Demographic Trends and Policies in the Quest for Sustainability

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IV. DEMOGRAPHIC TRENDS AND POLICIES IN THE QUEST FOR SUSTAINABILITY

It is high time that our two disciplines of law and medicine come together to address the issues involving demographic and environmental effects on the effort to insure a sustainable world. Dr. Eric Shivian, representing Physicians for Social Responsibility, has long worked to entice doctors into the environmental debate. He reminds us with convincing examples of the consequences of human activity on the survival of our own, as well as other, species.

The Brundtland Commission, named after the Prime Minister of Norway who chairs the Commission, is concerned with population and environmental issues. The Commission convened a special session in April, 1992 in preparation for the United Nation Earth Summit that took place in Rio de Janeiro in the summer of that year. The Prince of Wales was an active participant in this meeting, and in his address he said, “Two simple truths need to be writ over the portals of every international gathering about the environment. We will not slow the birth rate much until we find ways of addressing poverty, and we will not protect the environment until we address the issues of population growth and poverty in the same breath.”

The Prince is indeed correct in asserting that poverty cannot be
ignored. Without doubt the less developed countries, largely of the southern hemisphere, are preparing to confront the North in the next year’s World Conference on Population and Development in Cairo on the issues of inequity which affect population growth. Whatever the outcome, however, the amelioration of poverty and economic inequity is certain to be a slow and incremental process, and time is a luxury the world can no longer afford. With environmental deterioration accelerating, and the numbers of young men and women entering reproductive age increasing by twenty-eight percent just in the next decade, bold population policy and vigorous promotion of family planning is clearly necessary. The debate about the relative effectiveness of social and economic development versus strong family planning promotion has continued for almost thirty years. While each approach can be effective in its own right, the success stories in curbing population growth have been mostly in countries where social and economic development and a strong family planning program have had an additive effect. While both efforts ideally go hand in hand, inevitably economic development is slower, particularly in the so-called least developed countries. In the interim, policies which support female education, improved health, and child survival combined with provision of family planning will contribute to slowing the pace of their rapid population growth.

In spite of a loud minority, the overwhelming consensus is that population growth must be contained. While I prefer to believe that I am neither a “Cassandra” nor a “Pollyanna,” I agree with those who claim that world population will be stabilized in the coming century, but at what level? Whether growth will stop at eight billion, or ten or fifteen billion and at what cost in the quality of life of future generations is what troubles many grandparents, of whom I am one!

By 1993, a large majority of developing countries acknowledge the detrimental effect of their rapid population growth and the resulting economic hardship and deterioration of their environment. Support for explicit population policies is growing. Its implementation is tailored to each country’s social, economic, and cultural circumstances, but presently 129 countries provide direct support for family planning, with seventeen more providing it indirectly in the context of maternal and child health. Only four countries still discourage family planning. As a result, the most recent round of demographic and

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health surveys conducted by the Population Council produces clear
evidence that desired family size is declining. The United Nations
Population Fund reports a ten-fold increase over the estimated forty
million couples in developing countries who were using some form of
family planning in 1971, and a reduction in the average births per
woman in the developing countries from six children in the period
between 1965 and 1970, to 3.8 children by 1991. This represents a
remarkable drop of thirty-seven percent in a relatively short time.
Slightly more than half of the world’s couples now practice some form
of contraception, either to delay the first birth, to increase birth
intervals, or to limit family size. Despite wide regional variation,
desired family size is even beginning to decline in Africa, where
contraceptive prevalence is still the lowest in the world, largely due
to persistent cultural constraints. Accordingly, some attention is be­
ginning to shift from emphasis on the demand side to the supply side
of implementation of population policy. According to data released by
Population Action International (formerly called the Population
Crisis
Committee), there are 300 million couples who still lack access to safe
and effective contraception at the present time.

Aside from the provision of services, there remain very significant
medical, cultural, and religious barriers to access yet to be overcome.
These are now being addressed in family planning programs through
a number of changes in the way and in the atmosphere in which
services are delivered. Family planning is increasingly being inte­
grated into primary health care in general and maternal and child
health services in particular. In recognition of the health benefits of
child spacing and family size limitation, there is a well established
statistically valid health rationale for delaying the first birth, for
lengthening the interval between births, and for limiting family size,
irrespective of the issue of population growth. In Nigeria, for exam­
ple, Dr. Ransome Kuti, Minister of Health (and a highly respected
pediatrician) has encouraged family planning as preventive medicine
and an integral part of primary health care. Nigerian women under
age eighteen or over thirty five, women whose last pregnancy was
within two years of the current pregnancy, and women with more
than four children, are designated as obstetrically “high risk.” These
categories, based on pregnancy outcome statistics, call for specific
counseling on family planning in the course of prenatal care. The
concept of “too soon, too close and too many” is similarly being

adapted as part of maternal and child services in other developing countries.

The conduct of family planning education and service delivery is also changing. What was once known as "motivation" in the past has too often led to overzealous salesmanship, often with material incentives. This is now steadily giving way to education and an emphasis on counseling. The training of family planning providers is emphasizing "quality of care." In several training workshops which I recently attended in East Africa, the curriculum included equal contents pertaining to elements of counseling and quality of care exercises along with the contraceptive technology subjects.

The demographic and health surveys program along with current studies in cultural anthropology indicate that even some of the deeply rooted cultural barriers to birth control are subject to change. One example involves historically negative male attitudes toward family planning. I recall conducting a postpartum clinic in a large teaching hospital in Uganda in 1969, where the mothers, many of whom already had six, seven, or eight children and wanted "a rest" were forbidden by their husbands to accept family planning. Such "veto" power on the part of men is beginning to change as the heads of state in several African countries have utilized their official authority to encourage husbands to allow their wives to practice birth control.

The resistance to family planning in cultures where ancestry and descent and the fear of family extinction have been a preoccupation for many generations is also beginning to change. An example is in East Africa, where anthropologist Jack Caldwell and his colleagues have discovered that three countries, Botswana, Zimbabwe, and Kenya, have achieved a reduction in infant mortality to a rate below 70 deaths per 1000 births, and these are the only countries in sub-Saharan Africa which have reached this level (generally above 100/1000 births among other countries in the region). At the same time, these are also the only three countries in which the ten percent threshold, which is considered an indicator that fertility decline has begun, has been exceeded. In these countries, between twenty-seven and forty-four percent of women are now using contraception.

Economic realities have also affected attitudes. A farmer in rural China recently told me that there is now so little land that can be divided for the next generation to inherit that there is no longer an

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incentive to have a large family. Fathers to children in Thailand with limited means have asserted that with the advent of compulsory primary education the cost of school fees and school uniforms are a deterrent to the traditional large family. While clearly much more change is yet to be achieved, these few examples exemplify that attitudes are subject to change and beginning to do so.

What are the macroeconomic realities in the quest for sustainability? As the pursuit of population stabilization progresses, it is now estimated, according to the Brundtland Report, that the current worldwide levels of monies spent on population programs of about 4.5 billion dollars per year will have to be doubled to nine billion by the year 2000. This figure is based on a United Nations target to increase the number of couples using family planning in developing countries by fifty percent in this decade. The nine billion dollar annual target includes about 4.5 billion from international assistance, 3.5 billion from governments of developing countries themselves, and about one billion from users. Actually a number of the major donors have begun to increase their population assistance in spite of the difficult economic situation of the past decade. International funding tripled over the last two decades, but adjusted for inflation and for the number of couples entering the reproductive age, per capita support has continued to be underfunded.

A few examples of increasing support are as follows: The World Bank is now finalizing plans to expand its annual population assistance from $300 million in 1991 to $500 million by the year 2000; The United Nations Population Fund, with ninety-six donors in 1991, increased its income to $225 million in that year. That is an increase of 5.9 percent and it expects a similar increase in 1993; and The European Economic Community has joined the circle of multilateral donors, and now shows a willingness to lead large efforts out of Europe.

Perhaps the most important developments have been in government activity in the population field among developing countries themselves. In addition to increased support for female education, which correlates closely with reduced fertility, the legitimization by government officials of the practice of family planning, as noted above, has helped to shift cultural attitudes toward fertility control, with an impact particularly on male attitudes.

Finally, a brief summary of the role of the United States in this multinational effort is in order. Ever since the 1960s the United

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States has been a leader in international support for population projects, although in the decade of the 1980s our leadership was eroded during the Reagan and Bush Administrations. The executive branch was responsible for withholding funds for the United Nations Population Fund and the "Mexico City Policy" which led to cessation of support of the International Planned Parenthood Federation. The policy also prohibited U.S. assistance to foreign non-governmental organizations which provide abortion information or service.

In spite of these constraints, congressional support for family planning assistance to developing countries continued. With the support of Congress, the U.S. Foreign Aid Funding Bill for fiscal year 1993 increased international population assistance to $350 million. This was an increase of $100 million over the 1992 level. The newly-elected administration headed by a president strongly supportive of reproductive rights, and a vice president who is a dedicated environmentalist, promise a greater U.S. leadership in the next decennial United Nations Population Conference to be held in Cairo in 1994. The president has already signed the memorandum overturning the infamous Mexico City Policy.

Although the U.S. has traditionally been the largest donor in terms of actual dollars, our annual population assistance still amounts to only three-tenths of one percent of our gross national product, while several other donor nations provide proportionally more. Whether the favorable attitude of the new administration and the Congress will be translated into tangible funding increases in the face of our current budget crisis remains to be seen. Meanwhile, the fact that the number of reproductive age couples in developing countries continues to outpace the total effort of multinational population assistance can no longer be ignored. The world's population is still growing at the pace of 100 million per year, threatening the sustainability of our fragile global environment. Whether the combined political will and economic strength of both developed and less developed countries will meet this challenge depends heavily upon actions to be decided at the 1994 World Conference in Cairo on Population and Development. Let us all stay tuned!