

## IS THERE A POPULATION IMPLOSION?



Nicholas Eberstadt's article in the March-April 2001 issue of Foreign Policy entitled "The Population Implosion" touched off a minor sensation among those in the fields of population policy and demography. In the article, Eberstadt argued that the contemporary era of global "population explosion," in which world population had nearly quadrupled in a century, is ending. He also questioned the wisdom of ongoing efforts to depress birthrates, arguing that "the continuing preoccupation with high fertility and rapid population growth has left the international population policy community poorly prepared to comprehend (much less respond to) the demographic trends emerging around the world today"—namely, subreplacement fertility patterns, the aging of many societies, and intensive and prolonged mortality crises such as HIV/AIDS.

The Environmental Change and Security Project invited Dr. Eberstadt and five other population professionals (Stan Bernstein of the United Nations Population Fund; Carmen Barroso of the MacArthur Foundation; Amy Coen of Population Action International; Sonia Corrêa of the Brazil Institute of Social

and Economic Analysis; and Parfait M. Eloundou-Enyegue of Cornell University) to participate in an on-line forum on the state of demographic trends and population policy. Using "The Population Implosion" as a catalyst, we wanted the forum to address questions such as: Should population growth continue to be considered a pressing international issue? How should we interpret the mixed messages in recent statistics and projections about the population growth rate? Has the recent success in bringing growth rates down led to a false sense of security and a resultant decline in family planning funding? What is the importance of demographic shifts in some developed countries? Should those countries, in fact, be promoting higher birth rates?

The resultant debate was erudite, passionate, and quite illuminating. A transcript of the forum's postings follows excerpts from Dr. Eberstadt's article.

## Excerpts from "The Population Implosion"

By Nicholas Eberstadt

It may not be the first way we think of ourselves, but almost all of us alive today happen to be children of the "world population explosion"—the momentous demographic surge that overtook the planet during the course of the 20th century. Thanks to sweeping mortality declines, human numbers nearly quadrupled in just 100 years, leaping from about 1.6 or 1.7 billion in 1900 to about 6 billion in 2000.

This unprecedented demographic expansion came

to be regarded as a "population problem," and in our modern era problems demand solutions. By century's end, a worldwide administrative apparatus—comprised of Western foundations and aid agencies, multilateral institutions, and Third World "population" ministries—had been erected for the express purpose of "stabilizing" world population and was vigorously pursuing an international antinatal policy, focusing on low-income areas where fertility levels remained relatively high.

To some of us, the wisdom of this crusade to depress birthrates around the world (and especially among the world's poorest) has always been elusive. But entirely apart from its arguable merit, the continuing preoccupation with high fertility and rapid population growth has left the international population policy community poorly prepared to comprehend (much less respond to) the demographic trends emerging around the world today—trends that are likely to transform the global population profile significantly over the coming generation. Simply put, the era of the worldwide “population explosion,” the only demographic era within living memory, is coming to a close.

Continued global population growth, to be sure, is in the offing as far as the demographer's eye can see. It would take a cataclysm of biblical proportions to prevent an increase in human numbers between now and the year 2025. Yet global population growth can no longer be accurately described as “unprecedented.” Despite the imprecision of up-to-the-minute estimates, both the pace and absolute magnitude of increases in human numbers are markedly lower today than they were just a few years ago. Even more substantial decelerations of global population growth all but surely await us in the decades immediately ahead.

In place of the population explosion, a new set of demographic trends—each historically unprecedented in its own right—is poised to reshape, and recast, the world's population profile over the coming quarter century. Three of these emerging tendencies deserve special mention. The first is the spread of “subreplacement” fertility regimens, that is, patterns of childbearing that would eventually result, all else being equal, in indefinite population decline. The second is the aging of the world's population, a process that will be both rapid and extreme for many societies over the coming quarter-century. The final tendency, perhaps the least appreciated of the three, is the eruption of intense and prolonged mortality crises, including brutal peacetime reversals in health conditions for countries that have already achieved relatively high levels of life expectancy.

For all the anxiety that the population explosion has engendered, it is hardly clear that humanity will be better served by the dominant demographic forces of the post-population-explosion era. Nobody in the world will be untouched by these trends, which will have a profound

impact on employment rates, social safety nets, migration patterns, language, and education policies. In particular, the impact of acute and extended mortality setbacks is ominous. Universal and progressive peacetime improvements in health conditions were all but taken for granted in the demographic era that is now concluding; they no longer can be today, or in the era that lies ahead.

### THE GLOBAL BABY BUST

The world's population currently totals about 6 billion, rather than 9 billion or more, because fertility patterns also changed over the course of the 20<sup>th</sup> century. And of all those diverse changes, without question the most significant was secular fertility decline: sustained and progressive reductions in family size due to deliberate birth control practices by prospective parents...

Indeed, subreplacement fertility has suddenly come amazingly close to describing the norm for childbearing the world over. In all, 83 countries and territories are thought to exhibit below-replacement fertility patterns today. The total number of persons inhabiting those countries is estimated at nearly 2.7 billion, roughly 44 percent of the world's total population.

Secular fertility decline originated in Europe, and virtually every population in the world that can be described as of European origin today reports fertility rates below the replacement level. But these countries and territories today currently account for only about a billion of the over 2.5 billion people living in “subreplacement regions.” Below-replacement fertility is thus no longer an exclusively—nor even a predominantly—European phenomenon. In the Western Hemisphere, Barbados, Cuba, and Guadeloupe are among the Caribbean locales with fertility rates thought to be lower than that of the United States. Tunisia, Lebanon, and Sri Lanka have likewise joined the ranks of subreplacement fertility societies...

The largest concentration of subreplacement populations, however, is in East Asia. The first non-European society to report subreplacement fertility during times of peace and order was Japan, whose fertility rate fell below replacement in the late 1950s and has remained there almost continuously for the last four decades. In addition to Japan, all four East Asian tigers—Hong Kong, the Republic of Korea, Singapore, and Taiwan—have

---

*These excerpts, figures, and tables from Nicholas Eberstadt's article “The Population Implosion” are reproduced with permission from FOREIGN POLICY 123 (March/April 2001). Copyright 2001 by the Carnegie Endowment for International Peace.*

---

reported subreplacement fertility levels since at least the early 1980s. By far the largest subreplacement population is in China, where the government's stringent antinatal population control campaign is entering its third decade.

The singularity of the Chinese experience, however, should not divert attention from the breadth and scale of fertility declines that have been taking place in other low-income settings. A large portion of humanity today lives in countries where fertility rates are still above the net replacement level, but where secular fertility decline is proceeding at a remarkably rapid pace...

The remarkable particulars of today's global march toward smaller family size fly in the face of many prevailing assumptions about when rapid fertility decline

is striking for the absence of broad, obvious, and identifiable socioeconomic thresholds or common preconditions. (Reviewing the evidence from the last half-century, the strongest single predictor for any given low-income country's fertility level is the calendar year: The later the year, the lower that level is likely to be.) If you can find the shared, underlying determinants of fertility decline in such disparate countries as the United States, Brazil, Sri Lanka, Thailand, and Tunisia, then your Nobel Prize is in the mail.

Two points, however, can be made with certainty. First, the worldwide drop in childbearing reflects, and is driven by, dramatic changes in desired family size. (Although even this observation only raises the question

---

**What accounts for the worldwide plunge in fertility now underway? The honest and entirely unsatisfying answer is that nobody really knows—at least, with any degree of confidence and precision.**  
—Nicholas Eberstadt, “The Population Implosion”

---

can, and cannot, occur. Poverty and illiteracy (especially female illiteracy) are widely regarded as impediments to fertility decline. Yet, very low income levels and very high incidences of female illiteracy have not prevented Bangladesh from more than halving its total fertility rate during the last quarter-century. By the same token, strict and traditional religious attitudes are commonly regarded as a barrier against the transition from high to low fertility. Yet over the past two decades, Iran, under the tight rule of a militantly Islamic clerisy, has slashed its fertility level by fully two-thirds and now apparently stands on the verge of subreplacement. For many population policymakers, it has been practically an article of faith that a national population program is instrumental, if not utterly indispensable, to fertility decline in a low-income setting. Iran, for instance, achieved its radical reductions under the auspices of a national family planning program. (In 1989, after vigorous doctrinal gymnastics, the mullahs in Tehran determined that a state birth control policy would indeed be consistent with the Prophet's teachings.) But other countries have proven notable exceptions. Brazil has never adopted a national family planning program, yet its fertility levels have declined by well over 50 percent in just the last 25 years.

What accounts for the worldwide plunge in fertility now underway? The honest and entirely unsatisfying answer is that nobody really knows—at least, with any degree of confidence and precision. The roster of contemporary countries caught up in rapid fertility decline

of why personal attitudes about these major life decisions should be changing so commonly in so many disparate and diverse locales around the world today.) Second, it is time to discard the common assumption, long championed by demographers, that no country has been modernized without first making the transition to low levels of mortality and fertility. The definition of “modernization” must now be sufficiently elastic to stretch around cases like Bangladesh and Iran, where very low levels of income, high incidences of extreme poverty, mass illiteracy, and other ostensibly “nonmodern” social or cultural features are the local norm, and where massive voluntary reductions in fertility have nevertheless taken place.

#### **SEND YOUR HUDDLED MASSES ASAP**

The natural growth of population in the more developed countries has essentially ceased. The overall increase in population for 2000 in these nations is estimated at 3.3 million people, or less than 0.3 percent. Two thirds of that increase, however, is due to immigration; the total “natural increase” amounts to just over 1 million. Over the coming quarter century, in the U.S. Census Bureau's projections, natural increase adds only about 7 million people to the total population of the more developed countries. And after the year 2017, deaths exceed births more or less indefinitely. Once that happens, only immigration on a scale larger than any in the recent past

can forestall population decline...

The issue clearly will not be supply, but rather demand. Will Western countries facing population decline opt to let in enough outsiders to stabilize their domestic population levels? Major and sustained immigration flows will entail correspondingly consequential long-term changes in a country's ethnic composition, with accompanying social alterations and adjustments. Such inflows will also require a capability to assimilate newcomers, so that erstwhile foreigners (and their descendants) can become true members of their new and chosen society...

### A GREY WORLD

The world's population is set to age markedly over the coming generation: The longevity revolution of the 20th century has foreordained as much. The tempo of social aging, however, has been accelerated in many countries by extremely low levels of fertility...

Population aging will be most pronounced in today's more developed countries. By the U.S. Census Bureau's estimates, the median age for this group of countries today is about 37 years. In 2025, the projected median age will be 43. Due to its relatively high levels of fertility and immigration (immigrants tend to be young), the population of the United States is slated to age more slowly than the rest of the developed world. By 2025, median age in the United States will remain under 39 years. For the rest of the developed world, minus the United States, median age will be approximately 45 years. And for a number of countries, the aging process will be even further advanced...

Population aging, of course, will also occur in today's less developed regions. Current developed countries grew rich before they grew old; many of today's low-income countries, by contrast, look likely to become old first. One of the most arresting cases of population aging in the developing world is set to unfold in China, where relatively high levels of life expectancy, together with fertility levels suppressed by the government's resolute and radical population control policies, are transforming the country's population structure. Between 2000 and 2025, China's median age is projected to jump by almost 9 years. This future China would have one-sixth fewer children than contemporary China, and the 65-plus population would surge by over 120 percent, to almost 200 million. These senior citizens would account for nearly a seventh of China's total population...

### DEATH MAKES A COMEBACK

Given the extraordinary impact of the 20th century's global health revolution, well-informed citizens around the world have come to expect steady and progressive improvement in life expectancies and health conditions during times of peace. Unfortunately, troubling new trends challenge these happy presumptions. A growing fraction of the world's population is coming under the grip of peacetime retrogressions in health conditions and mortality levels. Long-term stagnation or even decline in life expectancy is now a real possibility for urbanized, educated countries not at war. Severe and prolonged collapses of local health conditions during peacetime, furthermore, are no longer a purely theoretical eventuality. As we look toward 2025, we must consider the unpleasant likelihood that a large and growing fraction of humanity may be separated from the planetary march toward better health and subjected instead to brutal mortality crises of indeterminate duration...

In the early post-World War II era, the upsurge in life expectancy was a worldwide phenomenon. By the reckoning of the U.N. Population Division, in fact, not a single spot on the globe had a lower life expectancy in the early 1970s than in the early 1950s. And in the late 1970s only two places on earth—Khmer Rouge-ravaged Cambodia and brutally occupied East Timor—had lower levels of life expectancy than 20 years earlier. In subsequent years, however, a number of countries unaffected by domestic disturbance and upheaval began to report lower levels of life expectancy than they had known two decades earlier. Today that list is long and growing. U.S. Census Bureau projections list 39 countries in which life expectancy at birth is anticipated to be at least slightly lower in 2010 than it was in 1990. With populations today totaling three-quarters of a billion people and accounting for one-eighth of the world's population, these countries are strikingly diverse in terms of location, history, and material attainment.

This grouping includes the South American countries of Brazil and Guyana; the Caribbean islands of Grenada and the Bahamas; the Micronesian state of Nauru; 10 of the 15 republics of the former Soviet Union; and 23 sub-Saharan African nations. As might be surmised from the heterogeneity of these societies, health decline and mortality shocks in the contemporary world are not explained by a single set of factors, but instead by several syndromes working simultaneously in different parts of the world to subvert health progress...

In sub-Saharan Africa, a different dynamic drives mortality crises: the explosive spread of the HIV/AIDS epidemic. In its most recent report, the Joint United Nations Programme on HIV/AIDS (UNAIDS) estimated that 2.8 million died of AIDS in 1999, 2.2 million in sub-Saharan Africa alone. UNAIDS also reported that almost 9 percent of the region's adult population is already infected with the disease. By all indications, the epidemic is still spreading in sub-Saharan Africa. As of 2000, UNAIDS projected that in several sub-Saharan countries, a 15-year-old boy today faces a

Social aging sets in motion an array of profound changes and challenges and demands far-reaching adjustments if those challenges are to be met successfully. But social aging is primarily a consequence of the longer lives that modern populations enjoy. And the longevity revolution, with its attendant enhancements of health conditions and individual capabilities, constitutes an unambiguous improvement in the human condition. Pronounced and prolonged mortality setbacks portend just the opposite: a diminution of human well-being, capabilities, and choices.

---

**Given today's historically low death rates and birthrates, however, the arithmetic fact is that the great majority of people who will inhabit the world in 2025 are already alive.**

**—Nicholas Eberstadt, "The Population Implosion"**

---

greater than 50 percent chance of ultimately dying from AIDS—even if the risk of becoming infected were reduced to half of current levels...

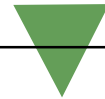
#### **THE SHAPE OF THINGS TO COME**

Looking toward 2025, we must remember that many 20th-century population forecasts and demographic assessments proved famously wrong. Depression-era demographers, for example, incorrectly predicted depopulation for Europe by the 1960s and completely missed the "baby boom." The 1960s and 1970s saw dire warnings that the "population explosion" would result in worldwide famine and immiseration, whereas today we live in the most prosperous era humanity has ever known. In any assessment of future world population trends and consequences, a measure of humility is clearly in order.

Given today's historically low death rates and birthrates, however, the arithmetic fact is that the great majority of people who will inhabit the world in 2025 are already alive. Only an apocalyptic disaster can change that. Consequently, this reality provides considerable insight into the shape of things to come. By these indications, indeed, we must now adapt our collective mind-set to face new demographic challenges.

A host of contradictory demographic trends and pressures will likely reshape the world during the next quarter century. Lower fertility levels, for example, will simultaneously alter the logic of international migration flows and accelerate the aging of the global population.

It is unlikely that our understanding of the determinants of fertility, or of the long-range prospects for fertility, will advance palpably in the decades immediately ahead. But if we wish to inhabit a world 25 years from now that is distinctly more humane than the one we know today, we would be well advised to marshal our attention to understanding, arresting, and overcoming the forces that are all too successfully pressing for higher levels of human mortality today.



**Amy Coen, Population Action International**

I want to thank the Woodrow Wilson Center's Environmental Change and Security Project for organizing this discussion. Then I want to jump right into some questions for Nicholas Eberstadt, author of "The Population Implosion." These questions are rooted in my own experience as a reproductive health provider for all my working life.

Dr. Eberstadt asserts that foreign assistance to family planning programs overseas is unwise, and that government-run family planning services are "a questionable investment." Yet he acknowledges throughout his article that low-income couples around the world increasingly express a preference for raising small families. Would Dr. Eberstadt agree that there is a growing demand worldwide for family-planning services and information?

Recent analyses indicate that roughly 75 percent of potential clients in sub-Saharan Africa cannot afford family planning methods at current contraceptive wholesale prices alone. This calculation excludes the not-insignificant costs of providing services related to contraception. Moreover, these contraceptives and related services become even less affordable to the poor after an unwanted childbirth. Would Dr. Eberstadt agree that governments should play a role in helping low-income women gain access to the means to safely manage their own childbearing, especially when they themselves clearly want that access?

Studies have found that, when family-planning services are more expensive than low-income users can afford, users will often risk less-effective traditional methods or rely on abortion (which is illegal and unsafe in many developing countries). Many providers offer counseling and basic maternal and child services and can treat septic abortions. Shouldn't some of the costs of family-planning services be subsidized for low-income clients, particularly when research shows the positive effects of such services on national economics and the health and well-being of women and children?

Just as importantly, governments do have a legitimate interest in the impacts of growing populations on the nations they govern; and the same policies that improve individual health and well-being also slow population growth. More than half a billion people live in countries where water stress or scarcity hampers economic development and health. But the number of people with

water shortages is significantly lower than it would have been had governments, the United Nations, the World Bank, and nongovernmental organizations not invested decades ago in improved family planning services for developing countries. And continuing to expand access to reproductive health care is a crucial way to stem worsening scarcities of water and other critical natural resources. The largest generation ever of young people is now entering its reproductive years, and a higher proportion than ever before wants to postpone childbearing and limit family sizes. If these young people succeed in their own reproductive aspirations, world population could level off in this century. No population "implosion" is likely, by the way—only an end to population growth that won't be sustainable for very long.

Should governments support the revolution in childbearing, which benefits us all? Or should they frustrate it, telling young people essentially that "when it comes to sex and reproduction, you're on your own. Good luck!" The latter flies in the face of the abundant evidence that access to reproductive health services contributes to individual economic well-being as well as to broader social, economic, and environmental benefits.

Dr. Eberstadt's opinion of foreign assistance and public services implies that he considers the impacts on their private sector too great. Shouldn't we weigh those putative effects against the impact of unintended childbearing, unsafe abortion, and the lives of roughly half a million women who die each year from causes related to pregnancy and childbirth? Shouldn't governments be making efforts to close education gaps, to at least narrow income gaps, and to help improve their citizens' quality of life?

In "The Population Implosion," Dr. Eberstadt points to Brazil as a model of a successful nongovernmental program. But though largely self-sufficient now, Brazilian nongovernmental family-planning organizations and private providers were assisted for decades by foreign donors who subsidized contraceptives and marketing efforts and helped pay for training and research. Brazilian organizations have done a remarkable job providing reproductive health services in often-difficult circumstances. Yet a recent study concluded that there is a need in Brazil to develop further decentralized public-sector reproductive health services in order to: (a) provide care for underserved populations; and (b) improve the mix of contraceptive methods, which is still weighted

## FORUM PARTICIPANTS

**Stan Bernstein** is senior research adviser at the United Nations Population Fund.

**Carmen Barroso** is the population director for the Program on Global Security and Sustainability at the John D. and Catherine T. MacArthur Foundation.

**Amy Coen** is president of Population Action International.

**Sonia Corrêa** is a researcher with the Brazilian Institute of Social and Economic Analysis (IBASE) in Rio de Janeiro, where she coordinates the Gender Initiative. She is also research coordinator for sexual and reproductive health and rights with Development Alternative with Women for a New Era (DAWN).

**Nicholas Eberstadt** holds the Henry Wendt Chair in Political Economy at the American Enterprise Institute in Washington, DC.

**Parfait M. Eloundou-Enyegue** is an assistant professor of development sociology and demography in the Department of Rural Sociology at Cornell University.

toward female sterilization.

Without government or donor involvement in the early stages of economic development, how does Dr. Eberstadt propose that low-income couples obtain decent quality reproductive health services? In “The Population Implosion,” he urged his readers to pay greater attention to the upsurge in infectious disease—much of it, of course, sexually transmitted. Yet in his longer discourse on fertility decline, Dr. Eberstadt never acknowledged the health benefits of access to family planning on women’s health and social status. He fails to mention the health and economic risks inextricably linked to unprotected sex, high rates of unwanted pregnancy, unsafe abortion, and high rates of maternal and infant mortality. Nor does “The Population Implosion” treat the detrimental effects of early childbearing on girls’ educational attainment and on women’s participation in the labor force. Yet in 1990, even before the full impact of AIDS was felt, the World Health Organization calculated that reproductive illnesses accounted for about 38 percent of all premature death and disability among reproductive-age women in sub-Saharan Africa (compared to 8 percent among similarly-aged men). For Indian women, this statistic reached 28 percent. Among African women, the risk of dying from complications of pregnancy, childbirth, or unsafe abortion is now 1 in 15. It is 1 in 3,750 for women in the United States.

Are the benefits of family planning and related programs too trivial for the United States to consider investing in these programs? Are women not part of Dr. Eberstadt’s economic calculus? Or do the challenges of absorbing a high proportion of elderly in the population (a few decades after fertility decline begins) outweigh the immediate health and social benefits of family planning for women today?

I look forward to this discussion. It is indeed valuable to consider where world population is likely to go from here, and what the implications of that are for all societies—poor as well as wealthy. Just as importantly, I hope we will consider the many non-demographic benefits to expanding access to those client-centered reproductive health services that offer a range of choices on family planning and disease prevention.



***Sonia Corrêa, Brazil Institute of Social and Economic Analysis***

I want to thank the Woodrow Wilson Center’s Environmental Change and Security Project for the invitation to participate in the forum. For somebody entering this conversation from a feminist and developing-

country perspective, this is a privileged opportunity to engage with the population debate as it is being currently framed in the United States. From this viewpoint, I am somewhat surprised by the absence thus far of explicit references to the International Conference on Population and Development (ICPD) Program of Action formulated at Cairo in 1994. Let me briefly recapitulate the work of the ICPD.

In Cairo (and a year later in Beijing), the global population policy agenda clearly shifted from an emphasis on fertility control measures (which translated into vertical family planning programs) to a framework combining:

other cases where policies were/are not so strict but which are quite far from success stories in terms of respecting and promoting reproductive rights. (Bangladesh, Indonesia, Vietnam, and India are just a few illustrations.)

On the other hand, full respect for human rights is also necessary in countries experiencing “sub-replacement fertility.” To force people to have babies they do not want is as abusive as to sterilize people against their will. And, as we know, sometimes this is done through extremely draconian measures: it suffices to recall the Ceaucescu regime’s restriction of abortion in Romania, which resulted in dramatic increases in maternal mortality

---

**Although Cairo meant a fundamental transformation of the population debate, Dr. Eberstadt’s arguments are, by and large, constructed as if the global policy environment remained fundamentally informed by the fertility-control premises of the 1960s and 1970s.**

—Sonia Corrêa

---

(a) the respect for human rights; (b) the promotion of human development (health, in particular sexual and reproductive health as well as education, employment, and sustainable livelihoods); and (c) gender equality and equity.

Although Cairo meant a fundamental transformation of the population debate, Dr. Eberstadt’s arguments are, by and large, constructed as if the global policy environment remained fundamentally informed by the fertility-control premises of the 1960s and 1970s. As I see it, the “Cairo Agenda” should not to be forgotten or abandoned—not least of which because it illuminates both the demographic trends underlined by Dr. Eberstadt and the problems raised by Ms. Coen. Ms. Coen is right in calling attention to the fact that fertility dropped in countries as diverse as Brazil, Iran, and Italy because “couples” currently prefer smaller families and therefore need information and means to make their reproductive decisions. But I would like to add other elements to the picture.

Decisions with respect to the spacing and number of children must be free of coercion and discrimination. They must be grounded in the respect for the human rights of involved persons—or, to be more precise, respect for the reproductive rights of involved persons. Consequently, much work and expense remains, even in those countries where fertility has decreased or is rapidly declining. This is particularly true in places where decline has resulted from stringent fertility control policies. The most evident example is China. But the same applies to

rates.

A second missing piece is gender inequality (or gender relations). An extensive bulk of literature is available to demonstrate that, in most settings, reproductive intentions of women widely differ from reproductive intentions of men. In many places even today, women have children they did not want simply because they are entirely subject to what their husbands/partners want, say, and do. Extended families and communities frequently reinforce these constraints. Consequently, it is important to underline that reproductive rights as defined by the ICPD (a definition that includes access to information and family planning methods) does not refer exclusively to couples but to *couples and individuals*, and that women must be empowered (against all odds) to fully exercise these rights.

But gender analysis, while being extremely relevant to understand high fertility regimes, is also meaningful to examine what happens in societies experiencing (or moving towards) sub-replacement fertility. Feminist analyses of what is occurring in Japan, Italy, and Spain indicate that, in a democratic environment, women will not have more children than they want (or consider they can cope with) if deep changes in gender relations do not take place. In these countries, women are demanding a fairer distribution of responsibilities and workload between women and men with regard to the burdens of “social reproduction.” Along the same line, policy definitions of Nordic countries suggest that even positive incentives to have larger families may not work properly if the unbalanced gender division of labor is not



addressed and modified.

Last but not least, emerging mortality trends can and should be examined through a gender lens. Let's consider, for instance, the factors underlying the dramatic losses in life expectancy observed in sub-Saharan Africa under the impact of HIV/AIDS. It is impossible to contain the pandemic in the African continent without consistently addressing gender inequality, particularly in the domain of sexuality. Yet recent increases in mortality rates in Eastern Europe and Russia reveal that a disproportionate number of those dying are men. I would like to ask Dr. Eberstadt: how can we explain these differentials?

Finally, I want to comment more specifically to Ms. Coen's posting. She refers explicitly to reproductive health services and other critical sexual and reproductive health problems (such as abortion, maternal mortality, and sexually transmitted diseases). Although she ends her argument by mentioning the non-demographic benefits of these programs, the emphasis is mostly on family planning. I would like, therefore, to remind the forum as well that sexual and reproductive health—as defined by the ICPD—is not simply “other services attached to family planning.” Rather, it is a broader policy agenda in which family planning is but one component (although a very important one).

To illustrate this point, I will use the example of my own country. In Brazil, fertility rates have declined as rapidly as in China, and contraceptive prevalence is reaching industrialized countries' level. However, maternal mortality rates in Brazil remain unacceptable; pre-natal and obstetric care still require much improvement; and, most importantly, HIV infection among Brazilian women keeps increasing (when overall transmission is decreasing). This last trend is directly related to gender inequality (women still do not have full power to negotiate in the domain of sexuality) as well as to contraceptive prevalence patterns (it is not surprising that a sterilized women will not use a condom when having sex with their husbands). The Brazilian experience also indicates that lower fertility neither automatically translates into poverty reduction nor prevents environmental degradation.

I will later have additional comments on the references made by Ms. Coen and Dr. Eberstadt to Brazil as well as on the implications of global economic trends for current demographic trends. But I would rather conclude now by saying that I am also convinced that we face great (and many) human development challenges, few of them directly related to population dynamics. These challenges certainly require much intellectual investment and mobilization of public and private resources as well as creative solutions. However, they

cannot be simply understood as a move from the population bomb crisis to the population implosion crisis. Most principally, the policy discussions related to them should no longer—after the UN Conferences of the 1990s—be narrowed down to the old debate regarding more or less funding for family planning.



***Carmen Barroso, The MacArthur Foundation***

First of all, appreciation is due to the Environmental Change and Security Project for hosting this important discussion. Thanks also to Nick Eberstadt for agreeing to discuss his long-held skepticism regarding population policies. He rightfully calls attention to the importance of changes in age structures, and he joins the voices urging control of rising mortality in sub-Saharan Africa and elsewhere. His discussion of population policies is nevertheless misdirected for two major reasons.

First, there is no population implosion on the horizon. While global fertility has declined sharply, the world's population is still expected to grow from 6.1 billion today to 9.3 billion in 2050, according to the just released projections of the United Nations. The UN's past projections of world population in 2000 have proven highly accurate. In a letter to *Foreign Policy*, John Bongaarts points out that, even in the industrialized world, the significant declines expected in some populations (e.g., Russia, Japan, Germany, and Italy) are offset by the expected continued growth in the United States, Canada, and Australia. As a result, by 2050, the industrialized world of today is expected to have a population close to the current 1.2 billion.

Second, the population policies Dr. Eberstadt criticizes are not the ones prevailing today. The new paradigm adopted in the 1990s is oriented by a human rights approach. Its major purpose is to create enabling conditions for responsible reproductive choices. The creation of these conditions is needed in high fertility and low fertility settings alike. Dr. Eberstadt's arguments are directed against a “crusade to depress birthrates” that is at total odds with the consensus reached at the International Conference on Population and Development back in 1994. Sonia Corrêa has made this point beautifully. I only want to point out that gender equality—the most important “enabling condition” that is at the core of current approaches to population policies—is also key to avoiding below-replacement fertility. Women in industrialized countries typically want

two children. If society's organization of the "care economy" did not put an enormous burden on the shoulders of those who want to combine children with a career, we could well see some increase in fertility.

Dr. Eberstadt is absolutely right on the need to arrest the forces bringing higher levels of mortality in important parts of the world. It should be stressed, though, that population policies that make available the information and the barrier methods needed for the practice of safe sex are also the best means of prevention of AIDS, one of the major causes of mortality in Africa today—and likely to be soon in Asia and other parts of the world.

Two thousand grantmakers gathered in May at the annual meeting of the Council on Foundations and gave a standing ovation to Kofi Annan when he presented his plan for a \$10 billion effort to halt the global spread of AIDS. Economists are now making the case for adequate resources for the fight against AIDS: they argue, for instance, that the devastation wrought by AIDS in Africa is precluding the higher levels of productivity needed to bring down the price of oil.

The resources needed for fighting AIDS and the obstacles on the ground may seem daunting, but the successful cases of Brazil, Uganda, and Senegal show that they are not insurmountable. It is true that, even in the case of Brazil, gender inequalities are still a problem. But Brazil has shown that dire predictions can be reversed. It has been able to stem the AIDS crisis because it had the most important requirement for doing so: political commitment. And it was the demand of Brazilian civil society that made AIDS a priority of that country's government. At the MacArthur Foundation Population Area, we are proud to have contributed to this effort by helping to support those Brazilian women's organizations and AIDS activists that have forcefully articulated that demand. I offer this example to illustrate the point that population policies can and must be linked to sexually-transmitted diseases and thus to the control of mortality.

Finally, I would like to welcome the emphasis Dr. Eberstadt gives to the transformation of age structures. Policymakers that ignore this transformation will end up planning for yesterday's world. It would be important to consider the different paces at which age structures are changing in different countries in the context of a globally-connected world. Policies and conditions in one country have important implications for others.

For example, the latest report of the Inter-American Development Bank examines the "demographic dividend" that Latin America may have as a result of the gap between its demographic transition and that of developed countries. In other words, developed regions

have large retirement-age populations looking for greater capital returns on their big pools of savings, which might lead to long-term investments of these savings in other regions (such as Latin America) with large numbers of young productive workers. Some poorer countries also benefit from the substantial remittances sent by young migrants who are working in industrialized countries. The migrants usually send these funds directly to their families; but the remittances are now also taking the innovative form of "home town associations." Based in industrialized countries, these cooperatives fund infrastructure and development work in their participants' places of origin. These examples show that not all the important effects of changes in age structure are immediately obvious.

In conclusion, both (a) the recognition of these issues' complexity, and (b) the acceptance of the values underlying rights-based population policies call for moving away from the 200-year old dispute between the pessimist Malthus and the optimist Condorcet. The current debate should be about how we can take account of current demographic changes as we try to maximize individual happiness and social, racial, and gender equity.



**Stan Bernstein,**  
**United Nations Population Fund**

I'd like to join the other participants in thanking the Woodrow Wilson Center's Environmental Change and Security Project for giving us the opportunity to have this important discussion about population trends, their social bases, and their consequences and programmatic implications. I would like to join Ms. Coen, Ms. Corrêa, and Dr. Barrosso in stressing that, in the area of population, decades of experience and increasing responsiveness to grassroots concerns have produced a powerful, complex, and sensitive international consensus. Human rights are central to our understanding of population programmes—the right (a) to make informed and responsible decisions about child-bearing and the means to implement them; (b) to health and to development; and (c) to women's rights in multiple realms. These rights are basic. Population policies and programmes are properly parts of the entire health and social development agenda.

As Ms. Corrêa so clearly reminds us, gender issues are central to understanding the dynamics that produce the outcomes we observe—whether they relate to

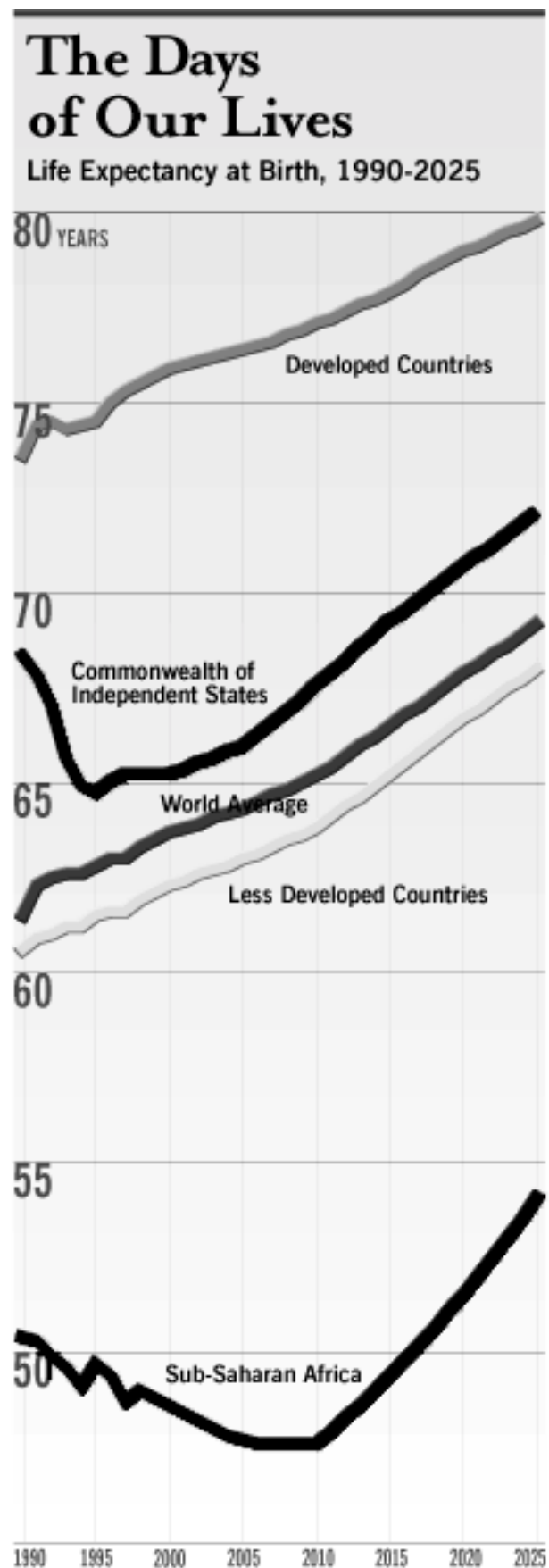
mortality, fertility, education, migration, disease susceptibility, or life prospects. This is a far more insightful approach for the analysis and definition of policies, programmes, and priorities than the curiously disembodied focus on population totals of Dr. Eberstadt.

Dr. Eberstadt's *Foreign Policy* article at times confounds past trends and future projections, particularly in the area of fertility. For example, its graphs and text present fertility estimates and projections for 1975, 2000, and 2025 as though they are equally accurate and certain. Of course we need to make reasonable medium-term projections and plan our policies and programmes, often with substantial lead times. But we also need to deal with substantial existing problems seriously rather than assuming them away to a projected future.

The historical record of projections is quite good at highly-aggregated levels, but more inaccurate at the country level. Projections are also often wrong in the relative contributions of mortality, births, and deaths to the totals. (Projections of 40 years ago got the total current populations right, but underestimated the pace and timing of fertility and mortality declines.) Projections of future demographic parameters can only be an educated extrapolation of existing trends. Dr. Eberstadt quite correctly raises questions about the certainty of projecting continuing improvements in future mortality trends. He is far more trusting of the certainty of fertility declines than evidence would warrant. There is something almost automatic about his presentation of "secular fertility declines"—despite his protestations that we remain ignorant of the causes of these declines, or his failure to recognize that couples and individuals everywhere have always adjusted their family sizes (if less efficiently and with more deaths), even prior to modern contraceptives.

As he concentrates on sheer numbers, Dr. Eberstadt fails to take note of the choices and dynamics underlying these figures. Curiously, he professes wonder about any engines and drivers of economic, demographic, and other social trends. His only comment is to revive an outdated argument about whether economic progress is a pre-condition for fertility decline. (Recent evidence confirms a bi-directional relationship, with demographic change providing a "bonus" that provides opportunity and stimulus for accelerated economic and social progress.)

Our current understanding is less simplistic. Income effects alone are complex and situation specific. They are associated with (a) parental education and investments in children that lower desired family size, and also with (b) an increased ability to afford larger families. The effects



Source: From latest projections, U.S. Census Bureau, International Database ("The Population Implosion," FOREIGN POLICY 123)

of poverty on fertility declines are similarly complex. Important factors include: (a) desires to avoid further costs of children (especially increasing education costs); (b) the benefits from additional hands for subsistence work and resource scavenging; and (c) constrained access to the means to regulate family size. The calculus changes in different settings when the real and anticipated social costs and benefits from boys and girls are added to the mix. No wonder Dr. Eberstadt prefers to treat these issues as a black box that only produces one reduced fertility outcome. People who design national policies and programmes have no such luxury.

We know that a variety of factors interact to shape the development course of nations. No single element acts as a pre-condition, and deterministic causation is a will-o-the-wisp in the analysis of personal agency and social choice. Failure to find it should not hinder sensible policy. We do know what matters—not as deterministic tripwires, but as part of a dynamic of progress. These factors include: (a) declines in mortality (particularly infant and child mortality); (b) increases in women's education and social empowerment; (c) changing social norms; (d) increased discussion of family coping strategies (including family planning and education) in communities and within families; and (e) structural changes in societies that alter the rewards and costs both of variously-sized families and of investments in children's advancement.

Some of the historical examples that puzzle Dr. Eberstadt (e.g., Bangladesh and Kerala) are less puzzling when improvements in women's education, the strengthening of civil society organizations, and investments in health infrastructure (including reproductive health programs) are taken into consideration. Some of his statements on the role of tradition are also oversimplified, failing to understand that cultures adapt and provide meaning over time, not by "vigorous doctrinal gymnastics," but by elaborating their core values.

Projections also change as reality changes, responding to unfolding circumstances. The UN Population Division's most recent revision of projections to 2050 adds over 400 million people to the projections made just two years ago. Over 60 percent of this addition comes from slower fertility declines in 16 of the world's poorest countries. A small number of large countries account for the rest of the upward revision. This demonstration of uncertainty is an important antidote to clear narratives, but also is dwarfed by the levels of increase. By 2050, we will add over 3 billion people, nearly all of them in less-developed regions, presenting continuing challenges for public services, social infrastructure, economic development, and environmental quality. The projections

that lead Dr. Eberstadt to conjure up the specter of a "population implosion" include a tripling of the numbers living in the least-developed countries.

Some of the trends of declining fertility that underlie the projections are due to the significant investments made by sources as diverse as national governments, international assistance programmes, nongovernmental organizations, local communities, private enterprises, and individuals. Some of these investment trends remain positive; some have shown stagnation. As a result, it is likely that further upward adjustments in many of the population projections will occur, particularly in least developed countries. Concern has been increasing that supplies of reproductive-health commodities (for family planning, safe motherhood, and prevention and treatment of sexually transmitted diseases) are endangered. A meeting in early May 2001 was held in Istanbul as part of a process of stakeholder consultations to mobilize political commitment and the needed resources to (a) ensure greater choice in commodities and services, (b) improve their quality, and (c) advance integrated programmes.

The simple fact is that the challenges for the less-developed countries of the world remain multiple, serious, and simultaneous. Substantial technical and financial assistance will be needed to build conducive environments, to mobilize public and private resources, and to build partnerships in communities and families. Governments also need to improve their accountability and to address local priorities.

We cannot look dispassionately at total population numbers as though the people alive today are already well-served. Existing gaps and shortcomings are abundantly clear. For example, there are over 1,400 maternal deaths worldwide daily. More than one-third of all pregnancies globally are unwanted or unplanned. There is high recourse to abortion where family planning services are weak. 904,000 new cases of treatable sexually-transmitted diseases (half to men and women ages 15-24) are reported *daily*, as are 16,000 new cases of HIV/AIDS. We are not meeting the needs and guaranteeing the rights of millions of people now. We are also facing a 40 percent increase in reproductive-age populations in the coming two decades.

Adverse trends in international assistance most dramatically affect the poorest countries. After increasing during the ICPD process and its immediate aftermath, funds for population and reproductive health programmes have stagnated for several years. There is now growing interest in a global fund to combat HIV/AIDS. Increased funding from international donors, foundations, national authorities at various levels of

administration, the private sector, civil society, local communities, and people's pockets will be needed to strengthen education, health (including reproductive health) and other development initiatives.

Dr. Eberstadt tries to paint a picture of mortality and fertility trends combining to depopulate the world. We can sincerely hope that this vision motivates actions to counter negative trends, including: the erosion of public health programmes; declining public resource allocations

countless "unwanted pregnancies" across the world.

To the average person, simultaneous warnings about population implosion and explosion must be intriguing. The question, of course, is: which of these stories is true? Or indeed, are these stories mutually exclusive? And to the extent that they are not, what does Dr. Eberstadt's article suggest about those countries that are still experiencing population growth, and about the relevance of family planning programs in these countries?

---

**We cannot look dispassionately at total population numbers as though the people alive today are already well-served.**

—Stan Bernstein

---

to health and education, particularly in times of social and economic crisis; and delays in improving and supporting public, private, and informal systems for old-age support. It is a mystery how any reading of current trends and needs can lead to a call for reversing decades of support to population and reproductive health programs and the progress they have spurred.

To a large extent, though, Dr. Eberstadt's view is biased from his vantage point in a highly-developed society. The problems of these societies, including those from changing age structures, are real and need redress. His portrait of some is greatly overdrawn. The demographic concept of "dependency," for example, bears no sensible relation anymore to the facts of people's lives. I will have more to say about the situation in more developed settings after we hear his response to the comments so far.



**Parfait M. Eloundou-Enyegue,**  
**Cornell University**

**N**o demographic news seems to be good news. Before having the opportunity to raise a glass to the end of the "population explosion," the world is now asked by Nicholas Eberstadt and others to brace itself for a "population implosion." The implications of this phenomenon are perhaps as ominous as the widespread famine and ecological degradation that was envisioned in the 1960s as an inevitable consequence of rapid world population growth. And as if this rapid pendulum swing were not dizzying enough, the public must also reconcile two divergent stories—one told by Dr. Eberstadt's article, and the other made up of those familiar accounts of

My view is that, while "The Population Implosion" provides a compelling account of the emergence of below-replacement fertility in many countries, this account is also consistent with both continued attention to rapid population growth in many countries and with a continued role for family planning programs. To reconcile these views, at least five distinctions are important. These include distinctions between (1) Western and world trends, (2) national and individual interests, (3) sufficient and necessary factors in fertility change, (4) a restricted versus an expanded view of family planning programs, and (5) demographic and political solutions. Each of these points is discussed below.

### **1. Western Versus World Trends**

One main problem with Dr. Eberstadt's article is that it unnecessarily strains to cast a largely-Western story into a global story. While Europeans and an increasing number of other countries have indeed reached below-replacement fertility levels, this pattern is by no means universal. Even by generous standards, below-replacement fertility is found only among 44 percent of the world population. This is hardly a statistical majority, only an influential minority. One could haggle about the 44 percent figure, but this is a minor point (the threshold of 2.1 children would exclude some of the countries listed among below-replacement nations; in 1998, Sri Lanka and Tunisia were still listed at 2.1 and 2.2, respectively).

If sub-replacement fertility has "come close to describing the norm for childbearing the world over," as Dr. Eberstadt puts it, then that "world" certainly does not include Africa and many other countries in the Southern Hemisphere. Despite recent declines, fertility levels in Africa remain above four children per woman in most countries—the Kenyan story and a few other

exceptions notwithstanding. (The decline in the number of births per woman in Kenya over the last twenty years—from 7.8 to 4.6—is closer to three than to four.) It is likely that these declines in fertility will continue, but it is unclear how rapidly that will occur. The rate will depend in part on how fast the largely-urban changes in fertility spread to rural populations, which still constitute two-thirds of the sub-Saharan African population.

On the other hand, if one wanted to focus attention on worldwide trends, warnings about baby scarcity are premature. There are clearly enough babies to go around—they simply do not have the desired national origin. Again, the issue is not global but regional. In short, the article universalizes a Western story. While declines in national populations may become an issue for the rest of the world at some point in the future, many countries still deal with rapidly growing (rather than shrinking) populations.

## 2. National Versus Individual Regulation

Population policy must deal with possible tensions between national interests and individual preferences. The shift from “explosion” to “implosion” in some countries may mean that, after decades of cracking down on prolific couples, policymakers may now seek to crank up individual fertility engines to suit new national priorities. The challenge is reversed, but the principle is unchanged. If one is committed to the idea that individual choices should supersede national goals, then a “laissez-faire” stance should apply equally to policies trying to curb population growth and to policies aimed at boosting fertility. “The Population Implosion” questions the “wisdom of the crusade to depress fertility around the world,” but its attitude seems less hands-off when it comes to dealing with impending population implosion in Western countries. This is inconsistent—unless, of course, rapid population growth is more innocuous than the prospects of population decline.

One question is whether individual couples left to themselves would eventually redress the decline in Western fertility. Will strong economic incentives (or authoritarian measures) have to be devised? Another question for individual countries and the entire world is how low will be deemed too low. One could certainly survive in a world with a population half its current size. At the moment, concerns about “explosion” and “implosion” are largely national rather than individual obsessions. Most people around the world seem content with their fertility, except for the barren and the substantial number of mistimed and unwanted fertility cases in developing countries. One can argue that meeting these individual

goals (before national goals) is the first order of business. When individual goals are met, then policies to align behavior with national priorities are in order. At this point, the question becomes whether one knows enough about fertility motivation to understand if policies are likely to depress fertility or prop it up.

## 3. Sufficient Versus Necessary Causes for Fertility Change

Dr. Eberstadt’s article also suggests that the honest answer to questions about the factors that account for the worldwide decline in fertility is that “nobody really knows.” This modesty is laudable but overstated. Not having a single, universal explanation for fertility decline does not mean that nothing is known; it simply means that known factors cannot be reduced to a single cause.

Among key factors that have contributed to reduce world fertility, one may include: (a) changes in the costs of and benefits of children, (b) infant mortality, (c) individual aspirations, (d) women’s roles, (e) access to contraception, or (f) family organization. To induce a fertility decline, any of these factors may be sufficient, and none is necessary. Whether any given factor is important depends on the context and stage in the fertility transition. If a Nobel Prize is to be awarded for explaining the decline in world fertility, it will have to be shared by thousands of empirical studies on fertility determinants. Not having a single and obvious answer may be unsatisfying, but it is not an indication of cluelessness. As with any factor, the significance of family planning programs has been contingent on time and place. But in most recent cases, these programs have been critical in reducing fertility once the demand for them is present. This brings us to the next point: the continued role of family planning programs.

## 4. Restricted Versus Broad View of Family Planning

“The Population Implosion” is skeptical about the role of family planning programs, pointing out that notable changes in fertility have occurred in the absence of organized family planning programs. The obvious counterpoint is that an exception does not make a rule. As with any other factor or policy intervention, family planning is not a *sine qua non*. Yet it has played a special role in enabling change—once fertility aspirations begin to change.

More importantly, the potential role of family planning programs in developing countries has broadened beyond fertility limitation and into the realm of human

capital formation. The use of contraception contributes to improved reproductive health by (a) reducing the health risks associated with unsafe abortions and high-risk pregnancies, and (b) by shielding populations from the spread of AIDS. These health contributions alone are sufficient grounds to continue promotion of contraception.

In addition, family planning programs can help reduce educational inequalities, especially those associated with sex and large family size. Gender gaps in schooling have been closing steadily in the developing world as increasing numbers of families commit to equalizing educational investments among their children. In this context, reducing unwanted pregnancies among schoolgirls may become a more important contribution in closing the gender gap in secondary schools. Socioeconomic inequalities in schooling are also growing in many countries. While large family size had previously not been an impediment to schooling in many developing countries, recent research suggests that the educational and economic penalty associated with large family size is growing as schooling costs rise and as extended family solidarity erodes. To the extent that limited access to contraception partially contributes to the larger size of low-income families, family planning programs can significantly contain the growth in these educational inequalities.

## 5. Demographic and Political Solutions

A population implosion certainly raises new scientific and policy challenges. While the agenda of fertility research has exclusively been concerned with decline factors, the challenge now facing researchers may be to understand conditions that encourage couples to have a minimum of two children. In my view, Dr. Eberstadt is correct in noting that the “continuing preoccupation with high fertility has left the international population policy community poorly prepared to respond to the demographic trends emerging today.” New theories and new empirical insights are needed.

At the same time, let us note that a demographic solution—migration—exists. Perhaps more than the demographic research community, national policy communities are the most unprepared to respond to current demographic trends in general and this solution in particular. Again, there are enough babies to go around today, and international migration would overcome the current “baby squeeze” in Western countries. Of course, this may not be a palatable solution for many governments. But neither would other scientific solutions that may be eventually required—say in wage structure,

taxation, mandatory retirement ages. . .

The challenge is not so much to find new scientific solutions as it is to mobilize the political support necessary to implement new or existing solutions. As long as the specter of immigration remains scarier than the crumbling of social security systems (for instance), the viable demographic fix of migration will not be used. On the other hand, when declining population becomes a sufficiently compelling threat, known but politically unpopular policies will be enacted. Mandatory “two-children” policies may well be the result.



**Nicholas Eberstadt,**  
**American Enterprise Institute**

Like all the other respondents in this forum, I too would like to thank the Woodrow Wilson Center’s Environmental Change and Security Project for graciously organizing this dialogue. Further, I am pleased that my essay in *Foreign Policy* should have provoked so much reflection, and stimulated such diverse contributions. Conversations such as this one are valuable not only for illuminating areas of contention or disagreement, but also—no less importantly—for dispelling misperceptions and identifying common ground.

Taken together, the text of the five preceding postings comes to over 6,500 words; that corpus of comments and critiques cover a wide swath of intellectual terrain. The authors also pose quite a few specific questions to me (Amy Coen alone has nearly a dozen), some of which invite extended, nuanced, and highly detailed replies. Rather than fully address each and every point the authors raise—to do so might require a small book!—I will attempt to attend to what I identify as their most pressing questions, concerns, and objections in a succinct manner, while raising some questions and concerns of my own in the process.

I should start by addressing a fundamental misapprehension of fact that seems to be shared by most of my interlocutors. The authors chide me for characterizing the current thrust of international population policies as anti-natalist. They imply—or assert explicitly—that my characterization is (at best) badly outdated. In particular, I am faulted for not appreciating the significance of the 1994 International Conference on Population and Development (or ICPD, also known as the “Cairo conference”), which (in Carmen Barroso’s words) created a “consensus” in the population community that is “at

total odds” with what I termed “a crusade to depress birth rates.”

I wish all that were so. Unfortunately, the facts speak otherwise. As anyone familiar with its deliberations should know, the Cairo conference resulted in a “Programme of Action” that is expressly anti-natalist: indeed, the policy interventions proposed in it are specifically justified on the basis of their perceived promise to depress Third World birth rates, and thereby slow global population growth.

The ICPD’s secretary general, then-UNFPA Executive Director Nafis Sadik, could hardly have been clearer on this point. At the April 1994 Preparatory Committee for the ICPD, Dr. Sadik warned that “[w]orld population today is 5.7 billion. It will reach either 7.27 billion or 7.92 billion by the year 2015, depending on what we do over the next two decades”—meaning, of course, whether or not the international community would embrace the conference’s anti-natalist population program.

The “Programme of Action” ratified by the Cairo conference unambiguously endorsed the principle of using population programs to reduce birth rates, and thus to staunch world population growth. To quote the fourth paragraph of the document’s Preamble:

“During the remaining six years of this critical decade, the world’s nations by their actions or inactions will choose from among a range of alternative demographic futures. The low, medium and high variants of the United Nations population projections for the coming 20 years range from a low of 7.1 billion people to the medium variant of 7.5 billion and a high of 7.8 billion...Implementation of the goals and objectives contained in the present 20-year Programme of Action...would result in world population growth during this period and beyond at levels below the United Nations medium projection.”

Though Dr. Sadik’s favored population target—no more than 7.27 billion persons by the year 2015—was not impressed upon the final Cairo text, the centrality of that target to the proceedings, and to the policies endorsed, was absolutely unmistakable. Thus the *New York Times* report on the conference and its “Programme of Action” (“U.N. Population Meeting Adopts Program of Action,” September 14, 1994, A2) explained that:

“The aim of the declaration is to stabilize the world’s population at about 7.27 billion by the year 2015—compared to 5.67 billion today—and avoid an explosion that could put the world’s population at 12.5 billion in the year 2050.”

There we have it. As officially enunciated, the ICPD “consensus”—the lapidary statement of purpose for

current international population efforts—unequivocally aims to reduce current Third World birth rates and future human numbers; and includes specific, numerical targets by which to evaluate the success of the quest.

We may of course argue whether anti-natalist population policies are inherently dubious (my view) or inherently desirable (the view of many in the contemporary population movement). Either way, however, it is not tenable to object to the depiction of contemporary international population policy as “anti-natalist.”

Another confusion shared by some writers concerns the explanation of past fertility trends and prediction of future population prospects. Many intellectuals no doubt entertain their own pet theories for why childbearing happened to decline in a certain place during a particular period—or, say, where fertility rates will be heading for a given country in the decades ahead. It is nevertheless essential to distinguish between subjective intuitions and surmises on the one hand and rigorous, robust, and generalizable results on the other.

With varying degrees of civility, authors in this forum criticize my article for being insufficiently attentive to current research and theories about fertility change. (In some instances, though, respondents perceive disagreements where none in fact exist: I would fully concur, for example, with Professor Eloundou-Enyegue’s comment that “[n]ot having a single, universal explanation for fertility decline does not mean that nothing is known; it simply means that known factors cannot be reduced to a single cause.”) Yet it is necessary to recognize the limits of our understanding of fertility change as a phenomenon, and the operational consequences that those limitations impose. For, plainly speaking, the fact is that we have no reliable basis for long-range projections of future fertility, and no methodology for explaining unambiguously sustained fertility changes from the past.

Why did fertility levels decline across Europe over the course of the Industrial era? Reviewing the contending theories of his day, and the evidence adduced for them, historian Charles Tilly put it well in 1978: “The problem is that we have too many explanations which are plausible in general terms, which contradict each other to some degree and which fail to fit some significant part of the facts.” I do not believe any serious student of Western demographic history would take issue with that assessment today. But what obtained for Western countries holds equally for the low-income regions here and now.

Just as we cannot unambiguously explain the fertility trends of the past, so we cannot confidently anticipate the long-term fertility trends of the future. As the UN



## THE ENVIRONMENTAL CHANGE & SECURITY PROJECT'S E-MAIL FORUM FOR ENVIRONMENT, POPULATION, AND SECURITY ISSUES

The Environmental Change and Security Project (ECSP) urges you to subscribe to its e-mail forum for environment, population, and security issues—ECSP-FORUM. This forum serves as a means for practitioners, scholars, and policymakers to participate in a dialogue with others in the community. The purpose of ECSP-FORUM is to provide a forum for: discussing relevant issues and research; posting current policy questions; and listing relevant policy, scholarly, and teaching resources. Accessible from the ECSP Web site or by e-mail, it is a convenient and resourceful tool for all interested in the topics of environment, population, and security. Discussions will be archived and fully searchable through the ECSP Web site, providing a useful reference point for accessing information at a later date. There is no charge to subscribe.

To subscribe to the ECSP Forum, send an e-mail to [listproc@listproc.net](mailto:listproc@listproc.net) and:

- 1) Leave the Subject heading blank
- 2) In the text box, type sub ECSP-FORUM your name. For example, sub ECSP-FORUM Jane Doe.

For more information, please visit our website at <http://ecsp.si.edu/listserv>

Population Division's 1997 Expert Group Meeting on Below-Replacement Fertility emphasized: "There exists no compelling and quantifiable theory of reproductive behavior in low fertility societies." The same, incidentally, may also be said for above-replacement-fertility societies.

For all these reasons, credulous declamations about the latest population projections for the year 2050 (of the sort that several authors in this forum have volunteered) are profoundly misguided. No science today can permit one to predict how many babies the now-unborn are going to bear a half-century hence. My *Foreign Policy* essay focused on the demographic horizon circa 2025 since—barring catastrophe—we can expect most of the people alive today to be living then, and most of the people in that future world to be already here, alive today.

But it is not possible for population projections made today to anticipate reliably either the tempo, or even the direction, of global population change some fifty years from now. Nor is that fact a closely guarded secret. The authors in our dialogue who draw attention to the UN Population Division's latest global projections neglect to mention that the UNPD releases not one but three so-called variants, all officially designated to be equally plausible—or that the "low variant" series imagines a world in 2050 in which total human numbers have already peaked, and are in the process of indefinite decline.

On a more immediate time horizon, deaths are poised to exceed births in the world's more developed regions. This is not a futuristic speculation, but rather an arithmetic reality. According to the UN Population Division's aforementioned assessment, that crossover

might occur as soon as the year 2003—in other words, just a number of months from now. Thereafter, immigration could potentially forestall population decline for this grouping of countries—but no science today permits us to predict the immigration policies of tomorrow.

Here again: one may find the prospect of prolonged negative levels of natural increase for a consequential fraction of humanity to be inherently of interest (my view), or instead to be a matter of indifference (apparently, the view of some contemporary students of population). But denying or ignoring this prospect surely can serve no useful purpose.

Now to move on to some of the specific questions raised. Most concerned my assessment of family planning efforts in low-income countries, and my view of the appropriate role for the United States or international organizations in those activities.

To allay some of Ms. Coen's apprehensions: I did not write that government-run family planning programs is "a questionable investment"—that phrase comes from a caption added by the editors of *Foreign Policy*, not by me. Nor did I ever write that expenditures on international family planning programs were "unwise." If she rereads the passage in question, she will see that I argued the international "crusade to depress birth rates" is of "arguable merit." (Surely Ms. Coen can differentiate between a voluntary family planning program and an anti-natalist population campaign?) Finally, Ms. Coen's assertion to the contrary notwithstanding, I did not "point to Brazil as a model of a successful non-governmental

program.” My precise words were: “Brazil has never adopted a national family planning program, yet its fertility levels have declined by over 50 percent in just the past 25 years.” Perhaps she will enlighten us as to why those bare facts I adduced would lead her somehow to conclude that I viewed Brazil’s programs as a “success”?

My perspective on the scope for and role of international family planning programs, not surprisingly, is shaped by my assessment of the determinants of fertility in the environs in which those programs are meant to operate. Two rather different views of fertility levels and their determinants in low-income regions coexist within the population community today. At the risk of

through voluntary family planning services surely have their place. (It is arguably a more prominent place today, given the mounting threat of HIV/AIDS and other STDs, than it might have been some decades earlier.) But in the final analysis, I see no persuasive argument for preferential allocation of public health funds to family planning over alternative health services. Judicious and effective public health policy requires a comprehensive weighing of cost and benefit—and in high-mortality settings, there are surely many other health interventions that must compete with family planning for the limited funds available. Note that this will remain true even if the overall health budget is substantially increased. Note

---

**It is not possible for population projections made today to anticipate reliably either the tempo, or even the direction, of global population change some fifty years from now.**  
—Nicholas Eberstadt

---

some oversimplification, these two views can be characterized as “supply side” and “demand side” in orientation. The former holds that fertility levels in low-income societies could be significantly reduced by greater public provision of subsidized family planning services—since, in this view, there remains an enormous “unmet need” for such services among Third World populations. The latter maintains that the primary determinant of fertility levels in low-income regions is in fact the desired family size of the parents in question, and that family planning services will consequently have relatively little impact on Third World fertility levels—so long as those programs are voluntary rather than coercive in nature.

My own assessment comports very closely with the “demand side” interpretation. That is to say: I would argue that compelling evidence suggests desired or preferred family size is the best given predictor of actual fertility levels in low-income settings—and suggests further that the expected reductions in fertility to be achieved through the extension of voluntary family planning programs and the diminution of “unwanted” or “excess” fertility are generally rather modest.

Though I am skeptical about the demographic claims that have been advanced for voluntary family planning in low-income settings, I believe there is a strong case to be made for voluntary family planning programs on the grounds of health. Indeed, expected health benefits are in my view the legitimate rationale for public provision of family planning services.

Within the overall constellation of health problems in low-income regions, the afflictions that can be redressed

further that the cry of “unmet need” is not persuasive in redirecting funds toward family planning programs. (Low-income populations endure a panoply of “unmet needs”; “unmet need,” indeed, is characteristic of the condition of being poor.)

Given some of the comments and questions posted, it may be apposite for me to emphasize at this juncture that I am no more partial to pro-natal population programs than I am to anti-natal ones. I do not personally favor pro-natalist policies in sub-replacement fertility settings, and never have. I would have thought my essay was perfectly clear in indicating that immigration should be a preferred policy instrument for dealing with some of the problems that might be exacerbated by prolonged sub-replacement fertility or incipient population decline. Evidently not.

Let me conclude by raising a question of my own—one arising from our dialogue here. It concerns the term “reproductive health.” I fully recognize that, in the new linguistics of population policy, “reproductive health” is offered as the justification for the continuation—and, indeed, the expansion—of what are sometimes called “international population activities.” Yet it is by no means clear to me that proponents of “reproductive health” agree on the meaning of the very banner they commonly champion.

In our dialogue, for example, Sonia Corrêa—a fervent promoter of “reproductive health”—argues that “[d]ecisions with respect to the spacing and number of children must be free of coercion and discrimination. They must be grounded in the respect of human rights

of involved persons.” Amy Coen likewise extols the virtues of “expanding access to client-centered reproductive health services”—but at the same time celebrates the reproductive health “achievements” of governments that deny their subjects the most basic individual rights, including the right to determine their own preferred family size.

At the same time that my essay in *Foreign Policy* was coming out, Amy Coen was releasing Population Action International’s (PAI) new study, “A World of Difference: Sexual and Reproductive Health & Risks.” The study offers, among other things, a ranking of international “reproductive health” risks for women from 108 mostly low-income countries around the world (accessible electronically at [http://www.populationaction.org/worldofdifference/rr2\\_risktable\\_frameset.htm](http://www.populationaction.org/worldofdifference/rr2_risktable_frameset.htm) ).

Among the top ten countries in the aforesaid ranking of “reproductive health” risks are: China and North Korea. That’s right: China and North Korea. China, the state that embraces coercive population control, including involuntary abortion and state-mandated postnatal medical infanticide against the mother’s wishes. North Korea, the country in the grip of a state-made famine and society-wide mortality crisis—the precise spot on earth where ordinary citizens are perhaps the very least free to exercise rights of personal choice even during non-famine years. Believe it or not, in PAI’s study, both China and North Korea were rated as enjoying better “reproductive health” than New Zealand!

Is Sonia Corrêa comfortable that she and Amy Coen mean the same thing when they proclaim the goal of “reproductive health”? Is North Korea generally viewed by other authors on this forum as a frontrunner among developing countries in the race toward “reproductive health”? How about China?

I realize that I have much to learn about what population activists mean by “reproductive health.” Educate me.



**Stan Bernstein**

**W**hen we began this discussion forum, I looked forward to an honest, open, and serious airing of views and an engagement of different perspectives. We all need to advance our education.

Dr. Eberstadt’s response to our earlier submissions, however, leaves me disappointed and uncertain of both his openness and intent. Nearly seven years after the Cairo

Conference he offers a serious (and I fear deliberate) misreading of the analyses, principles, and recommendations of the Programme of Action (PoA). I address a subset of the propositions and questions Dr. Eberstadt advances.

Is the Programme of Action “anti-natalist”? The first section of his reply argues that the PoA is an “expressly anti-natalist” document. His evidence for this conclusion consists of reference to a paragraph in the Preamble and a journalist’s interpretation. From these he conjures “specific numerical targets” related to birth rates and human numbers that do not exist. The only quantitative goals relate to: (a) universal access to reproductive health services, (b) universal completion of basic education; and (c) reductions in infant, child, and maternal mortality rates. The UN General Assembly Special Session in 1999 added further benchmark indicators (for HIV/AIDS education and prevention, for quality and completeness of reproductive health services, for elimination of unmet need for family planning, etc.) to monitor the process of implementation.

Where does this purported agenda come from? The Preamble suggests that if the recommendations are implemented, fertility might proceed at below the medium variant projection. This did not reflect any anti-natalist agenda. The medium variant projection is regularly based on expectations from prior trends. The PoA’s call for improved education, gender equality, reduced mortality, strengthened reproductive health services (and the integration of them into improved systems of primary health care) among other development strategies could not help but foster change. This is how demographic futures depend on “what we do.”

Even if Dr. Eberstadt doesn’t recognize this logic, I can speak from personal experience. I was involved in the process that led to that phrase. It emerged from analyses of unmet demand for family planning and the impact of addressing these desires on future fertility and future demand. Such calculations were needed for some of the resource estimates that were included in the PoA. This work reflected our state of knowledge based on past experience of supply and demand dynamics. It in no way set a target.

His final piece of “evidence” is a newspaper article stating: “The aim of the declaration is to stabilize the world’s population at about 7.27 billion by the year 2015....” Those of us active in population work have long lamented the inaccurate understandings of demography by the press. Surely Dr. Eberstadt knows that stabilization of global population by 2015 could never have been intended or attained. Any demographer

(whatever their view of the levels, trends, or value of fertility) understands population momentum. His endorsement of this characterization is an abdication of a demographer's professional responsibility.

The description of comprehensive reproductive health programmes (in paragraph 7.6 of the PoA, too long to duplicate in full here) deserves more of Dr. Eberstadt's attention. It even includes the prevention and treatment of infertility (where appropriate to local circumstances and priorities, as in regions of Central Africa with high impacts of reproductive tract infections). Attention to the document as a whole would be a useful part of Mr. Eberstadt's continuing education.

The PoA does indeed in several places recognize various advantages to population stabilization. But it clearly recognizes stabilization as a side benefit of promoting consensus development goals, not as a guiding principle. The analysis rests on the understanding that people should be empowered to make their own choices, and the faith that this will lead to both individual and collective benefits.

A portion of the population community (to name a few: A. McIntosh, J. Finkle, P. Demeny, L. Lassonde and M. Wheeler) has even criticized the PoA in print because it failed to articulate demographic goals. I think these critics underestimate the wisdom and influence of empowered people that the PoA recognizes. But at least these critics faithfully read the lines of the document rather than impute hidden motivations between them.

If there is a problem with the PoA, it lies not in its conception, but in the pace of its implementation. Progress has been significant, but added resources are needed—financial, institutional, personal, and political.

What are the roles of explanations of fertility change and of population projections? There is no point in reiterating the points many of us have made about factors that contribute to fertility change. Dr. Eberstadt does not address the causal factors that many of us pointed to—education, gender equity, mortality reduction, information and service access, the economic and social context of fertility decisions, for example. Instead, he suggests that lack of consensus on mathematical relationships or the complexity of the causal web renders long-term projections unreliable.

We are all appropriately humble about long-term projections (the PoA restricted its horizon to 20 years), but we must make decisions in the present and mid-term. Demographic projections are more reliable over a longer term than those of economics and meteorology, and we constantly make behavioral adjustments based on those. Investments to address the causal factors

referenced will surely effect demographic, economic, and social trends for the better. Referring to “operational consequences that those limitations [i.e., in our understanding] impose” forecloses but does not enlighten the discussion. I would prefer it if Dr. Eberstadt had translated his concern into a call for investments in research, including operational research. In his earlier writings, he had expressed much greater confidence in UN demographic projections; his skepticism about their soundness has surfaced only after those projections have been revised upward.

Projections certainly do serve to alert us to future trends and expand the horizon of policymakers beyond short-term priorities. (I'll only mention in passing that the UNPD variants are not designated equally plausible; the medium has always been characterized as the “most likely.”) A number of the participants in this discussion, for example, have already recognized the need for more-developed countries (and a growing number of developing countries) to address the challenges of changing age structures. Rather than denying or ignoring this prospect, we have discussed it. I refer Dr. Eberstadt and other readers to *The State of World Population Report 1998* (“The New Generations”) for an extended discussion of the policy issues for addressing: (a) the largest cohort of adolescents ever; (b) the growing number of older persons; and (c) the implications of these changes (including for gender and intergenerational relationships). The issues in low-fertility settings concern policies regarding housing, education, employment, labor, pension systems, work-family relations, gender, and generational equity as well as immigration. These challenges are not met by denying real needs in many low-income countries, or by withholding donor support from efforts to assist them.

What is the role of reproductive health (including family-planning) programmes? Dr. Eberstadt recognizes that separating “supply” and “demand” views is an oversimplification. The dynamics of how these factors interact (and affect financial and social costs) is where the true story lies. Even in the area of family planning, his assertions fail to recognize the diverse role of programs (beyond public provision of subsidized services) in legitimizing discussion (even across barriers of age and gender), removing operational barriers, fostering markets, and ensuring equity. The issue applies as well to the full range of reproductive health services that the PoA supports. Would Dr. Eberstadt contend that slow progress in lowering maternal mortality and morbidity is largely a matter of “demand” factors rather than “supply” of services, and that programmes should not address both?

Market failures are common and substantial. Reliable and comprehensive information is not available (a condition for efficient markets) because a private firm won't make the needed investments if others may realize the returns or when the market is underdeveloped because potential clients are too poor. Decision-making is done by couples or families, and women (who bear the greater burdens and risks from unwanted pregnancies, unattended or complicated deliveries, sexually transmitted diseases, etc.) are too often denied a voice.

Intergenerational impacts also legitimate public concern and action. An unwanted pregnancy (whether it happens to a girl or her mother) can remove that girl from school, as can the death of a mother from HIV/AIDS or pregnancy complications. The social and economic impacts of failures to invest in health, including comprehensive reproductive health, affect the quality of life and the course of development of countries. Over half of the burden of disease afflicting women of reproductive age in developing countries is related to sex and reproduction. Significant externalities justify public expenditure.

The PoA recognizes that the true goal is comprehensive quality reproductive health care in the context of primary and higher level health care systems. Priorities among the components must be made on the basis of existing needs, existing capabilities, community demand, and the availability of efficacious interventions. Rather than rehearse arguments about the value of family planning (the World Bank has long recognized it as a cost-effective high-priority component of basic health-service packages), I would simply contend that it is a central component of overall reproductive health, particularly in light of both the extent of unintended pregnancy and sexual and reproductive diseases. Unmet needs for reproductive health services exact too large a social and personal burden to be glibly dismissed as part of the condition of being poor. Dr. Eberstadt's indifference to equity concerns conceals a profound insensitivity to the pain, suffering, and restricted opportunities of women, particularly poor women.

Though others might be better respondents, I also suggest that he misrepresents the Population Action International "reproductive health index." China (ranked 32th from the best), North Korea (34th), and New Zealand (35th) are in the Low Risk country category (25 countries are in the Very Low Risk category—admittedly, mostly wealthy industrialized countries). The Low Risk category is described by PAI as follows: "In most of these 35 countries, fewer than 1 in 20 teenage girls gives birth annually and women have, on average, fewer than

three children. While almost all women receive care in pregnancy and childbirth, they are still five times more likely to die from maternal causes, on average, than are women in the Very Low Risk countries. Abortion is available on request in many of these countries. HIV prevalence is below 1 percent of adults in all but one of the countries in this category." Serious arguments could be made for different weights to the diverse elements of the profile that would shift the ordering within the useful broad categories. But Dr. Eberstadt's general mischaracterization is not analysis but polemic.

There is no "semiotic schism" about reproductive health. There is full unanimity (even, I would hope, with Dr. Eberstadt) on the importance of fully voluntary and informed choice, comprehensive services and women's opportunity and empowerment. Our efforts are directed towards that end with full respect for the letter and spirit of the PoA principles. I welcome his voice in helping hold countries accountable for programme failures, and hope he would also recognize progress in ensuring that basic rights are upheld and basic needs are met whenever and wherever it occurs. I regret his apparent contempt for the goals.



***Carmen Barroso***

I will address the issue of whether or not Cairo signaled a new approach to population policies, which is different from the "crusade to depress birth rates" Dr. Eberstadt so deplores.

The Cairo Program of Action offered a careful assessment of demographic trends and their implications, and these are presented in the context of sustainable economic growth and sustainable development. Furthermore, it does not establish targets, which had been misused in the past. The Program of Action asserts clearly the primacy of individual rights, reproductive health, and gender equity. Chapter II (on Principles) is based on universally recognized international human rights. Principle 4, for instance, states that "advancing gender equality and equity and the empowerment of women, and the elimination of all kinds of violence against women, and ensuring women's ability to control their fertility, are cornerstones of population- and development-related policies."

Numerous articles in the Program express the new reproductive health paradigm. Paragraph 7.3, for instance, says that reproductive rights "rest on the recognition of

the basic rights of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children, and to have the information and the means to do so, and the right to attain the highest standard of sexual and reproductive health.” It also includes their rights to “make decisions concerning reproduction free of discrimination, coercion and violence. . .” Even fervent promoters of views which are in the minority among population experts should be able to differentiate between this language and anti-natalist population campaigns.

The interpretations that emerged soon after the adoption of the Program of Action were as revealing as the Program itself. There was a strong reaction against Cairo, coming from what Dr. Eberstadt would consider the anti-natalist camp. For some influential population professionals, the goals set by Cairo were irrelevant (or even counterproductive) for stabilizing population growth. Elaine Murphy (from Program for Appropriate Technology in Health) and Tom Merrick (from the World Bank) addressed these criticisms in a paper presented at the 1996 Meeting of the Population Association of America, and later published in the *Harvard International Review*. They tried to assuage the fears of anti-natalists by arguing that the holistic individual-centered approach of Cairo is a more effective strategy to achieve fertility reduction and other desirable development objectives. A less sophisticated person might even think that their argument reinforces the thesis that Cairo is, in fact, part of an anti-natalist campaign. But the compatibility between reproductive rights and fertility reduction does not mean anything more than that. A win-win correlation for many; a dubious situation only for those who espouse a pro-natalist ideology.

The real test of the Cairo approach is the degree to which each country is taking up the commitments contained in the Program of Action. Many national and regional assessments have been made, but there is still no comprehensive survey of all countries’ compliance. Still, there are many encouraging signs—as pointed out, for example, by Françoise Girard in her analysis of Cairo +5 that was published in the *Journal of Women’s Health and Law*. However, there is no doubt that there is much to be done. The reality on the ground in many places is light years away from our hopes. That is why we need to join forces with Dr. Eberstadt when he states that there is a strong case to be made for voluntary family planning programs on the grounds of health. Reproductive health afflictions have been under-appreciated and should be elevated above their current status because they are pervasive and debilitating in the lives of hundreds of millions of women. Beyond that, the women’s

empowerment and anti-poverty agendas—both essential for effective enjoyment of reproductive rights—are also still very far from achieved. Rights-based population policies can help us move in that direction.



**Sonia Corrêa**

Entering the forum debate for the second time, I want to thank Stan Bernstein and Carmen Barroso for their insightful contributions in clarifying the contents of the Cairo consensus, which have not been properly apprehended by Dr. Eberstadt. However, in addition to what has been said, I want to point out that at least one core element of the Cairo consensus also appears in Dr. Eberstadt argumentation. I am referring to the abandonment of simplified frames to explain the correlation between individual decision-making, economic dynamics, and demographic trends. This aspect has been previously addressed in the debate. But it seemed important to underline it at this further stage as another crucial component of the ICPD paradigm shift as well as a point of agreement among us in spite of many divergences.

Given that Mr. Bernstein and Dr. Barroso covered most aspects that I would like to raise, I want—as promised in my first entry—to briefly examine the “Brazilian case” that has been mentioned a few times in this conversation. Starting with Dr. Eberstadt article, Brazil also appeared in Amy Coen’s reference to distortions in contraceptive prevalence and the role of family planning organizations. It then appeared in my own first posting, which emphasized persistent gender inequalities as one factor explaining the distortions and gaps in sexual and reproductive health indicators. Carmen Barroso has, in addition, touched on the successful outcomes of Brazil’s HIV/AIDS policy.

This recurrent quoting of Brazil is not surprising—after all, two Brazilians are involved in this conversation. And the country’s rapid fertility decline in the absence of a population control policy has puzzled demographers since the 1980s. However, as is often the case in international debates, the interpretation of what happened is contradictory and inaccurate. I am afraid that the bits and pieces raised here may add to the confusion. Rendered accurately, the Brazilian case may illuminate some of the core issues under debate.

Among the many authors that scrutinized the Brazilian demographic transition, Faria (Faria, V. (1989). “Políticas

de governo e regulação da fecundidade.” *Ciências Sociais Hoje, Anuário da antropologia, política e sociologia*. São Paulo: Vértice Editora) remains as the landmark point of reference. He interpreted the “surprising” fertility decline as the non-anticipated outcome of a few policies implemented during Brazil’s military régime (1964-1985): (a) the expansion of the health system and consumer credit; (b) wider social security coverage; and (c) expansion of communication systems, particularly television. Together with rapid urbanization, these policies led to a preference for smaller families. Feminist analyses have enriched Faria’s frame by including gender. Since there was (and still is) a strong male reluctance to use contraception, women became the agents of the transition.

From the early 1970s on, female demand for contraceptive methods skyrocketed. But until 1985, the public health system did not offer contraceptive assistance. Consequently, the demand was “responded to” by non-governmental family planning agencies and, predominantly, by the market. On the “good side” of this early picture, women learned—from both the family programs and the drugstores—that it was possible to regulate fertility. On the “bad side,” the lack of information and the bad quality of family planning services discredited reversible methods.

Although marginal in quantitative terms, the role of Brazil’s nongovernment family-planning system in favoring this culture of discredit was not irrelevant. In a context where abortion is illegal and reversible methods “did not work,” women rapidly moved towards a “preference” for sterilization. In absence of a clear public policy, female sterilization started being offered by various schemes (direct payment to doctors and exchange for votes in election periods). These trends were already identified by the early 1980s when, under the pressure of the women’s movements, a national women’s health program (PAISM) was formulated. Its frame and contents anticipated ICPD’s PoA by ten years.

But implementation of PAISM was slow and problematic. It was affected by political and institutional instability and by the delay in implementing the public health system—as defined by the 1988 constitution (SUS). Most principally, it has taken much time and advocacy to persuade Brazilian policymakers and health managers that it was strategic to invest in women’s sexual and reproductive health. In the second half of the 1990s, however, clear progress has been made with respect to pre-natal care, obstetric assistance, and access to abortion in the case of rape and risk of life. In 1997, a family-planning law was adopted, establishing clear norms for sterilization procedures. But the distortions in contraceptive

## POPULATION AND ENVIRONMENT LINKAGES SERVICE

### New Web site from the National Council for Science and the Environment

The Population and Environment Linkages Service brings comprehensive and reliable information to researchers, students, policymakers, government officials, and others around the world who are working on or concerned about the linkage between population growth and the environment. It was begun in response to calls for such a service in the 1994 International Conference on Population and Development (Cairo Conference) Programme of Action. This project’s innovative and rational approach to information (as well as the involvement of stakeholders in the process) seeks to facilitate greater access to material on population-environment relationships and promote more coordinated exchanges among researchers and others.

This service includes links to books, reports, journal articles, newspaper articles, news analysis, maps, conference papers, data sets, slide shows, organizations, regional overviews, laws, bills, and court decisions from around the world. Different topics can be explored on this Web site, including such issues as biodiversity, climate, conflict, demographics, development, fisheries, food, forests, freshwater, health, migration, policies, urbanization, and women.

For more information or to add a link to this site, please contact Dr. Peter Saundry, Executive Director of the National Council for Science and the Environment at 1725 K Street, NW, Suite 212, Washington, DC 20006-1401. Phone: (202) 530-5810; Fax: (202) 628-4311; and E-mail: [cnie@cnie.org](mailto:cnie@cnie.org).

prevalence (and high percentage of C-sections associated with sterilization) crystallized by ten years of policy delay are not so easily deconstructed.

Brazil's STD-HIV-AIDS program is partly a result of PAISM as well as the result of civil society pressures on the Ministry of Health. Having started later (in 1988) than PAISM, however, the STD-HIV-AIDS program benefited from a more functional public health system. Most importantly, this program was quickly given high priority by both the Brazilian government and international agencies. Since 1993, the policy has also been financially supported by a World Bank loan that ensures its institutional infrastructure, as well as by investments in the NGO sector working in advocacy and prevention.

What might explain the imbalance between the two policies in terms of priority and funding? The first is the strikingly lethal impact of HIV/AIDS; gaps in reproductive health mostly result in morbidity that is not easily measurable. But it is also crucial to remember that ineffective reproductive health policies basically affect poor women, while the HIV/AIDS pandemics impacts on both men and women and cuts across classes and income levels. One clear effect of this imbalance is that there was not, until very recently, even any collaboration between the two programs. Of course, the prevalence of female sterilization does not facilitate the prevention of HIV/AIDS among women, whose levels of infection skyrocketed the last ten years (most principally among married women).

What lessons can be drawn from the Brazilian experience? The first is that the market is not the best solution to respond to sexual and reproductive health needs; as Stan Bernstein has pointed out, it often fails. The implementation of consistent and effective sexual and reproductive policies requires policy prioritization, public funding, and a comprehensive approach. The Brazilian case speaks strongly against narrow and vertical programs, even if they are broader than family planning. It illustrates the relevance of consistently integrating sexual and reproductive health and health sector reform agendas, as recommended by the Cairo+5 final document.

Secondly, the Brazil case also suggests that a slow pace in policy implementation crystallizes distortions that are difficult and costly to correct. Donor countries that are not complying with their financial commitments as well as recipient countries that are not persuaded of the

relevance of the Cairo agenda should be aware of this. Lastly, the Brazilian story also indicates that, even when the political atmosphere is favorable, it is not easy to raise women's needs and a gender perspective to high policymaking levels. But it also tells us that when civil society voices are taken into account as early as possible in the policy process, the chances are greater of achieving a better policy outcome.

I want to end by responding to the queries Dr. Eberstadt posed directly to me. I will not extend myself with respect to my interpretation of sexual and reproductive health, as this has been brilliantly done by Carmen Barroso and complemented by my own views on the Brazilian experience. However, I want to react to the question raised about a potential divergence between my own and Amy Coen's perspectives.

It seems clear that both Ms. Coen and I are in full agreement in regard to women's empowerment and great priority to sexual and reproductive self-determination. But I will certainly disagree with Ms. Coen's position if she is advocating that these broad premises be narrowed down into simply "more funds to family planning." This move would take us back to the immediate post-Cairo controversies so well described by Carmen Barroso (translated, "given the scarcity of resources, lets get back to the well-known family-planning agenda"). And this recurrent tendency to trim down the Cairo agenda is to a large extent determined by the U.S. political climate. I can understand why, under the morally conservative rule of George W. Bush, U.S.-based organizations would do whatever they can to retain financial resources for the so-called population field. However, we will not do justice to the global nature of the ICPD "consensus" by adjusting it now and then to North American political conjunctures.

Finally, I think the major problem we face globally is not scarcity of resources per se but rather the challenge of a skewed distribution of resources—between men and women, between North and South, and between the private and public sectors. It may take long to redress this imbalance. But making efforts in that direction is also an integral part of the ICPD PoA (Chapter III). Moreover, in the course of the last 25 years of struggling for gender equality, we have also apprehended the meaning of historical patience. We can wait. 