer most, particularly the members in Sub-Saharan Africa or, to a broader extent, the ones classified as the least developed countries because these are the ones which in many ways lag behind the world, which are usually unable to overcome their problems on their own with limited resources, and which therefore need help and assistance at least to provide their people with secure living conditions.

Of course, all these initiatives and strategies towards a healthier population cannot be implemented successfully by governmental or non-governmental organizations alone. Ensuring the sustainability of these initiatives over the long term requires partnership and cooperation at national and international level among agencies, civil society organizations and the media along with governments through legislative activities and funding and supporting mechanisms for research, education and training programs.

Appendix 1: Main Demographic Indicators for OIC Member Countries, 2006								
Country	Crude Birth Rate	Crude Death Rate	Crude Growth Rate of Population	Infant Mortality Rate (Per 1000 live births)	Life Expectancy at Birth			Total Fertility Rate (Average number of live births per woman)
					Both	Male	Female	
Afghanistan	46.6	20.3	2.63	160.2	43.3	43.2	43.5	6.69
Albania	15.1	5.2	0.99	20.8	77.4	74.8	80.3	2.03
Algeria	17.1	4.6	1.25	30.9	73.3	71.7	74.9	1.89
Azerbaijan	17.4	8.4	0.90	60.2	65.6	61.5	70.3	2.06
Bahrain	17.8	4.1	1.37	16.8	74.5	72.0	77.0	2.60
Bangladesh	29.8	8.3	2.15	60.8	62.5	62.5	62.5	3.11
Benin	38.9	12.2	2.66	79.6	53.0	51.9	54.2	5.20
Brunei	18.7	3.2	1.55	13.6	75.1	72.9	77.3	2.00
Burkina Faso	45.4	14.3	3.11	89.2	51.6	49.8	53.5	6.47
Cameroon	35.6	13.0	2.27	67.2	52.3	51.7	53.0	4.58
Chad	43.1	17.0	2.61	103.8	47.0	46.0	48.1	5.68
Comoros	36.9	8.2	2.88	72.8	62.4	60.0	64.7	5.03
Cote d'Ivoire	35.1	14.8	2.03	89.1	48.8	46.2	51.5	4.50
Djibouti	39.5	19.3	2.02	102.4	43.2	41.9	44.5	5.31
Egypt	22.9	5.1	1.78	30.7	71.3	68.8	73.9	2.83
Gabon	36.1	12.2	2.40	54.4	54.5	53.2	55.8	4.74
Gambia	39.4	12.2	2.71	71.6	54.1	52.3	56.0	5.30
Guinea	41.8	15.5	2.63	90.0	49.5	48.3	50.7	5.79
Guinea-Bissau	37.2	16.5	2.07	105.4	46.9	45.1	48.7	4.86
Guyana	18.3	8.3	1.00	32.2	65.9	63.2	68.7	2.04
Indonesia	20.1	6.3	1.38	33.3	69.9	67.4	72.4	2.41
Iran	16.3	5.6	1.07	39.3	70.3	68.8	71.7	1.72
Iraq	32.0	5.4	2.66	48.6	69.0	67.8	70.3	4.18
Jordan	21.2	2.6	1.86	16.8	78.4	75.9	81.0	2.63
Kazakhstan	16.0	9.4	0.66	28.3	66.9	61.6	72.5	1.89
Kuwait	21.9	2.4	1.95	9.7	77.2	76.1	78.3	2.91
Kyrgyzstan	22.8	7.1	1.57	34.5	68.5	64.5	72.7	2.69
Lebanon	18.5	6.1	1.24	24.2	72.9	70.4	75.5	1.90
Libya	26.5	3.5	2.30	23.7	76.7	74.5	79.0	3.28
Malaysia	22.8	5.0	1.78	17.5	72.5	69.8	75.4	3.04
Maldives	34.8	7.1	2.77	54.9	64.4	63.1	65.8	4.90
Mali	49.9	16.9	3.30	107.5	49.1	47.2	51.0	7.42
Mauritania	41.0	12.2	2.88	69.5	53.1	50.9	55.4	5.86
Morocco	22.0	5.6	1.64	41.0	71.0	68.6	73.4	2.68
Mozambique	39.0	20.7	1.83	112.1	40.8	41.2	40.4	5.35
Niger	50.7	20.9	2.98	118.2	43.8	43.8	43.7	7.46
Nigeria	40.4	16.9	2.35	97.1	47.1	46.5	47.7	5.49
Oman	36.2	3.8	3.25	18.7	73.4	71.2	75.8	5.77
Pakistan	28.1	8.2	1.99	70.8	63.4	62.4	64.4	3.84
Palestine	34.5	3.9	3.07	20.5	72.7	71.2	74.4	4.83
Qatar	15.6	4.7	1.08	18.0	73.9	71.4	76.6	2.81
Saudi Arabia	29.3	2.6	2.68	12.8	75.7	73.7	77.8	4.00
Senegal	38.3	11.2	2.71	61.4	56.3	55.0	57.7	5.13
Sierra Leone	45.8	23.0	2.27	160.6	40.2	38.0	42.5	6.08
Somalia	45.2	16.6	2.86	114.6	48.5	46.7	50.3	6.76
Sudan	35.3	15.2	2.01	96.8	47.9	47.1	48.8	4.79
Suriname	17.6	5.5	1.21	20.8	73.0	70.3	75.8	2.05
Syria	27.8	4.8	2.29	28.6	70.3	69.0	71.7	3.40
Tajikistan	27.4	7.2	2.02	45.0	64.2	61.2	67.4	3.14
Togo	37.0	9.8	2.72	60.6	57.4	55.4	59.5	4.96
Tunisia	15.5	5.1	1.04	25.2	75.1	73.4	77.0	1.74
Turkey	16.6	6.0	1.06	39.7	72.6	70.2	75.2	1.92
Turkmenistan	25.6	6.2	1.94	55.2	68.0	64.9	71.2	3.19
Uganda	48.1	13.0	3.51	68.5	51.0	50.1	51.9	6.88
United Arab Emirates	16.1	2.2	1.40	13.9	75.5	73.0	78.1	2.44
Uzbekistan	26.4	7.8	1.85	70.0	64.6	61.2	68.1	2.91
Yemen	42.9	8.3	3.46	59.5	62.1	60.2	64.1	6.58
OIC	28.6	9.2	1.94	67.5	59.8	58.6	61.2	3.67
World	20.2	8.4	1.18	45.2	65.4	63.6	67.4	2.61
Developed Countries	11.0	10.3	0.07	6.7	76.6	73.1	80.4	1.60
Developing Countries	22.3	8.0	1.43	49.6	64.1	62.5	65.9	2.84

Source: US Census Bureau, International Data Base.