and large, very religious. Thus, there are strong reasons for studying South Asian countries collectively.

THE ROLE OF POPULATION PLANNING PROGRAMMES

As already pointed out in the introduction, fertility has not declined notably in South Asia despite official anti-natalist policies in the region. As early as the 1960s almost all the South Asian countries acknowledged high population growth rates, too high to be sustained by the prevailing economic growth rates. The alarm of these high population growth rates was felt largely because of rapid declines in mortality experienced by South Asian countries soon after they achieved Independence in the late 1940s. Consequently, each of the states has adopted an official family planning programme with a fairly active propagation of fertility control within marriage.

For differing reasons, the population programmes of each of the South Asian countries are not regarded as particularly successful. In fact, the programme in Pakistan, and in the most part, in Bangladesh and Nepal can be termed unsuccessful in their primary objectives of bringing fertility rates down and in raising contraceptive use rates which have not changed radically in these countries. Also, in India where fertility decline has been noted for 1960–1985, it has occurred more in the recent past. Sri Lanka is the only country where fertility has declined substantially and contraceptive use rates are notable. Thus the major question to be addressed, in the context of lack of fertility decline in South Asia, is why population programmes lacked success in this setting.

In most cases in South Asia the need for a programme and the nature of services to be provided, (with the exception of some non-governmental organizations), evolved from policies at the top which were administered down. Fertility policies were rarely discussed with the community for whom the services were designed. Because of the doomsday scenarios presented to prompt government action to be taken, careful planning of fertility policy, in terms of a particular country's needs, may have been sacrificed. Hasty decisions, based on expediency usually prevented feasibility studies to be made of indigenous methods preferred and the adaptability or suitability of the modern contraceptives to be introduced.

Unfortunately one negative outcome of this expediency has lead to misgivings about modern contraceptives in South Asia [Mamdani (1972)]. The negative publicity of the failure of certain methods and the fear of side-effects of methods such as the widely used IUD has had a damaging effect on the success of population programmes in South Asia. Illustrations of this are that to date, the proportion of women who say they want no more children but who do not want to use available methods due to fear of side-effects in Pakistan, is non-negiligible [Government of Pakistan (1986)]. Also the experience of forced sterilization during the period of the

Emergency in India has been a source of negative publicity for family planning efforts far outlasting the actual period of implementation. Experimentation with previously widely untested methods and a hasty formulation of fertility policy may have been a strong reason for the lack of success of population programmes in South Asia.

The success of family planning programmes ultimately depends on how they are administered at the grass-root level. Accessibility and relative ease faced by the potential user in utilizing a supply outlet is critical. In many of the South Asian programmes this crucial link has not been given much heed. Programme outlets tend to be concentrated in urban areas and are very sparsely available in rural areas where the majority of South Asians reside. One important element on the supply side in the case of South Asia has been the lack of suitable personnel, (in particular female staff who are critical in a setting where sex segregation is strictly observed) who are willing to work at government salaries particularly in the more remote rural areas. Another supply-side constraint is that though family planning services are ideally combined with a strong maternal child health programme and melded in with existing health outlets, such an amalgamation has only recently been taken up with conviction in most of South Asia.

The failure of the population programmes in South Asia, in contrast to those of South East Asia, can be partly attributed to the reasons that they were not in tune with the target population's need. Merely providing a target population with contraceptives, even though the supply of family planning outlets may in fact also be a constraint, can only achieve limited success. In terms of dissemination of knowledge of methods of contraception, the success of the programmes, has been more notable, however. For instance, in Pakistan, knowledge of at least one contraceptive method has been in the region of 60–65 percent since 1968-69 soon after the inception of the programme in 1965 (National Impact Survey 1969). Thus, despite the notable pervasiveness of knowledge of the existence of a means of fertility control, there is considerable resistance to its adoption. This is in contrast to the situation in Europe where sharp declines in fertility were achieved in the absence of modern contraceptive technology. This technology is more readily available (even if only in few selected clinics) in developing countries today. Thus the low contraceptive use rates found in South Asia reflect not just a failure of the programmes to provide contraception in an acceptable and accessible form, (which may perhaps be an easier issue to tackle) but *also* the general desirability of high fertility in these societies.

DEMAND FOR CHILDREN AND CHILD-SURVIVAL

One of the binding common characteristics shared by South Asian countries is that large numbers of children are considered desirable. In the most part, children

continue to be advantageous to the family: they are less costly than their anticipated returns (economic and social) and their calculus has not altered much over time. Thus the view widely held 15 to 20 years ago, that high fertility was an outcome of the populace's lack of awareness of birth control was clearly a wrong premise on which to base optimistic scenarios of fertility decline. A strong family planning programme can be effective in expediting or enabling couples to control their fertility only when substantial proportions of them have the desire to control family size. In the absence of that precondition, fertility policy would be more fruitfully aimed at efforts to tackle change in fertility norms. Economic support of high fertility can undoubtedly only be removed once the economies of these countries become sufficiently advanced. Also religious beliefs are thought to be a hindrance for fertility programmes in South Asia. Although the three major religions, Buddhism, Islam and Hinduism are practised in South Asia it is more the religiosity and the beliefs attached to the importance of fartility rather than the actual prescriptions of the religions which emerge as a negative factor in the acceptability of fertility control.

Whereas most of South Asia has experienced declines in mortality since the 1920s in the case of Sri Lanka and 1940s and 1950s for India, Pakistan and Bangladesh, infant child mortality rates in the region remain notably high with the exception of Sri Lanka. About one-fifth of children die before reaching age 5 in most of the South Asian countries even in 1985 [World Bank (1988)]. The low chances of child survival are a factor to be contended with when explaining the lack of fertility change. These may at least have affected the lack of change in desired family size over time in the countries of South Asia. Fertility policies in South Asia have only recently made the link between the low survival of children and high fertility. Thus policies to increase child survival, with a view to their close impact on fertility, have only been utilized in recent years.

THE ROLE OF DEVELOPMENT ON FERTILITY

Though targets of fertility reduction are incorporated into the official plans of most of these countries, they are not usually integrated with other development efforts. Thus, fertility policies and economic and social planning are treated quite separately by policy-makers. Consequently, population policy has remained isolated from other related development efforts. Though there is abundant research on the interlinkages between the social sectors, rural development, child survival strategies and improvement in women's status with the determinants of fertility and its decline, official fertility policy has only recently worked these linkages into their population programmes. Further, such interlinkages remain largely on paper and are rarely incorporated into actual interventions.

The emphasis of the programmes (except in Sri Lanka), has been almost

entirely focused on controlling fertility and not on other sectors known to affect fertility closely, such as education and health. A factor that emerges from the South Asian experience is that widespread poverty in South Asia has not prevented fertility declines from occurring in relatively poor states like Kerala in India and in Sri Lanka. Also Pakistan, which has the highest per capita income of the region, has not experienced any notable fertility decline. Thus, increases in income, at least at the national level, do not seem to be a sufficient prerequisite for fertility decline. Moreover, development in terms of rises in per capita income or even in levels of industrialization and urbanization, may be much less important than other factors such as political awareness, egalitarian traditions and particularly a more broad-based, wider access to education as preconditions for fertility decline. Such changes have not necessarily corresponded with equivalent development in most of South Asia.

The record as far as educational levels is concerned is most impressive for Sir Lanka and perhaps poorest for Pakistan and there seems to be a crucial link in the explanation of fertility decline in the former and none in the latter. In particular, Pakistan lags far behind in the achievement of enrolment rates for girls as compared to all other South Asian countries. It points to the likelihood that countries with better progress in terms of wider access for both males and females rather than increase in per capita income *per se* are likelier to experience the demographic transition faster.

With the exception of Sri Lanka, there is not just the problem of education being a low priority sector but also wide gender disparities in educational attainment rates. Since maternal education is thought to influence fertility more critically than paternal education [Cleland and Rodriguez (1988)], it is discouraging that girls and boys face quite unequal chances of acquiring schooling in the case of South Asia, in fact it is one of the peculiarities of the region, reflecting the generally lower status of females.

In the case of Pakistan, it is also found that the inequality in schooling by gender, leads to worsening odds of schooling for girls in the future generation as uneducated mothers are unlikelier to school their daughters than educated mothers. The proportions of educated mothers in South Asia are currently very low and unless the educational pyramid for girls widens rapidly, this has far-reaching negative consequences for intergenerational fertility [Sathar *et al.*(1988)].

CONCLUDING REMARKS

South Asia does seem to be following its own particular route towards achieving demographic transition. Official population programmes, though a failure in terms of bringing fertility rates down, do collectively point to the finding that:

(i) Despite the existence of officially sanctioned population programmes

and a substantial conventionally measured unmet need, there is extreme resistance to the adoption of controlled fertility; and

(ii) Though the programmes have succeeded relatively better in promoting "knowledge" of modern contraception, ready adoption of these methods has not followed.

The South Asian population programmes prove the strong intellectual point that where a strong demand for a large number of children prevails and it is coupled with far from ideal quality of family planning services, an official anti-natalist policy may have nothing but a symbolic purpose. The exceptions of Kerala in India, Matlab in Bangladesh and, of course, Sri Lanka merely support the above argument because quality of services provided as well as conditions affecting the demand of children have led them to experience fertility decline.

Also with regard to the "Development is the best contraceptive" school, Pakistan becomes a case worth studying, where rises in per capita income placing it in the middle-level economies, has still not brought about commensurate fertility declines. From the experience of South Asia it would seem that those societies which have invested more in social sectors, particularly in establishing a more equitable and widespread system of health care and education, are the ones which have experienced earlier fertility declines e.g., Sri Lanka, West Bengal and Kerala. Thus, the quality of development experienced may be more important than mere rises in levels of per capita income in terms of bringing about changes in fertility. Perhaps relative equality of distribution of resources may be an important factor in this regard.

REFERENCES

Cleland, J., and G. Rodriguez (1988) The Effect of Parental Education on Marital Fertility in Developing Countries. *Population Studies* 42 : 3.

ESCAP (1985) *Mortality and Health Issues: Review of Current Situation and Study Guidelines.* Bangkok: ESCAP. (Asian Population Studies Series, No. 63)

Mamdani, M. (1972) *The Myth of Population Control.* London: Mortality Review Press.

Pakistan, Government of (1986) *Pakistan Contraceptive Prevalence Survey 1985.* Islamabad: Population Welfare Division.

Sathar, Z., N. Crook, C. Callum and S. Kazi (1985) Women's Status and Fertility Change in Pakistan. *Population and Development Review* 14 : 3.

World Bank (1988) *World Development Report.* Washington, D C.: Oxford University Press.