

The Preface by Steve Sinding for the Supplement with four PAA papers.

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More than three years have passed since the International Conference on Population and Development at Cairo. At last spring's annual meeting of the Population Association of America, I thought it would be useful to ask four experts, each with a distinctive perspective on the ICPD and its aftermath, to reflect on its significance and its accomplishments, now that much of the dust has settled. The following papers are the product of that inquiry. Individually, they represent a rich tapestry of insights and observations. Collectively, they are a microcosm of the many points of agreement, and the smaller number of disagreements, that today characterize Cairo's post-mortem. Fred Sai, the permanent chairman of the Cairo conference and the principal steward of its remarkable consensus, reminds us of the many advances made at Cairo, in expanding the definition of services from family planning to reproductive health, in defining more precisely than ever before the specific development approaches that most influence reproductive outcomes, and in emphasizing the central role of women's status and empowerment in the population equation. He argues that, rather than setting the demographic agenda back, Cairo enriched and expanded it. Jack Caldwell takes a somewhat different tack on the demographic impact question, arguing that the effect of the organized women's movement on the Cairo programme of action was to shift attention from reducing high fertility rates and rates of population growth to improving women's reproductive health and individual wellbeing - a shift that he predicts will reduce Western aid for family planning and reproductive health programs to the detriment of Africa, in particular. Adrienne Germain, a central figure in the women's health movement, maintains that Cairo represents a retreat from population policy only if one defines such policy in an overly narrow way. If one sees population policy in the broad sense of promoting reproductive freedom as well as a series of actions in other development sectors that reinforce low desired fertility, Cairo was very much a demographic conference. She chides demographers for their propensity to define population policy solely in terms of demographic targets and contraceptive goals. Finally, Alaka Basu warns that a new orthodoxy - reproductive health - replaced the older neo-Malthusian orthodoxy at Cairo. She laments that the new orthodoxy is harder to attack because it is cloaked in the language of human rights and universal egalitarian and altruistic goals. Yet, she argues, the new orthodoxy of

women's health and rights has yet to pass the empirical test: does the evidence suggest that it will produce the desired demographic outcomes and will it result in healthier, better off individuals and families? Basu presents a framework for assessing the many tradeoffs that policymakers must face in choosing among the programmatic alternatives. There is no question that Cairo changed the landscape of population policy. But the jury is out on whether the road to population stabilization will be made easier or more difficult to build through the changed terrain. These four authors offer their opinions (and predictions) on this question. In so doing, they have posed very well the questions that must be answered before the next global population conference, which, if tradition is obeyed, will be held in 2004.

The ICPD Programme of Action: pious hope or a workable guide?



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There is much to be proud of in the consensus that emerged from the tough negotiations during the Preparatory Committee Meetings and at the population conference in Cairo. The inclusion of 'development' in the official title of the conference marked a significant move away from discussing population issues in the divisive context of demographic targets, towards a global recognition that the problems associated with rapidly growing human populations were now part of a broader human development agenda. The Programme of Action, approved by consensus, contains no demographic targets. Its emphasis on the need to ensure the alleviation of poverty and equity between and within nations served further to reduce significantly some of the North-South conflicts that were present at the 1974 Bucharest World Population Conference, where it was argued by several developing countries that 'development is the best contraceptive', and the 1984 Mexico City International Conference on Population, where it was agreed that population and development were two sides of the same coin, but where the United States and the Vatican, plus a handful of countries, opposed all discussion of abortion, and played down the importance of family planning.

The ICPD Programme of Action recognizes women's education, equality and empowerment as paramount, and the importance of providing family planning within the context of full sexual and reproductive health care is stressed. It applies basic human rights principles to population and family planning programs, and rejects coercion, violence and discrimination. It recognizes the central role of sexuality and gender relations in women's health and rights; asserts that men must be fully involved, but without veto, in decisions involving fertility, sexual behaviour, sexually transmitted disease and the welfare of their partners and children; and recognizes unsafe abortion as a major public health issue.

Beyond that, Cairo signalled an understanding that population is at last seen as part of the necessary investment in people, without which none of our development or environmental problems will be solved. Educating girls and making women truly equal partners in development, reducing infant and child mortality, promoting safe motherhood, giving access to quality family planning, tackling the problems of STDs, and providing clean water and adequate food and nutrition, are all connected with improving reproductive and family health and reducing family size. Slowing population growth, in turn, will feed back its social, economic and environmental benefits.

Another major Cairo achievement was that NGOs were very fully involved in the ICPD process at all stages, and many representatives of non-governmental family planning associations were also members of their national delegations. As a result, the Programme of Action reflects several concerns that emanate from the NGO sector rather than governmental positions. Traditionally NGOs have played an important role in providing information and services to groups in society not well served by government programs, such as the poor, ethnic minorities, adolescents and prostitutes. They have also addressed sensitive issues such as abortion, violence against women and female genital mutilation. All these are areas

emphasized by the Cairo and Beijing conferences. Already there is evidence that governments are working with NGOs to help them implement the programs which they signed up to in Cairo and Beijing. NGOs are also helping in other areas which ICPD stressed, such as the decentralization of public health programs to promote community participation in reproductive health care.

An important Cairo achievement was the avoidance of major North-South conflicts, and this was largely because the conference preparatory process and the Programme of Action clearly recognized the globality of population, sustainable development and environment problems. It was accepted relatively early in the preparatory process that affluent lifestyles and excessive waste production in the wealthier Northern countries, and not only rapid population growth in the poorer South, contribute to global population and sustainable development problems.

The need for poverty alleviation programs was also accepted—and this was taken forward at the Copenhagen Social Summit—which is an essential plank to all attempts to lower fertility and human numbers. But, arguably, the main achievement was the acceptance that population problems cannot be tackled through a macro-numbers approach: solutions must be found at the micro level. So much of what needs to be done turns on a proper understanding of people as individuals and communities, on the status of women and the provision of proper sexual and reproductive health care.

The Fourth World Conference on Women endorsed this approach, and indeed proposed further steps towards improving women's status, education, empowerment and reproductive and sexual health. It is important to acknowledge the influence of the feminist movements on the enlarging of the program base which has been reflected in the achievements of the Cairo and Beijing conferences. Their campaign against women's bodies being 'used' by demographic and target-based population programs has been a powerful one. Although some women's groups may go too far in their rejection of modern contraceptive methods, and may fail to give full credit to the empowering effect of fertility control on women's lives, it is clear that their opposition to coercive programs has been largely useful and positive; and indeed, their position on caring, demand-driven programs has been supported or reinforced by recent demographic research.

The Cairo recommendations therefore challenged us to change our approach to population programs, family planning and reproductive health and not to give them up. First, the high-quality data that became available from the World Fertility Survey in the 1970s and more recently from the Demographic and Health Surveys have shown a high level of unwanted fertility in almost all countries covered. These surveys confirmed the universal desire of people to have smaller families, to control the timing of births and to have access to the means to do so. The unmet need, and the demand, for family planning were shown still to be vast.

The most conservative estimates of unmet need were based on the proportions of women who expressed a wish to delay or avoid pregnancy but who had not obtained contraceptive protection. These calculations yielded a range of figures from 12 to 21 per cent of women in the developing world. These were based on the early DHSs which, in the main, omitted single women, as well as couples using an unsuitable, unsafe or unreliable method, and those who were dissatisfied with the method they were currently using. Including such couples would obviously increase the estimates of demand for family planning greatly.

It became clear, as people began to look at why there was so much unmet need, that the lack of availability or the inaccessibility of services was only one reason. There would be much more uptake of family planning if services were planned with community involvement, and oriented towards clients, offering them real choices and paying more attention to them as individuals and their total circumstances. This expansion is at the heart of the Cairo agenda.

Meanwhile, the call for concerted action over rapid population growth continued, sparked by groups in the economic development and the environment communities. These groups saw the growth in human numbers as a block on achieving both economic growth and sustainable environment. This renewed fears of a revival of demographically driven family planning programs just as the need for programs which sought to put clients' needs first were being recognized.

It was research led by our colleague and the organizer of this meeting, Steve Sinding, that bridged the gap between those who saw a need for demographic goals and those supporting individual rights. He showed in 1992 that confrontation between these two groups was not necessary: programs designed to respond to the individual reproductive needs and aspirations of women or couples could achieve as much as those designed to achieve demographic targets. If women could have only the number of children they desired, he found, the effect on total fertility rates would, in 13 out of 17 countries where the government had quantitative targets to reduce fertility, more than exceed those targets. Applying the same procedure globally, meeting the contraceptive needs of the 17 per cent of women of reproductive age in developing countries, outside China, who were not achieving their family size preference, would result in a fall in total fertility rate that more than matched that required to meet the UN medium projection for 2000.

A rise in 15 percentage points in contraceptive prevalence is associated with decline of around one point in the total fertility rate, so if the 12 per cent figure of unmet need were satisfied, the result would be a 0.87 decline in the present developing country total fertility rate to one of 3.03. If the more liberal estimate of 15-17 per cent unmet need were to be used, the result would be even more dramatic and approach the UN low population variant projection by the year 2000 of a TFR of 2.855.

By the time of ICPD, there was a clear consensus on the need for a more comprehensive, client-centred view of services and for family planning to be part of a wider reproductive health approach. In this approach, the whole life cycle of people's health needs in relation to sexuality and reproduction is taken into account. The unfinished agenda to increase access to and improve the quality of existing family planning services still remains, but the range of services is expanded according to the particular needs of communities. Under this holistic approach, these extra services may include providing care for women during pregnancy and for mothers and babies after delivery; providing gender-sensitive information, education and counselling on sexuality; taking care of people's concerns of sexually transmitted diseases and infertility; HIV/AIDS prevention; the prevention and management of unsafe abortion and the provision of safe abortion services where legal.

All these different elements of sexual and reproductive health are connected, and gains in one area will more than probably have beneficial repercussions in other areas. People are much more likely to take advantage of family planning when they find their other needs and concerns are being recognized as well. One example is of a family planning client who is screened for risk of sexually transmitted disease before being fitted with an IUD. A good family planning provider will of course make sure a client who is found to be at risk is offered an alternative method. But under the holistic approach, she will be given the chance to express and realize her needs for guidance, treatment or referral for her sexual and reproductive health concerns.

To assess the impact of ICPD on population policies and programs round the world, UNFPA invited countries to share their experiences in implementing reproductive-health interventions. Almost two-thirds of the countries which responded have begun to take steps to broaden existing family planning and related programs to include other reproductive health information and services.

Many developing countries are seriously making program and structural changes to make implementing the ICPD recommendations a reality. For example, in Mexico, post-Cairo, the Ministry of Health began by merging the maternal-child care and family planning directorates into one new directorate of reproductive health. The national reproductive health program includes family planning, adolescents' reproductive health, safe motherhood, women's health and sexually transmitted diseases, with an overall gender perspective. The new thinking in the family planning sector includes strengthening women's roles, highlighting men's responsibility in the reproductive process, and the prevention and management of infertility. Advocacy, education and communication efforts will be used to spread the message; mass media are used to tell health workers, clients and the general population about reproductive health. To help other countries mirror Mexico's efforts, the Partners in Population and Development Initiative is ready to support South-to-South transfer of experience.

Another example is the Government of India, which as a direct result of the recommendations of the Cairo Conference, has abandoned the target-based, 'births averted' approach which it had used for over 40 years, and is now pursuing a more holistic, community-based approach.

Most African countries, always uneasy about family planning, have welcomed the new approach and are actively seeking both technical and resource help for implementation. Donor agencies are also providing the necessary stimulus and guidance to ensure the broader approach. In 1995 USAID held a major conference-workshop in Nairobi to formulate an agenda, based on experience, to integrate family planning and reproductive health care.

The UN and its agencies have undertaken various specific measures to ensure follow-up of the recommendations of ICPD. There is an inter-agency group chaired by UNFPA to work out the aspects of implementation that each relevant agency would undertake. It also is to help provide a centre for co-ordination of the activities.

In the area of reproductive health the World Health Organization has helped to identify various elements which should go into a comprehensive health program and have started popularizing this. This Family and Reproductive Health Programme has been given extra visibility by being headed by an Executive Director, the equivalent of an Assistant Director-General. Under her have been grouped various divisions and units dealing with different aspects of reproductive health. These include the HRP (Program for Research in Human Reproduction), adolescent health, child health and development, and the unit on women and health.

This innovative approach by WHO is a signal to all government health authorities as to what they can do to help implement the ICPD recommendations. The more overt involvement of UNICEF recently in the issue of Safe Motherhood and birth spacing would probably not have happened without the shift in program thinking that Cairo agreed.

The holistic approach advocated by ICPD is in harmony with all modern thinking on development, and should not be taken as a de-emphasizing of the importance of fertility reduction activities. The fact that there are 'add-ons' and new approaches in the ICPD Programme of Action was not intended to imply that family planning was considered less important: it is just as important, but is now seen in a wider context. More tellingly, some object that to expand family planning to embrace all sexual and reproductive health services will inevitably lead to a dilution of basic services and that family planning associations will be unable to cope or afford the extra services they are expected to provide.

It is true that some will be unable to cope; but the proof that it is possible is that some were already providing much fuller services before Cairo, and others have started doing so since. And part of the spirit of Cairo is to encourage all family health organizations to co-operate more closely with each other and other agencies. The other side of the coin is that many agencies which could have played a role in fertility management were not doing so

when the programs were so narrowly focused. With the new approach more agencies are able to see their potential more clearly. The new approach, if anything, provides a broader base and a greater variety of acceptable agencies and individuals advocating the cause of population and family planning in development.

The question about cost is however a very real one. Of course it costs more money to provide extra services, and this was recognized in the ICPD funding targets. It is true that some of the wealthier nations have so far not shown much sign of honouring the commitments made in Cairo; and if they do not, implementation will naturally be difficult and the benefits for human development and lower population growth are unlikely to be achieved. But this difficulty surely should not be turned into a criticism of the Cairo concept of extending sexual and reproductive health care to all.

The new international population movement: a framework for a constructive critique*

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Abstract

This paper suggests that the old (neo-Malthusian) ideological orthodoxy which informed much of the population policy debate until the mid-1980s is in danger of being replaced by a new orthodoxy which is also unduly one-sided and simplistic. In addition, this new ideology, which received such a boost at the Cairo conference, is under even less pressure to re-evaluate some of its premises because it is motivated by more obviously altruistic and egalitarian concerns, and a challenge to its premises runs the risk of being interpreted as a challenge to these humane goals. However, letting ideology inform research and policy can have self-defeating consequences when it ignores the complexity of the real world, the frequency of trade-offs, and the many ways in which there may be a conflict between policy-relevant empirical findings and these ideological goals. The paper explores some of these issues in the context of Cairo and presents a framework which may be used to develop a constructive critique of the new international population policy agenda.

Traditional population policy received a major drubbing at the United Nations Conference on Population and Development held in Cairo in 1994. But the Cairo statement was actually the culmination of a long-simmering discontent with the ideology and methods of traditional population policy: a discontent that had manifested itself in several forums in the 1980s but required the political clout of the international women's movement to enter the public and policy consciousness.

In many of these critiques, population policy is rightly equated with family planning policy. In addition, these critiques have often gone further to criticize the ideological and political underpinnings of traditional population research as well, the main criticism being that such research was often little more than a means of justifying or legitimizing family planning policy, or else refining the operational aspects of family planning programs (see, for example, Hodgson 1983; Demeny 1988; Greenhalgh 1996).

The last ten years therefore have witnessed an accumulation of writing and discussion on the negative features of traditional population policy and the need for a paradigm shift. Around and since the Cairo conference, the dominant or at least most visible feature of this paradigm shift involved a move from notions of population control to notions of reproductive health. If one sifts through this large and still burgeoning writing, a few distinct strands of criticism emerge as the key complaints of population policy and its old staple, the family planning program.

First, family planning programs are driven entirely by demographic goals and targets. That is, what they seek is a reduction in population growth rates, with little concern for client needs and problems, or what is called the 'user perspective'.

* An earlier version of this paper was presented at the session 'Where is the International Population Movement Going?' at the annual meeting of the Population Association of America, Washington DC, 27-29 March 1997. I thank participants for comments during the session. For extremely useful comments on an earlier draft of the paper I would also like to thank Stan Becker, John Bongaarts, John Casterline, John Cleland, John Knodel, Mary Katzenstein and Basia Zaba.

Secondly, family planning programs are by their very nature coercive and have the potential to seriously abuse human rights and especially the reproductive rights of women. For both these reasons, family planning programs need to be replaced by 'reproductive health programs' which replace larger demographic goals with the goals of individual clients.

Thirdly (as mentioned above) the family planning program approach to population policy is bolstered by an influential chunk of mainstream population research which seems to exist only to justify the existence of such programs.

Fourth, in addition to providing reproductive health care, the empowerment of women is the primary ethical and effective way to improve the quality of life of a population (which is, after all, what population policy is, or at least should be, all about), as well as incidentally to bring down fertility.

Empirical evidence and philosophical reasoning is sought to back many of these criticisms. But their most important strength is that they have a strong emotional and human appeal; they are so obviously born of the concern for individual welfare and individual rights that appeared to be missing (even if it was not actually missing) from the collective welfare rationale that often characterized earlier population policy¹. This sense of altruism appeared to be missing from earlier pronouncements on population not only because it was less often openly professed; it appeared even more to be missing because these earlier pronouncements had an emotionally distasteful hierarchical element: they smacked too much of the developed countries telling the developing world what to do, of governments telling people what to do, and of men telling women what to do. At all these levels, it appeared all too plausible that the 'teller' had his own agenda, which could be quite divorced from the welfare and perspective of the potential 'doer'.

Population research was often believed to collude in this earlier endeavour to the extent that its own agenda took the demographic goal of family planning programs for granted and concerned itself more with elucidating the various ways and the various conditions in which family planning programs could be made more demographically effective. That this research endeavour could in turn be motivated by a concern for individual rights and welfare often tended to get lost in the dry and 'scientific' tone of most of the research output in population studies.

The Cairo conference and the events leading up to it made a signal contribution by bringing these welfare issues out into the open and by making them the explicit focus of population policy. However, this paper suggests that the population movement today faces a real danger of throwing out the baby with the bathwater in its attempt to dissociate itself so completely from the findings and recommendations of past research and policy. There is much in this body of research and recommendations that is not inconsistent with the goals of protecting and promoting human rights and individual welfare; the best way of reconciling the goals and methods of the old population movement and the new international population

¹ But even before the Cairo conference this rationale had increasingly changed to one concerned with the impact of high fertility on individual and family welfare; an acknowledgement of this change is missing from much of the current reproductive health literature.

movement (henceforth referred to as the IPM²) would be to develop an internal critique of the latter analogous to the one that was so devastatingly developed of the former³.

If such a critique of the new IPM is not developed, then the new IPM, in spite of its visibly more laudable motives, stands to become as politicized and one-sided as the old IPM seemed to be; a situation that then risks advocating and legitimizing ineffective or occasionally even detrimental policies in the same way as the old IPM did. There are several signs that this danger is becoming increasingly real. The most important of these is the apparent consensus on the reproductive health approach as the only effective approach to population policy. 1982 PAA president John Kantner (cited in Greenhalgh 1996) wrote with reference to the family planning movement of the 1960s: 'Heady times, those, and something in it for everyone—the activist, the scholar, the foundation officer, the globe-circling consultant, the wait-listed government official'. It is difficult not to see an exact parallel with the reproductive health agenda of today.

Not only have international organizations and funding agencies all changed their mandates and their funding priorities to reflect this new paradigm shift in population policy, national governments too have taken their cue from these changes and adopted what they call a reproductive health approach in an uncritically abrupt way. The giving up of demographic targets is the most dramatic way in which this has occurred not only on a global scale (the Cairo report is remarkable for its about-turn on the matter of population goals between the second and third prepcoms, a switch too sudden to avoid the suspicion of political expediency), but national governments too have thrown family planning programs and personnel in some disarray by the sudden disavowal of demographic goals.

As in any discussion in which advocacy is a central feature, some of the discussion on the new reproductive health agenda is general and some of it is focused; more distractingly, some of it is clearly laid out but much of it is also ambiguous. In particular, it is ambiguous in its use of language, as opposed to its policy prescriptions. The most common confusion within the new IPM is that caused by the way it uses interchangeably the terms 'health programs', 'family planning programs' and 'reproductive health programs'. It is never very clear whether this interchangeability is taken to be a description of the situation in the field or refers to a goal of the new paradigm that is being proposed.

Moreover, the use of language by the new population literature and reproductive health rhetoric is infectious. Virtually any agency, governmental or non-governmental, today brings the term 'reproductive health' into its agenda whether or not it is in context. Population-related agencies are of course the worst offenders: either they have replaced the word 'population' with 'reproductive health', a clear case of category mistake; or, if they are bold or unwise enough to continue to harp on 'population' issues, they have appended the term 'reproductive health' to any use of the word 'population'⁴.

² I use the acronym IPM to refer not only to the international population movement but also often to the international reproductive health movement (for which the population movement is increasingly a proxy) and sometimes to the international women's movement (for which the population movement is increasingly the spokesperson).

³ This critique of the old style of population policy was incidentally not wholly a critique from the outside; the issues from the 1980s of any population research journal are replete with attempts to reframe the population issue and question some of the basic assumptions of population policy.

⁴ A March 1997 news release from the Population Council in its announcement of a new centre 'to study African population issues' then immediately covers itself in the first sentence by stating that the centre has been established to foster research 'on population and reproductive health issues'. The body of the announcement however does not mention reproductive health at all and makes it clear that the centre's primary interest will be in understanding the mechanics of demographic transitions in sub-Saharan

In spite of such dangers and confusions, the new changes in policy direction may of course be empirically and theoretically justified if put to the test. But they do need to be put to the test and supported with a wider range of research. This research currently is too one-sided and geared to supporting reproductive health policy in the same way that earlier research was geared to supporting family planning policy. Just as this body of research tended to be unmindful of the larger social and political context of reproduction, the wholesale embrace of the reproductive health agenda also requires such neglect of the larger context of fertility, an understanding of which is crucial for academic understanding of reproduction of course, but also for framing policies which do not universalize the experiences of Third World women or of societies⁵.

And in the same way as earlier, this new research can be best strengthened not by doing more of the same but by subjecting to critical scrutiny four aspects of itself: (1) the way it formulates the 'population problem'; and the validity of its recommendations from the standpoint of (2) empirical justification of its hypotheses; (3) ethical rationales; and (4) feasibility. None of these critical approaches need be undertaken in the spirit of destroying the reproductive health approach to population policy; instead they must be seen as a means of clarifying and strengthening a population policy which continues to be explicitly based on an ideology of promoting human rights, reproductive rights and social welfare.

In the following sections I outline the possible framework of such a critique. Three things that this framework does not do are worth mentioning. First, it does not dwell too much on the positive features of the new IPM; these are already well known and widely acknowledged even by the staunchest advocates of traditional population policy. Secondly, this framework is often unable to go beyond research recommendations to actually discuss findings. This inability is an outcome of the continuing politicization of population research and policy; we simply do not know enough about the limitations of the new IPM because we have not thus far found it politically or financially feasible to explore these limitations⁶. And finally, this is not a framework for dissecting the social and political construction of demographic

Africa to initiate policies to sustain or accelerate such transitions. This is a perfectly legitimate research activity and little is gained by the political acknowledgment of reproductive health issues out of context.

The Indian government in the latest version of its population policy, which is shortly to be placed before Parliament, talks of a reproductive health package which will include also the national eradication of malaria, leprosy, tuberculosis, blindness and AIDS (*Economic and Political Weekly* 1997). Quite apart from the confusion implied by such indiscriminate use of terms with very specific meanings, there is the very real fear that language will become a political substitute for action.

⁵ In a recent issue of the *New York Times*, there was a long article on the position of the National Organization of Women on the presence of an all-girls school in Queens. In spite of many students and alumnae testifying that the school served an essential educational purpose because it catered to girls from the kind of cultural background which made learning in the presence of boys difficult, NOW insisted that the school be made co-educational because as, its spokesperson explained, NOW wanted to be consistent about its stand on equal access to schools. What this approach lacks is what Sen (1970) calls the distinction between 'basic' and 'non-basic' value judgements. It treats equal access to schools as a basic value (that is, a value which is adhered to under all conceivable circumstances), instead of modifying this principle when an unseen contingency occurs to now propose for example, that equal access is a non-basic value judgement, and advancing the education of girls is the basic value judgement.

⁶ Even when some of the potential criticisms of the new population policy approach are acknowledged, they are rarely explicitly addressed. For example, Sen, Germain and Chen (1994a) in their introductory chapter to an influential report on the new approach, clearly mention some of the criticisms of this approach; but the next paragraph, which is presumably an attempt to rebut some of these criticisms, goes off on a tangent, not taking any of these criticisms specifically into account. In any case, possibly for strategic reasons, these criticisms of the reproductive health agenda are becoming increasingly muted.

knowledge and policy, an area on which there is a slowly emerging but penetrating literature (see Greenhalgh 1996), but for exploring the validity of the policy outcomes of this construction.

However, not all of this criticism requires basic research; existing research in mainstream population studies can often be profitably reviewed and re-evaluated to feed into it even if it true that this research was motivated by more than academic interest⁷. In addition, basic demography is very good at accounting procedures which greatly simplify many of the more theoretical arguments. But, for strategic reasons, this review and re-evaluation does need to be undertaken by the IPM itself; when such a review throws up unexpected or even uncomfortable findings, at least it cannot be accused of the hawkish motivational biases that the old IPM is seen to have in the popular imagination⁸.

Three years after Cairo, it makes sense to assert that the new IPM has come of age and needs the criticism that will keep it on its toes. Such introspection is essential if the new IPM is not to fall prey to the dogmatism that it has accused the older IPM of sinking into, even if this time it is dogmatism with a human face.

Formulation of the problem

The reproductive health approach cannot be faulted as an approach to the problems of reproductive health, especially among women, and in its goal of responding sensitively to these problems. However, since it has been set in the context of population policy and not health policy, it owes itself a clearer stand on the population question and a more detailed consideration of the implications of the reproductive health approach to this stand. Three related questions may be asked in this context: is there a reproductive health problem that needs interventions? Is there a population or excess-fertility 'problem' that could benefit from interventions? Is the population problem synonymous with the reproductive health problem or is the reproductive health problem a subset of the population problem?

On the first question, the reproductive health lobby has provided the information and the arguments for a strong affirmative answer which few could challenge. Even the most tentative numbers suggest that the reproductive health problem is worthy of much discussion. But on the next two questions, much remains to be learned. One may deduce the position of the international health movement on the importance of slower population growth as a worthwhile goal from two sources: from the statements made on this matter and, perhaps more importantly, from the statements *not* made.

The international women's movement which determined so much of the Cairo deliberations has never been very explicit about its own position on the population and

⁷ At the same time there is a great need to draw inspiration from research which is not guided or motivated by policy considerations. As Greenhalgh (1996) highlights, such research which is divorced from policy motives tended to be sidelined by funding agencies and political exigencies, therefore often by population scientists; however, there is still a substantial body of knowledge, especially in the neighbouring disciplines of anthropology and history, which can inform the policy process in a more rounded way, because it is concerned with the larger political and social context of individual behavior.

⁸ The politics of population policy continue to plague the discourse of the new IPM in much the same way as they did the old. Unsubstantiated allegations of ulterior motives are still common. For example, see the remark in Sen (1994) that in the face of the reproductive health challenge, the old population 'establishment', while seeking more and more official funds for family planning, continues to argue that 'such funds should only be used for contraception (rather than reproductive health more integrally)' and that this population establishment also argues that 'worrying about the quality of family planning services is an unaffordable luxury in a time of financial stringency' (p.68). It would be extremely difficult to find any individual or agency today callous or foolhardy enough to say the latter in particular.

development debate. It never agreed very clearly with the orthodox position that contemporary developing countries have much to gain from a reduction in their population growth rates, which, given the universal goal of continued mortality decline, means a reduction in current fertility levels. However, and this is significant, it has never explicitly or implicitly challenged this viewpoint either⁹. This is surprising, given that one of the most powerful criticisms of family planning programs could be that they are an aberration in a world which needs or wants high fertility. But the developments leading up to and after the Cairo conference did not throw up any variants of Mahmood Mamdani or Julian Simons, and the mainstream women's movement did not even exploit the possibilities available in academic 'revisionism', which believes that population growth is a neutral factor in economic and social development. Either of these approaches would have given much greater legitimacy to a population policy entirely in a reproductive rights and reproductive health framework.

However, it is of course also possible that the silence is because population goals are irrelevant to the priorities of the international reproductive health movement. That is, the only reason the reproductive health approach entered the population policy debate is because traditional population policy has been inimical to reproductive health. If that is the case, the international population movement (which then cannot be synonymous with the international women's movement or the international reproductive health movement) needs to heed this criticism, but also needs to define its own position on the population question. There is nothing inherently abusive or intrusive about demographically driven population policy, and a concern for reproductive health can be quite consistent with a simultaneous concern with larger questions of interventions to encourage fertility decline. But given that there will still remain much scope for debating the borderlines between population policy and reproductive health policy, the ideal situation would be for the international women's movement in reproductive health to develop its own version of legitimate population goals which can then be meshed into the larger population goals of countries¹⁰.

Thus far, the pointers suggest that the international women's and reproductive health movement may not be in major disagreement with the old IPM's assessment that fertility decline is a worthwhile goal at the individual level and perhaps also at the societal level. Its disinclination to actively oppose this viewpoint is one such pointer. More tellingly, the few statements that have been made on this matter usually fall in the category of statements which agree that fewer births in the developing world might be a good thing for all concerned: see, for example, the January 1995 issues of the *National Times*, the official publication of the National Organization for Women. Such agreement is also indicated by the volume of writing that adds that a reproductive health approach will also reduce fertility.

This implicit agreement may sometimes be motivated by strategic concerns: McIntosh and Finkle (1995) suggest that it made it easier for the women's movement in Cairo to gain allies from sympathetic population and family planning agencies; at a subregional level such

⁹ It has rightly challenged the position that population growth is *the* key issue in development and social welfare; but it has not openly questioned whether it is *a* key issue.

¹⁰ For example, the IPM may take the stand that local demographic goals, which often characterized the target approach in the Indian family planning program, need to be replaced by fertility and mortality goals which are determined for much larger units such as the state, as well as at the national level. Indeed, the Cairo document does agree that demographic goals may 'legitimately be the subject of government development strategies' (United Nations 1994). But then it sidelines criticism by leaving fertility goals completely out of its later recommendations for time-bound goals in population policy. It is then hardly surprising that in practice, a dissatisfaction with local targets seems to have resulted in a discarding of any kind of fertility goals in newer national policies.

agreement may be exploited to get greater official support for some of the non-demographic goals of the women's movement (Basu 1997a); but it may more often be genuine. Whatever it is, and together with its internal disagreements, the current position of the reproductive health movement on the population issue needs to come out of the closet. Indeed, an airing of some of the internal disagreements on this question will go far towards making it more robust and legitimate.

Given the pointers mentioned above and given the academic literature which tilts in the direction of favouring lower fertility even when it is motivated by concerns about individual rights and not larger political or economic interests, it is likely that when pressed, the IPM too will be on the side of the lower-fertility lobby. It may take its cue from the organizer of the Cairo conference, the UNFPA, which while wholeheartedly accepting the reproductive health approach, still slips in the phrase 'the universally accepted goal of population stabilization' in its endorsement of this approach (UNFPA 1996)¹¹. It could get a stronger cue from the inter-agency task force of the United Nations which, being only slightly less constrained by the Cairo ideology, goes as far as to reiterate the need to continue 'efforts to slow population growth' (United Nations 1996).

National governments too, whatever their rhetoric at international conferences¹², have been on the whole very conscious of the benefits of lower population growth rates for their countries. But, given the speed with which many national governments have dropped population stabilization goals from their population policies after Cairo, the reproductive health movement may be forgiven for being more cynical about the pre-1994 pronouncements of governments in both the developed and developing world on these matters. However, even if political expediency is a hallmark of government pronouncements, joint statements from developing countries, such as the Bali Declaration on Population and Sustainable Development (1992) and the Non-Aligned Summit on Population and Development (1992), as well as the planning documents of developing countries, nevertheless provide a useful framework for understanding these countries' own perceptions of population issues, even if these tend to be coloured by the developed-country viewpoint. Moreover, at least some national governments, India in particular, were concerned about population growth issues well before these became internationally fashionable¹³. Others, China in particular, continue to commit themselves to active efforts to reduce fertility in defiance of the Cairo coyness on the question and under the Cairo statement on protection of the principle of national sovereignty.

In addition to all these official pronouncements, the pre-1994 research output in the area of population and development has much to offer to the women's and reproductive rights

¹¹ The UNFPA is also careful in its use of language. While it avoids espousing fertility goals, it does not abandon them completely. The report of its Secretary General on the progress in implementing the Cairo plan of action states that 'population issues are more than just demographic concerns' (Sadik 1996); that is, it does not exclude demographic concerns. This statement is similarly vague in its use of population policy terminology; while its reference to the importance of 'population information, education and communication' can be read as consistent with the reproductive health program agenda because it could include mechanical information about contraception and health matters, it can equally well be read as a continued endorsement of active efforts to motivate fertility decline.

¹² In fact, at the plenary session of the Cairo conference, this rhetoric was strongly in the direction of concern about their population growth, a concern that was mirrored in the speeches of representatives from the developed countries, but which disappeared completely from the final program of action produced from the conference.

¹³ Indeed, in spite of the scrapping of demographic targets in India since April 1997, the new minister for health and family planning has reiterated her commitment to reduced population growth and recently even went as far as to propose a new slogan, 'One is Fun'. Needless to say, this slogan is unlikely to catch on.

activist; it has even more to offer to the human rights activist. But this does not mean an uncritical acceptance of the pro-fertility-decline position. In particular, there may be a case for acknowledging the views of the revisionists (as exemplified in the National Academy of Sciences report of 1986) and perhaps even of the pro-growth group. While the revisionist position may be as politically motivated as the alarmist position, its empirical evidence cannot be simply ignored and calls for a fresh attempt to reconcile its stance with the antinatalist stance of policy and popular views about population growth in developing countries¹⁴. Here again beginnings have been made in population studies (e.g. McNicoll 1995) which suggest new ways of re-examining the revisionist position¹⁵. Some recent empirical research even ventures to suggest that the Coale and Hoover model of population and development linkages may be respectable after all (Higgins and Williamson 1997).

In any case, the population control establishment has in recent years made quite a strong case for reduced fertility from the standpoint of individual women, children and families (National Academy of Sciences 1991; Lloyd 1993), whether the outcome measure is health, education, intra-family discrimination, or, paradoxically, women's status itself (Dixon-Mueller 1994) or even reproductive health itself (Caldwell 1997). But here again, some of the findings may not be as generalizable as they are made out to be by those in favour of fertility control and the IPM needs to sift the evidence. For example, adolescent fertility may be less bad for women and children in situations where it is socially sanctioned and supported by family networks than where it is a feature of the socio-economically most deprived (National Academy of Sciences 1993; Basu 1997b).

It may well be that the reproductive health movement will be swayed by such case-study considerations to decide that fertility reduction is not a universally¹⁶ useful social goal, in which case it will have to remain as a watchdog of those who think it is useful, and still re-evaluate the place of reproductive health policy in overall health policy. Alternatively, it may decide that it is not a goal that needs active chasing because all indicators are that the fertility transition is on course worldwide. While it is true that fertility decline does appear to be a feature of many parts of the developing world, this stand will need to take into account the fact that minor differences in the pace of fertility decline or the level at which fertility stabilizes can lead to drastic differences in final population numbers. For example, Bongaarts and Amin (1997) estimate that if India's fertility stabilizes at half a birth above replacement this will result in a population with over a billion more individuals in the year 2100 than if it stabilizes at replacement level.

If pressed, it is on the whole likely that the new IPM will endorse the value of a more rapid reduction in fertility in the developing countries. In that case, the policy implications which follow need a re-evaluation. In the spirit of the reproductive health critiques of traditional family planning programs, the reproductive health approach needs to develop its own internal critiques which take fertility goals into account and which also elaborate on the substantive, ethical and feasibility aspects of its recommendations. To begin this, the IPM needs to call for more research on the rationale for encouraging lower fertility. If this rationale

¹⁴ A report by 58 National Science Academies a few years later (Science Summit 1994), on the other hand, states unequivocally that 'humanity's ability to deal successfully with its social, economic and environmental problems will require the achievement of zero population growth within the lifetime of our children'.

¹⁵ In addition, the IPM may well have to turn upon itself its old criticism of universal population and family planning goals and acknowledge that the population problem takes different forms and is differently important in different settings; in which case the policy implications which follow will also have to be suitably disaggregated rather than set from above by the IPM.

¹⁶ By 'universal' I refer of course to the universe of developing countries, not the world as a whole.

is entirely based on individual welfare and rejects the possibility of externalities, then the ethical policy prescriptions which follow will have to be weaker. The costs of population growth to collective welfare are not at all settled in the academic literature; yet their estimation, at regional and subregional levels, has profound implications for what interventions are ethically permissible (see Hardin 1968).

The next three sections suggest some ways in which these critiques may be developed by those sympathetic to the reproductive health approach in principle.

Population and reproductive health policy: substantive issues

If the goal of population stabilization is treated as legitimate as long as it does not impinge on human rights and reproductive rights, then the question which follows is whether the reproductive health approach (which includes female empowerment) to population policy is an appropriate or at least sufficient mechanism for achieving this goal, even if it is a necessary component of a sensitive population policy. That is, can a reproductive health policy be synonymous with population policy? This simple question hides many complications and cannot be answered in the straightforward way suggested by the current politically correct reproductive health approach. This section attempts to briefly untangle some of these complications so that more realistic responses to the question can be generated.

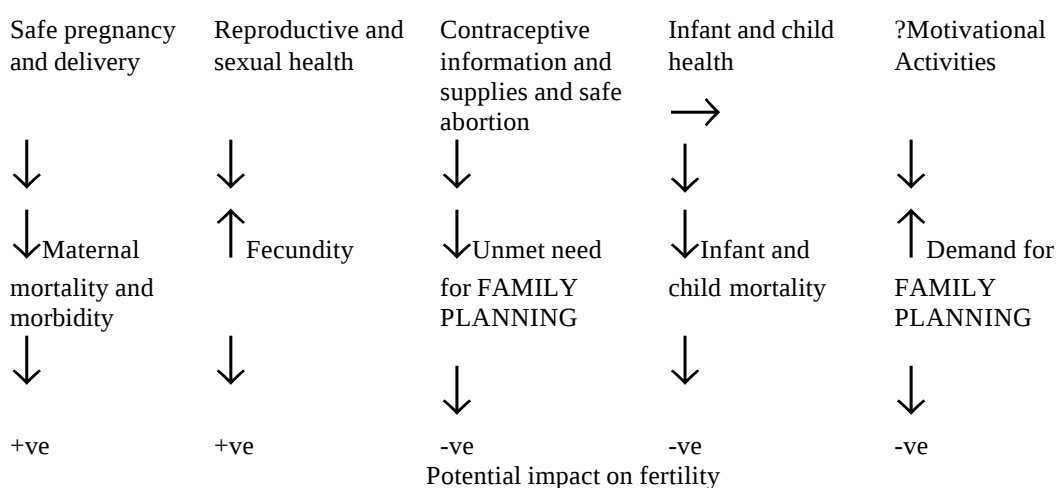
A part of the answer to this question hinges on what the IPM sees a reproductive health program as doing. To paraphrase the most stringent demands made in the large volume of writing on this subject, such a program should aim to help people enjoy sexual relations without fear of infection, unwanted pregnancy or coercion; to regulate fertility without risk of unpleasant or dangerous side-effects; to go safely through pregnancy and childbirth; and to bear and raise healthy children. In addition, given all that was said at and after Cairo, one may add the empowerment of women as an integral part of the reproductive health approach. This is a tall order and it is not surprising that some effort is now being expended on developing cost-conscious and feasible programs which prioritize some of these activities¹⁷.

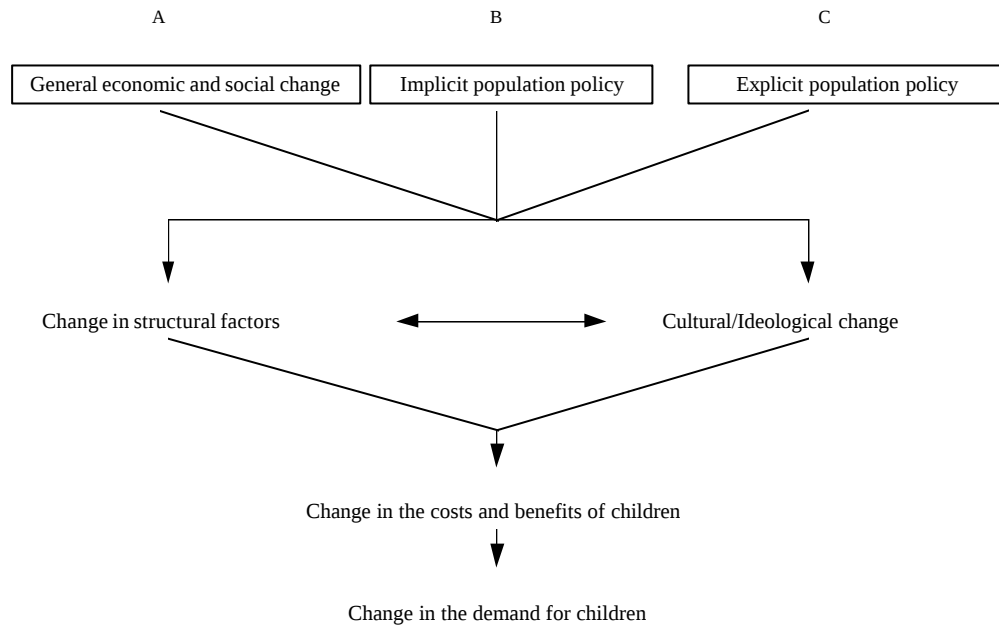
In addition, in fairness to the old IPM, it must be acknowledged that family planning programs and, especially, the Maternal and Child Health programs which later replaced them in many countries, were in principle at least aimed to address a substantial part of the reproductive health agenda. They were less explicit in focusing on sexually transmitted diseases and on sexuality, but the latter at least is a relatively recent concern even of the feminist discourse, and MCH programs can be forgiven for not having adopted it.

In any case, in the context of a population policy which believes that fertility reduction is a desirable outcome, can the reproductive health approach stand alone? Figures 1 and 2 present a framework for analysing the possible interventions to achieve a fertility decline, not all of which can be an explicit part of population policy. Figure 1 represents a 'supply'-oriented approach to fertility decline which concentrates on satisfying what is now called the 'unmet need' for birth control. The contention of the reproductive health lobby is that a reproductive health approach, while meeting the reproductive health needs of its clients, will incidentally also reduce fertility significantly by mopping up this unsatisfied existing demand for fertility control. For this contention, it draws on that part of the family planning literature which justifies the existence of family planning programs even in the absence of other changes or policies that reduce the 'demand' for children (e.g. Sinding, Ross and Rosenfield 1994). It distinguishes the reproductive health approach from the family planning approach in

¹⁷ As a ideal to strive for, there is no doubt that the reproductive health goal describes a very desirable world, but it requires more attempts not only to prioritize its own sub-goals relative to one another (which is currently being attempted), but also to prioritize its sub-goals relative to other health goals.

providing a more comprehensive set of reproductive health services, but even more so in terms of ideology; the reproductive health approach is structured around meeting client needs while the old family planning approach is motivated by larger demographic concerns. But at the operational level, if the family planning program does all that it is supposed to do, it seems difficult to castigate it for also having its own internal population agenda, as long as this agenda does not involve compromising any of its reproductive health goals. The crucial operational difference is that family planning programs have traditionally been sidetracked by their demographic objectives into compromising these reproductive health goals; but this is not necessary.

Figure 1**Reproductive health programs and the potential for fertility change****Figure 2****Factors which change the 'Demand' for children**



The question then is, will a reproductive health program lead to significant reductions in fertility without additional developments or interventions? This question has two parts: is the level of unmet need really everywhere large enough to lead to levels of fertility that now seem desirable if it is satisfied? And is all unmet need amenable to fulfilment by a reproductive health approach? On the first part, all the evidence suggests that there is no universal answer and in many parts of the world the level of unmet need may still be too low to lead to sufficient falls in fertility if this need is met. For example, Bongaarts and Bruce (1994) document an unmet need level of about 23 per cent for sub-Saharan Africa, but even if this were met, contraceptive prevalence would rise to only about 40 per cent, a level not high enough to reduce total fertility rates to anywhere near replacement levels. On the other hand, the Asian countries in their sample have much lower levels of unmet need and even satisfying 77 per cent of need may not be enough to pull fertility sufficiently low. It may be that the reproductive health approach itself will increase the demand for contraception as unmet need is fulfilled because it will also in the process reduce some of the other barriers to demand, infant and child mortality in particular. But a careful reading of the various documents leading up to the Cairo conference suggests that even at full efficiency, that is, by meeting all the requirements of a good reproductive health policy, population growth goals can only be met if the goals themselves are revised downwards. This pragmatic consideration probably lies behind UNFPA's subtly changing messages: at the second prepcom it called for efforts to realize the low-fertility projections of the United Nations, but at the time of the third prepcom it stated that a good reproductive health program had the potential to keep population numbers below the medium-level projections.

Regarding the second part of the question above, it may be reframed as: is lack of access to safe and effective contraceptives the only barrier to contraceptive use by those sexually active persons who 'do not want another child (ever or in the near future) but are still not using any effective contraception'? There is a large and growing literature, some of it very technical, on the concepts, measurement and meaning of unmet need and on its potential for

reducing fertility (Westoff and Pebley 1981; Westoff 1988; Bongaarts 1990, 1991; DeGraaf and de Silva 1996; DHS surveys); the IPM should use this research to guide discussions on unmet need which are less universally framed. Given the fact that countries with different levels of contraceptive use are distinguished by much more than the nature of their family planning programs, the reproductive health movement should perhaps not resort to blanket assertions about the potential for its approach to reduce fertility.

In particular, we need much more information on the meaning of 'unmet need' not in terms of its technical calculations, but in terms of what it says about the women it refers to. Analysis of DHS data which looks at why women who do not want another child are not using contraception (e.g. Bongaarts and Bruce 1994) suggests that it is not usually a question of simple 'access' to contraceptive services, but has more to do with lack of information about contraception and fears, legitimate as well as unfounded, about the health risks associated with various methods of birth control. Both these gaps can presumably be filled by a good reproductive health program, but such a program is unlikely to be able to deal with the 50 per cent of unmet need that seems to result from larger institutional and social factors that the DHS surveys capture very imperfectly by categorizing these into the stock variables of religion, fatalism and 'husband's disapproval'. These factors do not elucidate the validity of responses about intentions to bear another child (how much of this response is an outcome of politeness for example) and the intensity of wanting no more children. 'Where there's a will, there's a way' seems to be a proverb well supported by the historical experience of fertility decline at least.

A well implemented reproductive health program can certainly go a long way in promoting reproductive health and incidentally promoting fertility decline¹⁸. But unless it is combined with a strategy to actually decrease the demand for children, either through the reproductive health program itself or through other changes or interventions in people's lives, it is unlikely to meet population growth goals as well. Incidentally, this is even more a criticism of the family planning program approach to fertility reduction (see Pritchett 1994). But its application to the reproductive health agenda also hinges on what the 'IEC' activities of the reproductive health program (activities which the Cairo statement does promote) are agreed to constitute. If these are confined to providing the information needed to meet individual fertility goals but do not actually try to influence these fertility goals through a campaign of information about the benefits of lower fertility, then they may be seen as focusing on the supply-side aspects of contraception. But if they actually encourage greater fertility control, then they fall into the set of factors that influence 'demand' as discussed below. But the stand of the new IPM on this issue is not clear.

Figure 2 presents three categories¹⁹ of factors which can conceivably change fertility through changing the costs and benefits of childbearing, in other words, the 'demand' for children; and the two routes through which these factors can have their effect. Most of the literature on the determinants of fertility change can fit into this framework. Both the old and the new IPMs are agreed that economic and social development broadly defined (Box A, Figure 2) can alter the balance of costs and benefits of children in the direction of a lower

¹⁸ This decline can be achieved not only through increasing effective access to safe contraception, but also through reducing the high levels of child loss which prevail in much of the developing world and which are hypothesized to lead to a desire for higher fertility, even at constant completed family sizes. In addition, a significant negative effect on fertility is likely if the Cairo call for easier and safer access to abortion services is heeded. But it is also possible that a good reproductive health program will *increase* fertility through increasing fecundity as maternal and sexual health improves. Needless to say that is a benefit that no population goal can compromise.

¹⁹ These categories and these routes are of course much more overlapping than the boxes imply.

demand for children. While state policy does affect the pattern and pace of development, which in turn influence the costs and benefits of childbearing, these policies need not be state-driven and, moreover, it is difficult to know exactly how these policies and events at the macro-level impinge on fertility decisions at the micro-level.

But boxes B and C in Figure 2 have greater policy relevance and contain many things besides family planning and reproductive health services. The IPM needs to grapple with some of their contents to develop a position on the role and validity of interventions to reduce the demand for children. The new IPM has focused so exclusively on one of the possible interventions, the empowerment of women, that it has failed to address two related questions. First, is the empowerment of women a sufficient way to reduce the demand for children? And second, is the empowerment of women the only effective way to reduce fertility?

To begin with the second question, one way of looking at interventions which may reduce fertility (that is, reduce the demand for children) would be to categorize these interventions into those which target fertility directly and those which influence fertility through means that are not directly related to fertility. The former may be called *explicit* fertility policy, the latter *implicit* fertility policy. The latter may be undertaken for their presumed fertility-reducing effects (but they may also be motivated by concerns that have nothing to do with fertility reduction); but involve interventions which drastically change other aspects of life as well. That is, implicit policy is implicit only insofar as it does not involve actually being tied to a fertility goal or making prescriptions about family size even when it includes an underlying demographic agenda. In this sense, my use of the term is different from that of Johansson (1992) who refers to implicit population policy as that which is not consciously driven by demographic concerns. But the policies that make up implicit population policy are the same in both cases.

Another major difference between the two sets of potential interventions may be found in the way they change the costs and benefits of children. Implicit fertility policy increases the costs, or decreases the benefits, of all children, so that the higher the fertility, the higher the total costs in a simple multiplicative way. Explicit fertility policy on the other hand imposes higher costs on specific births, for example, higher order-births or births to teenage mothers, so that lower fertility is associated with lower per capita costs of children.

Some examples are in order here. Through implicit fertility policy, the costs and benefits of children can change in the direction of all children becoming more expensive by a variety of changes in social and economic circumstances²⁰. These include compulsory education, an effective ban on child labour, and increases in women's participation in the labour force, in the desire for material goods, and in parental aspirations for children. All such interventions work by increasing the direct and opportunity costs of children and/or reducing the benefits of children. Note that these changes may be structural or they may be ideological, as the intermediate level in Figure 2 suggests. Johansson (1992) stresses one aspect of the latter, the imposition of an ideology of 'parental altruism' whereby the intergenerational flow of resources is reversed in the direction of parents to children; this is a state-sponsored version of Caldwell's (1977) intergenerational wealth flows hypothesis, in which the reversal of flows may be instigated by agencies or events other than the state. In an ideal situation, such imposed parental altruism which increases the costs of high fertility should be accompanied by a parallel 'state altruism' which reduces the costs of low fertility.

Compulsory universal primary or even secondary schooling, as opposed to mere increased access to schooling or greater investments in female education, provides a good example of implicit population policy. There is much evidence that by increasing the costs of

²⁰ Many of these changed circumstances are similar to those resulting from natural, that is, not policy-induced, social and economic change of the kind captured in Box A in Figure 20.

children at the same time that it decreases their benefits, mass schooling may be a major route to fertility decline (Caldwell 1980). It may also be viewed as one way for families to get out of the poverty trap imposed by illiteracy and low skills and is indeed called for today as an essential investment in human resources. At the same time, given the theoretical reasons for high fertility which hinge on the economic value of children, compulsory schooling can be viewed as an unethical burden on poor families. Obviously there are value judgements involved in one's stand on compulsory schooling, but on the whole even the liberal-egalitarian position has not come out strongly against it. Instead the position is that such an intervention is desirable but must be backed by services to reduce the immediate costs of low fertility and of children being unable to contribute to family income in poor households.

Mention must also be made of the large and growing literature that suggests the important role of non-structural changes which promote an ideology conducive to lower fertility. More sophisticated and less Eurocentric versions of traditional diffusion theory (e.g. Cleland and Wilson 1987; Bongaarts and Watkins 1996; Kreager forthcoming) and more pragmatic experience with promoting the small-family norm through the mass media in many countries, suggest that an antinatalist population policy can change voluntary reproductive behaviour often without corresponding changes in the circumstances of people's lives, including women's empowerment; in fact this new ideology may then change these structural circumstances in addition to changing fertility. Where such ideology-changing approaches to reproductive change fit into the agenda of the new IPM is an issue that needs much clearer analysis. The role of such propagandist population policy is certainly not unproblematic, especially when it functions through propagating the value of the increased consumerism that fewer births can facilitate, thereby partly removing at least one environmental argument (that of greater consumption of scarce resources) against high fertility.

On the other hand, explicit fertility policy changes the costs and benefits of the n th child more than it does for children of birth order less than n . Thus, it may not allow free education or health care for children of third and higher-order births; or it may bar parents of more than three children from holding public office; or it may provide special incentives to parents of two or three daughters who stop after three births. Such policies are not necessarily coercive; that is, these are different from policies which directly enforce contraceptive acceptance, but they tend to get lumped together in the literature.

The new IPM does not sufficiently address the potential effectiveness, ethics, or feasibility of either of these classes of interventions. While it considers interventions to increase the status and empowerment of women (an intervention which is one of the several possible in principle in Box B) as a necessary and essential responsibility of the state, the underlying assumption in the IPM literature is that other kinds of interventions to reduce fertility are intrusive and definitely not the hallmark of a benevolent state. This duality may well be justified, but as yet we do not have much empirical evidence in either direction. The new IPM needs to reopen the question of possible and unfeasible, effective and ineffective, ethical and unethical interventions to reduce fertility, before it formally rejects, as opposed to informally neglecting as is happening now, any of the possible explicit or implicit interventionist routes to fertility decline. And in each case, there is no doubt that an attempt should be made to include the many, often unexpected ramifications of policy, and the many ways what is effective, feasible and ethical in a laboratory setting may to be destructive in the field.

The only internationally politically correct intervention to reduce fertility today—the empowerment of women—is also too uncritically endorsed in the new population policy. Taking the positive aspects of this intervention as given, I will turn to some of its more doubtful features. The earlier paragraphs and Figure 2 have already indicated that from a purely instrumental point of view, there are many other explicit and implicit interventions

which can reduce fertility. This is not just theory; there is sufficient empirical evidence from history (e.g. Johansson 1992) and from contemporary populations that female empowerment is not a necessary condition for fertility decline²¹. The new IPM may then respond that it is the only ethical intervention in the set of interventions covered in Boxes B and C in Figure 2. Once possible interventions are seen in the framework of Figure 2 and of the last paragraph, it is not clear that all the possible interventions in Boxes 2 and 3 can be dismissed as unethical.

Conversely, one may ask what women's empowerment means; more importantly, how automatic it is for the theoretical means of female empowerment to actually increase empowerment, and how universal is the female demand for these means of empowerment. These questions are not an attempt to promote the status quo, but to point out a crucial problem with the interpretation of empirical findings. For example, after education, women's employment is the most routinely sought measure to improve women's status; indeed it is often considered superior to education in its potential for improving women's lives (Sen, Germaine and Chen 1994a); if women's labour force participation rises, what criteria does one use to judge if this is a positive development? It may be a positive development for its instrumental value in reducing fertility or even increasing autonomy, but that is not to say that it is good in itself or good because it increases gender equality; both these considerations may have less immediate value to the women who now get employment. The determinants of happiness or even contentment are not universal and largely depend on the socio-cultural context in which they are assessed; in addition, in many societies male employment is not at all an attractive thing that women want to share, especially since they do not have the 'wives' at home to make life in the labour force more palatable. Several survey and anecdotal findings support the assertion that economic activity is not a universally valued goal for women²².

Population and reproductive health policy: ethical issues

The new IPM has been devastatingly and effectively critical of the ethical basis of the old school of family planning-based population policy. This action was doubly important because for the first time it opened up the question of the ethics of population policy in a systematic way, earlier criticisms having been confined to complaints about specific excesses by family planning programs. However, the new IPM's interest in the ethical aspects of population policy does not go far enough. In particular, it does not examine closely enough the many ramifications of its own recommendations for policy.

Criticizing the critique of the old IPM is not the focus of this paper²³; what is sought instead is an analogous ethical critique of the new IPM. It is not necessary that this critique will discredit the new IPM; what is needed is an open discussion of the many ethical implications of the new population and reproductive health movement, that may be missed by

²¹ Indeed, real empowerment may well increase fertility after a point. This seems to be possible from the finding in many parts of western Europe that there may be an 'overmet demand' for contraception, with ideal family sizes often being higher than actual family sizes (Commission on the European Communities 1990), and clear signs of a fertility increase in the country with the greatest gender equality and female autonomy, Sweden.

²² Johansson (1992) suggests that it never was. In England and Wales for example, child labour was seen as one way for women to leave the labour force and lead a better life.

²³ But see Mason (1994) for a well reasoned response to the charge that family planning programs violate human rights. Mason's paper predates the Cairo conference but does not seem to have informed the Cairo agenda. This neglect is consistent with McIntosh and Finkle's (1995) contention that the demographic input into the final Cairo meeting suddenly disappeared after having been a major component of the preparations leading up to the meeting.

an approach based largely on an anti-family-planning-program agenda. Some of these implications as well as a large number of contending ethical approaches, in the context of population policy in general and not specifically in the context of the new IPM, have been well summarized by Bok (1994) in one of the most comprehensive and widely-cited documents on the goals and methods of the new IPM, the volume edited by Sen, Germaine and Chen (1994b). But the issues raised by Bok do not reappear forcefully enough in the rest of this document as contentious questions to be debated and discussed²⁴; they do not even appear in the introductory chapter summarizing the report. This silence may be read as a continuing politicization of the population issue unless it is broken by debate from within the IPM itself.

The development of an internal critique of the ethics of the new IPM requires the tools of moral philosophy as well as of population studies. This is daunting, but not impossible, as suggested by some recent attempts, most notably that by Sen (1994). This section introduces just three interrelated areas of ethical conflict and ambiguity in the new IPM agenda which an effective critique could begin by addressing. These three areas deal with the possible confusions and tensions between (1) individual rights and individualism; (2) human rights and women's rights; and (3) voluntarism and coercion.

Individual rights and individualism

The language of the new IPM is surprisingly full of the unalienable rights and freedoms of individuals, especially when women's rights are being discussed. It is true that the Cairo document and related publications often use the phrase 'rights and responsibilities', but the only responsibilities that are spelled out are those to be assumed by the 'other': men, society or the state; reproduction is treated as a private matter and since the act of reproduction is a female activity, complete female autonomy is sought over this act. This is ironical because one of the central tenets of feminism is that the personal is political and because, by promoting the notion of inalienable autonomy, the IPM is legitimizing the very individualism that it has historically contested. Not only is the ideology of individualism a Eurocentric concept which non-European cultures may not necessarily endorse²⁵, this ideology could flourish historically only by placing large categories of individuals—slaves, women, the poor—outside its pale. Once it is granted that all individuals have the same rights, the ideology becomes very difficult to sustain without parallel notions of social obligations and responsibilities. Not only are equality and autonomy not the same thing, complete equality and complete autonomy cannot really go together.

Feminist criticisms of unrestricted free markets and the havoc they can cause can plausibly be applied to the ideology of individualism in reproductive rights; in any event such a criticism is worth discussing. This criticism has nothing to do with reinforcing the social roles of women as daughters, wives and mothers. But it has much to do with acknowledging

²⁴ Correa and Petchesky (1994) in this volume carry some of the possible arguments much further, by developing the useful notions of bodily integrity, personhood and equality as the foci of reproductive rights. But there is still much scope for further thought on these matters, and in particular on the distinction between reproductive rights and sexual rights. There is also a distinction between reproductive rights and reproductive health rights which is not clearly specified in, for example, Boland, Rao and Zeidenstein (1994).

²⁵ Not endorsing a universal ideology of individualism is however not the same as not endorsing an ideology of universal individual rights. As Sen (1997) explains, the frequently professed dichotomy between Western values and what have been called 'Asian' values is not a real dichotomy; the concept of some inalienable individual rights has existed at one time or another in all societies and often exists in diverse forms even within any single homogeneous society.

social organization (even if in a newer, more desirable form) in which individual freedoms cannot exist without responsibilities to the collective. As a general, rather than a feminist concept, individualism has been blamed for its tendency to encourage individuals to view other human beings as mere obstacles in their path; and there is not much evidence that women alone will not give in to this tendency because of their inherent caring abilities, or because of their historical experience of oppression.

To return to the implications of the tension between individual rights and individualism for an ethical population policy, the new IPM needs to explain much more clearly the responsibilities that go with women's reproductive rights. Rights to bodily integrity, including protection from violence and from unwanted abortions or sterilizations, may be treated as inalienable, and have been treated as inalienable even by the old IPM, even if they were sometimes breached in the field; but it is difficult to make a case for absolute individual rights over reproduction itself. And if freely chosen but 'responsible reproduction' is indeed the goal, then policy needs some clearer guidelines on how it encourages such responsibility. The reproductive health approach is silent on the role of the reproductive health program in actively encouraging individuals to have fewer children, as opposed to merely providing the services for birth control and informing them about the mechanics of safe and effective birth control.

Quite apart from not acknowledging in its policy concerns that the state and society in general may have a stake in reproduction, the new IPM approach emphasizes antagonism between men and women on reproductive matters more strongly than seems to be warranted by the evidence. This focus on gender disagreements makes female martyrdom the explanation for continuing high fertility in developing countries in the narratives of both the old-style and the new IPMs. The old family planning literature, and some of the current literature as well, assumed that there were significant differences between male and female family size preferences and high fertility represented the dominance of the male preference. But, since there is slender evidence to support this hypothesis (see Mason and Taj 1987; Basu 1992; Stycos 1996), more sophisticated analyses are concerning themselves with male-female differentials in attitudes to contraception rather than to fertility (Biddlecom, Casterline and Perez 1996); the implication is often that a significant part of the 'unmet need' for contraception is due to male resistance to male and female contraception. But this assumption needs to be examined further. It is not intuitively surprising that male and female fertility goals may not be significantly different, since most motivations for high fertility apply to both sexes; and it may well be that reported differences in attitudes to contraception are also more subtle than they appear: after all, the unmitigated oppression of women and their forced exposure to all the health risks of pregnancy and contraception impose costs on their husbands and families as well.

In any case, it is agreed in the literature that quite apart from program implications, we know very little about interpersonal differences in attitudes and preferences, and there is an increasing sense from anthropological studies in the developing world that the marital relationship is not one of universal discord. If the co-operative element of this relationship can be highlighted as much as the antagonistic one, there may be more to gain strategically than a persistent allusion to individual rights. In addition, this approach would make more ethical sense because it would recognize many of the constraints on men and households, constraints that are as institutionalized as the pressures on women to submit to patriarchy.

Human rights and women's rights

Over the years, feminism has become a metaphor for a perspective that focuses on the needs and problems of all vulnerable groups, not just women. But in the hands of the new IPM, the feminist agenda has become more and more exclusively women-focused. Although the Cairo

conference, and especially the Cairo statement, made token mention of the various marginalized groups that a human rights approach to welfare must include, the subsequent interpretation of this statement and attempts to implement it give the impression that women are the only legitimate clients of a humane population policy.

Men in particular get unfairly left by the wayside in this new agenda (see Basu 1996). The Cairo document is replete with references to men; indeed the draft document placed before the third prepcom conference contained many 'new issues' related to men which its cross-referencing had discovered were missing from the Mexico and Bucharest agendas (see Johnson 1995); yet all these references are to the 'responsibilities' of men, and hardly ever to their corresponding rights. Men are now expected to take greater responsibility for their 'sexual and reproductive behaviour and their social and family roles' (para 4.25), and 'to share more equally in family planning, domestic and child-rearing activities and to accept the major responsibility for the prevention of sexually transmitted diseases' (para 7.8); while 'reproductive health-care programs should be designed to serve the needs of women' (para 7.7). Indeed, many commentators say that *health* programs, not just reproductive health programs, should be 'women-centred' (Ravindran 1995).

This unmitigated focus on women's health, equality and empowerment downplays the very real health, equality and empowerment needs of poor, illiterate and unskilled men, who are as marginalized by development and population policies as women; it also underestimates the positive and co-operative aspects of gender relations in a way which not even the women clients of the new IPM are likely to endorse. While gender-related violence and general exploitation are certainly rife and need the kind of focus that the new IPM provides, at the operational level there is much strategic and ethical sense in also focusing on class and other distinctions that often cut across gender lines.

Other vulnerable groups should also be a more visible part of the new population policy discourse: for example, the Women's Declaration on Population Policies is surprisingly silent on groups such as children and the old; but population policy needs to expand to consider the rights of future generations as well. This is an issue on which the environmentalists and the feminists have some disagreement, even if often superficial (Sen 1994), but a critique of the new IPM would benefit from discussion on whether human rights should treat individuals as 'tenseless' (McNicoll 1995) and accord as much concern for the well-being of those to come as for those already alive.

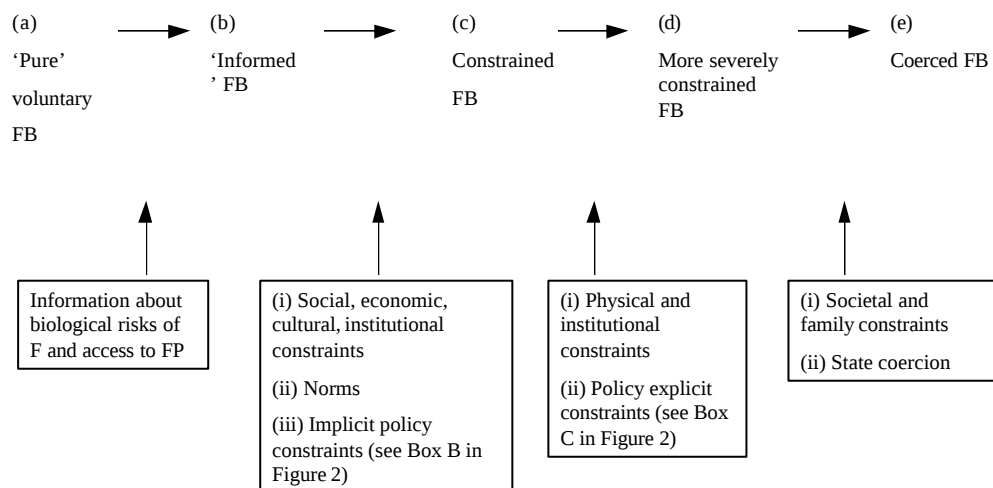
Voluntarism and coercion

All current versions of the agendas of the IPM agree that any control of fertility must be completely voluntary. But quite apart from the question of whose volition is respected given the hypothesized intra-household conflicts on this matter, there is the deeper question of the meaning of voluntarism and the role of population policy in promoting such voluntarism in reproductive behaviour. When does population policy exceed its brief and become coercive?

Voluntary and coerced activity by individuals may be represented on a continuum depicted in Figure 3 in the context of fertility behaviour in developing countries. Movement from one state to the next (which is smooth and not discontinuous in the way depicted in the figure) as well as entrenchment in any particular state may be facilitated by the events or interventions listed in the boxes below the arrows before different states of voluntarism. The new IPM has clarified, and almost all ideologies are agreed, that coerced fertility behaviour (position e) should not exist. But state policy is not the only means of imposing such coercion²⁶; as evidenced by the growing numbers of female foeticides in many parts of Asia, families themselves are not averse to coercive behaviour to achieve strategic demographic goals.

Figure 3

Voluntarism and coercion in fertility behaviour (FB)



A more relevant comment on Figure 3 is that while position (e) *should* not exist, position (a), 'pure' voluntary behaviour, *does* not exist. Nor for that matter does position (b), which is as far as the new IPM allows population policy to go. Even in the absence of explicit or implicit population policy, reproductive behaviour is constrained in either direction by a number of institutional, social and economic factors which determine the economic as well as

²⁶ Indeed, Box (d) suggests that state policy may sometimes be unfairly blamed for such coercion: for example, in India, the government's goal of an NRR of one has been blamed for sex-selective abortions because it allows each woman to have only one daughter (Menon 1993); this transposing of the concept of the average number of daughters per woman to the number of daughters desirable for each individual woman is perhaps an unwelcome outcome of a welcome development, the increasing involvement in population issues of lay advocacy groups, but such misunderstandings need monitoring because they are so influential.

non-economic costs and benefits of childbearing and children. Not all or even many of these constraints are in the direction of promoting the welfare of all individuals and if fertility reduction is agreed to be socially or individually desirable, then antinatalist population policy may well be cast in the set of constraints that change the balance of incentives and disincentives to reproduction in the direction of greater welfare. That is, population policy is merely one of the many constraints on reproductive behaviour and to object to it on the grounds that it constrains reproductive behaviour is to make an objection that trivializes the other real and often much more insurmountable constraints on such behaviour. Indeed, well-founded and altruistic population policy may reduce some of the other constraints on reproductive choice (see Blake 1994[1972]).

This is an issue to be debated by the agencies and individuals involved in the new IPM, not merely at an abstract philosophical level, but in terms of concrete proposals which are permissible as being within the limits of acceptable state interventions. Usually these interventions should have their own intrinsic justifications as well, for example interventions to increase women's education and empowerment, or to raise the legal minimum age at marriage; but they may sometimes be purely instrumental as long as they do not transgress the human rights agenda of the new IPM.

One possible framework within which possible interventions may be placed is described below. This framework acknowledges that much of life is a series of compromises and then seeks those interventions which minimize the harmful compromises. In addition, this framework acknowledges that not all possible interventions are focused on women; there is much that is feasible that has little bearing on women's empowerment. In such a framework, non-coercive possible interventions to reduce fertility may be overlappingly classified into three groups: (1) interventions which **enable** low fertility²⁷: these interventions are of course the best among those possible in that they make it worthwhile for women and families to reduce fertility because they remove some of the disincentives to low fertility and thus encourage the positive 'co-operation' of people in fertility decline that Sen (1994), for example, advocates. Measures in this category would include information and supplies for safe and effective contraceptive use; education and other empowering tools for women; greater investments in the health and survival of children; greater social security.

But such measures may often not be enough to dislodge the institutional, cultural and economic constraints on low fertility, so that policy interventions may have to include (2) measures which **constrain** high fertility: in this category would be largely those policies that pass more and more of the costs of childbearing to parents or families themselves. More selectively, they may pass on to families the costs of higher-order births. The ethics of both these sets of disincentives to high fertility need to be debated, especially since they often involve the welfare of children. In addition, constraints on high fertility may include implicit policies such as those which increase the economic roles of women. While these may be treated as 'enabling' interventions if they work through increasing the non-reproductive options of women, the view of women's employment that is usually assumed in the literature, they may be viewed as 'constraining' interventions if they work for example by increasing the incompatibility between women's productive and reproductive roles.

(3) Interventions which are merely **instrumental**: policies which increase the costs of childbearing and decrease its benefits but are difficult to define as being either benign or restraining, because they have ambiguous consequences and because their effect on people's lives may change with time. These interventions include those that enforce compulsory schooling for children or ban child labour. While such activities may eventually be seen as

²⁷ Since the Cairo conference, much has been made of the need for 'enabling' conditions to allow women to exercise their reproductive choices (e.g. Correa and Petchesky 1994; Sadik 1996).

leading to conditions that enable low fertility, in the short run and in the absence of other supports, they may just as well work only by constraining high fertility.

Population and reproductive health policy: feasibility issues

At one level, it is too soon yet to determine if the reproductive health approach is feasible or not. There is now a massive effort under way to design and implement the new policy (Pachauri 1995; National Academy of Sciences 1997); this effort is led by a consortium of international research and funding bodies and local non-governmental organizations; national governments seem to be still trying to make sense of the new paradigm and dealing with it in a piecemeal, often largely rhetorical manner.

At the same time, there are a few feasibility issues that internal critiques of the new IPM can address at this early stage. Most of them relate not so much to the costs of the new approach as to who is to bear these costs. In particular, as Caldwell (1997) worries, there is the strategic question of the readiness of donor governments to contribute heavily to programs which do not directly serve their larger global interests. In addition, there is the question who is to bear these costs in the climate of structural adjustment policies in many developing countries, where there is an increasing tension between meeting welfare goals and offloading government responsibility for individual welfare.

But there are also internal contradictions in the reproductive health agenda. Take the question of contraceptive choice and availability in the reproductive health program. The new IPM is insistent that women's control over their reproductive capacities is essential and calls for greater research into women-friendly contraception (Fathalla 1994); at the same time men are to be encouraged to take much greater responsibility for contraception. In which direction is policy to tilt?

The Cairo document, as opposed to a narrower reproductive health program which is taken here to include the empowerment of women, is also problematic from the policy point of view. In deference to multiple interests, it is dense in recommendations and diplomatically says everything about everything; on this general tendency, see Demeny 1994. So it leaves national governments to their own devices unless the IPM makes greater efforts to prioritize issues, even if the reproductive health agenda gets first place.

Programs in the field also need to work out effective monitoring techniques. Although the Cairo document specifies only the health goals for a new population policy, there is an implicit and explicit assumption that the reproductive health agenda will also have a significant demographic effect. The only real way to know this is to test for it and it is essential that reproductive health programs include some fertility effect evaluation component, even if the relative failure or slowness of this effect is not the decisive factor in defining success. But as a research tool and to guide other aspects of population policy, such evaluation has a major role.

Conclusion

This paper has not questioned the validity of and the need for the new agenda of the international population movement. The politics that led to the development of this new agenda can only be faulted for its motives at the margins; the bulk of the new program is motivated, and, as importantly, seen to be motivated, by goals which are more often sensitive to individual needs and human rights than earlier, more impersonal versions of population policy in the developing world. In addition, by opening up the old IPM to critical academic scrutiny, the reproductive health approach has forced a discussion of the meaning of population policy and population research.

However, the new population policy is itself now ripe for introspection, not about its motives but about its practical recommendations and about its assessment of the population 'problem'²⁸. Such an internal critique, developed by the movement itself but drawing upon the experience of mainstream population research and policy in a less one-sided way than previously, can only strengthen the movement and refine its ability to match methods to goals.

In particular, this paper calls for an airing of the internal dissents within the movement. While a public consensus was essential for strategic reasons at the time of the Cairo meeting, open discussions of some of the dissatisfactions felt by individual agencies within the movement will make it much more sensitive to local realities and increase its claims to legitimacy in the long run.

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²⁸ Most post-Cairo deliberations by the new IPM (including by UNFPA; see Sadik 1996) on the progress of the Cairo agenda focus on how well it is being implemented. The deliberations do not include any debate on or even reference to the possible weaknesses of this agenda. See, for instance, the many special sessions on this subject organized at the meetings of bodies like the Population Association of America and the International Union for the Scientific Study of Population, including the forthcoming IUSSP Conference in Beijing.

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Addressing the demographic imperative through health, empowerment, and rights: ICPD implementation in Bangladesh

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Since the Cairo conference, debate has flourished about whether or not the ICPD Programme of Action constitutes 'population policy.' The negative view is that the ICPD agreements contain no population projections, no demographic analyses, and no specific goals for contraceptive acceptance or fertility decline. Where, therefore, is the 'population policy'? The positive view is that the Cairo agenda does constitute population policy in the broadest sense. It supports reproductive freedom, and it promotes other policies to generate conditions conducive to smaller family size. Thus, in demographic terms, the Cairo agenda directly addresses the determinants of both wanted and unwanted fertility.

The divergence in views about Cairo may, in fact, have more to do with concern about allocation of conventional 'population' resources, both human and financial, than with the ICPD paradigm itself, or with demographic realities. The nay-sayers argue that Cairo's 'reproductive health approach' will be far more expensive and less efficient than vertical family planning programs. Rather, they say priority should be given to meeting the unmet need for contraception, as conventionally defined. They further argue that 'population' resources, small to begin with, certainly should not be stretched to cover the kind of 'social engineering'—that is, health, empowerment, and rights—mandated by the ICPD. If there is to be any 'social engineering', they say, it should take the form of incentives or other persuasive measures directly targeted on fertility and, in particular, contraceptive use.

Proponents of the Cairo agenda, on the other hand, argue that a reproductive health approach will be more cost-effective in meeting demographic goals in at least two ways: first by reducing contraceptive dropout and failure rates, and second by appealing to the younger individuals and couples who, in demographic terms, need to delay sexual initiation and marriage, and contracept earlier and longer. Proponents of ICPD also look to broad 'social engineering', rather than fertility-centred propaganda or incentives, to counter what Judith Blake called the 'coercive pronatalism' of everyday life. That is, we argue for creation of socio-economic conditions in which it makes sense for individuals to have two or fewer children, conditions that foster gender equity and poverty alleviation. The Cairo Programme of Action is clear: such social investments are to be made by broader development agencies and budgets, not from family planning budgets; nor would ministries of health and family planning be responsible for their implementation. Rather, the role of population professionals and agencies is to undertake necessary research and advocate for broader policy change. Let us examine the case of Bangladesh.

After some 20 years of an intensive, vertical family planning program, the contraceptive prevalence rate has risen to 45 per cent; the total fertility rate has dropped to 3.4.

From a family planning program perspective, Bangladesh is a 'success' story. But is the current, technology-centred 'population policy' the one to maintain in the next two decades? Consider the following facts. On a number of widely acknowledged counts, the quality of contraceptive services in Bangladesh is very poor, and discontinuation and failure rates, though improving, are high. Maternal mortality has hardly fallen and is among the world's

highest, estimated to be 4-5 per 1000, some say 6-8 per 1000; one-quarter to one-third of these deaths are due to botched abortions; the resort to unsafe abortion is due in large measure to inadequacies in the family planning program. Marriage at ages younger than 15 is still common, and half of adolescent girls aged 15-19 are already married. Only 15 per cent of projected future population growth can be addressed solely by contraceptive services to prevent unwanted pregnancy. Fully 85 per cent of the projected future growth will come from the very large cohorts of young people now entering their—potentially—sexually active years. We need to be concerned about their age at sexual initiation and marriage, the timing of their first and second births, and whether they are given access to sex education and reproductive health services, including but not limited to family planning, whether or not they are married. And finally, HIV/AIDS has arrived in Bangladesh and, along with conventional STDs, prevalence will explode, as is occurring in neighbouring countries, if a broader reproductive health approach is not taken.

On the basis of a commitment to health and justice, and to achievement of population stabilization, the Government of Bangladesh, together with all but two of the major donors and international agencies active in the sector, have framed the first Bangladesh national health and population sector strategy. The strategy takes the Cairo agenda as its starting point and refines it to suit Bangladesh conditions. I have just returned from the latest round of work to develop the details of a new five-year program and financial package to implement this national Health and Population Sector Strategy. Among the many lessons from our experience so far is that major shifts are required in the demographic, or more broadly, population, research agenda. Bangladesh surely has one of the largest bodies of demographic studies of any country; while helpful, that literature falls far short of what is needed to design and implement a sector strategy based on the ICPD agenda.

Central to the Cairo agenda is the concept of sexual and reproductive health and rights. This concept creates a new lens, filtered by sex and gender, through which to scrutinize the assumptions, research questions, program assessments and policy analyses of the population profession. Our experience in Bangladesh leads us to posit a new framework of analysis and a research agenda for a post-Cairo demography. That agenda would give higher prominence to the social context of sexual, marital, and reproductive behaviour across all three elements of John Bongaarts's framework: preventing unwanted pregnancy, reducing desired family size, and slowing demographic momentum. It includes those conditions that contribute to both the 'accidental' and the 'deliberate' fertility and health outcomes with which we are concerned: the currently 'wanted' aspects of sexual activity, relationships, marriage, and desired family size; and also the 'unwanted' aspects of sex, violence, forced early marriage and childbearing, problematic contraception, unsafe abortion, sexual and reproductive morbidity and mortality, and infant and child death and illness.

Our demographic survey tools are not up to the task: the DHS in Bangladesh as elsewhere, for example, does not survey the young and unmarried; nor have they analysed and published data on abortion, safe or unsafe. Such surveys do not assess the social context of decision-making yet they have been primary tools used for program planning. With some very important exceptions, such as Mead Cain's work on patriarchy, and recent analyses of the interaction between family planning and women's empowerment in Bangladesh by Ruth Simmons, and by Sidney Schuler et al., most demographic research in Bangladesh on fertility and family planning has been narrowly focused on contraceptive acceptance and use, and on fertility reduction.

At least five research areas require emphasis, not only in Bangladesh but worldwide, to support implementation of the Cairo agenda.

The first is the **situation of young people**, their life choices, including, but not limited to, their sexual and reproductive desires and behaviour. About 47 per cent of the population of

Bangladesh is currently less than 15 years old. By 2010, Bangladesh will have approximately 31 million people aged 10-19. This 'demographic imperative' requires a major shift in our understanding of the 'clients' to be served. Without neglecting traditional program clientele—married women of reproductive age—research is needed to inform action directed toward educating and influencing young people about sexuality, gender relations, mutual consent and respect in sexual activity and union formation, and the means to prevent both pregnancy and disease.

Second is the **significance of both sex and gender** which underlie reproductive and health-seeking behaviour. Neither of these has yet been explored in detail in Bangladesh: we have only the crudest understanding of the cultural meanings attached to sexuality, the power relations between women and men in sexual and marital relations, or the negotiation of fertility decisions.

Third is the **decision-making environment**. The Cairo agenda mandates social, economic and political initiatives at the national level to create an enabling environment for the exercise of sexual and reproductive health and rights, and for population stabilization. The health and population sector strategy work in Bangladesh recognizes that changes have occurred, for example, in the status of women in the last 20 years. Quantitative and also qualitative research, like that by Simmons, is needed to document these changes. Their multiple benefits, as well as their costs, need to be evaluated, along with additional means to improve girls' education, women's employment, their political participation, and their legal status.

Fourth is **applied demographic research** to estimate the costs and the benefits of reproductive health services, including family planning. We need better methods to assess the costs and the benefits of alternative modes of service delivery (village-based versus clinic-based workers, for example), based not simply on contraceptive acceptance, but on continuing contraceptive practice; not only on family planning performance, but on reproductive health outcomes; not only on fertility impact, but on health impacts. Similarly, extensive operations research is needed to develop and test the most appropriate clusters of services, and priorities among them, given both needs and resource constraints. Further, we need to develop and test effective IEC messages, beyond the simple family planning messages of the past, and modes of delivery to multiple audiences, including, especially, young people. Finally, we need new evaluation methods and program indicators beyond contraceptive acceptance, CYP and the TFR. The list is very long.

Fifth, and critically important, is engaging the population profession in **assessing and promoting changes in broader national development policies**. The shift from family planning to a wider reproductive health approach has been the central concern so far in the Bangladesh sector work, including some attention to adolescent sexual and reproductive health needs. More challenging even than this work is creation of broader 'population policy' for the nation. This requires involvement of ministries of planning, finance, women's affairs, education, labour and rural development and, ultimately, the cabinet, among others. In this regard, the Bangladesh Government, a leader in the Cairo negotiations, needs to redesign its overall development strategies and allocation of resources to emphasize gender equity and poverty alleviation. This is a tall order. The population profession, including researchers, technical agencies and donors, could, indeed must, assist by redesigning their own conceptual planning tools, by expanding data bases (on, for example, gender differentials in schooling and employment), and by assessing both the costs and the multiple benefits of increased investments in girls and women, as well as poverty alleviation.

The Cairo agenda, and specifically the research agenda proposed above, is based on consideration of three decades of family planning research and program experience. The Cairo agenda is a demographic agenda. It offers demographers, and all other population

professionals, unprecedented opportunities to expand our vision, to revitalize and strengthen our field, and to broaden the base of popular and political support for our work. The international population movement can and should do no less to meet the enormous demographic challenges that lie ahead.

Reaching a stationary global population: what we have learnt, and what we must do

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What we have learnt

The basic lesson is that human beings are willing to control their fertility, as was shown by the onset of fertility decline in France in the late eighteenth century and by the much broader decline of the last third of the nineteenth century in Western Europe and English-speaking countries of overseas European settlement. This was by no means inevitable, for it was possible that survival was so important that human beings had been biologically programmed to want to go on reproducing.

The second important point is that fertility transition was a social phenomenon, as shown by the fact that large numbers of persons adopted fertility restriction at about the same time. Clearly, the communication of ideas and beliefs was involved, a conclusion reinforced by the Princeton European Project demonstrating the importance of homogeneous language areas in its spread (Coale and Watkins 1986). In a suitable social and economic situation, the idea and practice of fertility control spreads. There have been sceptics about the communication thesis because so little written material about fertility control has survived from the period. But it must be realized that the message was spread not only by supporters of fertility control but also by its opponents who were quick to point out the signs and likely causes of fertility decline.

The important lesson from the first decline was that the idea of fertility decline can spread and can be acted upon. Furthermore, such a change in human behaviour will find its supporters and new philosophies justifying it. In due course, in modern times, such a movement will be subject to academic analysis which may well supply a broader base for arguing the inevitability, and perhaps the desirability, of such change.

This certainly happened in the case of the fertility transition. It was made easier by the fact that our intellectual furnishings had been deeply penetrated by Malthus's argument that resources, especially food, tend to increase more slowly than population. This thesis lay dormant but it was certain to reassert itself if unusually rapid population growth began among poor populations.

Such a situation developed after the Second World War in propitious circumstances for the doctrine of global fertility decline to be spread. The 1950-51 round of censuses showed that Third World populations were growing unexpectedly rapidly as a result of unforeseen steep declines in mortality. The circumstances were such that it was inevitable that the demand should be made to organize fertility control on a global scale. The majority of couples in the West were now practising fertility control, and this provided the real constituency for advocating that others should do it. There was a belief in assisted development which was fanned by Cold War competition. Some groups and countries took the lead, but this merely speeded up the process (cf. Caldwell and Caldwell 1986; Harkavy 1995; Sinding 1996).

In spite of the spread of ideas and of groups willing to offer assistance in achieving fertility decline, no major Third World decline occurred during the first two decades after the Second World War. This threatened to cause a revision of demographic transition theory, and suggestions began to be put forward that fertility had declined in the West because of its

unique family system, in which no assistance with the costs of rearing children could be obtained from outside the nuclear family.

These ideas were largely destroyed by the beginning of a widespread fertility decline from about 1965 in much of Latin America, and in Asia, starting first with parts of East Asia, and then successively with Southeast and parts of South Asia. The Latin American transition had similarities to the European one in that levels of socio-economic development approximated those of Europe at the onset of its fertility transition. In sub-Saharan Africa, where such levels had not been reached, there was no decline and has still been little decline.

The all-important exception was Asia. This is appreciated when it is realized that the current global birth deficit below the 1965 level is 80 per cent explained by the Asian fertility decline, 10 per cent by an unpredicted drop in fertility in the developed world, and 10 per cent by change in the rest of the Third World. Indeed, three-fifths of the global decline and four-fifths of the Asian one can be explained by change in two countries, China and India, which together contain only 38 per cent of the world's population.

What happened? I suggest that two circumstances dominated all others. One was the build-up, led at first by the West, of a belief in birth control. The other was the invention of the Asian national family planning program (see Leete and Alam 1993; Caldwell 1993).

The first was very largely an intellectual revolution, and its basis was laid in the apparently quiescent years up to 1965. It fed on ideas that mostly originated in academia and foundations. It spread through learned and popular books. It became a mainstay of the mass media, and it successively captured Western governments and international organizations. This demonstrated the power of ideas. The ferment—what I have called elsewhere ‘the talking down of fertility’—probably hastened the Latin American fertility decline in that it spread information and ideas that served as a counterpoise to the Church. It also accelerated research on better contraceptives and made their use more respectable not only in the Third World but also in the West, thus hastening both the sexual revolution and below-replacement fertility.

The conversion of much of Western academia was important. Third World students went home influenced by demography programs as well as teaching in a host of other disciplines ranging from economics to geography and more broadly by attitudes in the student community and in the wider society. These students returned home convinced of the need for fertility control, and, in due course, became national leaders, advisers, committee members or teachers of more students. In our study of the leadership of Third World population programs and of the circumstances leading up to them, it became apparent that the great majority of the activists had experienced decisive Western influence of this kind (Caldwell and Caldwell 1986). An important instrument in the battle to bring down fertility has been Western, especially American, technical aid, but it would not have been accepted by governments or the mass of the people but for the preceding intellectual exports.

The national family planning program is largely an Asian invention. This is clear from the astonishment expressed by Notestein (1951) when Prime Minister Nehru announced that he would create such an institution in India. That decision had direct roots in the Bhole Report (Indian Government 1946), one of the final undertakings of colonial India, and more distant roots in the Malthusian interpretation of the Indian situation which had been common among both British and Indians in the colonial Indian Civil Service.

These family planning programs spread to most of Asia. Their dominant characteristic was that they were not merely another social service but were accompanied by governmental and elite moral leadership in favour of restricting family size. This would have been impossible or difficult in the West, Latin America, sub-Saharan Africa or the Middle East. In Asia, unpredicted by foreign intellectuals, the task tapped into a much older tradition of elite moral leadership: Confucianism or Brahmanism or more recent traditions of leadership by

independence movements and their army leaders. Perhaps the single most important aspect of these programs was their near-simultaneity irrespective of the national socio-economic levels.

With colleagues, we have been investigating the extraordinary phenomenon of a successful major reduction of fertility in poverty-stricken and Muslim Bangladesh (Khuda et al. 1996). This has lately been attributed largely to the fact that it is now known how to design an effective family planning program and that a sufficiently well-funded one was put in place.¹ The truth is undoubtedly far more complex. There has been some economic and more social change. But the existence of the family planning program and its success depends on the fact that the elite are strongly committed to it. In terms of civil servants, this has roots in undivided India and undivided Pakistan. Even during the Ayub Khan program of the 1960s, family planning was more convincingly promoted by East Pakistan administrators than by those in West Pakistan. This was largely because critically dense populations were so apparent, but this view was based not only on numbers but on the ideational interpretation of those numbers: early travellers saw prosperity in dense numbers and spoke of 'Golden Bengal'.

What happened in Cairo

The Western consensus on the need to curb population numbers was based largely on projected figures of growth. It was these that led to technical aid programs providing more money for family planning programs than they did for most other social programs. They did this in spite of the fact that the attitude of the Catholic Church meant that there was some political danger in doing so. They proceeded to do so largely because there was intellectual near-consensus that population growth had to be curbed.

The ICPD experience, not merely the Programme of Action but also the publicity given to the Conference and Prepcom III, has tended to shatter this. The argument was chiefly for family planning programs with a human face. But, in order to give this absolute priority, there was practically no emphasis on total population numbers and excessive population growth. The fact that the global summit conference on population and development was not seized with this priority will not be lost on governments and their electorates, certainly not in the West and probably not elsewhere. In these circumstances, it is doubtful whether technical aid support in constant dollars will be maintained, let alone increased to the extent that had been suggested at the conference.

Not only was the effective Asian mechanism, the national family planning program, not credited with being necessary to achieve eventual stationary population, but the programs were injured in other ways. The accusation that they were patriarchal seemed aimed at state leadership itself. The attack on numbers and targets must weaken attempts to make fertility reduction a central goal. All this renders the family planning programs just another health service of chief concern to the countries in which they are found.

This does not mean that there is no credit side to the Cairo agenda. Kindlier, more concerned, more client-oriented family planning programs are greatly to be desired, although it should be realized that many of the deficiencies in the past arose almost entirely from inadequate health infrastructure. Furthermore, the empowerment of women in this area suggests the availability of a range of contraceptive choices. Cafeteria services may be expensive, but they are also effective. In Bangladesh's Matlab District contraception reached a new plateau every time a new method was added to the available services (Caldwell and Caldwell 1992). India would almost certainly have reduced fertility further and faster if its program had enthusiastically offered a range of methods.

¹ Most strongly in Carty, Yinger and Rosov 1993, drawing on Cleland et al. 1994.

The posing of the individual against aggregate numbers, and contraception with a better-quality service against the need to reduce fertility, will almost certainly have several effects. They include the shattering of the intellectual consensus, a reduction in technical aid for family planning, less likelihood that the public and the media will protest at the diminution of such aid, and an increasing belief that these programs are the business of the individual nations themselves. This will almost certainly reduce the growth in size of the only vehicle that can take better reproductive health to the majority of poor Third World women, namely the national family planning program. On balance, this may produce a better situation in Asia, where fertility decline is well under way in most countries, where governments hold strong views about fertility decline, and where little technical aid is now needed for the programs. Even here, there are exceptions like Pakistan, Afghanistan, Nepal, Laos, Cambodia, and possibly the Philippines.

Sub-Saharan Africa

The achievement of stationary population within the next 100 years, and whether that can be achieved at less than double our present numbers, depends very largely on what happens in sub-Saharan Africa. Even the Medium United Nations Projection, which incorporates a steeper contemporary fertility decline than is actually taking place, implies that the region's population will at least quadruple and may move towards being not eight per cent of the world's population but 20 per cent (UN 1995), in a region with a scarcity of potentially good agricultural resources.

Fertility is declining in a few sub-Saharan African countries but their total populations are too small to have yet resulted in any perceptible change to the regional fertility level. Because of a different cultural and social situation, the attitudes of African governments and elites approximates the situation in Asia over 30 years ago. There is little evidence that the typical Asian national family planning program is well suited to sub-Saharan Africa. The elites are not fully convinced. The need for fertility restriction is not largely confined to the married couple, as it was in most of Asia. Much of the early potential for fertility reduction is among the unmarried where contraception offers the possibility of deferring pregnancy and marriage. Much of the demand for contraception is from persons who do not want to be seen at family planning clinics (Caldwell, Orubuloye and Caldwell 1992). In parts of West and Middle Africa this forms a majority of the demand,² and there is also evidence that social marketing cannot fill that gap.

These are arguable points. What is more certain is that the major new family planning frontier is sub-Saharan Africa. At present the region constitutes ten per cent of the world's population but has 18 per cent of its births. By 2040-50 the latter proportion will grow to 23 per cent according to the United Nations Medium Projection and 27 per cent according to its Low Projection. In these circumstances, a lessening of Western resolve to curb population numbers may have a major impact. Furthermore, if the spread of family planning depends on the existence of adequate reproductive health care, then that spread may be very slow. The health infrastructure is the world's poorest and the West has shown reluctance to assist its improvement even in countries where ten per cent or more of the adult population is HIV-positive.

² Cf. Demographic and Health Surveys, Ondo State, Nigeria, 1986, Nigeria 1992 and Cameroon 1991.

Final note

ICPD's advocacy of improvement in women's autonomy, status, education and reproductive health is to be greatly commended. But the opposition of these goals to that of completing the demographic transition, shown mostly in Cairo by silence on the subject, almost certainly means changes in both intellectual and technical aid consensuses. The intellectual consensus had been attacked head-on by Simon (1981), but, except for its effect on the American delegation to the 1984 Mexico City Conference, with nothing like the effectiveness that the women's movement achieved by changing the target. It is doubtful whether Western governments will ever again give the same support to Third World family planning programs. The chief effect may well be on the demographic transition in sub-Saharan Africa. Those most interested in improving Third World reproductive health may close ranks with the population movement as they find that adequately funded family planning programs are the main vehicle for carrying improved reproductive health services, but it is doubtful if that will bring back the full support of Western governments. Family planning movements would, nevertheless, be well advised to embrace improved reproductive health for reasons of equity, funding and survival, while the reproductive health movement would be well advised to seek greater accommodation with those aiming at achieving stationary global population. Funders will find it difficult to give resources to family planning without earmarking substantial amounts for reproductive health.

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