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Getting to Replacement: Bridging the Gap between Individual Rights and Demographic Goals

Introduction

THE international family planning movement began forty years ago as a concern for individuals. The central premise and rationale of this movement was and is to enable couples, women in particular, to exercise control over their own reproduction.

However, beginning mainly in the 1960s, as governments became gradually more and more concerned about rapid population growth, the national perspective came to override the individual perspective. In Asia in particular, the explosive rate of population growth caused governments to worry increasingly about their ability to provide adequate levels of health, education and other social services, as well as to keep food production on a par with demographic increase. At the same time, governments worried that individual motivation to limit family size was not sufficient to produce a socially optimal demographic outcome. Demographers of the day were, for the most part, dubious that voluntary family planning programmes alone would be sufficient to stem the high rates of population growth (Davis 1967). Thus, the great debates of the 1960s and 1970s: development versus family planning; voluntarism versus direct interventions to influence reproductive behaviour. This debate, I think, was largely the result of ignorance—ignorance about how much fertility was unwanted and how much reproductive desires would change if family planning information and services were provided.

The pessimists, some of them famous names in demography and economics, developed strong and persuasive theories about why the poor and the uneducated, eking out a marginal existence, *should* want large families. Family planners, on the other hand, saw great demand wherever good services were available, but their position was less successful in the struggle for policy preeminence. The economic determinists carried the day at the Bucharest World Population Conference of 1974. Their pinion, that structural social and economic conditions must change if fertility is to decline, prevailed in the form of such phrases as 'development is the best contraceptive' and 'take care of the people and population will take care of itself.'

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The result was a general ambivalence about family planning on the part of many governments and a basic disposition to assume that population growth would decline in proportion to the extent that governments could achieve success in such development programmes as primary health care and basic education. Direct funding for family planning stagnated after 1974 as a result of this ambivalence. Family planning services did not spread as rapidly as they might have and the quality of those services was not as high as might have been. One could even argue that the period between 1974 and the present represents two lost decades of opportunity in the family planning field.

A few governments, pessimistic about the efficacy of family planning in reducing population growth rates and continuing to fear the consequences of rapid population growth, imposed population policies that were to a greater or lesser degree coercive. These policies, often implemented in clumsy and heavy handed ways, produced severe backlashes in a few places as citizen's organizations, women's groups in particular, reacted strongly to efforts to compel them to adopt particular methods of family planning. A revulsion against administratively set targets and field worker quotas emerged. Whichever approach was taken — social and economic development programmes that would reduce desired family size, or direct interventions to change reproductive behaviour — they were based on a lack of confidence about how people would behave given the option of high quality family planning services (Bruce 1981; Jain 1992).

[^]The World Fertility Survey and the Demographic and Health Surveys have changed things. These internationally comparable research programmes have shown that there is a high level of unwanted fertility in almost all countries. As a result of these survey programmes, it is no longer necessary for governments to operate in ignorance. They now have data available to them on unwanted fertility and on people's desire to control it. There is conclusive evidence of unmet need and unmet demand for family planning (Bongaarts, *et al.* 1990; Cleland and Wilson 1987).

At the same time that news about demand for family planning was spreading within the development community, the environmental movement, building up to the Earth Summit at Rio, was reawakening global calls for action on population growth. The environmental movement saw the rapid growth in human numbers as one of the fundamental factors that had to be addressed if environmental sustainability was to be achieved. But the concern of the environmentalists reawakened the fear of many of the groups that had suffered or become alarmed about the heavy handed demographic policies of the earlier era. After two decades of effort to sift the rationale for family planning from demographic to health objectives, and success in persuading governments to focus on the underlying poverty that gives rise to high desired family size, these groups feared that a new demographic imperative would produce another wave of coercive or top-down population policies and massive low quality family planning programme effort (Mazur 1992).

In the face of this concern about a renewed demographic agenda and with so much recent data on individual fertility preferences and desires available, I decided to see what the demographic results of meeting unmet need would be and to compare that with the demographic targets which governments have set I thought that if it is possible to show that meeting the goals of individual women and couples through voluntary family planning

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would produce the same or better results than striving to achieve targets set by governments, perhaps we could at long last find the common ground that has eluded us for so long.

Demand for family planning is measured by the now familiar concept of *unmet need*, originally defined by Charles Westoff and Luis H. Ochoa (1991): the percentage of fecund women of reproductive age who say that they want no more children, wish to space the next birth or did not want their current pregnancy, and who are not presently using a method of family planning. (There is disagreement over how accurate a measure of unmet need this is). Bongaarts (1991) has shown that the number of such women who are actually in need of family planning services may be overestimated by this measure which includes pregnant and amenorrheic women because, they may, in fact, have had no desire to prevent pregnancy. Ross, on the other hand, points out that it may *underestimate* demand by omitting those often excluded from surveys: the unmarried, current users who want a better method, users of failure-prone methods, the ambivalent, etc. In any case, the measure has the advantage of being comparable across countries and, in a general sense, being representative of the size of the potential clientele for family planning services beyond those women (and men) already being reached.

The paper attempts to calculate what the demographic effect would be in each country if unmet need were satisfied immediately. For countries for which the information is available, this estimate is then compared with the targets stipulated by the government, converted where necessary to prevalence of contraceptive use (i.e., if targets are stated in terms of fertility or population growth rates, they are converted to the proportion of couples who would need to be practicing family planning in order to achieve those demographic outcomes).

We then look at global estimates of unmet need as a measure of the total demand for family planning beyond the 51% prevalence calculated by Bongaarts, Mauldin and Phillips (1990) in 1990 for the world as a whole. Achieving the UN median variant projection of population is stipulated as a target in the Amsterdam Declaration of 1989. This translates, in the Declaration, into a contraceptive prevalence of 56% by 2000. It should be noted, however, that there is of course no real global target since each country must be free to set its own objectives. Therefore, the global figure is taken as a proxy for the sake of comparison with the analysis at the national level.

Present Trends in Fertility and Contraceptive Use

From Figure 1 it can be seen that overall contraceptive use in the developing countries has expanded dramatically since 1960 but that the total number of women not using any form of contraception has declined only slightly because of the enormous expansion in the number of women in the reproductive age groups. Projections to the year 2010 show that, even though the number of women estimated to be using contraception again expands quite dramatically, the number of women not using contraception also increases substantially. This illustrates the enormous need for contraceptive coverage if replacement level fertility is even to be approached in the first quarter of the next century. Figure 2 shows the proportions of all women who want no more children or wish to space the next birth who

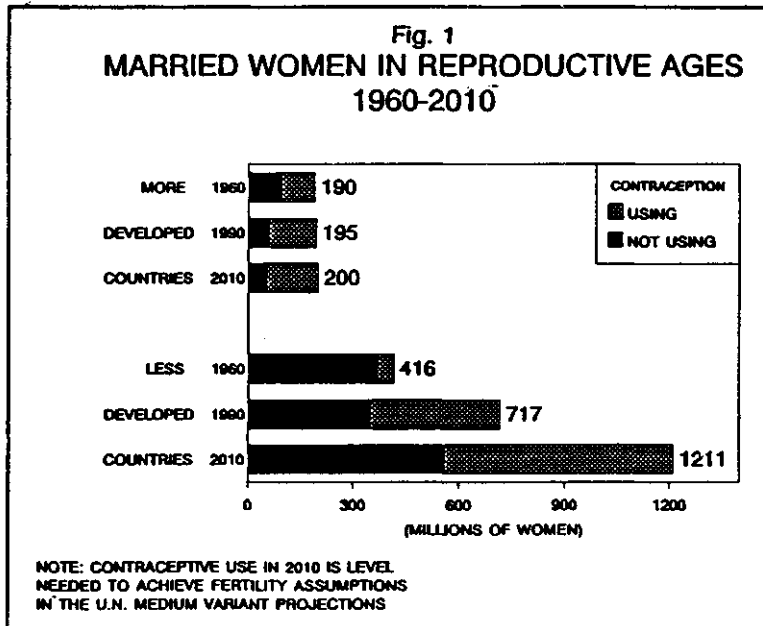


Fig. 1. Married Women in Reproductive Ages 1960-2010.

are and are not currently using contraception. As can be seen, sub-Saharan Africa lags far behind Asia, North Africa and Latin America in the proportion of unmet need. It is also interesting to note that the proportion of women with unmet need increases with fertility, suggesting that younger women with fewer children are more likely to be users of family planning than older women who already have many children. Figure 3 shows the decline in fertility that can be expected five years after the Demographic and Health Survey was carried out in the countries listed, as a result of respondents' statements about future intentions. As can be seen, despite the relatively high fertility rates in Africa, a number of countries show significant prospective declines in fertility on the basis of women's statements about desired future fertility. Indeed, some of the African countries (e.g. Kenya, Mali, Togo and Uganda) show prospective declines that equal or exceed those of lower fertility countries in which family planning services and information are already much better established, like those in North Africa and Latin America. (The prospective declines in Asia are quite low because of the already comparatively very high contraceptive use and low fertility rates in those countries.)

Figure 4 shows the relationship between fertility and development, and demonstrates that the gap between actual fertility and stated desired fertility is constant at different levels of development. It is noteworthy both that desired and observed fertility decline sharply with

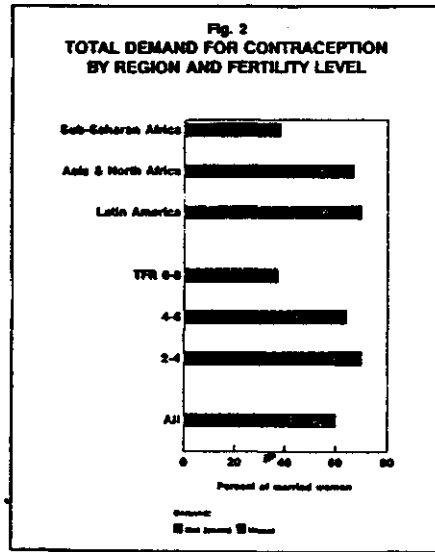


Fig. 2. Total Demand for Contraception by Region and Fertility Level.

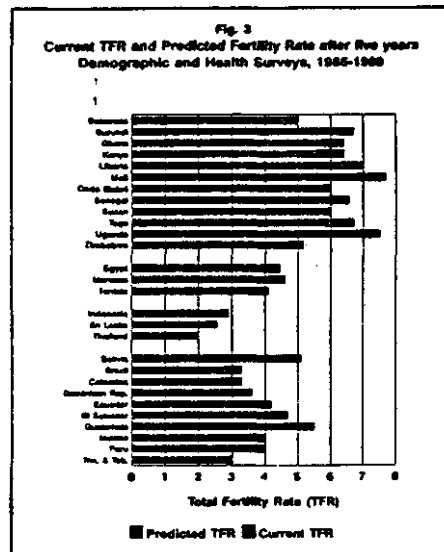


Fig. 3. Current TFR and Predicted Fertility Rate after Five Years Demographic and Health

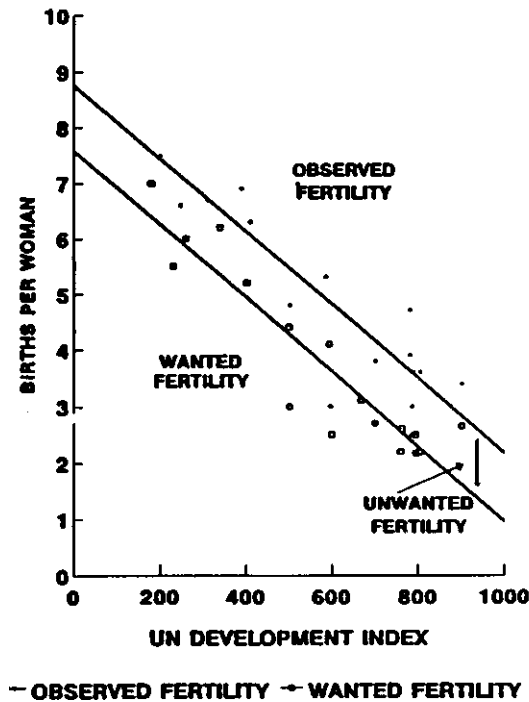
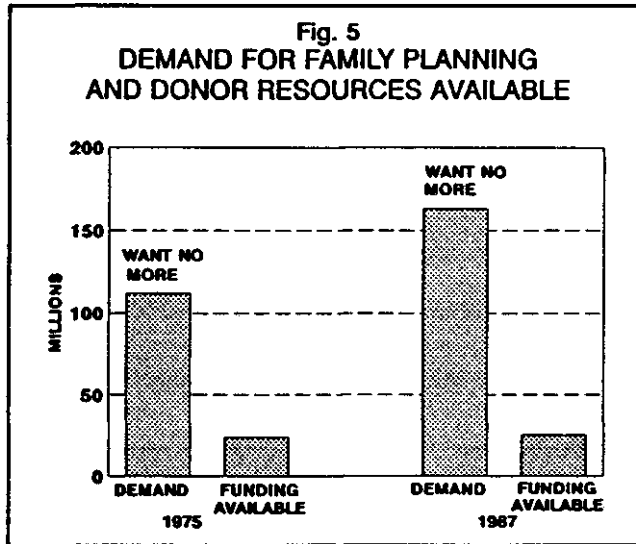


Fig. 4. Wanted and Observed TFR by Level of Development (18 DHS Countries).

level of development and that the extent of unwanted fertility remains relatively constant across the entire development spectrum. This suggests that some level of demand for family planning exists at all levels of development. Finally, Figure 5 shows the rather significant increase in the number of women worldwide who are estimated to want no more children between 1975 and 1987. While the number who indicate they want no more is only a partial measure of the demand for family planning (it excludes those who use family planning for spacing purposes, a particularly important factor in Africa), the increase of 50 million women over the twelve year period demonstrates a strong increase in the need for family planning, while the funding available has remained virtually stagnant in 1975 dollars. In other words, nominal increases in total funding have been offset by inflation over the twelve year period.

Satisfying Unmet Need versus Achieving Targets: The Evidence

Table 1 lists 12 of the 29 countries of the developing world which, according to UN compilations, have quantitative demographic targets. These 12 have conducted Demographic and Health Surveys recently so that the estimated unmet need for family planning could be calculated. The last column compares the demographic targets with the unmet need



/ Fig. 5. Demand for Family Planning and Donor Resources Available.

for these 12 countries. A negative number indicates that the satisfaction of unmet need would result in a contraceptive prevalence rate higher than that which would be achieved by meeting the demographic target. For example, in Tunisia where the target CPR was 51% in 1991 and the actual CPR was nearly 50%, meeting the target would have resulted in an increase in prevalence of 1 %, whereas satisfying unmet need would have resulted in a 15.7% increase in the contraceptive prevalence rate. Thus, the figure in column five is minus 14.5. In 9 of the 12 countries, satisfying unmet need would exceed the government established targets by amounts ranging from 7.9% to 40.9%. In India, the unmet need figure is based only on desire to terminate childbearing. If spacing had been included, it is almost certain that satisfying unmet need would exceed target prevalence. Thus only Nigeria and Ghana have targets whose realization would require more than simply satisfying expressed need for family planning, and both of these are countries where service availability is still severely constrained.

The attempt was then made to look at the issue on a more global basis. We began by calculating the total number of married women of reproductive age in the developing countries which, including China, we calculated to be approximately 716 million. Including China, Mauldin (1991) estimated that 51% of these women were using some form of contraception in 1990. That would represent 365 million women currently using contraception, and 351 million not using contraception. Bongaarts estimates, including China, approximately 17% of the women in the developing world presently have an unmet need for contraception (compared with earlier estimates of 21 % using Westoff's more liberal

TABLE 1 : COMPARISON OF TARGETS AND UNMET NEED

<i>Country</i>	<i>Target¹</i>	<i>Year</i>	<i>TFR</i>	<i>CPR</i>	<i>Unmet need</i>	<i>CPR Effect of Achieving Target vs. Meeting Unmet Need</i>
Bangladesh	CPR 40 by 1990	1991	4.9	39.9	41.02	-40.9
Botswana	CPR 15 by 1985	1988	4.9	33.0	26.92	-26.9
Dom Rep	CPR 57 by 1986	1991	3.3	56.4	15.03	-14.4
Egypt	CPR 60 by 2000	1991	4.38	47.6	25.22	-12.8
Ghana	TFR 4 by 2000 (CPR 45.8)	1988	6.41	12.9	26.63	+6.2
India	CPR 60 by 2000	1988-89	4.2	40.1	18.34	+1.6
Indonesia	CBR 23 by 1990 (CPR 54.8)	1991	3.02	49.7	13.03	-7.9
Kenya	TFR 5.2 by 2000 (CPR 42.3)	1988-89	6.50	26.9	28.93	-13.5
Nigeria	TFR 4.0 by 2000 (cpr 45.8)	1990	6.01	6.0	20.82	-19.0
Pakistan	CPR 16.6 by 1988	1990-91	5.9	11.9	28.02	-23.3
Peru	TFR 3.0 1995-2000 (CPR 60.9)	1991-92	3.54	59.0	59.03	-20.8
Tunisia	CPR 51 by 1991	1988	4.30	49.8	15.73	-14.5

*Figure includes only those who want no more children and are not using contraception. It does not include respondents who wish to space or defer the next birth.

¹Where TFR was given as a target, the CPR was calculated using the formula $(TFR = 7.03 - 0.0662 \text{ Prevalence})$. Where CBR was given as a target, the CPR was calculated using the formula $(CBR = 46 - 0.042 \text{ Prevalence})$.

²Westoff and Ochoa (1991).

³Bongaarts (1991).

⁴Family Planning Practices in India. *Third All-India Survey* (1988-1989) Operations Research Group.

estimate), If one assumes that there is no unmet need in China, we ought to lower the Bongaarts figure by the proportion that China represents of the reproductive age population of the developing world. This yields an unmet need of 12% — a very conservative estimate indeed. Bongaarts and others estimate that a 15% increase in contraceptive prevalence will produce approximately a one point decline in the total fertility rate. If we apply the 12% figure of unmet need this would result in a .87 decline in the TFR from the present level of 3.9 for the developing countries as a whole. The result would be a total fertility rate, if the 12% unmet need were satisfied, of 3.03 children. Thus, even using this conservative estimate

of unmet need, it appears that the satisfaction of unmet need would result in a decline from just under 4 to just over 3 children per woman, or a decline of 50% between present fertility and replacement level fertility. Certainly, if one used the more liberal estimate of 15% to 17% unmet need, the result would be even more dramatic. While the figure would still be significantly higher than replacement level, if one also assumes that the desire to limit or space births would continue to grow as a percentage of the total number of women at risk of pregnancy, one could even suppose that the satisfaction of unmet need over the remainder of the century could cut the total fertility rate to as low as 2.8 children. Indeed, Mauldin estimates that if current programmes satisfied 85% of the unmet need, the TFR would equal the UN *low* population variant projection by 2000: 2.855.

Implications

While the analysis summarized above is very rough and preliminary, it strongly suggests that very significant demographic impact would result from family planning and reproductive health programme efforts that attempted no more than to satisfy the stated reproductive wishes of the women of the developing world. The analysis strongly suggests that such an approach would equal or exceed what could be accomplished by achieving stated demographic targets of most countries. The policy implication is clear: abandon the use of demographic targets and express the objectives of family planning programmes solely in terms of achieving a fully satisfactory response to the stated desires of women and couples. This does not, by any means, suggest that the provision of family planning services is the only thing that needs to be done to achieve replacement level fertility and eventual population stabilization. Clearly, continued intensive efforts to alleviate poverty, raise living standards, and improve the conditions for women in the developing countries will be required before desired family size coincides with replacement level fertility. But, it is equally clear that intensive investments in extending the provision of family planning and reproductive health services to all who have stated a desire or need for those services would carry the world a very long way toward replacement level fertility while efforts to promote social and economic progress continue to create the conditions which are conducive to smaller desired family size. (It is likely that enhancing the quality of such services will, itself, stimulate increased demand for them. There is substantial evidence to support such optimism.)

In short, while it is quite appropriate for countries to set long term demographic objectives in the context of a comprehensive development strategy (one that includes raising literacy, educational opportunities for women, lower infant mortality, improved maternal and child nutrition, etc.), it is neither desirable nor necessary for those objectives to be applied as targets for the provision of family planning and reproductive health services because of the potential for abuses of human rights that such short term targets could produce. This preliminary analysis very strongly suggests that there is no conflict between satisfying individual needs and achieving social objectives. That should come as very good news to those who fear that targets would result in abusive family planning and to those who, more generally, favour user oriented, demand-driven social service programmes.

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