

IMAP Statement

on safeguarding reproductive rights in the face of declining fertility

Profound changes in demographic patterns are taking place globally. Birth rates are falling in most countries around the world. Some governments have begun to question the legitimacy of contraception and parenthood by choice, as well as challenging the principle of gender equality.

Introduction

This Statement has been prepared by the International Medical Advisory Panel (IMAP) and was approved in November 2016.

Profound changes in demographic patterns are taking place globally. Birth rates are falling in most countries around the world. Many governments are concerned about the impact of population ageing, and its consequent effects on lower economic productivity and escalating costs for medical care for older people. Some argue that birth rates must be stimulated to increase again. A few have begun to question the legitimacy of contraception and parenthood by choice, as well as challenging the principle of gender equality.

This concern may also result in reduced focus on 'the other side of the story', namely that 225 million women who wish to avoid or delay pregnancy are not using modern contraception.¹ Such restrictive approaches contravene people's right to "reproduce and the freedom to decide if, when and how often to do so" as agreed at the 1994 International Conference on Population and Development, and reiterated through the 2015 Sustainable Development Goals.

Much of the current public discourse is based on a misunderstanding of basic demographic concepts and trends. Indeed, on average, women in countries with low birth rates want more children, while women in countries with very high birth rates want fewer on average. Therefore, the 'right' thing to do is also the 'smart' thing to do.

The purpose of this Statement

The purpose of this Statement is to provide background information to inform both advocacy and programmatic planning to support reproductive choice in a range of demographic contexts. The Statement concerns itself with declining fertility rates. It does not address infertility, or reduced capacity to conceive and bring a pregnancy to term.

Intended audience

This IMAP Statement is primarily intended for use by IPPF Member Associations and other organizations committed to ensuring choice for women and men about whether and when to have children.

Background

Here are some global demographic trends that are influencing policies and programmes.

FERTILITY LEVELS HAVE FALLEN

Globally, in 1950,* women had five children on average; by 2015, this number had halved to 2.5.² By 2015, 46 per cent of the world's population lived in countries with fertility at or below the so-called 'replacement level' of around 2.1 children per woman. Around 10 countries had 'lowest low' fertility at 1.3 or below (including Moldova, Singapore and Spain). However, the average remains at five children per woman in sub-Saharan Africa, with around six countries at the 'highest high' fertility levels, above six.^{3,4}

* Data sourced from the United Nations Population Division often refer to a date range (for example, 2010–15). For ease of reference, we refer to the end point of the range (for example, 2015).

Some countries, especially in Eastern Europe, have seen temporary stagnation or decline in life expectancy. Estimates show that improving life expectancy would have a greater effect on preventing population decline than attempts to increase birth rates.

LIFE EXPECTANCY HAS INCREASED GLOBALLY

Average life expectancy increased by 50 per cent in the period 1950 to 2015, from 47 years to 71 years. However, some countries, especially in Eastern Europe, have seen temporary stagnation or decline in life expectancy. Estimates show that improving life expectancy would have a greater effect on preventing population decline than attempts to increase birth rates.⁵

EFFECTS OF MIGRATION – IMMIGRATION AND EMIGRATION

Migration significantly affects population growth and structure. In general, Western Europe and the USA have experienced immigration, which has contributed to their current modest population growth, whereas Eastern Europe has experienced emigration, further contributing to population stagnation or decline. However, the general trend is that fertility levels of immigrants gradually adjust to that of host populations. For example, in Denmark in the period 2009–13, the overall total fertility rate was 1.8. Western immigrants had a total fertility rate of 1.5; non-Western immigrants of 1.9.⁶

POPULATION GROWTH IS SLOWING

As global fertility levels decline, population growth is slowing. Around 20 of the 100 or so countries with low fertility levels are experiencing population decline. The rest still have a high proportion of women of reproductive age along with net immigration, which results in modest growth.⁷ However, global population is still growing by 80 million a year. It is estimated that the majority of world population growth will take place in sub-Saharan Africa, where population is projected to quadruple from 1 billion to 4 billion between 2015 and 2050.⁸

OPPORTUNITY FOR A 'DEMOGRAPHIC DIVIDEND'

Declining fertility results in an opportunity for a 'demographic dividend'. In high fertility countries, the proportion of children is high. When fertility declines, the proportion of children also declines, and the proportion of people of 'working age' (often referred to as those aged 20–64 years) increases. After several decades, the proportion of 'older people' (those aged 65 years and above) increases. This transition takes several decades. It is seen as a window of opportunity, where a possibility for a 'demographic dividend', and economic growth, is high. It has been credited with one-quarter to one-third of the economic growth in East and South East Asia since 1970.⁹

However, economic growth and demographic growth are not automatically linked. 'Working age' is not a demographic concept but is a policy decision that defines retirement age: at various times it has been 50–55 in China and 60–70 in Europe. 'Working age' does not translate into 'working'. Employment rates vary greatly and in many countries there is a large proportion of young unemployed people. Promoting increased birth rates in countries with high youth unemployment makes little sense. Finally, reaping the economic benefits of the dividend depends not only on the proportion of the population in the workforce. It also depends on whether the working age population is healthy and educated, permitting capital accumulation and rising productivity for a second demographic dividend, as people can work into older age if jobs are knowledge-based and require less demanding physical labour.^{10,11,12}

Therefore, policies which promote the general welfare of the population also make economic sense, and may have greater impact than focusing only on increasing the birth rate.

GENDER EQUALITY MAY BE ASSOCIATED WITH HIGHER BIRTH RATES

As late as the 1990s, the OECD countries* that had the lowest fertility levels were those where women had the highest levels of participation in the labour market. This trend has now been reversed: countries with the highest female labour participation rates have the highest fertility levels. The shift seems related to economic stability, flexibility of labour markets that allow part-time work, availability of child care as well as equitable gender relations at home.^{13,14,15,16,17,18}

GAP BETWEEN ACTUAL AND DESIRED NUMBER OF CHILDREN

On average, women in high fertility countries want fewer children than they have; in low fertility countries they want more. One study estimate states "in the last 20 years, the level of unwanted births has stayed at 2 across African countries but has, on average, decreased from 1 to close to 0 in other developing countries," mostly for women with little education.¹⁹ The situation is the opposite in low fertility countries. For example, in the 25 member countries of the European Union in 2011, the average actual total fertility rate was around 1.6, but the mean personal ideal number of children was 2.4. The biggest gap between actual and desired numbers was for women with higher education.²⁰

* OECD is the Organisation for Economic Co-operation and Development.

EFFECTS OF INFECUNDITY ARE INCONCLUSIVE

Infecundity is not yet conclusively identified as contributing to low fertility. One of the few studies to compare levels of infecundity concludes that levels are fairly similar in high, middle and low income countries, and that they have not changed significantly over the past two decades, although they have declined somewhat in sub-Saharan Africa and South Asia.²¹ However, births in the European Union increased in the period 2000–08, only to decline after the financial crisis. This pattern is unlikely to have been caused by an epidemic of infecundity after 2008.²²

ESCALATING HEALTH COSTS ARE NOT CAUSED PRIMARILY BY AGEING POPULATIONS

Health costs are escalating in many high income countries, partly due to the increasing health needs

of an ageing population who experience more illness than younger people. However, while these challenges are real, there is also evidence to indicate that increasing health care costs are not only related to ageing but also to inefficiencies of health systems as well as the number of healthy life years which varies significantly from country to country. The main proportion of increasing medical cost is due to increasingly expensive medical treatment for all ages.

RATIONAL CONCERNS OVER PRESSURE POINTS

Changing populations, declining population size and ageing are pressure points and trigger rational concerns related to health, economics and migration.²³ In 2013, 37 per cent of governments worldwide had policies to lower population growth, 20 per cent had policies to raise it.²⁴

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GOVERNMENT APPROACHES TO DECLINING FERTILITY

Limiting access to family planning and disincentives

There are several historical examples of countries **limiting access to contraception** for demographic reasons (for example, France in 1920, Romania in 1966, Bulgaria in 1968), but no clear current examples.

On limiting access to abortion, there are numerous recent examples of political debates, but few enactments of restrictions based on a more or less explicit demographic rationale (for example, Georgia, Japan, Macedonia, Russia, Serbia, Singapore, Turkey). Many of the restrictions relate to 'waiting periods' for women to decide whether or not to go ahead with an abortion, and religious authorities have been active in some debates.^{25,26}

In Iran, proposed disincentives include **limits to access the labour market** for unmarried men and women.²⁷ These measures are found to have little effect on fertility over time, as couples find other ways to circumvent policy.²⁸

Incentivizing higher fertility

This includes two major types of incentives:

Targeted pro-natalist measures include financial incentives (cash, services, tax breaks). In the OECD33 countries, the average expenditure on these measures is 2.55 per cent of gross domestic product.^{29,30} Countries using this strategy include Austria, Germany and Russia, and Ukraine until 2014.³¹

Broader family and societal measures that facilitate reconciliation of childbearing and work include workforce reforms; paid and employment-protected parental leave (varying between 0 weeks in the USA to 164 weeks in the Slovak Republic); accessibility of child care (for the proportion of children aged under three enrolled in child care, it varied between 65 per cent in Denmark to 5 per cent in the Czech Republic).³² In general, countries that have such broad approaches also have a higher total fertility rate (for example, Northern Europe, France) although exact causality is difficult to establish.

Toolkits have been developed that attempt to estimate the effect of each of these measures.³³ Generally, the targeted pro-natalist measures appear to have had little effect; the broader family and societal measures have somewhat more impact.³⁴

Adaptation

This includes both reforming pension systems to become more sustainable, but also moving away from seeing low fertility as a 'problem to be solved' but rather as a symptom of societal issues such as economic uncertainty or gender inequality and, indeed, questioning the conventional wisdom of believing in 'replacement level fertility' as an ideal.^{35,36}

It is vital to continuously assess national policies related to reproductive rights, in particular any that use inappropriate demographic arguments to reduce clients' full, free and informed reproductive choices, or that propose perverse incentives and coercive practices related to reproductive choice.

In summary, countries have adopted many policies to try to increase birth rates. They include restricting access to family planning, which has little effect in the long term. Other policies provide cash incentives to families who have more children, but the present demographic consensus is that these policies are extremely expensive, yet have little effect. Countries have also improved general support for families, such as child care, and this seems to have had some effect on birth rates, as well as improved welfare in general.

Recommendations for Member Associations

FOR PROGRAMMING

- Continue to provide or refer clients for contraceptive services that support full, free and informed choice – including a diverse contraceptive method mix, and a wide variety of service delivery and price points – and provide comprehensive and integrated sexual and reproductive health services. Ensure that these services are available for both older and younger clients, as the demographic profile of the country changes.
- Ensure explicit and supportive counselling on reproductive intentions as part of all contraceptive and peri-natal service provision.
- Infertility care is often neglected in the continuum of care in reproductive health. Ensure infertility care and prevention is included in service provision.

FOR ADVOCACY

- Continuously assess the government's approach to demographic changes. If appropriate, link up with demographic experts to help interpretation (including IPPF Central Office). Utilize the messages presented above to challenge the view that increasing the birth rate is the main solution to economic problems.
- Advocate for government to take advantage of the demographic dividend by investing more in young people.
- Continuously assess national policies related to reproductive rights, in particular any that use inappropriate demographic arguments to reduce clients' full, free and informed reproductive choices, or that propose perverse incentives and coercive practices related to reproductive choice. Advocate for universal access to information and services as stipulated in the Programme of Action of the International Conference on Population and Development.

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GLOSSARY: KEY CONCEPTS

Demography refers to the scientific study of human populations primarily with respect to their size, their structure and their development.³⁷

The demographic dividend refers to a temporary situation in which fertility rates have recently dropped, resulting in a high proportion of working age to non-working age population.³⁸

Dependency ratio refers to the ratio of people who are not of working age divided by those who are of working age. The definition of 'working age' is variable. For example, total dependency ratio is sometimes defined as those aged (0–19) + (65+) divided by those aged (20–64). Old age dependency by that definition is those aged (65+)/(20–64).³⁹

Europe, unless otherwise stated, refers to countries included in the United Nations European Commission for Europe.

Infertility is defined as "a disease of the reproductive system defined by the failure to achieve a clinical pregnancy after 12 months or more of regular unprotected sexual intercourse."⁴⁰

Low, middle and high income countries are terms defined by the World Bank as countries with an average yearly gross domestic product per capita in 2014 of under US\$1,045, between US\$1,045 and \$12,736, and over US\$12,736 respectively.⁴¹

Medically assisted reproduction is reproduction brought about through ovulation induction, controlled ovarian stimulation, ovulation triggering, or assisted reproductive technology procedures, and intrauterine, intracervical and intravaginal insemination with semen of husband/partner or donor.⁴²

Population momentum refers to the tendency for population growth to continue beyond the time that replacement level fertility has been achieved because of the relatively high proportion of women in the childbearing years (generally defined as ages 15–49).⁴³

Replacement level fertility refers to fertility rates that under current mortality conditions ensure that newborn girls will bear on average one daughter, meaning that a population exactly replaces itself from one generation to the next, without migration. In most populations that level is 2.1. It is more than 2, as it takes into account two factors: 1) some children will die before reaching reproductive age, and 2) sex ratio is usually at least 1.05 boys for 1.00 girl. The former factor is greater in populations with high mortality (for example, in some African countries 10–15 per cent of the population die before reaching reproductive age). The latter is greater in populations where sex selection occurs (for example, in China sex ratio at birth is estimated at 1.19). In those situations replacement level fertility will be higher.⁴⁴

Total fertility rate is the average number of children a hypothetical cohort of women would have at the end of their reproductive period if they were subject during their whole lives to the fertility rates of a given period and if they were not subject to mortality. It is expressed as 'children per woman'.⁴⁵

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WHO WE ARE

The International Planned Parenthood Federation (IPPF) is a global service provider and a leading advocate of sexual and reproductive health and rights for all. We are a worldwide movement of national organizations working with and for communities and individuals.



IPPF
 4 Newhams Row
 London SE1 3UZ
 United Kingdom

tel: +44 20 7939 8200
 fax: +44 20 7939 8300
 email: info@ippf.org
www.ippf.org

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