VIEWPOINT

Population Policy, Research and the Cairo Plan Of Action: New Directions for the Sahel?

By Sara Pacqué Margolis

In the years following the 1994 International Conference on Population and Development (ICPD) in Cairo, Egypt, academic researchers have engaged in intense debate over the potential gains and losses that might result from the revolutionary changes that underlay the Cairo Plan of Action. Alison McIntosh and Jason Finkle, for example, argued that during the preparatory activities for the Cairo conference, a new approach to population growth evolved—one that favored the interests of the individual over those of society.[1] Population policy was redefined by means of an emphasis on reproductive health and the empowerment of women, while the traditional macrolevel demographic rationale that links population and development was downplayed.

McIntosh and Finkle concluded that as the Cairo Program of Action was negotiated, the demographic chapter was severely cut, and that "this dilution of the document's demographic content has led population specialists to criticize the inadequacies of relying on a policy focused on the individual in those areas of the world where there is little demand for contraception, where economic development is stagnant or declining, and where religion and culture tend toward pronatalism."[2]

The francophone Sahelian region (specifically, the countries of Burkina Faso, Chad, Mali, Mauritania, Niger and Senegal) is an area of the world usually thought to embrace all of the characteristics referred to in the previous sentence. I contend here, however, that in reality the Sahel differs from the above description. In fact, a critical adjective is missing from the above quote if it is to be applied to the region: "In those areas of the world where there is little *apparent* demand for contraception, where economic development is stagnant or declining, and where religion and culture tend toward pronatalism," a policy paradigm emphasizing basic individual human rights with a focus on health—especially for the least empowered—may be more likely to result in national demographic objectives being reached.

Policy and Research Agenda

A basic premise of my argument is that population policy shapes the nature and content of research, which in turn drives the information base available for program planning. The pre-Cairo, macrolevel demographic rationale that shaped population policy emphasized analyses of interrelationships between demographic, economic and environmental parameters and principally required data from censuses and surveys. In the Sahel, this demographic rationale, which underlay population policies and programs before the ICPD, reinforced what a United Nations (UN) document argues to be a francophone emphasis on "technical" (quantitative and descriptive) rather than "substantive" (interdisciplinary and explanatory) demographic training and research.[3]

Few francophone African universities offer demographic training, and their capacity to undertake demographic research is limited. Consequently, in francophone Africa, the majority (70–80%) of demographers have been trained at the Institut de Formation et de Recherche Démographiques (IFORD), the UN-affiliated regional center in Cameroon, which offers a masters-level program.[4] In its course work and field applications, IFORD provides training primarily in formal and statistical demographic methods and in survey methodology. In this capacity, IFORD has been tremendously successful in fulfilling its mandate: the creation of a cadre of professionals able to collect and analyze data for socioeconomic planning. Partly as a consequence of the technical orientation of IFORD's training, though, francophone African government offices do not have the human resource capacity to undertake explanatory demographic analyses on any significant scale.[5]

The Centre d'Etudes et de Recherche sur la Population pour le Développement (CERPOD), a Sahelian intergovernmental population research center, has attempted to address this bias toward formal, statistical analyses in the region. It has developed an intersectoral research agenda and implemented new research initiatives that incorporate qualitative and microanalytic studies of communities and individuals.

However, progress toward a more intersectoral and explanatory (particularly a more reproductive health–oriented) approach has not been easy. The larger regional intergovernmental system of which CERPOD is a part (the Comité Inter-Etats pour la Lutte Contre la Sécheresse au Sahel, or CILSS) is still driven by the pre-ICPD demographic rationale which argues that a rapid rate of population growth is an important constraint to sustainable development in the Sahel. As a result, the CILSS mandates research on the linkages between population growth, food security and natural resource management.

Consequently, CILSS officials have questioned CERPOD's work in the domain of reproductive health. To these officials, the reproductive health sector seems to be beyond the demographers' field of application. Furthermore, as CERPOD increasingly attempts to expand its research methods to include qualitative research

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and microanalytic studies of communities, families and individuals, staff members are called upon to defend their use of scarce resources on studies that in the view of the CILSS are of limited scope and questionable relevance.

It is apparent that demographic training and research in the Sahel have for the most part been limited to macrolevel functions such as the collection and analysis of census and survey data. The content and scope of this analysis and training are constrained by the demographic rationale underlying the region's population policies, which were drafted and adopted in the late 1980s and early 1990s. I believe that the demographic information base and related analyses derived from census and survey data have distorted understanding of the region's demographic parameters. Specifically, the demographic rationale has prevented advances in the content and form of demographic training that have occurred elsewhere. The resulting restriction in the nature and scope of demographic research has led many to hold a mistaken conviction that there is little demand for contraception in the Sahel.

The Sahel's Demographic Reality

There are a number of reasons to believe that the apparent lack of demand for contraceptives among those in the francophone Sahel region may be in part an artifact of predominant demographic survey methodology. First, as a result of the social and cultural proscription on premarital sexual activity—and, more importantly, on premarital childbearing—in the Sahel, many surveys have not asked adolescents and young women who are not in a union about their reproductive history and intentions.

Second, in this region, marriage is a process rather than a discrete event; thus, in combination with the known problems of age and date reporting, it is difficult to assess with any confidence trends in age at first sexual activity, first marriage and first birth and their chronological ordering. Finally, for unmarried adolescents, admitting involvement in stigmatized behavior such as premarital sex, childbearing, abortion and contraceptive practice is extremely difficult.[6]

These limitations clearly undermine our confidence in the validity of data used to assess levels and trends in age at first marriage and intercourse, abortion and contraceptive attitudes and practices—particularly as these data pertain to adolescents and women not in a union. A recent example brings this problem into bold relief. During the pretest of the Mali Demographic and Health Survey (DHS), out of 230 women in the Bamako sample, only one admitted to having ever had an abortion.[7] The survey team and the DHS resident advisor seriously questioned the validity of this information, sensing the respondents' discomfort in answering the questions on unwanted pregnancy and abortion.

Their skepticism would appear to be supported by clinic-based data. Although such data are known to be subject to numerous biases, physician reports suggest that the level of abortion practiced in Bamako is much higher than these survey data would lead us to believe. For example, one physician reported that more than 50% of her weekly caseload consisted of clients experiencing postabortion complications.[8] In this context, the danger is that relying solely on survey data might "demonstrate" conclusively to Ministry of Health officials and other government planners that premarital sexual activity, unwanted pregnancy and abortion are not critical problems for their populations.

In addition to the problems inherent in using survey data to investigate the very sensitive issues of adolescent reproductive health, CERPOD's research has also demonstrated the general inadequacy of macrolevel data in describing the demographic experience of Sahelian populations. In the Sahel, the demographic realities of urban and of rural life are very different. Levels of premarital sexual activity and the demand for and use of modern contraceptives may seem fairly low at the national level, but women in urban areas report substantial levels of need.

For example, an analysis of DHS data for Niamey (the capital of Niger), Ouagadougou (Burkina Faso's capital) and Dakar (the capital city of Senegal) revealed that 22–48% of all women had had sexual relations prior to marriage.[9] Although trend analysis of premarital sexual activity was not possible, focus-group research led the authors of the study to conclude that premarital sexual activity had intensified in urban areas, apparently as a result of an increase in age at first marriage. However, the quantitative analysis revealed that the intensity of premarital sexual activity in the three urban areas was not associated with their relative degree of urbanization or level of education, findings contrary to commonly observed correlations.[10]

As has been documented elsewhere for West Africa,[11] CERPOD's research confirms that the stigma surrounding adolescent sexuality is focused not on sexuality itself, but on the potential risk of pregnancy and childbirth. Focus-group findings from adolescents, parents and health service providers indicate that contrary to popular belief, the motivation among unmarried, sexually active adolescents to use modern contraceptive methods to avoid undesired pregnancy and infection with the human immunodeficiency virus is extraordinarily strong.

Furthermore, and most important for program planners, CERPOD's research indicates that this previously undocumented and still latent demand for contraception in urban areas of the Sahel is largely unmet because of tremendous barriers to contraceptive access. For example, young men and women are hindered by lack of information, poor patient-provider interactions (characterized by providers' intimidation, judgmental attitudes and condescension), lack of counseling and follow-up, and high cost.

Our understanding of Sahelian demographics has also been transformed to an astonishing degree by the relatively recent decision to include in demographic surveys women not currently in a union. In essence, this permits women to be classified according to their individual-level characteristics, rather than by their societally assumed characteristics. These new data from the Sahel demonstrate that ever-use and current use of modern contraceptives is higher among never-married, sexually active women than among currently married women.[12]

In some cases, the data strongly defy conventional wisdom. The final report for the 1995–1996 Mali DHS is among those that demonstrate that current use of modern contraceptives among women (and men) not in union and sexually active is higher than prevalence among those in union.[13] Among Malian women and men in union, the prevalence of modern contraceptive use is 4.5% and 8.5%, respectively. The corresponding levels for women and men who are sexually active but not in union are 27.3% and 47.3%.

While the higher demand for and practice of modern contraception among never-married women in the Sahel may be surprising, qualitative data from CERPOD's research suggest that these levels may be even higher than are documented in the survey data. Thus, it appears that very different research approaches, both in methods and in models, will be required to capture the true contraceptive dynamics of these Sahelian populations. Microanalytic research on birthspacing strategies, including the use of modern contraceptives in an apparently natural-fertility rural population in northern Gambia, is an excellent model of the needed approach.[14]

A New Agenda

I have argued here that the assumption that there is little or no demand for contraception in countries like those of the Sahel may in part be an artifact of the methods, models and means of demographic estimation used in the region. In other words, if you don't ask the right questions, you will get the wrong answers. If the demand and unmet need for modern contraception is misunderstood, then population programs' lack of impact may result from our failure to determine the appropriate target populations and the associated barriers to method use. This at least may be the case in the Sahel, where population programs continue to tenaciously target married men and women in their reproductive years.

In large part as a result of these observations, the U.S. Agency for International Development (USAID) mission in Mali took a nontraditional approach to the design of population activities when developing its strategic plan for the years 1996–2002. This new approach is to reduce population growth rates by targeting youths (those younger than 25). USAID's Mali strategy has been broadened to encompass activities necessary to improve the health status and well-being of youths and to generate a demand for smaller families. Based on the premise that the low status of women in Mali contributes to the demand for high fertility, the strategy focuses on girls and young women, by concentrating on an integrated package of basic education (emphasizing girls' education), child survival, reproductive health and income-generation activities for youths.

While a broad definition of "population activity" may appear to be nothing new to most academics or health and population program planners, this strategy has been met with high levels of skepticism and resistance by some, both within USAID and among development partners in the region. The strongest skeptics have often been economists and other development agents working in the fields of food security and natural resource management. This should come as no surprise, given that the traditional demographic rationale underlying population policy and programs placed population research and demographic analysis in the hands of economists. Some economists are thus naturally reluctant to allow the "population problem" to be taken out of their hands again. Furthermore, defending innovative approaches against the criticisms of skeptics can be difficult, given the meagerness of microlevel data derived from operations research and from anthropological and microdemographic studies in the region—especially when compared with the huge macrolevel demographic database underlying economists' paradigms.

Pronatalist politicians and religious leaders (enforcers of traditional culture and norms) were also expected to be skeptical. However, we discovered that these people found the individual-level health and empowerment rationale (the ICPD Plan of Action) not only acceptable, but very convincing as well. In fact, in my experience, traditional, pronatalist decisionmakers are often ready to allocate funds to population programs as a means to reach health objectives, but are rarely convinced by a societal-level demographic rationale (i.e., that population growth must be reduced to improve economic growth or national human resource capacity).

Some researchers have proposed that "norms are not behavioral straitjackets,"[15] as is often assumed. (The latter view may also be the unspoken assumption behind the quotation from McIntosh and Finkle.) Experiences with CERPOD and USAID Mali validate this proposal, and further demonstrate that norms are constantly in the process of change and construction. If we accept the premise that policy drives this construction, and that "populations readily graft new cultural norms and technologies onto their extant repertoires,"[16] then we now may be better poised in Mali to promote a new body of health-protective practices. In a highly pronatalist environment, a population policy that casts family planning as a "normative" means of protecting the health of children or of young men and women provides an invaluable counterweight to "normative" religious or political opposition to family planning.

The strength of this approach was clear when the proposed Mali "youth" strategy was presented to officials within the Prime Minister's office and the ministries of health, basic education, and foreign affairs, as well as to representatives of the many nongovernmental organizations working throughout the country. The data, though sparse, spoke for themselves—particularly the data on young age as a risk factor for AIDS infection and mortality, for maternal morbidity and mortality, and for infant and child mortality.[17]

One piece of information that particularly silenced detractors was an estimate that one out of seven women in Mali would die from maternal causes.[18] Its effectiveness related not just to the level, or to the fact that the risk of maternal death was higher in Mali than in any of the other countries in that report; its impact also derived from the explanation that in large part the risk was so great because of the high proportion of all pregnancies and births that are contributed by the youngest, "highest-risk" age-groups. In Mali, children often bear children, and the audience readily understood that in speaking of the one in seven Malian women who would die of maternal causes, we were talking about their sisters and daughters. During my six years of working in the Sahel in population policy and program development, I have never witnessed any macrolevel demographic argument in support of family planning have as rapid and forceful an impact as this individual-level health argument.

While these data did indeed speak for themselves, it was the Cairo agenda that provided us with the political mandate to speak the data. What the ICPD Plan of Action has encouraged in this part of the world is the voicing of the health needs of disempowered populations—particularly women and youths. In the case of Mali, as with elsewhere in the Sahel, it appears to be the disempowered and therefore silent demographic groups that are driving the fertility transition, yet this reality continues to be hidden behind a mask of social "appearances" constructed by long-standing biases in how data are collected, analyzed and disseminated.

Conclusion

What ends should population policy and research serve? In the Sahel, a reorientation of population programs and demographic research toward the individual may help achieve demographic objectives more rapidly than the macro approach. This reorientation includes the delivery of appropriate, high-quality reproductive health services and the attainment of a better understanding of the determinants of reproductive health behavior (such as decisionmaking within the household, financial and social costs of contraception, willingness and ability to pay, quality of care and sources of information, to name just a few).

Ironically, the rationale underlying the argument for a reorientation of population programs toward the individual and toward reproductive health is purely demographic: It has been asserted elsewhere[19] and has been suggested by CERPOD's research[20] that the African fertility transition will be characterized by fertility decline at all ages, both inside and outside of marriage. Most importantly, given the higher fertility rates among those at younger ages, the Sahel popula-

tion's very young age distribution (e.g., approximately two-thirds of Mali's population being younger than 25) and the relatively high potential demand for contraception among young (especially urban) residents, younger women will probably make the major contribution to overall fertility decline. This is likely to occur more rapidly to the extent that appropriate (high-quality) services are available. Such a scenario has already been shown to have occurred elsewhere in the subcontinent.[21]

Our goal must be to maintain the momentum. The reorientation of demographic training and research in francophone Africa could ensure the region's capacity to measure actual demographic dynamics and their determinants. Supporting the potential of the ICPD political mandate (the individual-level reproductive health mandate) can help create a new understanding of what is meant by population programs, programs that are more likely to meet the basic needs of individuals and in so doing bring about fertility decline in the Sahel.

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