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

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What we have learnt

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

What happened in Cairo

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

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

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

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

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

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

Sub-Saharan Africa

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

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

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

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

Final note

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

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