QDD.

A Question of Development

Syntheses AFD studies and research

JUNE 2020 | N° 46

Population, Demographic Growth, and Development in the South

A historical perspective on population policies as a factor for economic development

Seven countries of the South are regularly cited for the population policies they implemented to navigate the demographic transition: Bangladesh, Mexico, Tunisia, Ethiopia, Kenya, Malawi, and Rwanda. Comparing these policies helps highlighting their distinctive features as well as the good practices they have in common pertain family planning.

Population growth management policies as development tools

A shift in demographic perspectives

Initially, most nation states in the South were somewhat in favor of (or indifferent to) population growth; since the mid-twentieth century, however, health progress have led to a significant decline in mortality. These countries have experienced very high population growth. Many countries have chosen to focus on socio-economic development, thus aiming to curb population growth through fertility control. To do so, there are direct measures—such as promoting access to family planning as well as information, education, and outreach campaigns aiming to raise awareness or act on the desire for children—and indirect policies (not always linked to population policies)—such as promoting women's rights, raising the legal age for marriage, and ensuring gender-equal inheritance.

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Key figure

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Seven countries in the South have successfully completed their demographic transition thanks to integrated family planning programs

Between coercion and respect for human rights

Even though the 1960s and 1970s were sadly marked by coercive policies in Asia and South America, population policies contribute to the well-being of families and the general population when they are based on respect for human rights. Family planning access and promotion must be integrated into the healthcare system and designed as part of a framework of consistent and multisectoral action. Some countries have successfully supported their demographic transition process with more integrated family planning programs. Seven of these are regularly highlighted in the literature: Bangladesh in Asia, Mexico in Latin America, Tunisia in North Africa, but also more recently Ethiopia, Kenya, Malawi and Rwanda in Sub-Saharan Africa.

Varied political dynamics

The governments of these seven countries all share a strong concern regarding population growth, despite different time frames and geopolitical situations. This concern stems from the awareness of the lack of resources needed to ensure the supply of labor and infrastructure development, as well as that of increasing land pressure, leading to soil erosion, land fragmentation, and overgrazing. In all these countries, controlling population growth has become a tool for development. Such vision of development has been promoted since independence by the political leaders of Tunisia (1954) and Bangladesh (1971). In other countries, support came much later (for instance, in 1993 in the case of Ethiopia), spurred on by international debate. In Mexico, the government was clearly influenced by Latin American economists and demographers at the very end of the 1970s. International agencies (the United Nations), the World Bank and the International Monetary Fund, as well as development cooperation agencies from the North, have also strongly encouraged and supported government initiatives on this matter, especially in the four African countries discussed here. Concurrently, the medical profession and civil society, direct witnesses of the dramatic consequences of the burden of repeated maternities, were also often mobilized to improve access to reproductive health and to education. Civil society organizations were pioneers in the matter and their actions were later supported by the international community.

What kind of public population policies have been enacted?

The support or, failing that, the non-interference of religious institutions

In all of these countries, even before the promulgation of a comprehensive population policy, nationwide consensus has had to be reached; governments have had to ensure that other institutions, especially religious groups, were involved in the actions taken, or at least that they were unable to oppose them. For instance, in Tunisia, H. Bourguiba highlighted the compatibility of family planning with Islam. In Mexico, the Catholic church had assured it would not oppose family planning programs. Rwanda proceeded differently and deployed legal means to prevent religious institutions from obstructing its policies.

Institutional strength as a foundation for the national deployment of family planning

All the countries studied have invested in their infrastructure. They have created institutes and tools to measure population trends, allowing them to set certain goals. Bangladesh and Rwanda have had to rebuild their healthcare system following a civil war, and have also taken the opportunity to try promoting family planning. The countries under review have all worked to achieve several prerequisites in terms of the healthcare system, such as training enough health professionals on a continual basis, or putting in place supply systems for contraceptive products to avoid any risk of shortages. Three strategies have proved critical to ensuring access to family planning among the whole population: (1) systematically creating family planning services in all healthcare facilities; (2) implementing outreach actions (such as community health systems, door-to-door canvassing…) in order to reach the most vulnerable and geographically remote populations; and (3) minimizing costs or even ensuring free family planning in order to overcome barriers to use. The sustainability of these schemes is essential, at the risk of seeing these efforts come to a halt, as they did in Malawi when contraceptive prevalence dropped after public subsidies ended. The collaboration of governments with the private sector and the non-profit sector has proved crucial in most of these countries, as has the financial and technical support of international or cooperation institutions.

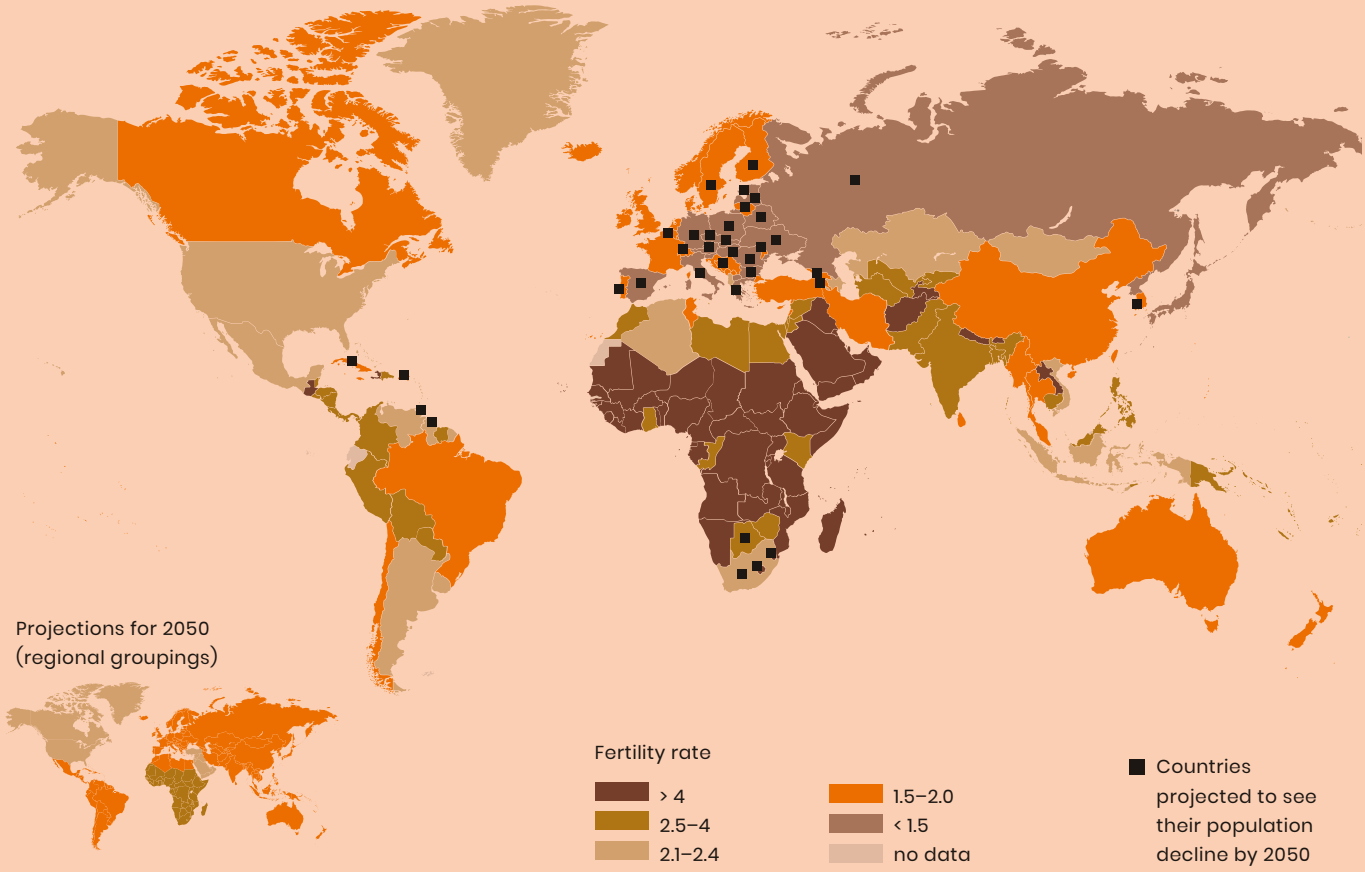
Multisectoral collaboration is a condition for achieving the objectives set by population policies

In addition to health ministries, which are generally responsible for the integration of family planning with maternal and child healthcare issues and sexual and reproductive health policies, other ministries have also addressed these questions in all countries under review. Since the International Conference of Population and Development of Cairo (ICPD) held in 1994, health ministries have also incorporated sexual and reproductive health (combating HIV-AIDS and other sexually-transmitted diseases) among their objectives. At the same time, other ministries have integrated policies promoting women's rights (education, prevention of all form of violence).

Information, education and communication (IEC) campaigns as intervention strategies

The generalization of healthcare services in all the 7 countries went hand in hand with information campaigns about existing methods. These campaigns aimed to raise public awareness of population issues and to convey new desirable family models. In addition, some countries strove to involve men and to improve access for young and unmarried populations—Niger's "school for husbands" is one such example.

Map 1 — World fertility patterns



Sources: UN, US Census Bureau, adapted from *Alternatives économiques*

The development of women's rights is an essential but indirect determinant of fertility

In addition to family planning, sexual and reproductive rights and women's rights in general have undergone profound change in all countries under review. Significant efforts were deployed in order to improve the education level of women and enable them to participate in labor markets, thereby giving them more influence in decisions regarding number of children and birth spacing, as well as delaying the age of first marriage and first birth. Inheritance rights remain fraught with inequality in Tunisia and Bangladesh, where males are favored over females, making mothers dependent on having male descendants.

Access to voluntary termination of pregnancy is still unfinished business

The question of access to abortion was not treated equally among the countries under review. The only country allowing abortion without restriction up to twelve weeks is Tunisia. Nevertheless, access to voluntary termination of pregnancy as well as contraception is currently losing momentum in this country. In Mexico, abortion was only liberalized in the state of Mexico. Other countries have bypassed unrestricted legalization by securing certain types of abortion: in Ethiopia, abortions are allowed in cases of rape, and any woman invoking this reason is provided with access to abortion services, whereas in Bangladesh, abortion is technically illegal but women are allowed to terminate early pregnancies through menstrual regulation.

Developing sustainable population policies remains a long and winding path

The focus on vulnerable populations cannot be taken for granted

Beyond the measures adopted, the common point between these different policies is probably that they persisted over several decades and that investments were made in better governance mechanisms. In this sense, research in Mexico and Ethiopia shows that the first populations to feel the impact of policies are the most underprivileged (who do not have access to any alternative resources to regulate their fertility). Yet the policies were not quick or easy to implement in any of the countries. Neither are they immune to being challenged, as is currently the case in Tunisia.

The limitations of demographic "planning"

Our comparative work highlights a number of lessons. In particular, we note that the demographic objectives initially set were often unrealistic and overly ambitious. Often, targets did not take into account the age structure of populations, for instance, which not only means that population growth linked to the sheer numerical size of cohorts of reproductive age was not anticipated, but also that no preparations were made for an aging population.

Between state will and individual will, it remains difficult to confirm that individuals in these countries had given their full consent for the use of contraception. Some occurrences of human rights violations such as coerced sterilization or IUD placement have been observed. When it comes to matters of law, the choice of targets is important: for instance, it is better to prioritize unmet needs in contraception rather than to impose a target contraceptive prevalence rate, insofar as the former approach takes into account the fertility wishes of individuals, which vary from country to country.

The articulation between population policies and development remains to be questioned

Finally, in these countries, outcomes did not always correspond to the development vision that had been initially envisioned as a rationale for the population policies. Indeed, despite its fertility rate of 2.2 children per woman, Bangladesh remains one of the poorest countries in the world. Meanwhile, Mexico has experienced an increase in inequality and structural readjustment policies have resulted in drastic budget cuts to healthcare funds while the pension system shifted the emphasis to savings and family solidarity. Certain countries, Mexico among them, now acknowledge that small families do not fare better economically than large families. In African countries in particular, social safety nets are provided by the extended family network. In order to avoid increasing inequality, reducing family size must go hand in hand with the implementation of a continuum of complementary public policies that articulate the concrete commitment of authorities to the demographic agenda. Priority must be given to a truly egalitarian education from primary school to university, the promotion of reproductive health and family planning, as well as, lastly, the achievement of conditions for the employability of young people and women and the assurance of minimal protection to help them escape poverty traps.

Photo 1 - A family planning poster in Lalibela, Ethiopia

Photographic credit: CC-BY-SA, Maurice Chédel

References

Casterline J. B. (2017), "Prospects for fertility decline in Africa", *Population and Development Review*, 43(51): 3–18.

Cosio-Zavala M. E. (2006), "Politiques de population au Mexique" in Caselli G. *et al.* (ed.), *Histoire des idées et politiques de population, tome VII. Démographie. Analyse et synthèse,* Paris, INED, p. 625–646.

Guengant J. -P. (2011), *Impact des politiques de population sur les politiques sectorielles et les évolutions démographiques au Burkina Faso, au Mali et au Niger,* POPPOV Research Network, 5th conference on research on demographics, reproductive health and economic development, Marseille, France.

Haliemariam A. (2016), "Implementation of the Population Policy of Ethiopia: Achievements and Challenges", *Population Horizons*, (13):1:19–30.

Hardee K. and E. Leahy (2008), "Population, Fertility and Family Planning in Pakistan: A Program in Stagnation", *PAI Research Commentary*, Volume 3, Issue 3.

World Bank (2016), "What five Sahel countries learned from Bangladesh about strengthening population policies". http://www.worldbank.org/en/news/feature/2016/06/23/what-five-sahel-countries-learned-from-bangladesh-about-strengthening-population-policies. Accessed on 21 December 2019.

Publication Director Rémy Rioux
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Design and production Eric Thauvin

Agence française de développement (AFD)
5, rue Roland Barthes | 75012 Paris | France
Legal deposit 2nd quarter 2020
ISSN 2428-8926 | © AFD
Printed by AFD's reprography service

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