The policy agenda

"Population policy" is the province of government. By choosing how many resources and how much political authority to invest in a policy, a government determines the policy’s effectiveness. In its broadest sense, population policy is concerned with population distribution as well as with population growth. This chapter discusses population policy to reduce population growth. In the area of fertility reduction, inaction is itself a choice which has implications for both future policy and the room for maneuver that a government will later have. Religious and cultural conditions cannot be ignored in designing an effective policy to reduce fertility; actions culturally and politically acceptable in one country might be rejected in others. But religious and cultural characteristics do not rule out effective action. In every part of the developing world during the past decade some governments have made significant progress in developing a policy to reduce population growth.

Choosing from policy options is a matter for local decision. But foreign aid for population programs can help developing countries meet their population policy objectives and can increase the impact of aid in other parts of the economy. This chapter examines the elements of an effective population policy, the main policy issues in each region of the developing world, and how aid donors can complement the efforts of developing countries.

Population policy

A population policy to lower fertility needs to be distinguished from public support for family planning services. Family planning support has wider social goals than fertility reduction but more limited population goals than overall population policy. Family planning programs provide information and services to help people achieve their own fertility objectives. By contrast, population policy involves explicit demographic goals. It employs a wide range of policies, direct and indirect, to change the signals that otherwise induce high fertility. Effective policy requires action by many ministries, and thus an interministerial approach to setting policy and monitoring its results. And it requires clear direction and support from the most senior levels of government.

Family planning programs and other socioeconomic policies that can reduce fertility are often pursued by governments to achieve overall development objectives, irrespective of their effect on fertility. What distinguishes countries with a population policy from those without one is an explicit demographic objective and the institutional mechanisms to translate that objective into effective policy.

Policy steps

Table 8.1 summarizes the current state of population policy in twenty-six developing countries with 15 million people or more. In the table, an x shows those countries which have already taken a particular policy step. Countries are listed by region, and within regions in order of their 1982 family planning "index," explained in Chapter 6.

Developing a population policy takes time. Countries in which the policy to reduce population growth is recent tend to have taken fewer of the policy steps listed in the table. Others—China, India, Korea, and Sri Lanka, for instance—have had longstanding policies and tend to have taken more steps. But there are important exceptions. Countries such as Indonesia and Mexico have developed strong programs in a short period. In contrast, programs in Egypt, Kenya, Morocco, and Pakistan have made little progress for more than a decade. Progress can also be reversed. In five countries not shown in the table—Chile, Costa Rica, Fiji, Jamaica, and Panama—family planning indices have declined by as much as half in the past decade. In some countries population policy aims to increase population growth (see Box 8.1).
TABLE 8.1
Population policy indicators for selected countries with populations of 15 million or more

<table>
<thead>
<tr>
<th>Region and country</th>
<th>TFR 1982</th>
<th>Family planning index 1982</th>
<th>Demographic data</th>
<th>Political commitment</th>
<th>Institutions</th>
<th>Family planning</th>
<th>Incentives and disincentives</th>
<th>Birth quotas</th>
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Note: The following countries with greater than 15 million population were omitted because of lack of data: Afghanistan; Argentina; Burma; Islamic Republic of Iran; Democratic Republic of Korea; South Africa; Venezuela; and Viet Nam.

TFR = Total fertility rate.
Key: [ ] = very strong index; [ ] = strong; [ ] = moderate; [ ] = weak; [ ] = very weak or none. For explanation of index, see Population Data Supplement Table 6 and notes.

A Published census data and data from other household surveys on fertility, mortality, and contraceptive use (such as WFS or CPS) less than ten years old. B Official policy to reduce population growth expressed by high officials and in a national development plan, sometimes including specific demographic targets. C Existence of a population planning unit that integrates demographic projections into current economic plans and considers the effect of policies on demographic parameters. D Existence of a high-level coordinating body, such as a population commission, to set population policy, oversee implementation, and evaluate results of multisectoral policies. E Government financial support of private family planning associations. F Public family planning services. G Family planning outreach, including community-based distribution systems and/or fieldworkers. H Active use of mass media for information and education to promote family planning and small family norms. I Publicly subsidized commercial sales of contraceptives. J Elimination of all explicit and implicit subsidies that encourage large families (tax reductions for each child, family allowances, free or subsidized health and education services). K Incentives to individuals or communities to have small families. L Strong disincentives to discourage more than two births per woman, such as reduced services or an income tax for third and later-born children. M Policy to set quotas on the number of births permitted annually in a community under which couples must obtain permission to have a child.
Box 8.1  Pronatalist policies

In some countries governments feel that fertility rates are too low. This is so in several European countries such as France, Hungary, and Romania, as well as in Argentina, Bolivia, Burma, Chile, Guinea, Israel, Ivory Coast, and Kampuchea.

Hungary

Hungarian leaders have set a target of replacement-level fertility by 2000. They are relying on economic incentives that reduce the private costs of children. The incentives for childbearing are numerous: monthly payments for children (with a larger increase for the second child; in 1981 payment for each child was equivalent to 11.7 percent of the average wage); five months’ maternity leave at full pay and up to two and a half years at one-third of the average wage; a birth bonus equal to about one month’s salary; provided the mother attends prenatal consultations; unlimited sick leave (which is always at 75 percent of salary) for child care for the first year, sixty days up to the third year, then thirty days up to the age of six; partial downpayment for a house, depending on the number of children planned; subsidies on children’s clothing, milk, baby-care products, and school supplies; two additional paid holidays a year for one child under fourteen, five days for two, and nine days for three; and guaranteed job security for mothers.

Hungary placed restrictions on legal abortion in 1974, allowing it only for single, divorced, separated, and widowed women, married women over the age of forty, those who have had three children, and those without adequate housing. These restrictions occurred when access to modern methods of contraception had been much improved and their use had been encouraged. In 1977, 74 percent of married women of childbearing age were using contraception and 71 percent of all people practicing contraception were using an efficient method such as the pill and IUD.

Hungary’s pronatalist policies have affected the timing but not the number of births: couples are having the same number of children, but sooner. The total fertility rate increased from 1.8 in 1965 to 2.4 in 1975, the year after abortion was restricted. But it had fallen back to 1.9 by 1980. Economic incentives evidently do not offset the increased private costs—in money and time—of larger families. Incentives have created a fiscal burden, however. In 1982, maternity payments and family allowances amounted to 2.4 percent of GDP.

Romania

Romania has attempted to raise fertility by placing limits on both abortion and contraception. Abortion on demand was legalized in 1957 and was an important backup to withdrawal and rhythm, since no other contraceptive methods were available. By 1965 there were four times more abortions than live births. In November 1966 the government limited access to abortion to women over age forty-five, those with four or more children, those whose life was endangered, and those whose pregnancy was the result of rape. Restricted abortion was not accompanied by improved access to contraception. Modern contraceptives are available only for medical reasons. According to the 1978 World Fertility Survey, 58 percent of Romanian couples are using a method of family planning, almost all rhythm and withdrawal. Economic incentives for childbearing are relatively limited. In 1979 the child allowance was about 9 percent of the average wage, the maternity grant of 385 was paid only for third and later births, and maternity leave of sixteen weeks was the shortest of any country in central or eastern Europe. However, part-time work is being made more readily available to mothers of young children and creche facilities are being expanded.

The immediate effect of limiting access to abortion in Romania was to increase total fertility from 1.9 in 1965 to 2.9 in 1970; the birth rate rose from 14 to 27 per thousand between 1966 and 1967. But total fertility had gradually declined to 2.5 by 1980 and the birth rate to 19. Fertility is now above replacement level, but on a falling trend. As in Hungary, pronatalist policies in Romania have not been without cost; the cost, however, is not so much in financial as in health terms. Maternal mortality due to illegal abortion in 1977 was triple the rate of 1966 and continues to rise (see chart).

The development of population policy includes the following steps:

DATA COLLECTION AND ANALYSIS. Reliable data on population size, fertility, and mortality document the existence of rapid growth and allow projections of its consequences. This information is critical to generating and sustaining the political commitment of leaders to slower growth. Demographic data are also vital inputs for economic planning, policy formulation, and evaluation (see Box 8.2). Data needs include published
late political commitment into effective policy. The
coordination among the numerous sectors and the
cooperation among the numerous sectors and the
cooperation among the numerous sectors and the
cooperation among the numerous sectors and the
Institutions: The role of institutions is to translate political commitment into effective policy. The
experience of countries shown in Table 8.1 suggests the importance of institutionalizing two functions:

- Relating demographic targets to the policies and resources necessary to achieve them. A pop-
ulation policy should include consideration of the demographic benefits of a wide range of social pol-
icies, in education, health, and social security, as well as in family planning. It should also consider
the complementarities among these policies. This is fundamentally a planning function, one which
relates demographic variables and policy alternatives (item C). It is usually the responsibility of a
specialized unit within a planning ministry, such as the Manpower Board of the Ministry of Finance and
Plan in Ghana, and the Population Planning Section within the Planning Commission in Bangladesh.

- Coordinating and evaluating the implementation of population policy. This may require new
institutional arrangements if the scope of population policy is limited to, say, wider provision of
family planning. In this case, the policy coordinating body may be the one that also coordinates
multisectoral family planning activities. But as population policy becomes more complex, it is
likely to involve the joint efforts of other ministries: education (for population education and
female literacy); information (to encourage breast-

**Box 8.2 China’s census: counting a billion people**

China is rich in historical population statistics, having fairly good estimates stretching back to the Zhou dynasty, a
thousand years before the Roman censuses. But census taking deteriorated in the modern era. There was a head count
of just over 600 million Chinese in 1953. Data from the 1964 census, only recently released, showed a population of just
under 700 million.

In the first two weeks of July 1982, the
Chinese government marshalled a force
of 6.3 million census takers and their supervisors to carry out a new census, the largest ever executed anywhere in
the world. With rapid hand-processing, the
government published initial results in October 1982, far more quickly than
test censuses in low-income countries. Total population exceeded one
billion persons. By using advanced com-
puter technology supplied with the
assistance of UNFPA, the government
expects to publish complete results for
local administrative units before the end
of 1984.

With such a large undertaking some
compromises had to be made between
rapid feedback of results and complete
coverage. For example, census takers did
not visit residences but relied instead on
responses at places of work and other
central locations, a less satisfactory data
collection method. A subsequent survey
(see below) suggests that about 17 mil-
lion women may have been missed in the
census count.

In September 1982, less than three
months after completing the census, the
Chinese government conducted a retro-
spective fertility survey of over one mil-
lion persons, many of whom were vis-
ited in their homes by interview teams.
The survey found that fertility rose by 25
percent between 1940 and 1968, with ups
and downs in famines and recoveries,
before beginning the transition to lower
fertility in 1969. Fertility had reached a
low of about 2.2 in 1980, then rose by 18
percent in 1981. In that year more than a
third of women were not using contra-
ception and, despite the one-child policy,
over half of all births were second or
higher order. The survey thus identified
possible problems with the execution of
population policy.

The above-mentioned findings from
the census and the survey complement
each other and provide overall policy
guidance for Chinese population policy.
These data collection efforts are remark-
able achievements, in part because China
lacks the many years of experience that
countries such as India have in such
activities.

and analyzed census data not more than ten years
old and other national sample surveys document-
ing current fertility, mortality, and contraceptive
use at more frequent intervals (item A in Table 8.1).
Lack of reliable demographic data has hampered
the growth of political support for population poli-
cies in sub-Saharan Africa. Data collection and
analysis is a continuous process, necessary to
monitor trends and the effect of policies over time.

**Political commitment.** Support for slowing
population growth has been expressed in public
statements by the head of state and other national
leaders, and in written statements of national pri-
orities, such as a national development plan (item
B). These statements can range from a general
commitment to reducing population growth to
specific demographic targets (see Box 8.3). Coun-
tries with strong policies have been able to mobi-
lize visible and sustained political commitment,
not only at the highest levels of government but
throughout the political and administrative hierar-
chy, down to those who are in immediate touch
with the public. This commitment helps to forge
cooperation among the numerous sectors and min-
istries involved in population policy.

**Institutions.** The role of institutions is to trans-
late political commitment into effective policy. The
feeding and use of family planning); justice (age at marriage, incentives and disincentives); women’s affairs, rural development, and cooperatives (integrated population and development projects). For example, very few countries now give much priority to raising the legal age of marriage as part of demographic policy—more likely because the institutional framework to do so is poor than because the costs of implementing such a policy are high.

As the task of coordination becomes more complicated, the responsible body may need an independent base in the government (item D), separate from the delivery system for family planning. The institutional arrangements vary: a unit within an existing ministry of health or planning but with representatives from many ministries (Tunisia, Panama); an extraministerial committee (Egypt, Mexico); or a separate ministry devoted entirely to multisectoral population policies (Indonesia).

There is no consensus on what works best; sustained political commitment seems to matter more to the outcome than organizational structure.

### Box 8.3 Demographic policy objectives

At least forty-two developing countries—comprising more than three-quarters of the total population of developing countries—have adopted official policies to reduce the rate of population growth. Some countries have quantitative targets in terms of achieving a particular total fertility rate, crude birth rate, net reproduction rate, rate of population growth, or population size in a given year. The table summarizes current demographic targets for sixteen countries and compares them with the demographic outcomes implied by projections using World Bank estimates of standard and rapid declines in fertility (see Chapter 4). The policy targets are expressed in terms of the total fertility rate (TFR) or the crude birth rate (CBR).

Five of the countries shown have specified their targets in different ways. Bangladesh and Jamaica hope to achieve a net reproduction rate of 1 by the year 2000; for Ghana the goal is a population growth rate of 2.0 percent in 2000; for Uganda a growth rate of 2.6 percent in 1995; the official target in China is a population size of 1.2 billion in 2000. For these countries the TFR or CBR given in the table approximates what would be required to attain these objectives. In most countries the government’s official policy objectives are comparable to, or even more ambitious than, those required to achieve a “rapid” decline in fertility.

**Demographic targets and projections of fertility declines, selected countries and years**

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<td>CBR</td>
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<tr>
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<td>1988</td>
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a. TFR equals total fertility rate.
b. CBR equals crude birth rate.

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Not available.
FAMILY PLANNING. In many countries—such as Brazil, Nigeria, Sudan, and Tanzania—subsidized family planning is provided as a basic health measure for mothers and children although the government has not formally adopted a policy to reduce population growth. But once the objective of reduced population growth has been established, support for family planning services intensifies. As noted in Chapter 7, family planning policies tend to evolve in similar ways. Government programs are often preceded by private family planning organizations which eventually receive government financial support (item E). As political commitment increases, government assumes a bigger role, providing public services (item F), family planning outreach (item G), educational and informational activities (item H), and subsidized commercial distribution of contraceptives (item I).

Policy steps E to I help couples have the number of children they want. Virtually all countries in the table could reduce their fertility by increasing the availability and quality of family planning services. Countries with moderate and weak programs have yet to generate any outreach services; many with stronger programs, including outreach, fail to cover the entire population. Subsidized commercial distribution of contraceptives is not widely used, even among countries with relatively strong programs. Based on estimates of "unmet need" described in Chapter 7, there are about 65 million couples in developing countries who want to limit or space births but do not have effective access to family planning services.

INCENTIVES AND DISINCENTIVES. By ensuring that people have only as many children as they want, governments can slow population growth. However, this might not be enough to bring privately and socially desired fertility into balance. If a private-social gap still exists, it cannot be reduced simply by providing more family planning. Economic and social policies are indispensable to reduce this gap in the long run. They may take some time to have an impact on fertility, however. Items J to L are policies that close the gap more quickly: eliminating all implicit subsidies for large families (item J), offering financial or other incentives for small families (item K), and imposing disincentives for large families (item L). A large number of countries have disincentives built into their tax system and their benefits system for public employees, but these are generally mild and affect only a small part of the population. Only a handful of countries, even among those with the strongest programs, have more broad-ranging incentives and disincentives.

BIRTH QUOTAS. China is the only country to have implemented a system of assigning to communities (sometimes employees of a particular factory) a quota of births to be permitted each year (item M). Individual couples within communities are then given permission to have a child, with priority given to couples who have followed the recommendations for marrying only after a certain age, and who are older. The system of quotas, and the accompanying pressure to have an abortion when a woman becomes pregnant without permission, are an additional policy "step" over and above the extensive system of incentives and disincentives.

Policy and ethics

Birth control is not just a technical and demographic issue; it has a moral and a cultural dimension. Becoming a parent is both a deeply personal event and—in virtually all societies—central to community life as well. Procreation is held by many to be a right which is personal and fundamental, superior to any "good" which might be bought and sold, and subject to challenge only by some other right. The tradeoff between the rights and welfare of the current generation and those of future generations, insofar as a tradeoff exists, will differ in different settings. But regardless of setting, a public policy to reduce fertility must be sensitive to individual rights today as well as to long-run social goals, and must recognize the distinction between encouraging lower fertility (by changing the "signals" which influence people) and coercion. Governments need to recognize that once they are actively involved in reducing fertility, the methods they use require careful and continuous scrutiny.

Virtually all the programs to lower fertility recommended in this Report would also improve individual welfare; they pose no obvious tradeoff between present and future welfare. Programs to raise education and reduce mortality raise welfare. Family planning programs expand the options available to people, allowing couples to realize their own fertility objectives and improving the health of mothers and children. In many countries current fertility exceeds desired family size; within most countries, there is "unmet need" for family planning. Incentives and disincentives, carefully designed, can also meet the criteria of improving
welfare and allowing free choice. Incentives compensate individuals for the economic and social losses of delaying births or of having fewer children. Those who accept payment for not having children do so because they find this tradeoff worthwhile; they are compensated for some of the public savings from lower fertility. Similarly with disincentives: those who elect to pay the higher costs of additional children compensate society as a whole for the private benefits of more children. But incentive and disincentive programs require extra care to avoid unfairness and abuse, not only in their implementation but also in their design. Some benefits from an incentive program are bound to go to people who would have deferred pregnancy or limited births anyway; public subsidies may therefore benefit the rich unnecessarily. When payments are offered as an inducement to sterilization—which is usually irreversible—care must be taken that the poor are not being tempted to act out of short-term economic necessity contrary to their long-term interests. Such payments are usually quite small, since they are meant to compensate for time and travel costs. Governments that offer them have generally established procedures that make written consent mandatory, and have imposed criteria that potential clients must fulfill (such as having several children already). A waiting period between the decision, the sterilization, and the payment can also be a safeguard—though in inaccessible rural areas a waiting period may be impractical, since those seeking sterilization may find it hard to make even one trip to a clinic. Deferred incentives, as in the case of educational bonds or an old-age security payment, have the advantage of building in such a safeguard.

Incentives that offer schools, low interest loans, or a tubewell to communities where contraceptive use is high also directly link lower fertility to increased welfare. To the extent that all members can benefit from community incentives, individual welfare is improved. Care must be taken that the benefits of community incentives are distributed equitably, however. There is the danger that, in closely knit communities, some couples will be pressured to use contraception against their will. But community pressure always exists, and usually influences couples to have many children even when they would prefer not to. In Indonesia and Thailand community incentives are only loosely tied to actual use of contraception and are thus primarily promotional.

Like incentives and various socioeconomic pro-
grams, disincentives alter the balance of costs and benefits of having children. Rather than raise the benefits of having fewer children, however, they increase the cost of having many. They have therefore the disadvantage that they might unfairly penalize the poor. The rich will find it easier to accept the additional costs of more children, yet the poor may have greater need of children. And children, who have no choice in the matter, bear the costs of certain disincentives—those which give preference in schooling to the first born and which heavily tax family income. It is essential to design disincentives so that they avoid inequality; with care, however, they need be no more objectionable than any other taxes or subsidies.

Even policies that are theoretically voluntary can be implemented in a coercive fashion if not properly monitored. Many countries set performance targets for family planning workers in recruiting new acceptors. While some criteria for evaluating workers’ performance are clearly necessary, excessive pressure to achieve unrealistic targets threatens the voluntaristic nature of programs. This is the lesson of the Indian Emergency of 1976–77, when workers were subject to extreme pressure to achieve high sterilization quotas and many people were pressured to be sterilized against their will. Consequently, the party in power lost the next election. In more recent years, this program, operating on a strictly voluntary basis, has proved very successful.

To repeat an important point noted in Chapter 1, the ultimate goal of public policy is to improve living standards, to enhance individual choice, and to create conditions that enable people to realize their potential. Lower fertility is only an intermediate objective; a commitment to achieve lower fertility must not mean a willingness to achieve it at any cost. The successful experience of many countries already indicates that it need not.

**Policy priorities in developing regions**

The differences among developing countries, both in their demographic situation and in the evolution of their population policies, are profound. In sub-Saharan Africa, few countries have yet to take the first steps in developing a population policy. At the other extreme, in East Asia family planning services are accessible, political commitment is high, and governments offer incentives for couples to have small families. In all regions there is scope for reducing mortality, increasing literacy, and
improving the availability of family planning services. But in taking the next steps in population policy, each region faces a different set of issues.

**Sub-Saharan Africa: how to increase public commitment**

Sub-Saharan Africa has the fastest population growth rate and the highest fertility in the world. Between 1970 and 1979 population increased at 2.7 percent a year, up from 2.5 percent a year during the 1960s. In a few East African countries population is growing at 4 percent or more a year. Of the thirty-three sub-Saharan countries with more than 1 million people, thirty have a total fertility rate of 6 or more. Kenya, Rwanda, and Zimbabwe have fertility rates of 8 or more. Probably fewer than 10 percent of married women of reproductive age are using modern contraception. Sub-Saharan Africa is the only region in which fertility has not begun to fall, and in which population growth is expected to accelerate in the next decade.

Africa is also the poorest region, with a per capita income averaging only $482 in 1982—or $354 if Nigeria is excluded. During the 1970s per capita income grew in real terms by just 0.8 percent a year; if Nigeria is excluded, it declined. The region’s gross domestic product stagnated in 1981 and 1982, while population rose 2.7 percent in each year. Fertility in most countries is higher than income alone would predict (see Figure 8.1). But when Africa’s high mortality, low literacy, and largely rural population are taken into account, fertility is not unusually high. About a third of the adult population are literate in sub-Saharan countries, compared with half of adults in all low-income countries and two-thirds in all middle-income countries (see Table 8.2). Life expectancy at birth is forty-nine years, ten years less than in other countries at the same income level.

The poor economic performance of sub-Saharan Africa cannot be blamed on rapid population growth alone, nor will slower population growth solve all its economic problems. External economic shocks, as well as inappropriate domestic policies, have contributed to the region’s economic crisis. But rapid population growth is creating severe strains in some countries and, throughout the region as a whole, it is holding back improvements in living standards.

The strains are acute in a few countries and areas that are already overcrowded—Burundi, Kenya, Malawi, eastern Nigeria, Rwanda, and parts of the

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**TABLE 8.2**

**Development indicators: Africa compared with all developing countries**

<table>
<thead>
<tr>
<th>Country group</th>
<th>Per capita income 1982 (dollars)</th>
<th>Adult literacy 1980 (percent)</th>
<th>Life expectancy 1982 (years)</th>
<th>Primary-school enrollment ratio, female 1981 (percent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sub-Saharan Africa</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low-income</td>
<td>249</td>
<td>38</td>
<td>49</td>
<td>57</td>
</tr>
<tr>
<td>Middle-income</td>
<td>777</td>
<td>35</td>
<td>50</td>
<td>70</td>
</tr>
<tr>
<td>All low-income countries</td>
<td>280</td>
<td>52</td>
<td>59</td>
<td>81</td>
</tr>
<tr>
<td>All middle-income countries</td>
<td>1,520</td>
<td>65</td>
<td>60</td>
<td>95</td>
</tr>
</tbody>
</table>

*Note: Averages are weighted by 1982 population.*

a. Number of females enrolled in primary school as a percentage of all females of primary-school age.
Sahelian countries (see Box 8.4). These and other countries, such as Ethiopia and Upper Volta, have neither the physical capital nor the skills to compensate for a shortage of natural resources. A few countries—such as Angola, Ivory Coast, Nigeria, Zaire, and Zambia—are rich in natural resources, but need extra skills, as well as heavy investment in roads and storage and distribution systems to exploit those resources.

In all sub-Saharan countries, the labor force is growing rapidly, by more than 3 percent a year in most countries, meaning a doubling about every twenty years. Government revenues are growing slowly as a result of slow or no economic growth, so countries have had to struggle not only to provide jobs but to provide basic services such as education. In 1978 education was taking 16 percent of national budgets, but reached less than two-thirds of primary-school-age children. Only a tiny fraction of the people can obtain modern medical care. Human development in all its forms is essential to future economic progress but, as Chapter 5 showed, population growth makes it hard to achieve. These difficulties will remain, because sub-Saharan Africa’s current population of 385 million seems set to double by the year 2005. That much is almost inevitable. The real question is whether populations will merely triple in size in the next half-century or increase even more rapidly, to five or six times their current size.

Few sub-Saharan countries have explicit policies to reduce rapid population growth. Kenya was the first to adopt such policies in 1967, Ghana followed in 1969, and Mauritius in the early 1970s. There are recent indications of heightened concern about rapid population growth in Burundi, the Comoros, Malawi, Rwanda, Senegal, and Zimbabwe. About half the governments in sub-Saharan Africa provide family planning services for health and human rights reasons, but without any explicit demographic purpose. Limited services are provided by a few private associations and through an already overstretched public health system, with poor coverage of rural areas. Twelve sub-Saharan countries neither have population policies nor support family planning. Most are in Francophone Africa—Chad, Gabon, Guinea, Ivory Coast, Madagascar, Mauritania, Niger, and Upper Volta—where anticontraception laws from the colonial period are still in effect. These countries have no tradition of private family planning associations, which are elsewhere active in lobbying governments for public involvement.

What explains the limited development of population policy in sub-Saharan Africa? Population control is a sensitive political issue wherever religious and tribal groups are competing for resources. And much of the pressure for smaller families has come from (or is perceived to come from) western aid donors; this pressure can cause local resentment.

Even if these factors were less important, politicians would still be hesitant to propose smaller families when the demand for children is extremely high. Recent surveys in six countries found that women wanted between six and nine children in their completed families. Depending on the country, only 4 to 17 percent of currently married, fecund women wanted no more children, and most of them had already had at least six. In much of the region the concept of self-determined family size is unknown. Modern contraception is poorly understood and lacks social legitimacy. In this atmosphere couples who wish to use family planning services are discouraged from doing so. And, compared with other regions, infertility affects a disproportionate number of Africans, tragically depriving some women of any children (see Box 8.5). The threat of infertility discourages couples from controlling their childbearing through modern contraception.

Policy development and political commitment are constrained throughout the region by a lack of recent and reliable demographic data needed to demonstrate the magnitude and consequences of rapid population growth. Many African countries, particularly in Francophone Africa, do not have a long history of census-taking. In some countries where censuses have been conducted, the results have never been published because of political controversy. As a result, the size and growth rate of population for countries such as Ethiopia, Guinea, Nigeria, and Zaire are not known within a reasonable degree of certainty.

Yet census results are important in demonstrating to political leaders the need for population policy. The results of the 1976 Senegalese census implied a population growth rate of 2.9 percent a year, much higher than the 2.2 percent annual rate in the 1960s. This prompted the president to create the National Population Commission in 1978 to consider a population policy and family planning services. The 1960 census was a catalyzing factor for population policy in Ghana. The World Fertility Survey, conducted in Benin, Cameroon, Ghana, the Ivory Coast, Kenya, Lesotho, Mauritania, Nigeria, Senegal, and Sudan, has made an important contribution to improving demographic data.
Box 8.4 Africa: how much land, how many people?

Africa is often portrayed as an underpopulated region with vast acres of untapped land. It is true that its average population density is low—less than one-fifth of Asia’s. But considering the rudimentary farming practices in most of Africa, some countries are becoming crowded, at least in the sense of limited food production potential. This is one of the main findings of the FAO’s recently completed project, Land Resources for the Future.

Of course, the goal of self-sufficiency in food production cannot be recommended for all countries. But those which do not manage it must generate enough foreign exchange outside of agriculture to import food (or face the prospect of continuing dependence on food aid or rising malnutrition). For many African countries nonagricultural exports are unlikely to provide a viable short-term source of foreign exchange.

The FAO compared potential population-supporting capacities—determined by soil and climatic conditions and levels of farm technology—to actual and projected populations. The calculations for Africa as a whole confirm the conventional wisdom: even at subsistence farming levels (that is, no use of fertilizers or pesticides, traditional seed varieties and

in the region, but periodic sample surveys have generally not been institutionalized.

In the long run, social development—especially the education of women—is essential to reduce desired family size. More and better schooling for women will help to lower infant mortality, reducing the uncertainty about child survival which keeps family size high. An all-out attack on infant and child mortality and on infertility is imperative; as long as fate seems to govern family size, pronatalist norms will be reinforced and individual choice discouraged.

In the short run, family planning services could do more on two fronts, even in the face of relatively little unsatisfied demand for birth control:

- **Childspacing.** Extended breastfeeding and sexual abstinence have long been practiced in Africa to guarantee two to three years between each child. The principal aim is to protect the health of children and maximize the number who survive. Throughout Africa, there is potential demand for contraception to space births in both urban and rural areas. But spacing practices appear to be declining most rapidly in urban areas—where desired family size is likely to fall first. In Senegal, for example, both breastfeeding and postpartum amenorrhea are six months shorter in the capital city of Dakar than in rural areas. In Lagos, Nigeria, traditional childspacing practices are in decline and intervals between births are shortening. Unless contraception becomes a more readily available substitute, total fertility may increase and the health of mothers and children may worsen.

Programs in Rwanda, Tanzania, and Zaire have recently been set up to promote contraception for childspacing. In Zimbabwe, the Child Spacing and
cropping patterns, and no conservation measures), there is enough land to allow food self-sufficiency for a population 2.7 times larger than the actual population in 1975. When the results are tabulated by country, however, a much more complex picture emerges.

Of forty sub-Saharan countries (excluding Djibouti and the smaller island nations), fourteen do not have enough land—assuming subsistence level farming—to support on a sustainable basis populations as large as those already reached in 1975. The fourteen are Botswana, Burundi, Ethiopia, Kenya, Lesotho, Malawi, Mauritania, Namibia, Niger, Nigeria, Rwanda, Senegal, Somalia, and Uganda (see map); as a group, they account for one-third of the land area of sub-Saharan Africa and about half of its 1981 population.

In some areas of these countries—parts of Kenya, Ethiopia, and Nigeria, and much of Rwanda and Burundi—higher levels of inputs in denser areas mean more people are being supported. But these countries will face increasing difficulties as populations double again in the next twenty to thirty years. Small landlocked countries such as Rwanda and Burundi face particularly serious problems. Population pressure has led to more intensive farming methods, based on higher and higher labor inputs. But the remoteness of the countries and their terrain make it expensive to use advanced technologies; they also limit agricultural and nonagricultural export opportunities, and thus the scope for importing food. Low rainfall and remoteness also create considerable problems for Sahelian countries like Niger.

Nevertheless, there are eleven countries, largely in central Africa, still possessing extensive areas of underused land. According to the FAO, the land of the Congo and the Central African Republic is capable of supporting populations more than twenty times larger than they had in 1975; in the case of Gabon, the multiple reaches almost 100. Together, the land-abundant countries of sub-Saharan Africa occupy about 30 percent of the region's land, but account for only one-fifth of its 1981 population.

As populations increase further in the land-scarce countries of sub-Saharan Africa, the pressure for people to migrate to land-abundant countries will mount, particularly where they share a common border. Migration already brings mutual benefits to countries such as the Ivory Coast and Upper Volta. As pointed out in Chapter 5, however, the opportunities for accommodating population growth through international migration do have limits. Political and social factors introduce uncertainty even where economic benefits for both sending and receiving countries could be great. The recent expulsion of Ghanaians from Nigeria provides an example.

Throughout Africa, traditional methods of farming require more land per capita than in regions such as Asia, where irrigation and double-cropping are more common. To avoid a fall in agricultural output per worker, land-scarce countries will require new technologies—fertilizers, improved seed, and different farming techniques—supported by pricing policies to encourage production. But such measures alone might not be enough. According to the FAO's calculations, seven sub-Saharan countries—Burundi, Kenya, Lesotho, Mauritania, Niger, Rwanda, and Somalia—would not achieve self-sufficiency in food in the year 2000 (when their combined population is expected to reach about 80 million) even if their agricultural techniques were to match those now found on commercial farms in Asia and Latin America.

Family Planning Council provides 40 percent of national childspacing services, in addition to in-service training and contraceptive supply procurement for the Ministry of Health's childspacing program. Among women of childbearing age, contraceptive use is estimated at 15 percent. Formerly a private association, although heavily subsidized by government, the Council recently became a parastatal under the Ministry of Health and is intensifying its activities with funding from USAID; a doubling of field staff, recruitment of a full-time information and education staff, and expanded research capability are planned.

The emphasis on spacing means that programs throughout Africa must offer effective, reversible methods of contraception. Since most people will never have tried modern contraception, careful explanation, reassurance, and treatment of side effects will be critical. Such programs also provide an opportunity to encourage breastfeeding, which is still almost universal in Africa but declining in urban areas.

• Adolescents. In many countries—not just in Africa—there has been a sharp rise in premarital adolescent pregnancy, abortion, and sexually transmitted disease (see Box 8.6). Family planning services and advice can avert these unwanted births, abortions, and health risks. In Ghana education about family life is now part of the school curriculum. Eight other sub-Saharan countries are considering this step.

Middle East and North Africa:

rural outreach and expanding women's opportunities

The countries of the Middle East and North Africa
are quite diverse, ranging from one of the world’s poorest (Afghanistan) to five of the wealthiest (Kuwait, Libya, Oman, Saudi Arabia, and the United Arab Emirates). But 90 percent of its 260 million people live in thirteen middle-income countries. All share a common cultural heritage and are predominantly Islamic. Countries in the Middle East and North Africa have the second highest rates of population growth and fertility in the world, after sub-Saharan Africa. Between 1970 and 1982 their population grew at an average 2.9 percent a year; the total fertility rate in 1982 was 5.4. Migration is common, both into and out of the region and among countries within it.

In most countries fertility is higher than would be expected given per capita income (see Figure 8.2). Five high-income oil exporters, with per capita incomes of $14,820, had a fertility rate of 6.9 in 1982. In the past decade incomes in Jordan, Syria, and Algeria have risen strongly but total fertility has remained at more than 7. Income growth in these countries is recent and social development
has come more slowly. Low literacy (particularly among women) and high infant mortality help to explain high fertility. Also responsible are cultural, religious, and legal pressures that confine women to the home and restrict their property rights, rights within marriage, and ability to seek work outside the home.

Three countries in Figure 8.2—Egypt, Tunisia, and Turkey—have had a marked fall in fertility in the past decade; in all three, fertility is now below what would be expected for their income levels. In Morocco, fertility has declined more modestly. Unlike most other countries in the region, these four have policies to reduce population growth.

Government family planning programs began in 1964 in Tunisia, in 1965 in Egypt and Turkey, and in 1966 in Morocco. According to recent surveys, 24 percent of married women of childbearing age in Egypt, 38 percent in Turkey, and 41 percent in Tunisia are practicing contraception. Later marriage has also contributed to fertility decline. The change has been most dramatic in Tunisia, where the proportion of women aged fifteen to nineteen who are married fell from 42 percent in 1956 to 6 percent in 1975. In Egypt the proportion fell from 32 percent in 1960–61 to 21 percent fifteen years later; in Turkey, the decline was from 33 percent to 22 percent.

**Box 8.6  Teenage pregnancy**

Teenage pregnancy is common in both developed and developing countries, accounting for about 10 to 15 percent of births worldwide. And this understates the problem since many teenage pregnancies are terminated by legal and illegal abortion. Because couples in developing countries tend to marry earlier, most teenage pregnancy is within marriage. In developed countries, with later age of marriage, more teenage pregnancy occurs outside marriage. In 1979, for example, almost two-thirds of live births to American teenagers were to unwed mothers. As the age at marriage rises and urbanization loosens traditional social restraints on sexual activity, the incidence of premarital teenage pregnancy may increase in developing countries. In a Bombay hospital in the early 1970s, 12 percent of women admitted for abortions were younger than eighteen; of these, 92 percent were unmarried. In a major Lagos hospital the number of teenage pregnancies and abortions increased over a recent five-year period; 93 percent of the teenagers admitted were single girls of school age.

Teenage pregnancy—within or outside marriage—has adverse consequences for mothers and children:

- Childbearing poses greater health dangers for teenage mothers than for older women, and for their children. Children of teenage mothers are more likely to be premature, have low birth weight, and have a greater risk of death. As was shown in Box 7.1, postponing giving birth until the age of twenty or older would significantly reduce maternal and infant mortality rates.
- Many teenage pregnancies—particularly when outside marriage—end in abortion. If poorly performed, abortion is highly risky and may impair future fertility. Nearly 40 percent of adolescent pregnancies in the United States ended in legal abortion in 1978.
- Pregnancy and childbirth disrupt the education and career opportunities of young women. Teenage mothers frequently do not complete primary or secondary school. The time demands of childrearing can restrict their current employment possibilities, while limited education affects their future income-earning potential.
- The children of adolescent mothers are also worse off. Teenage couples are likely to have fewer economic assets than are somewhat older couples to support children, and single teenage mothers have even less. It is believed that many abandoned children—in Brazil, an estimated 16 million children or one-third of its youth—have young mothers who are unwed or in unstable unions. Studies in developed countries show deficits in the cognitive development of children of adolescent mothers that are partly attributable to the social and economic consequences of early childbearing, children of teenage mothers are likely to spend a considerable part of their childhood in one-parent households, and they are more likely themselves to have children while still adolescents.

Teenage pregnancy can be averted. When family planning services are combined with maternal and child health programs, information about family planning may reach only married women who already have children. To have an impact on teenage pregnancy, young people—with and without children, male and female, in and out of school—must also be reached. Family life education, including human reproduction, family planning, and responsible parenthood, is taught in schools in the Dominican Republic, Ghana, Korea, Mexico, and the Philippines. Kenya and Sierra Leone are developing similar curricula. Posters, radio, and television messages can be used to reach out-of-school youth.

For teenagers who are already pregnant the consequences can be minimized by providing continued educational and employment opportunities. A women's center run by the Jamaican Women's Bureau provides support and classroom instruction for pregnant women aged twelve to sixteen with the goal of returning them to school. Of the students registered at the center in 1978–79, almost two-thirds were placed in secondary schools, high schools, or vocational training schools, and 92 percent had not become pregnant again by the end of 1981.
FIGURE 8.2
Fertility in relation to income: selected developing countries in the Middle East and North Africa, 1972 and 1982

Despite these achievements, population growth remains rapid and acceptance of family planning slow. Total fertility, although reduced, is still 4 to 5 in Egypt, Tunisia, and Turkey, and about 6 in Morocco. In Egypt and Tunisia, an increase in the proportion of women of childbearing age has kept the birth rate high. Mortality has declined, and the rate of population growth has changed little. Population pressure has been eased in both countries by emigration, but poor economic conditions in Europe have reduced emigration from Tunisia and caused many emigrants to return. The rate of contraceptive use has remained at about 25 percent in Egypt for several years; increases have been slow in Turkey and Morocco. The number of new acceptors of family planning has barely risen in Tunisia for about five years.

There is ample evidence of unmet need for family planning services. Low and high estimates in Egypt ranged from 12 to 22 percent of married women of childbearing age in 1980. In certain areas unmet need is even higher. One study found that 82 percent of married women in rural areas of upper Egypt want no more children but are not using contraception, and that more than half of these women would like to use a method. In Jendouba, Tunisia, 46 percent of women who were not using contraception wanted no more children, and 22 percent said that they would like to space the next birth. When women in Marrakech, Morocco, were offered supplies of oral contraceptives through home visits, the rate of contraceptive use rose from 18 to 43 percent. In the Sfax region of Tunisia, household distribution increased the rate from 7 to 18 percent.

Continued progress in reducing fertility in these countries will depend both on better family planning services and on measures to improve the status of women.

- **Family planning programs.** Access to services in rural areas is still restricted. The Tunisian program has had difficulty reaching a dispersed rural population, which includes half of the married women of reproductive age. Services in Morocco and Egypt rely heavily on physicians and are clinic-based with little outreach. In Egypt only physicians may prescribe the pill and insert the IUD. The few outreach workers in place are not permitted to distribute contraceptives and are supposed to motivate only women who already have three children. In Morocco, nurses were only recently authorized to insert IUDs, and nonclinical distribution of the pill is still frowned upon. Yet experience in South and East Asia as well as in Latin America indicates that carefully trained paramedical fieldworkers can deliver many methods and increase contraceptive prevalence dramatically. Use of the media to promote family planning and small families has been limited in Morocco: not until 1982 were the Ministry of Public Health and the private family planning association permitted to broadcast family planning messages and show films.

The limited range of contraceptives available in Egypt and Morocco also restricts their use. Although the IUD and condoms are theoretically available, both programs favor the pill. Only one-quarter of outlets in Egypt are staffed or supplied to provide IUD insertions. Only one brand of pill is offered. Sterilization is legal but not promoted by the official program; abortion is prohibited. In contrast, the Tunisian program has made the pill, IUD, female sterilization, and abortion (in the first three months of pregnancy) more widely available.

- **The status of women.** Increasing the number of educated women could do much to reduce fertility in the region. Enrollment rates for girls in 1980
were still only two-thirds the rates for boys at both primary and secondary schools (see Figure 8.3); in twenty years the gap has not narrowed. An important exception is Jordan, where primary-school education is now universal and about three-quarters of secondary-school-age children of both sexes are enrolled. In Egypt, Morocco, and Tunisia universal primary schooling for girls has yet to be achieved. Female primary enrollment has increased steeply in Tunisia, and the male-female gap has been somewhat reduced. In Egypt the increase in primary-school places has barely kept pace with population growth; the primary-school enrollment rate has remained low and access is particularly limited in rural areas, where fertility is high. At the same time, much has been invested in expanding secondary schooling.

Women's status can also be improved by raising the minimum age of marriage and by changing laws that restrict women's social and financial rights. The legal minimum age of marriage for women in Tunisia was raised to fifteen in 1956, and then to seventeen in 1964. The legal minimum age in Morocco and Turkey is still fifteen. In Turkey other legal changes are under discussion: the repeal of a husband's automatic status as head of the family in favor of a system of "joint responsibility of spouses" and abolition of a husband's right of consent for his wife to be gainfully employed.

**Latin America and the Caribbean: reducing social inequities**

Almost all of the countries in Latin America and the Caribbean are middle-income, but with great demographic diversity. In four countries with per capita incomes exceeding $2,500—Argentina, Chile, Trinidad and Tobago, and Uruguay—population growth has slowed to below 2 percent a year and total fertility is nearing replacement level. The highest fertility in the region is in six lower-middle-income countries: Bolivia, Ecuador, El Salvador, Guatemala, Honduras, and Nicaragua. Total fertility in these countries exceeds 5 and population growth ranges from 2.5 to 3.4 percent. Fertility is high in the Caribbean, with the exception of Cuba, but emigration moderates population...
growth. Fertility has declined in the three largest countries—Brazil, Colombia, and Mexico—but population will still double in about twenty-five years in Mexico and in about thirty years in the others.

In short, population growth is rapid throughout Latin America and the Caribbean and will remain so until the 1990s at least. Populations are projected to grow by at least 2 percent a year in most countries, closer to 3 percent in much of Central America. Only in Argentina, Chile, and Uruguay will growth rates be lower. The labor force will grow by more than 2 percent a year until the end of the century. Urbanization will slow somewhat from its recent fast pace, but in some countries (Argentina, Chile, Uruguay, and Venezuela) 80 percent of the people are already living in cities.

No single issue is so important in Latin America as the manner in which opportunity and access are shared. Because of inequalities of income and wealth, and despite rapid economic growth in the past quarter century, millions of people still live in poverty. As economic growth accelerated after 1950, some areas and socioeconomic groups benefited more than others, widening income and wealth differentials. As development proceeds, those differences may start to narrow. One aim of public policy, particularly in health and education, is to promote equality of opportunity. Population programs have a related role to play: they can improve the chances of the poor by making it possible for them to devote more resources to each child.

Three countries, Brazil, Colombia, and Mexico, account for 60 percent of the region's 370 million people. Economically and demographically they are more advanced than the northern Andean countries, most of Central America and the Caribbean, but (except for central and southern Brazil) less advanced than Argentina, Chile, and Uruguay.

As is true elsewhere in Latin America, a major characteristic of these countries is their urban-rural contrast. In Colombia health facilities are concentrated in the urban areas; per household, public subsidies to rural health are less than one-seventh the national average. Life expectancy for urban Colombians is sixty-four compared with fifty-eight for those in the countryside. In Brazil current spending on education is as much as ten times greater per child in urban than in rural areas; urban teachers have on average more than eleven years of education, compared with six years for rural teachers. Literacy rates in rural Brazil are 48 percent, compared with 78 percent in the towns and cities.

Provision of family planning services is also greater in urban areas, especially in Brazil. The national government has not assisted or promoted family planning services, so most users rely on private suppliers. In the well-to-do southern state of Sao Paulo, 63 percent of women obtain contraceptives through a private doctor or a drugstore. This is difficult or impossible in rural areas. The Brazilian Family Planning Association (BEMFAM), a private nonprofit organization, does provide services to the poor. In the poor states of Rio Grande do Norte and Piaui, where BEMFAM is active, almost 60 percent of women use contraceptives. In Bahia, where BEMFAM does not operate, only 40 percent use contraceptives.

How is population growth related to inequality in these countries? Fertility is consistently and inversely related to household income and to education. Surveys in Brazil indicate that poor rural women bear twice as many children as do women from the upper 40 percent of urban households. Brazilian women who neither have paid jobs nor have completed primary school have more than twice as many children as working women who completed secondary school. Similar differentials occur in Mexico and Colombia. The well-to-do are able to spend more per child than are the poor and they have fewer children.

The extent of these differences was described in Chapter 4. In both Brazil and Colombia, the poorest 20 percent of households have almost one-third of all children—but only 4 percent of total income in Colombia and 2 percent in Brazil. The richest 20 percent of households, in contrast, have 10 percent of the children and 60 percent of the income in Colombia, 8 percent of the children and 64 percent of the income in Brazil. These differences are far greater than those in such countries as India, Thailand, and Malaysia.

Population policies have helped to reduce fertility in Latin America. In 1966 Colombia's Ministry of Health signed an agreement with a private medical association to provide a program of training and research that included family planning. By combining low-key public support with private family planning programs, the Colombian government has helped facilitate a rapid fertility decline.

The Mexican government adopted a population policy to reduce fertility in 1973 and began providing family planning services in 1974. By 1976 contraceptive use had doubled, almost entirely because of public programs. Between 1970 and
1980 fertility fell in both Mexico and Colombia by about one-third; in contrast, it declined by less than 20 percent in Brazil, a country in which the national government had not committed itself to a population policy or program (see Box 8.7).

This contrast becomes even sharper when it is noted that per capita real incomes nearly doubled in Brazil but were up by only 50 percent in Colombia and Mexico. Whereas Colombia and Mexico managed a sharp decline in fertility in relation to income growth, Brazil’s fertility decline was more modest (see Figure 8.4). If Brazil had followed the pattern of Colombia and Mexico, its total fertility rate would have fallen to 3.0 by 1982 given its income growth; in fact it was 3.9. With a population policy no more vigorous than that of Colombia and Mexico during the 1970s, Brazilian fertility might now be one-quarter lower than it is. Most of the difference would come from lower fertility among the poor, since it is they who would be assisted most by a public policy.

The advantages of lower fertility are already becoming apparent in some Latin American countries. In Colombia the number of enrolled primary-school students increased by 1.6 million between 1965 and 1975; in the 1980s the number of children in the primary-age group will grow by less than a million, easing the strain on the education budget. By 1990 the Colombian labor force will be growing by 2.2 percent a year, well below the 3.5 percent rate of the 1970s. With fewer new entrants to the labor force, a larger proportion of them can expect to qualify for high-wage jobs.

Looking ahead, Colombia and Mexico need to extend public family planning programs to the rural poor, and to do more to integrate population policy into the overall framework of development planning. Brazil’s popular private sector programs, long tolerated by the government, do not have adequate resources. There is significant unmet need for family planning in the poor Northeast. Brazil spends more than 4 percent of its GDP on health; by devoting a tiny share of that budget to family planning, it could extend family planning coverage to the 40 million people of its poorer regions.

Brazil, Colombia, and Mexico are not the only countries in Latin America where population policies could be effective against poverty and inequality. Ecuador, Paraguay, Peru, and the Central
Box 8.7 Changing policies and attitudes toward family planning in Brazil

Official Brazilian policy on population was, until 1974, implicitly pronatalist. The traditional official view, dating from colonial times, had been that Brazil would benefit from a large growing population to complement its vast territory and natural resources.

The first perceptible change from a pronatalist to a laissez-faire stance occurred during the 1974 World Population Conference, and at about the same time in the Second National Development Plan. Official statements maintained that Brazil’s 2.5 percent annual rate of population growth was not a serious threat to economic development, but they went on to recognize the responsibility of the government to provide family planning services to those who want, of their own free choice, to plan their families but are too poor to pay for the services that are available privately. Federal authorities gave tacit approval to a number of state-level family planning programs organized by the Brazilian Family Planning Association (BEMFAM), the Brazilian affiliate of the International Planned Parenthood Federation.

In 1977 the federal government took the first step to provide family planning services for the poor. It announced that the 1978-81 plan for maternal and child health would include family planning services for women for whom pregnancies would involve a high health risk. Then in October 1983 the minister of health announced that a broad new health program for women would be implemented beginning in 1984, with family planning assistance being included as part of a full range of maternal and child health care.

Underlying this more active involvement in family planning are three trends, not entirely unrelated: growing public awareness of Brazil’s population problem, including among important elites formerly opposed to family planning programs; a growing social demand for (and practice of) family planning; and the economic recession, which has heightened social tensions because of growing unemployment and underemployment and falling real incomes.

In March 1983 Brazil’s president told Congress that the country’s rapid population growth was capable of causing “social, economic, cultural and political imbalances” and proposed opening a broad debate which could lead to specific policy measures to deal with this threat. Fifteen days later, a Parliamentary Commission of Inquiry on problems associated with Brazil’s population growth was established in the Senate, and in mid-May the Ministry of Health sent the president a preliminary document on the proposed health program for women.

A recent military report showed that half of the young men who enrolled for military service in 1982 were rejected for medical reasons, and of these, 60 percent were likely to be unfit for service in the future because their physical and mental capacity had been permanently stunted. Statements by the Chief of Staff of the Armed Forces, in a newspaper interview in June 1983, differed from the traditional military view that Brazil needed rapid population growth to fill up its vast territory. Noting that the quality of recruits had been falling for some time, he said, “What we need in this country is a well-qualified and capable population. We do not need numbers of people . . . . A child who is not well fed in the first year of life suffers permanent mental damage, can never again be productive, and will always be dependent on society.”

The official position of the Catholic Church is to promote responsible parenthood only by natural means. But at least one theologian has publicly argued that “only the couple has the right to choose the means most appropriate for practicing responsible parenthood.” Increasing concern with social justice is likely to weaken further the church hierarchy’s opposition to government-supported family planning programs, as long as the state does not try to dictate how many children a couple should have or the means to be used to achieve their goal.

The taboo on public discussion of family planning in Brazil has now ended. A report on vasectomy was featured in a fifteen-minute program in prime television time on a Sunday evening in December 1983. A recent poll in the city of Sao Paulo found that 75 percent of those interviewed believed that couples should plan the number of children that they have. Civilian politicians in both opposition and government parties increasingly express the strong social demand for “democratization of access to family planning” and some opposition parties have called for legalization of abortion. (It is estimated that between 3 million and 5 million illegal and clandestine abortions are performed every year in Brazil, or roughly one for each live birth.)

A growing number of Brazilian politicians belong to an association of legislators favoring an active family planning policy, which hosted the first “Western Hemisphere Conference of Parliamentarians on Population and Development” in Brasilia in December 1982. A private organization, Pro Familia, recently organized a three-day “First National Conference on Maternal and Child Protection and Family Planning” with some 1,200 participants (80 percent of them women) in the auditorium of the federal senate. The conference recommended that family planning should cease to be a privilege of the well-to-do, and that the state, complemented by private institutions, should provide family planning information and services. The conference also recommended the creation of a new agency to coordinate a National Family Planning Program, revision of existing laws to allow the use of all means of contraception approved by the international scientific community, and inclusion in primary and secondary school curricula of material on human sexuality and the physiology of reproduction. The closing session of the conference was attended by the president of Brazil, the ministers of social welfare and the interior, the acting minister of health, a number of federal senators and deputies, and the chief of staff of the armed forces.
American countries could all benefit from stronger policies. Rapid population growth in El Salvador has been identified by many as a partial cause of its civil war. In Bolivia and Haiti, the poorest countries in the region, initiatives to slow population growth are among the most urgent policy needs to combat poverty.

South Asia: expanding and improving programs

The 930 million people of Bangladesh, India, Nepal, Pakistan, and Sri Lanka comprise one-fifth of world population and one-quarter of the population of developing countries. Although incomes in South Asia are among the lowest in the world, the region’s fertility has already fallen substantially (see Figure 8.5). In Sri Lanka, for example, the total fertility rate fell from 5.5 in 1960 to 3.5 in 1974; in India it dropped from 6.5 in the 1950s to 4.8 in 1982. The rate of contraceptive use (both modern and traditional methods) is 55 percent in Sri Lanka, the highest in the region. About 28 percent of couples in India use modern contraceptives. No other country at India’s level of socioeconomic development—measured by low literacy and per capita income and high infant mortality—has a lower level of fertility. Bangladesh and Pakistan have had more modest declines. In Bangladesh 19 percent of couples use either modern or traditional methods (see Figure 8.6).

What accounts for this impressive record? Continued progress in raising female literacy and lowering infant mortality, as well as a concerted effort to expand access to family planning, have both been important. Within India there is wide variation in fertility and in contraceptive use, a variation which closely corresponds to patterns of social development. For example, in the state of Kerala, which has the lowest total fertility (2.7 in 1978), 75 percent of rural women are literate, infant mortality is 47 per thousand live births, and 32 percent of couples are protected by modern contraception. In contrast, in the state of Uttar Pradesh total fertility was 5.6 in 1978, infant mortality is almost four times higher (171 per thousand), and female literacy and contraceptive use are, respectively, one-seventh and one-third the levels found in Kerala.

The experience in Sri Lanka is similar. Despite a per capita income of only $320 in 1982, infant mortality had been reduced to 41 per thousand and virtually all primary-school-age girls were enrolled in school. Of a contraceptive use rate of 55 percent, almost two-thirds comprised modern methods; total fertility had declined to 3.4.

Progress in South Asia has not been uniform, however, and rapid population growth is a source of continuing concern. In India and Sri Lanka mortality has declined as fast as, or faster than, fertility. As a result, population growth has increased in India—its population is now increasing by 16 million a year, more than in any other country, including China. India’s birth rate has remained at 33 to 34 per thousand since 1976; contraceptive use, steady at 23 to 24 percent since 1976, has only recently begun to rise again. Total fertility has stopped falling in Sri Lanka, and has been fluctuating between 3.4 and 3.7 since 1974. In Bangladesh contraceptive use increased from 8 percent in 1975 to 19 percent in 1981, but appears to have made slow progress since then (though the share of modern methods has apparently risen). In Pakistan only about 5 percent of couples practice contraception, and in Nepal only 7 percent. Both of these countries lag behind others in providing health and family planning services, although both show signs of a renewed political commitment to curb population growth.

The experience in Sri Lanka and in some Indian states suggests that much more could be done to bring about fertility decline. In every country there is considerable scope for reducing infant mortality, raising the legal marriage age, and increasing
female education—all of which would have a profound effect on fertility. In Bangladesh family planning and greater economic independence of women are jointly promoted through credit cooperatives for women (see Box 8.8). A few countries are moving beyond schemes that compensate those who adopt contraception to consider positive incentives for small families. Bangladesh has contemplated offering bonds to sterilization clients with two to three children and to couples who postpone a first pregnancy or space children at long intervals (see Box 6.4). India is considering a scheme to give “green cards” to couples sterilized after two children; these cards would entitle them to preferential access to social services.

Desired family size in Bangladesh is now about four; actual size averages about 5.5. Sri Lankan women are having on average one child more than they want. According to a 1979 survey in Bangladesh, as many as 41 percent of married women of childbearing age have unmet need for contraception to limit or space births. Pilot projects there have achieved rates of contraceptive use of 35 to 40 percent with modern methods, three to four times the prevalence of these methods nationwide. In Sri Lanka 44 percent of women of childbearing age who want no more children are nevertheless not practicing contraception.

To satisfy unmet need, family planning programs must resolve important issues of access and quality.

- **Access.** Better family planning outreach could go a long way to increase contraceptive use throughout the region. Access is most restricted in Nepal and Pakistan. In Nepal there is unmet need for contraception among 22 to 27 percent of eligible women. About half of currently married women in Nepal are unaware of a modern contraceptive method, and an additional 15 percent who are aware do not know where a method can be obtained. In Pakistan, three-quarters of married women of childbearing age knew of a modern contraceptive method in 1975, but only 5 percent were using one. A quarter to a half of these women had unmet need for contraception to limit births. Since then contraceptive use has stagnated. The government plans to meet the need for contraception by greatly expanding and upgrading services.

- **Method mix.** Family planning programs in South Asia have continued to emphasize sterilization to the neglect of reversible methods of contraception, particularly in India and Sri Lanka (see Figure 8.6). Sterilization accounts for more than three-quarters of modern contraceptive use in India and Nepal, two-thirds in Sri Lanka, and about half in Bangladesh. Sterilization is clearly in demand among couples who want no more children. But other forms of contraception are used less, largely because they are not widely available. Given the high rate of child mortality in South Asia, reversible contraceptive methods may be more desirable for couples who have had two or three children but who do not wish to be sterilized immediately. To maximize contraceptive use, both reversible methods and sterilization need to be made available.

The only widely available reversible method in India is the condom, which is provided through 400,000 retail outlets in the social marketing program as well as in family planning program outlets. The pill, important in countries such as Indonesia, is not offered through social marketing arrangements, and in 1981-82 was being distributed through only 4,500 rural and 2,500 urban out-
In Sri Lanka 25 percent of married couples of childbearing age were using traditional methods of fertility regulation (rhythm, withdrawal, and so on) in 1981, a doubling of the percentage since 1975. Such an increase in use of traditional methods attests to growing unmet need for more effective spacing methods. Only 664 centers offer the IUD; public health midwives have not yet been trained to perform insertions. Injectable contraceptives are popular in rural areas because of their convenience, but are available at only 120 centers.

Although Bangladesh continues to stress sterilization, its social marketing project has made avail-

Box 8.8 Family planning and women’s credit cooperatives in Bangladesh

The Bangladesh Rural Development Board has been sponsoring credit cooperatives for rural women since 1975, funded by IDA and bilateral cofinanciers as a component of two population projects. By providing training and income-earning opportunities, the program seeks to reduce women’s dependence on childbearing for their short- and long-term security. Cooperatives have also been used to transmit information about family planning. They provide a social setting that encourages acceptance and continued use of contraception.

Membership is open to all women who purchase a share in the cooperative, at ten taka (roughly $0.40). Members must save regularly and attend weekly cooperative meetings in their village. In some societies all members are loaned the same amount; in others the amount varies, depending on the number of shares, total savings, or length of membership. Credit is offered to individuals as well as to group enterprises. Loans carry an interest rate of 12.5 percent. Thana-level project officers review each cooperative’s loan program. All deputy project officers are women who have received 4 to 6 months’ special training.

Each cooperative sends one woman to a weekly thana-level training and development center several miles from the village. These representatives are trained in poultry raising, horticulture, health and family planning, loan policy, and cooperative law and procedure. They pass on this new information to society members during their weekly meetings and, in turn, take their members’ problems and questions to the training session.

As of July 1983 the program had established 1,215 cooperatives with 49,368 members, share capital of about $50,000, and savings of about $104,000. The demand for loans far outstrips the amount available, although the Sonali Bank has recently agreed to provide new capital. The repayment rate has been extremely high, always over 90 percent, often near 100 percent. Women have taken loans for processing paddy, muri, turmeric, mustard oil, dal, chili, fish, and peanuts; for buying livestock to raise and sell; for small enterprises, such as pottery, jute goods, or bamboo mats; and in a few cases for buying water to irrigate a rice crop or lease land for cultivation. Initially, most loans have gone to individuals to generate an immediate return on a traditional skill (such as paddy processing). As time passes, however, a higher proportion is going to groups of members for activities that provide a longer-run return, such as fish breeding, commercial poultry, and market gardening.

Family planning is on the agenda of cooperatives’ weekly meetings: the methods available, side effects to be expected, and how to obtain contraceptives and medical attention. Those interested in receiving services are referred to local family planning and health clinics. Cooperative leaders keep track of the contraceptive status of members, problems they may have in common, the need to switch methods, and special arrangements that need to be made for women who want to be sterilized or need other medical help.

A study by the Bangladesh Planning Commission in 1978 compared the knowledge and practice of family planning among cooperative members and nonmembers with similar socioeconomic backgrounds in the project area. In both groups, most women had positive attitudes to family planning. But cooperative members knew more about the different methods and a larger proportion were practicing contraception. Among all members, regardless of age, pregnancy, or marital status, 31 percent were using family planning. Of those who would otherwise be at risk of pregnancy (married, exposed, in the childbearing ages), two thirds were using a method. In contrast, about 19 percent of married women of childbearing age were practicing contraception in Bangladesh as a whole in 1981.

Another project combining work for women and family planning is in Maros Regency, South Sulawesi, Indonesia. It has generated income from poultry raising and tripled contraceptive use among members. Private family planning associations in thirteen African countries (Benin, the Gambia, Ghana, Kenya, Lesotho, Madagascar, Mali, Nigeria, Sierra Leone, Tanzania, Togo, Uganda, and Zaire) are also sponsoring pilot projects that promote planned parenthood alongside development programs for women.
able several types of condoms, pills, and spermicides. And the program has recently put more emphasis on IUDs by offering financial incentives to staff and compensation for travel and lost wages to acceptors. There are plans to train more fieldworkers in IUD insertions and menstrual regulation, but not all fieldworkers are in place, and not all of those who are have received adequate training. Injectable contraceptives have proved popular in pilot projects, but are available on only a limited basis under the supervision of a physician.

- **Follow-up.** As South Asian programs try to meet the demand for a wider range of reversible methods, following up acceptors will become even more critical. The emphasis on sterilization has meant that staff have had little continuing contact with clients. Lack of follow-up services greatly reduced the acceptability of the IUD throughout South Asia in the 1960s; it has only recently regained public approval. At present, family planning staff are judged (and are rewarded) according to the number of acceptors they recruit, not by the number of users they assist. Programs will have to adopt new performance criteria and incentive arrangements to stress regular contact with clients.

Certain administrative and operational difficulties also need to be resolved. Family planning services have undergone major reorganization in some countries. In Bangladesh, for example, health and family planning services were initially separate, then integrated, then divided, and are now reintegrated. The program in Pakistan has also recently undergone a major reorganization. Whenever there are such upheavals, staff morale and performance suffer. Other problems are manifest in all programs. In some cases salaries are so low that staff have to take on other work to support their families. Inadequate training, incomplete staffing patterns, and lack of supervision have also lowered morale and performance. Where it exists, supervision takes the form of enforcing accountability and targets rather than supportive training and advice.

Program managers have tried to overcome problems of morale and supervision in two ways: by paying workers according to their performance in recruiting acceptors, but this system carries the risk that follow-up services will be neglected; and by setting high program targets. But neither incentives nor targets can substitute for better training and supervision—the two requirements that are critical to improving the performance of family planning programs in South Asia.

### East Asia: incentives for small families

The countries of East Asia have experienced marked declines in fertility in the last decade (see Figure 8.7). Total fertility (less than 3) and rates of natural increase (about 1.5 percent a year, 2.2 percent excluding China) are the lowest of any developing region. For the most part, recent declines in fertility have occurred in countries where fertility was already lower than would be expected, given the region’s income. The most dramatic reductions have been in China: total fertility dropped from 7.5 to 2.3 over the past two decades, despite a per capita income of only $310 in 1982. Indonesia, the Philippines, and Thailand have also experienced remarkably rapid falls in fertility with only modest increases in income.

Population policy is more developed in East Asia than in any other region. In most countries, political commitment to reduce rapid population growth is high. Family planning programs are well established, with outreach to rural areas and a reasonable mix of contraceptive methods. Many governments, irrespective of level of income, have been highly successful in improving socio-economic conditions favorable to fertility decline. Ninety percent or more of all girls of primary-school age are enrolled in China, Hong Kong, Indonesia, Korea, Malaysia, the Philippines, Singapore, and Viet Nam. Overall, secondary-school enrollments are also high in a few countries—53 percent in Malaysia, 63 percent in the Philippines, and 85 percent in Korea. Life expectancy in China, Hong Kong, and Singapore has risen to seventy years or more and in most other countries exceeds sixty. In almost all countries, infant mortality has been reduced by half or more over the past twenty years. Nevertheless, further substantial reductions could be made in Indonesia (where the rate exceeds 100 per thousand live births), China (with a rate of 67), and Thailand, the Philippines, and Viet Nam (about 50).

Despite dramatic declines in fertility, population in the region will double in about forty-five years. Burma, Indonesia, Malaysia, the Philippines, Thailand, and Viet Nam all have annual rates of population growth of at least 2 percent a year. At its current growth rate of 2.4 percent a year, the population of the Philippines will increase by half (25 million people) by 2000. Even in China, with an annual increase of 1.2 percent, population will continue to grow rapidly for a long time because of the momentum of past growth. According to the standard projection, China’s population will...
increase by almost half, to 1.45 billion by 2050. Replacement-level fertility is still a long way off for Burma, Indonesia, Malaysia, the Philippines, Thailand and Viet Nam, with total fertility rates of at least 3.6; total fertility in Korea, at 2.7, is also still above replacement level.

Though contraceptive use is higher in East Asia than in most other developing regions, there is still considerable unmet need for contraception. Low and high estimates of unmet need are 19 to 49 percent of married women of childbearing age in the Philippines (1978), 20 to 31 percent in Indonesia (1976), 15 to 26 percent in Thailand (1981), and as much as 30 percent in Korea (1979). Actual family size exceeds desired family size by one child in the Philippines. More than half of eligible couples who want no more children are not using any method of birth control. And among the 36 percent of Filipino couples using a method, more than half are using less effective methods such as withdrawal and rhythm. In some countries family planning programs have not achieved complete geographic coverage. In Indonesia, for example, contraceptive use in the outer islands, where one-third of the country’s population lives, is less than half the level on Java and Bali—in some places much less. There are also marked regional disparities in access to services in the Philippines.

In addition, some countries have overlooked potentially important methods. The Indonesian program, for example, does not offer sterilization. Yet this method has been very popular in South Asia, Korea, Thailand, and some Latin American countries. Injectable contraceptives have been much favored in Thailand but are only recently gaining ground in Indonesia. The Korean program has emphasized sterilization; wider promotion of spacing methods might also lower fertility. The potential demand for spacing methods is demonstrated by the high resort to abortion in Korea. In the Philippines, improving the effectiveness of traditional methods and promoting more effective alternatives could have a substantial effect.

Given the relatively advanced state of population policies, more use could be made of incentives and disincentives. Among the countries of East Asia, China, Singapore, and to a lesser extent Korea, have made greatest use of measures to promote small families. Sometimes they have relied on individual incentives (such as giving priority in
housing schemes to parents with only two children. Some countries have also offered incentives to whole communities that reach specific targets for contraceptive use. Some governments also penalize those who have more than a certain number of children—for example, by the withdrawal of maternity benefits.

China has a complex structure of incentives, disincentives, and birth quotas to promote a one-child family (see Box 8.9). Most governments have not chosen to promote such drastic measures as those in China. And few have the administrative control necessary to implement national schemes of deferred payments or social security to promote smaller families.

In China the one-child policy has been challenged by an apparent preference for sons. The same bias in favor of sons exists in Korea, and has been partly responsible for keeping total fertility, now at 2.7, from declining to replacement level. To counteract this bias, governments need public information campaigns and legal reforms of inheritance, property rights, and employment. Incentives might also be offered to one- or two-child families with girls, such as lower educational and medical costs or preferred access to schooling.

**Donor assistance policies**

International aid for population programs has two major objectives: to assist governments and private organizations in providing family planning, information, and services, and to assist governments in developing population policies as part of

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**Box 8.9  China’s one-child family policy**

Birth control has been a national priority in China since 1971 when the government launched a new program to promote later marriage, longer spacing between births, and fewer children. In the late 1970s it became clear that, with the large number of women entering childbearing age as a result of past high fertility and falling mortality, even compliance with a two-child family norm would not reduce the rate of population growth enough to meet the national goal of 1.2 billion people by the year 2000. In 1979 Sichuan province instituted a policy designed to persuade married couples to have no more than one child. This policy was backed by a system of economic rewards to parents with more than one child who committed themselves to have no more, and penalties for those who had more than two. This soon became a national policy and individual provinces are all expected to implement such systems. In 1980 the vice-premier stated as specific goals that 95 percent of married couples in the cities and 90 percent in the countryside should have only one child. By 1982 most provinces and municipalities had introduced incentives and disincentives to promote the one-child norm.

Early results of the one-child campaign seem striking. The proportion of first births out of total births increased from 21 percent in 1970 to 42 percent in 1980 and 47 percent in 1981. By 1982 the proportion of first births exceeded 80 percent in each of the three large urban municipalities—Beijing, Shanghai, and Tianjin—and in five other provinces.

But several factors are working against the one-child policy.

- **Old-age security.** A compulsory pension system applies only to employees of state enterprises in urban areas, who constitute at most 15 percent of the labor force. A 1982 survey of rural production brigades in eleven provinces and municipalities found that only 1 percent of men over sixty-five and women over sixty received monthly pensions paid by welfare funds. For the rural majority, children remain the main source of old-age security.

- **The responsibility system.** The widespread introduction of the production responsibility system has given families a direct economic incentive to have more children, for two reasons. In some areas land for household use is allocated on a per capita basis, so more children ensures access to more land. In addition, whatever security for the elderly is provided on a collective basis will be reduced as collective income declines. In an effort to combat this, some brigades have introduced a double contracting system under which households are required both to deliver their quota of farm output to the state and to refrain from having an unauthorized birth.

- **Persistent male preference.** A preference for sons is a strong cultural impediment to having only one child. A 1980 survey of one-child families in Anhui Province found that 61 percent of the children of one-child certificate holders were boys. The pressure to have one child (and the desire for a boy) may have led to a revival of the practice of female infanticide, about which the Chinese government has expressed considerable concern. The 1982 census data on births in 1981 showed that there were 108.5 boys for every 100 girls at birth, an abnormally high figure.

- **Financing incentives.** Responsibility for financing incentives falls on local areas, not the central government. As a result there is great variation in the type and value of incentives. In a model county in Jilin Province in 1981 families pleading to have only one child were granted annual bonuses of almost fifty yuan—equivalent to 7 percent of average rural income—to last for fifteen years, and received a double-size private plot. For their single child they received an adult grain allowance and a special health care allowance. Yet in Hefei city in Anhui province, bonuses paid to parents were much lower—a one-time payment of ten or twenty yuan, a few towels, a thermos bottle, some toys, a wash basin, or even nothing at all.
their overall development strategy. Population assistance now amounts to nearly $500 million a year, equal to about 1.9 percent of OECD aid and about 1.5 percent of OPEC aid. At its peak, the population assistance share of aid was considerably larger—2.2 percent of OECD aid.

Since Sweden's first population grant in 1968, donors have transferred more than $7 billion in population aid (in 1982 prices). In terms of per capita receipts in the developing countries, assistance for population programs was lower in 1981 (the latest year for which complete data are available) than in 1974, the year of the World Population Conference in Bucharest (see Figure 8.8). The United States remains the biggest supporter of population programs—its government, along with private American foundations, provides about 40 percent of all aid for population. But its contribution has been falling in real terms since 1972. Japan is the second largest donor. Japan and other donors, including Canada, the Federal Republic of Germany, the Netherlands, Norway, and Sweden, have increased their share of the total. All gave $10 million or more in population assistance in 1982.

The main role of donors has been to provide supplies and training for family planning and related health programs; about two-thirds of population aid is devoted to family planning and related maternal and child-health programs. Donors also support basic data collection, operations and social and economic research, information and education activities, and policy and institutional development. In Asia and the Middle East, over 80 percent of assistance goes toward family planning services, in Latin America and Africa about 60 percent. In sub-Saharan Africa, almost a fifth of assistance is used to finance data collection; as Table 8.1 showed, data development is often an early step in heightening consciousness about population issues. As shown in Chapter 7, program development is often constrained by limited training, the absence of local institutions, and poor demographic information. Development of local capability must continue to be a priority for donors.

About $150 million is spent by donor governments for research on reproductive biology and contraceptive technology; such research contributes to methods that can be adopted in developing countries as well. Developing countries could benefit from larger sums spent on research and product development. Support by donors is critical since spending by the private sector in developed countries has fallen (see Box 7.2). Donor support could hasten development of institutions to provide a local base for social and economic research as well as for contraceptive research.

Donor assistance is provided both directly to country programs and through multilateral and nongovernmental organizations. The two largest organizations are:

- **The United Nations Fund for Population Activities (UNFPA).** More than 130 countries contribute to its annual budget of about $140 million. About 100 developing countries have requested and received UNFPA assistance. To guide its programming, UNFPA has assessed the needs of more than seventy countries. It receives requests for assistance that far exceed the money it has available.

- **The International Planned Parenthood Federation (IPPF).** A nongovernmental body of more than one hundred national family planning associations, IPPF had a 1983 program budget of $90 million, over half of which came as contributions from OECD countries. About one-third of its budget support is raised by member associations in their own countries. Countries receiving its largest grants in recent years are Brazil, Colombia, India, Mexico, and Korea.

About one-quarter of the population aid from the US government is administered through more than twenty nongovernmental organizations in the United States, particularly universities and research institutions. They cooperate with organizations in developing countries in service delivery.
and training, data collection and analysis, special projects, and biomedical and operations research. Family Planning International Assistance, a branch of The Planned Parenthood Federation of America, the American affiliate of IPPF, provides population assistance in more than forty countries. The Population Council, with a budget of $16 million from both public and private sources, provides technical assistance and supports social science and contraceptive research. The Pathfinder Fund is an example of smaller nongovernmental organizations. Pathfinder manages about $7 million in public and private funds, which are spent on innovative family planning services, women’s programs, and population policy development. These small programs, and similar programs in other countries, add to the flexibility and responsiveness of population assistance.

The World Bank supports population activities through IDA credits and loans to borrowers. Over a period of fourteen years, the Bank has committed $355 million for population projects, and had disbursed $215 million by the end of 1983 (including $38.4 million in fiscal year 1983 itself). World Bank finance is not available on terms as easy as most population assistance, much of which is given in the form of grants; nonetheless, Bank operations grew in real terms by more than 5 percent a year between 1977 and 1983. Over the past three years the largest disbursements have gone to Bangladesh, Egypt, India, Indonesia, the Philippines, and Thailand, which together accounted for more than 90 percent of Bank lending for population.

The World Bank also supports an active program of economic and sector work aimed at enhancing understanding of how population growth affects development prospects and how population programs can contribute to overall development. The Bank cooperates with other UN organizations, especially UNFPA and the World Health Organization, in research and analysis requested by member governments.

The predominance of foreign assistance within the population sector in many countries means that the attitudes and priorities of donors become significant. At the same time, the great number of donors—private, official, bilateral, and multilateral—means that their priorities may not always coincide. They may send conflicting signals to host governments, fueling internal controversies. Further, their numerous activities may not be complementary or represent the most efficient allocation of resources. Coordination among donors and with the host government is therefore extremely important for effective use of population assistance.

One sign of the success of international assistance is that many local governments now help pay for programs that only a few years ago were supported by international grants. Colombia, Indonesia, Korea, and Thailand are picking up a progressively larger share of the costs of their population programs. India has for many years paid for a large share of its program, and China has always completely financed its own program. This trend toward self-financing makes it possible to reallocate aid budgets to countries that are only starting to develop their population programs. For example, the share of the UNFPA’s budget going to Africa rose from about 12 percent during the 1970s to 23 percent in 1983.

Asia continues to receive the bulk of population assistance (51 percent of the total), followed by Latin America (20 percent), Africa (15 percent), and the Middle East (14 percent). Given the emerging pattern of needs described in Chapter 7, a substantial increase in assistance is needed, especially for Africa and South Asia. To meet unmet need in all regions in 1980 would have required spending $3 billion rather than the $2 billion that was actually spent (see Chapter 7, Table 7.6). By the same yardstick, spending for population programs in sub-Saharan Africa and South Asia should have been more than double what it was. Since Africa and South Asia are the poorest regions and most in need of external assistance, the bulk of the extra program support would have had to have come from international aid.

The analysis in Chapter 7 led to two estimates of required public spending for population programs by the year 2000. If developing countries are to achieve a “rapid” decline in fertility, $7.6 billion (in 1980 dollars), almost a quadrupling of 1980 spending, would be needed. The “standard” decline would require $5.6 billion. With two-thirds of external population assistance going to support family planning, foreign aid now supports about 25 percent of all family planning costs in developing countries. Assuming these proportions do not change, population assistance will need to triple (standard decline) or quadruple (rapid decline) its current level. A quadrupling would raise population assistance to an annual level of $2 billion (1980 dollars) by the year 2000. With no other changes in official development assistance, total aid for all assistance programs would increase by 5 percent, by no means an unmanageable addition to aid budgets. With the expected growth of industrial
countries as outlined in Chapters 2 and 3, and aid as a constant share of their GNP, expanded population assistance would by the year 2000 need to equal 3.3 percent (to achieve standard fertility decline) or 4.3 percent (to achieve rapid fertility decline) of total concessional assistance.

Thus, small differences in financial assistance from donors can, given effective policies in recipient countries, make a big difference in population change. Sustained progress, however, requires not just donor funds; it also requires a commitment by the international community to population programs as a critical part of the effort to improve people's lives.