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Population Policies and Reproductive Rights - Always in Conflict?

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The paper sets an agenda for action to address on the Concerns of Reproductive Rights and its related issues. The paper also underlines the importance of women empowerment, education of girls and puts emphasis on the urgent need of improving quality of services, reduction in infant morality and meeting unmet demand for the family planning.

Population Policies and Reproductive Rights Always in Conflict?

Most of us know why there are great concerns about demographic growth. As we meet, there are about 5.5 billion human beings, halfway between five and six billion. We add over a quarter of a million people to the earth every, day, day after day. The population of young people coming into reproductive age will expand by 25 % in the next decade. Depending on what we do in the next ten years, the earth's population will continue to grow until it numbers between 6 billion and an almost unimaginable 19 billion by, the end of the next century. India will have a population of over 1 billion just after the turn of this century.

This enormous population growth is one of the characteristics of the Demographic Transition through which our global civilization is passing. It is unique. It has never happened before. It will never happen again. It is a phenomenon of the past 200 years. And it will be finished in another 100 or 150 years. We are living in it.

What is this Demographic Transition? It is a term used to describe the transformation of societies as they move away from high birth rates and high death rates - and a very high percentage of the population dying before the normal life span elapses. Most die in the first year or before 5 years - and thereafter, probably of infectious disease.

The transition is an evolution toward low birth rates and low death rates, within which most of the death takes place in the last ten years of life expectancy. The cause of death tends to be chronic and degenerative diseases, and diseases of lifestyle.

This demographic transition has been completed in some industrialized societies; in a few, there are more deaths than births every year. It is underway everywhere in the developing world right now.

India is well into the transition with infant mortality rates that have fallen by half since Independence and life expectancy almost doubling in the same time. The rate differs; the phenomenon is the same. It is in all of our interest to accelerate this transition.

It is during this transition phase that rapid population growth period occurs. Births take place, many fewer deaths occur. The numbers accelerate rapidly. Once the transition nears completion, growth rates start to decline, and ultimately, population stability occurs. It is in all of our interests to hasten the year in which the planet will have its peak population. The earlier this happens, the smaller the number will be. If the peak of Bangladesh's population is reached in 2005, it will likely reach about 210 million. If another 20 years goes by, it will be closer to 280 million - more than double the present size.

If we had all the time in the world, if resources were allocated differently, we could wait the process out. Once traditional societies have completed the transition from subsistence and agriculturally based economies to modem industrialized economies, the desire for family size usually drops to around two children On a global level, this is replacement fertility, or stability. But this transition may take a long time.

This has governments around the world establishing population programs. These are almost all centered on the need to reduce family size.

Our question is - is it possible, or likely, that these programs can also be respectful of women, their families, their reproductive rights? And what kind of social research can we make sure takes place to try and ensure that this is so. That is the issue we must explore.

What is at Issue? The Reproductive Rights Concerns

- The concerns raised about these programs center on the fact that they are demographically driven. Among the preoccupations raised art following:

- The existence of targets is disrespectful of women (whose use of family planning far exceeds that of men); it treats them as numbers.

- Targets drive family planning workers emphasize quantity.

- Coercion has too often accompanied family planning programs: from the days of the India emergency program, to the ill-fated Pakistani programs, to China, to some of the early NORPLANT campaigns in Indonesia.

- There is concern about the unethical use of injectables and implantables, which have the potential to be used to solve social issues, not reproductive demand.

- Some reject hormonal contraception not just for themselves, but for all women.

- Some contest that there is too much medical dependency; that contraceptives have been developed that keep women dependant on providers.

- There is real anxiety about vaccines, and the unethical use to which these may be put.

- There are concerns that inadequate service levels, particularly in Government programs which are too often under-funded and undertrained, means that the level of service will not be appropriate for high technology contraceptives, or for contraceptives requiring extensive follow up.

These concerns have grown in the past few years and often resulted in angry explosions against family planning programs. It has come as a shock to those who have been involved long-term in the struggle for effective and humane population policies to find their efforts seriously questioned.

I don't think it is necessary to heap criticism on these early efforts in order to bring new knowledge and perceptions to bear, to improve and change. I also find it not too useful to deny that change needs to be made.

Why this resistance? In part, resource constraints. Those who fear that there are already not enough resources to go around would like to eclipse women's health concerns from family planning programs. Not to ignore these, I hasten to add, but to suggest that the very restricted funds available for population activities cannot be stretched even further to cover various women's health concerns. This is just not realistic. Let me quote Bernadine Healy, in the Journal of American Medicine: "....women's health in general - in terms of research, services, and access to care - has come of age and become a priority medically, socially and politically. "I would add to that this is women's health, as defined by women. We must welcome those who urge more emphasis on reproductive health. Proponents of reproductive health make us more responsive to the unattended health needs of women. They educate us about shortfalls of existing services, some of them very serious. And they offer us new approaches, which make family planning, and reproductive health services better and more widely used.

For example, can we legitimately advocate family planning without acknowledging the deaths, which results from unsafe abortions? A woman dies every about three minutes from unsafe abortion, Any after day, month after month. Can we be involved in clinics and family planning centers that do not pay attention to reproductive tract infections and sexually transmitted diseases? Even as little as diagnosis? These are necessary adjuncts to any responsible provision of fertility regulation services.

Technology is not the answer, but it is a very useful tool. The Population Council is proud of our role in developing contraceptives. We are particularly proud of the fact that as much attention is paid to software as hardware. We have learned over the years - with our own NORPLANTâ system as the chief, but not only, example that technology cannot be looked at in isolation. We must spend time and resources to make sure that the software of reproductive counseling, examination, follow-through, choice, reversibility options, are appropriate to the hardware available. Most of the criticism about modern contraceptive systems is in fact criticism that this all-important software is not given the importance the hardware gets. Where the criticism relates to real practices, we join in the criticism.

The escape from a world of relentless demographic pressure or lack of reproductive choice for women will be helped by the search for better technology. There are some real unmet needs that we at the Population Council will try to meet during the next

decade. Science is not predictable, but we hope to develop contraceptives, which will be developed to be used under the control of women and in varying circumstances. We need contraceptives for men, post-coital contraceptives, menses inducer or medical abortion, and perhaps most important for the health of the women and men of the world--contraceptives under the control of women that would also offer protection against sexually transmitted diseases and infections, most particularly AIDS.

The essential surrounding scientific knowledge is more and more available. We have well researched findings about delivery systems. We have established criteria for quality of care that treat clients well, also through research.

In short, we think there are a series of bridges between the extremes. There are extremists on both ends of this debate. Those who insist that the urgency of the demographic issue means that we must eclipse human reproductive rights, have something in common with those who want to abolish some forms of contraception: they both want to restrict choice in family planning programs, to make decisions for others.

But there are two communities left out by both of these extremes.

The reproductive rights of individuals and couples belong within international and national legal frameworks. These must be balanced with responsibility, or the rights of children to be wanted, and supported by both their parents.

Similarly, it is easy to assume the right to be spokespeople or to eclipse the real interests of the communities we serve, through the application of total prescriptions or total prescriptions. Their concerns may be for solutions that help their own negotiations with husbands, with families. They may prefer solutions that derive from their lack of privacy or their concern with health uncertainty about livelihoods.

Setting out the Consensus

There is consensus. In a few short decades, contraceptive prevalence has risen in developed countries - none of which have programs designed to decrease fertility, but most of which support better reproductive health - to about 70%. In three short decades, the prevalence of contraceptive use has risen from about 10% to over 50% in developing countries. In India, contraceptive prevalence is about 47%. This is an extraordinary

social and behavioral revolution. This has resulted in decreases in family size around the world. The total fertility rate, that is, the average number of children per women, has declined in India from about just under 6 four decades ago, to about 3.6 now. In developing countries generally, the figures are about the same - from 6.1 in 1960-1965, to 3.9 in 1985-1990.

The demand to limit families is growing in ways we do not yet understand. The economic imperative of smaller families is more and more the reality for the world's families. The roles and expectations of women are changing, even if slowly.

Finding Common Cause - Five Reasons to Work at it

Improving services for all: We at the Population Council are very proud of the work done by Judith Bruce and Anrudh Jain to set out this concept in a way that is based on the insistence of respect for women.

The six elements of our Quality of Care framework do offer protection against abuse:

[1] Choice of method must be provided. It refers to both the number and variability of methods provided, and the fact that those who wish to space and those who wish to limit may need different means.

[2] Information given to clients means enough information must be given to enable choice -information about the range, contraindications, advantages, side effects, what should be expected from service providers.

[3] Technical competence includes the observance of protocols, cleanliness, sufficient training IUDS, implants, and sterilization.

[4] Interpersonal relations - the personal dimensions of service, including no intimidation.

[5] Mechanisms to encourage continuity relies on follow-up mechanisms, home visits, managing continuation.

[6] Appropriate constellation of services refer to situating family planning services so they are convenient and help to meet pressing health needs - blending with post-partum, MCH, employee health programs, EPI and others.

Research has a continuing role to see how much or little existing services correspond to these desirable norms. There are research tools that do exactly this. It goes without saying that the norms must be developed locally - the norms of Calgary or Calcutta may not suit the situation in Chandigarh.

This framework has been the subject of extensive research, publication and documentation. There are situation analyses that check how well it is being applied. We should all use it, and press for its use. Accept no substitutes!

In Karnataka important change began six years ago which should be supportive of better quality of care. In elected bodies at the district, subdistrict and village levels, election proceeded through the normal process, but 1/3 of the places were reserved for women as well as dalits.

Evaluation of the impact of this program reveals that the attendance and performance of extension workers such as teachers, and health workers went up by almost 80%. Their masters, or users, were much more proximate. When users are paymasters, amazing, things happen.

The Panchayati Raj Constitutional amendment, generalized throughout this country, has the potential to improve local accountability, and therefore local service provision - on the ground research which includes monitoring can provide site to site comparisons which verify whether this is happening, and if not, why not.

We have to deal with how women are dealt with:

The truth of the matter is that feminists and those preoccupied with demographic pressures ought to be real allies. The reason: family planning will never be enough to meet demographic targets - we must go beyond family planning to find those sources of population growth which center on the role of women in Society.

The importance of Promoting Social Investment has been underplayed by the population community. For many years, the population field, (including the Population

Council), has been seen as identifying family planning, contraceptive use, as the primary means to achieve fertility decline.

We have not been wrong in this priority, but this priority alone is not sufficient. Put simply, meeting the unmet demand for family planning, though vital, is an inadequate approach. We must create conditions -- through selective, creative and ethically, sound social investment -- for women and couples to seek a lower number of surviving children. And these investments, if they are to find political constituents and acceptance by people in the highest fertility societies, must be help women; men and children today - not simply lay the foundation for a better life for the next generation.

Our task, though daunting, is easy to defend ethically as it calls on the adult generation to share more actively with their children. It calls for eliminating gender inequalities in schooling and the marketplace; it calls for a reduction in unproductive domestic labor; it calls for a far more equitable distribution of responsibilities in the family, especially with regard to the care of children.

We all have a stake in child survival - but let's include men, this time:

Child survival is something we want for itself. It also has proven logical links with demographic results. A high death rate among children and uncertainty among parents about the survival of children encourages high fertility in several ways. It makes the planning of families difficult, as there is always a fear that one or more children will die. Thus, the unpredictability and trauma of the death of the child, contributes to fatalism. (Fatalism can be seen in social terms as the opposite of participation, in the sense that fatalism brings about a withdrawal of participation in one's future.) The possibility that children will die also discourages parents' investment in their children's health and education, a perverse but very real effect. Parents, who feel "at risk", require excess births to insure the survival of a smaller number of children to adulthood.

The tremendous time costs of many child health strategies, especially to women, and the absence of efforts to draw on other family members, especially fathers, have been faults in current approaches. We cannot overlook the fact that an unequal value placed on children undermines parental willingness to participate. For example, in some countries, if the infant mortality rate among girls was equalized with that of boys, it would cut overall infant mortality by an appreciable portion.

When boys get care that girls don't get, it indicates that the community and the parents have the information they need and probably the resources, but not the will to act. Thus, policies and programs must deal with values, as well as practical strategies to insure child health and survival.

From a population and human welfare perspective, there is no compelling reason why the father-child link is any less important than the mother-child link. At the level of program, policy, and social debate, there must be discussion of the value of the father's role, the expectations of fathers and incentives for "good" fathering and sanctions for "poor" fathering.

Those who design maternal and child health programs and early childhood programs need to develop explicit expectations and supports for fathering. An oral re-hydration campaign, which included male imagery in its media, attracted the attention of the community better than those portraying the mother's role alone. Reproductive health and safe motherhood programs, have ample opportunities to draw on male partners -- in this, there are many missed opportunities. Making men into fathers and increasing their time and income investments in children could have a long-term impact, not only on gender equality, but also on children's well being and the satisfaction that men get from their lives

You can't get to demographic goals without a good deal more equality:

Next, there is the well documented and researched data which demonstrates that a desirable demographic outcome can be reached only when women are treated differently than they are now in most countries. Preferences for high fertility and the social and economic insecurity that underlie them are fundamental causes of high birth rates and rapid population growth. For us to reach the remaining way to replacement level fertility, women, on average, will need to bear 2 surviving children. Just as clearly, we have to go deeper into why most of the world's families still want more than 2 children. What we do know about the experience of other decades, other countries, and other families, suggests that we might help to create the conditions under which the number of children desired would fall, and fall quickly.

It should be remembered that the fertility transition which took place in Europe was without, the benefit of modern contraceptives. Virtually all the means available required male initiation and substantial male/female co-operation to obtain the desired end, whether it was through periodic abstinence or rudimentary forms of contraception.

Three things appear to have been happening: chances for child survival improved and economic development made children more costly. These two forces combined with strong social norms about family responsibility provided the incentive for the third factor -- men's co-operation in fertility limitation.

The inequalities with the greatest impact on fertility are gender inequality between men women, specifically between mothers and fathers; and inequality among children, especially inequality between boys and girls. In many societies, inequality in the roles of mothers and fathers, particularly with regard to the rights and responsibilities vis-a-vis children, promotes or sustains high fertility with a significant portions of unwanted. When partners disagree over the terms of sexual relations, contraceptives or disease protection, and numbers of children, the male is more likely to dominate.

There are differing incentives for men and women with regard to child numbers, the disproportionate burden on time and income expenditure for children women carry. Anyone studying comparative men and women's time budgets can clearly see the marked disparity. In many cultures, each additional child brings a measurable reduction in rest (and possibly health) to the mother. We have, for example, data from the Philippines, which indicates that men's time contribution is low and level from first to fifth child and actually declines after the sixth. This is not the case with women. Their is a heavy contribution from the beginning -- each infant requiring 10 hours of additional work per week -- each child under 6 measurably increases the time burden. Significant differences in the use of income between men and women have been revealed in recent research. Fathers and mothers often have contrasting expenditure priorities. Evidence suggests that mothers' spending is more child oriented. Either for reasons of self-interest or altruism, women typically devote the lion's share of their income to the welfare of others, principally their children.

Because men and women have markedly different time and financial obligations to children in some cultures, women hold a clear self-interest in limiting their fertility -- which men may not share. Inequality among children reflects inequality at the parental level, and independently works to sustain high fertility. Systematic evidence of discrimination against girls is measurable in distorted sex ratios. Parents' preferences for one type of child determine who survives infancy; they may make significantly different types of investment in living children. A few studies that have explored differences in educational outcomes for boys and girls in high fertility settings have found that the negative consequences of having many siblings -- or more specifically, younger siblings -- is much greater for girls than for boys. That is, girls that come from large families with large numbers of younger siblings are accorded much less education than their brothers.

Birth order is also a factor in differential care. Earlier born siblings may be expected to carry an extra burden of co-parenting younger siblings. Birth order interacts with gender. For example, in Taiwan the early-born children in large families do particularly poorly with respect to education, even worse if they are female. Foreshortened education and early marriage are often the fate of older girls from large families, with the result that patterns of early and high fertility are perpetuated and inter-generational inequality accentuated.

Put in the simplest terms, policies which seek to encourage parents to invest in children, must also understand that if families feel free to discriminate against some children, the goal of reduced family size may not be attained. A family that under conditions of equality could afford four children, under conditions of inequality may easily have six or seven.

This has some pretty serious consequences. It means that countries, which are serious about reaching demographic goals, have to take seriously the elimination of gender inequality. This can't just be a philosophy. It must be underpinned by a systematic set of policies and norms. Legal frameworks, which seem abstract to people's lives do, nonetheless, set norms. It is essential that development policies do not tie women's access to resources, including labor markets, to marital or sexual relationships with men or to their fertility status. That is, women should have rights not as mothers, daughters or sisters, but as citizens. Removal of gender bias from economic policy must include removing explicit and implicit constraints on women based on family or reproductive roles. Women, as individuals, must have rights to livelihoods on their own behalf if we want to reach our human and global goals.

Increasingly - in rich societies and in poor - the disadvantage women face will derive less from their gender than from their parenthood status. The imbalance between parents in economic and social responsibilities for children is becoming more serious, not less serious, in both industrialized and developing countries.

Something to Fight for Together - New Opportunities for Girls: There are no magic wands for any of these issue - but there is something that moves us further along than anything else we know about so far: universal primary school education. It works demographically in more than one way. Better primary school access has the effect of raising the cost of rearing children, but it also has the effect of preparing children for the emerging economies of their country and, indeed, the increasingly boundary-less international economy. In traditional societies with largely agricultural economies, children are a valuable source of labor.

The transition in their role is not absolute, as school-going children do clearly continue to contribute to family economies. As the nature of the child's contribution changes, so must the parents change their expectations of receiving returns on their young children's unskilled labor, to the expectation that they will become the beneficiaries in old age of the earnings of their skilled, educated children.

No one suggests this transition in thinking is unambiguous, straightforward, or easy to achieve, but policies, which promote universal primary school education, are closely linked with changes in parental and societal aspirations for children.

And school attendance has a powerful demographic effect. In 34 countries surveyed, girls with secondary education wanted 3.5 children on average. Girls with no education wanted 5. School - for the sake of our children, for the sake of our planet.

In the same vein - more opportunities for girls we have to get much more serious about stopping the "too early, too often" birth pattern that still persists in many places. It is not good for the young mothers, not good for the babies.

Later marriage in many societies could have as significant a demographic effect as the introduction of new contraceptives. Teenage pregnancy has a demographic effect, as well as an often, devastating human effect. The Safe Motherhood Initiative deplores that 500,000 women die each year from maternity related causes - a devastating effect on women, the family, and particularly young children; far too much of this is from too young motherhood.

We can devise effective and sensitive social reforms such as those that will encourage nontraditional roles for girls and boys or facilitate delayed marriages.

There have been many calls to increase the age of marriage for girls. There needs to be more, and the political and social leaderships need to be involved. Many countries have laws mandating ages of 17 and 18 for marriage that are regularly violated. But if we look to the local level, we will find some solutions to the complex task of giving reality to these laws. It is the local community, which is likely to provide guidance to the kind of social reforms that will empower girls to resist early marriage pressures from their families and society as a whole.

Educating a girl means valuing a girl. Educating a girl liberates the least empowered person in the family -- the youngest females -- from the heavy burdens assigned them in the domestic hierarchy.

Education enhances women's authority in their households and in their communities. In several high fertility traditional societies, women who have completed primary school and above about 3 children less than their unschooled moderately-schooled (1 to 3 years) counterparts. The observed reduction in marital fertility is linked to delayed marriage, effective contraceptive use and plausibly, the higher expectations held by, educated mothers for their children.

The educated woman as mother car, bargain for re resources for herself and her children; she can act on behalf of her girl as well as boy children, promote hygienic practices, and intelligently treat disease in Young, children. Thus, women with even a few years of education tend to have fewer child deaths than women with none.

Globally, a girl with secondary education typically marries at 21. A girl with none marries at 17. If the higher age were global there would be close to 1 billion fewer of us before our planet reached population stability. This is an astonishing figure.

In an effort to effect both short-term and long-term fertility as well as welfare, the Bangladesh government, with the support oil a consortium of donors is embarking on an ambitious primary education campaign for girls. The failure of Bangladeshi parents to send girls to school does not rest solely on a desire to keep their labor at home, but to protect their social status, both the girls' and the families'. In order to attract the participation of more girls in primary schools, the program aims to increase the number of primary schools, and to guarantee that each young girl lives within walking distance of a school.

More female teachers are being, trained -- as it is not acceptable in Bangladesh, and in many other Countries, for young girls to be taught by male teachers. The training of more female teachers has doubled the benefits. It offers employment for adult females and new roles for girls, as well as providing the necessary personnel to educate girl children. The third feature of the program is to subsidize the cost of books and related school fees for girls, but not for boys. This intervenes on the side of girls, and also to some extent on the side of parents. It recognizes that poor parents cannot educate all children without assistance -- that without subsidies, parents would tend to discriminate against female children.

From these examples we can draw several lessons. It is not enough for governments to mandate primary school education. They must offer facilities at convenient sites that are acceptably staffed; that many, parents in the poorest countries -- for the time being and maybe for the longer term -- will not be able to support the costs of educating children by themselves. The very poorest parents will not be able to forego the labor of all their children and to pay additional school fees. It may be necessary to create monetary incentives to afford parents the possibility of educating all their children especially girls, such as we see in the Bangladesh case.

Conclusion: Demographic Imperatives and Humanitarian Action

I think less conflict exists between demographic imperatives and humanitarian actions, than may seem, and I think research has a rich role in showing on a continuing basis that this is so.

We want girls and women in school. We want it because it will enhance their lives in immeasurable ways, and because if all young girls were in school, it would dramatically bring down population growth rates in both the numbers of children wanted, and the age of first childbirth.

We want later babies - to have healthier babies and less infant mortality, to give girls a chance to be educated, to find values; we want this because it could cause a decline in the maximum population the world will reach.

We want infant mortality to decline - because it is wrong that babies and young children should die, that families should suffer, and because there is no country on earth where fertility has declined before infant morality has fallen.

We want better quality of care because people should be well treated and given choices. This promotes more contraceptive prevalence, and therefore a better demographic outcome.

We want to meet unmet demand for family planning because it is wrong that women should have fertility which they do not want - as many as 26 million women in India put themselves in this category - this impedes them and their families from living better lives. Globally, if we met all of this unmet demand there would be a global difference of

almost 2 billion fewer in our future forecasts if we started to address these needs seriously.

We want to promote community-based participation in providing locally, acceptable health and family planning services. We need to increase the rate of inter-generational transfer of wealth from parents to children. Among the goals of a humane population policy are that men share in parenting, that women are freed from the overriding burden of parenting and granted independent livelihoods, and that children's needs, if not dominant over adults, are at least equitably met.

Broadening the constituency for effective and just population policies requires a spirit of inclusion and dialogue with political movements devoted to increasing women's status. We must achieve this by improving reproductive choice and health; I hope this afternoon will have contributed to that goal and I thank you for your attention.