Development Bank
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Population policy in South Africa:

Where to from here?

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Preface

There is growing consensus that reconstruction and development in South Africa should ensure the full and equal participation of all its people in all dimensions of the economy and society. DBSA is committed to enhancing the opportunity of all people to participate fully and equitably in the economy. Given the particular constraints faced by women, and the reality that the majority of the poorest people are women, it is essential that gender and therefore also population issues receive strategic policy attention.

DBSA does not follow an approach to demographic questions which blames population growth for poverty. Demographic trends are a reflection of socio-economic conditions, policies, and cultural factors. The key development challenge is not to lower the population growth rate, but rather to maintain an integrated approach to development which puts the improvement of quality of life at the centre. Achieving this will lead to a continued reduction in the rate of increase of the population.

The debate about population policy and its relevance to development was heavily politicised during the apartheid years. As South Africa embarks on an ambitious reconstruction and development programme it is timely to consider international and local experience objectively. A product of such objective consideration should be a fresh approach towards integrating demographic data into development planning and policy work.

This discussion paper was commissioned in order to inform Bank policy on population and was prepared by Barbara Klugman of the Women's Health Project at the University of the Witwatersrand. The advisory panel of the social dimensions of development policy programme recommended its publication as a contribution to policy dialogue.

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Section I: The international context

1. Introduction

This paper gives a brief outline of international thinking on population policy in its practical and ideological dimensions and how this has been translated into government policies in South Africa. It suggests a framework for considering demographic issues and planning, and options for the Reconstruction and Development Programme (RDP) and development institutions, such as the Development Bank of South Africa (DBSA), which need to consider demographic questions as part of their planning processes.

2. The concept of overpopulation

2.1 The relationship between the poor and resource usage

The view that population growth is responsible for a shortage of resources finds its basis in the popular concept of 'overpopulation'.

Overpopulation is defined in relation to resources and assessed in terms of per capita income, calculated by dividing aggregate income by the population. Increased per capita income can therefore only be achieved if total income is increased or if population size is reduced. The problem with this argument, however, is its use of average income as a crude measure of overpopulation, with the assumption that resources are equally divided among all members of the population, and that all members of the population have the same buying power and the same consumption patterns. In reality resources are not divided equally either at the national or international level.

The problem with the programmes developed and implemented within the overpopulation approach is that they have been imposed by countries or classes which consume more resources in order to control those which consume fewer resources without regard to consumption patterns.

2.2 Resource availability

The assumption that resources are absolute does not take into account the essential role of technology in facilitating efficient use of resources. It also ignores the role of the market in distributing resources nationally and internationally.

There are strategies for tackling resource shortages, and although resources may well be limited by absolute availability or unequal economic relations within and across countries, it does not necessarily follow that there are too many people.

Lowering the population growth rate is a long-term strategy to deal with the complex set of factors which determine resource availability. Except in cases of genocide, war, mass emigration or forced removals, lowering population numbers is a very slow process. Even when the growth rate falls rapidly, population numbers rise over a generation.

2.3 Demographic dynamics

Resource availability is one side of the overpopulation equation. The other is population numbers. These are determined by three patterns: fertility, mortality and migration. In the overpopulation argument trends in population growth are explained primarily in terms of demographic transition.

The model of demographic transition was developed from the analysis of demographic trends in Europe prior to industrialisation and into the twentieth century. Pre-industrial societies exhibited both high fertility and high mortality rates, which caused the population size to remain stable, a situation referred to by demographers as 'natural fertility'. In the process of industrialisation, with the benefits of modern medicine (Lawton, 1986), the mortality rate declined without a concomitant decline in the fertility rate. The explanation given for this is that people were still caught in the cultural constraints of the old order, in what is described as the second phase. Only in the third phase of demographic transition did the birth rate drop faster than the mortality rate, so that by the fourth phase they once again balanced each other out, but at a lower overall birth and death rate than in the first phase. According to demographic transition theory the escalating population growth rate in the South today is an inevitable part of the process of modernisation that all societies pass through. Population control is considered a means of reducing the population growth rate, with the rationale that the country in question does not have sufficient resources to cope with the escalating population.

In effect, this descriptive model has been used as an explanatory theory by most of the overpopulation lobby. They argue that the process of demographic transition is slow and that therefore specific interventions are necessary in countries with resource scarcity, to accelerate the decline in the fertility rate. The problem with this approach, however, is that it does not examine the many factors which cause fertility to decline in any particular context. As a result, it is not a useful tool in planning interventions.

3. The stakeholders

3.1 The United Nations and related agencies

After the second world war and with the end of colonialism, the overpopulation theory gained currency as an explanation for the poverty and lack of development of countries in the South. It did not, however, take account of the unequal economic and political relations between North and South. Often aid was subject to the adoption of a family planning programme by the country concerned. The main international bodies responsible for this process were the United Nations Fund for Population Activities (UNFPA), United Nations Children's Fund (UNICEF) and the World Health Organisation (WHO). The International Planned Parenthood Federation (IPPF), funded by the United States Agency for International Development, was also a central player.

These agencies have been guided by the assumption that a relationship exists between population growth and poverty. The first United Nations conference on population, held in Teheran in 1960, promoted the notion of access to contraception as a basic human right. The World Population Conference in Bucharest in 1974 argued that a serious attempt should be made to slow the population growth rate, and that at least one per cent of development assistance should be spent on this goal. The means for slowing population growth was through the

promotion of contraception, what became known as 'family planning' programmes. By the time of the Mexico conference in 1984, however, the emphasis had shifted from contraception to development as the answer to lowering the population growth rate, from family planning programmes to the socio-economic determinants of fertility decline.

In economic terms this was articulated as a debate between supply and demand. Some argued that there was simply a problem of supply—if people had access to contraception they would use it. Others argued that people did not want contraception because the economic, social or cultural conditions of their lives made many children desirable. According to the latter view population policies should focus on changing people's living conditions which in turn would ultimately lower the fertility rate (Knowles, 1993).

Countries in the South are increasingly articulating population numbers as a problem. Not all countries have population policies but most are dependent on the international population agencies to finance their family planning programmes. At the national level, most African countries which have a population programme institutionalise it through a National Population Commission which is chaired by a senior member of government. This is usually backed by a Population Planning Unit which is responsible for research, training and data analysis in human resources planning. The Unit uses this information to support both the process of development planning and the formulation and implementation of the National Population Programme.

The population debates of the eighties did not succeed in recontextualising the population problem by tackling questions of consumption, unequal power and economic relations. In addition, most of the funds allocated to population programmes have gone into family planning programmes despite the theorisation of population as an issue which needs to be addressed through broader socio-economic development programmes.

During 1994, in preparation for the International Conference on Population and Development in Cairo in September, the United Nations aims to develop consensus for the 'full integration of population concerns into economic and social activity and sustainable development' (Sadik, undated: 3). In effect, the debate between contraception and development has now been replaced by a discussion of how family planning programmes and other programmes focusing directly on population should be integrated into overall development plans. There has been a shift from the time bomb of overpopulation to a concern for quality of life both now and in the future, as encapsulated in the concept of 'sustainable development'. 'Population concerns' now encompass the environment, economic development, human rights, including gender equality, as well as sexual and reproductive rights[1] and health, although

[1] While reproductive rights and the development of reproductive health services, rather than contraceptive-only services, have become part of the dominant approach to human rights and women's health care, the concept of sexual health is newer. It refers to

- a capacity to enjoy and control sexual and reproductive behaviour in accordance with a social and personal ethic
- freedom from fear, shame, guilt, false beliefs and other psychological factors inhibiting sexual response and impairing sexual relationships
- freedom from organic disorder, diseases and deficiencies that interfere with sexual and reproductive functions.

The concept implies that the education of service providers should take cognisance of these needs in order to give them the skill to recognise and meet the overall sexual and reproductive health needs of the client.

these are strongly contested by powerful minorities such as the Catholic Church.

Whether this approach will translate into international financing for programmes other than 'family planning' or allied programmes such as 'population education' in the schools is not at all certain. It will depend to some extent on whether governments, NGOs and lobby groups mobilise around these issues and insist that international funders redirect funds away from vertical family planning programmes and develop new programme goals.

3.2 The women's health movement

In addition to the major international agencies described here, the women's health movement has had an impact on the population debate. In the 1960s, as part of the broader recognition of women's subordinate status in society, women's groups, mostly in the West, began to articulate the concept of reproductive rights. This was reflected in the view that women's bodies belonged to them; that they had the right to dignity and privacy; that health professionals ought to attend to the needs of women, not control them or look down upon them; that health services, contraception in particular, were there to serve women's needs rather than to meet population targets. The movement, comprising a wide range of groups and ideologies, was institutionalised through a women's health movement conference held every four years. By the mid-1980s, women's health networks had formed an international women's lobby which started to challenge other stakeholders, including the international funding agencies, scientific institutions and pharmaceutical companies involved in contraceptive development and testing.

The challenge has focused on a number of key areas: rejection of the overall way in which the population issue has been theorised; a critique of family planning programmes; an approach which locates contraceptive services within broader sexual and reproductive health services, and which emphasises meeting women's needs and hence providing quality health care for women; the repudiation of target-driven and incentive-based approaches to contraception provision; a critique of research into contraceptive development and effectiveness, its focus and methods, in terms both of provider-controlled contraceptives and of the lack of commitment to ensuring that women involved in contraceptive trials were fully informed about the trial process and the implications of participation and had freely chosen to participate.

The movement made a major contribution to ensuring that this perspective was reflected in international human rights instruments such as the Convention on the Elimination of Discrimination Against Women.

By the 1990s, the women's movement had become a major player in this area, and international agencies such as the WHO and IPPF had invited women from the women's health movement to review their policies and programmes, and to participate in them, in order to ensure that they are gender sensitive and not exploitative of women. While some women's organisations and individuals are entering into this terrain, others have chosen not to do so.

Section II: South Africa

4. Factors affecting the population growth rate

The National Party government articulated its understanding of demographic dynamics in South Africa largely within the international framework described above, although the World Population Plan of Action of 1974 explicitly stated that population policies could not be successful in the context of oppression, and specifically apartheid. South African population policies have ignored the political context in which they are implemented.

The theory of demographic transition was used to motivate for a population programme which would speed up the inevitable process of fertility decline. The National Party failed to take cognisance of the two other major determinants of demographic trends: mortality and migration.

4.1 The impact of discrimination on mortality

There is evidence that the process of colonisation and industrialisation in South Africa has increased the vulnerability of the African population to disease, in particular by lowering its nutritional status. The overarching system of discrimination deprived the African population of its traditional source of subsistence, land, and of access to effective education, training and employment, while giving the white population privileged access to these basic necessities. In addition medical care, which is the backbone of the demographic transition model, is inequitably distributed.

Thus the differential health status and fertility rates of the white and black population are not the result of an inevitable process linked to cultural behaviour as described by demographic transition, but rather the result of discrimination before and during apartheid. Basing interventions on demographic transition and hence on lowering fertility rates fails to take into account the importance of tackling the inequities within the population which have led to differential mortality rates.

4.2 The impact of migration

The above applies equally to another major influence on demographic trends in South Africa —migrancy. The backbone of apartheid was the system of migrant labour and influx control. This system severely limited the process of urbanisation which would otherwise have been the inevitable and positive response to industrialisation. Related to this system was the forcible removal of millions of people in order to maintain racially segregated Group Areas, and the ethnically constructed homelands.

This socially engineered population movement has determined the demographic profile of South Africa, not only in terms of its geographic distribution and density, and in particular the disproportionate distribution of women and men, but also in terms of fertility behaviour. The migrant labour system undermined the basic framework of social life. Husbands and wives were separated; fathers were absent; many marriages collapsed; many men developed new relationships and marriages in urban areas. If the position of women was subordinate before, with the loss of the land from which they secured subsistence, they lost their entire economic base and

became even more dependent on their absent fathers, husbands or sons for survival through financial remittances which often did not come.

While the practice of *lobola* remained, codes of behaviour which governed married life slowly collapsed. Social practices which ensured effective child spacing slowly declined. These include, for example, the custom of breastfeeding for long periods of time and abstaining from intercourse during this period; the holding of initiation schools for boys and girls where they were trained in appropriate sexual behaviour, including the practice of *ukusoma* (thigh sex) in order to avoid pregnancy before marriage; and the organisation of social life in such a way that the morality and sexual behaviour of adolescents was strictly monitored by young people only a little older than themselves. The taboo against pregnancy before marriage slowly lessened, as did the social mechanisms for ensuring that a young man take responsibility for procreation. While these sorts of changes have invariably occurred with industrialisation, the migrant labour system together with influx control regulations prevented the development of a stable urban and rural society with new social mechanisms to take over some of these tasks.

Lower birth rates are facilitated by the creation of economic security and security of land and housing, the creation of conditions under which people, both women and men, old and young people, are able to exercise control over their society, community and personal lives and to plan for the future.

5. Population policies of the National Party government

While the aim of this paper is to explore future direction in relation to population issues, it is essential to understand the context, ideology and practice of previous decades in order to assess future options adequately. For this reason this section focuses on demographic trends and the history of population programmes in South Africa.

5. 1 Population numbers—the basis of colonisation and apartheid

The entire colonisation process had a major demographic impact on the population in South Africa. In particular, the uprooting of populations, first through war and *treks* and secondly through the expropriation of most of the land for the use of the white population, framed the later policies of apartheid.

The entire apartheid concept and practice was based on explicit demographic considerations—the fear of losing political and economic control to the majority of the population. This gave rise to the reorganisation of the demographic profile of the country by the export of the African population to 'independent states'. In granting 'self-government' to Transkei in 1962, Prime Minister H F Verwoerd acknowledged this, stating that otherwise, 'in the long run numbers must tell' (Lever cited in Orieji Chimere-Dan, 1993). In 1972 Prime Minister BJ Vorster said, 'We would like to reduce them ... and we are doing our best to do so, but at all times we would not disrupt the South African economy' (Rogers cited in Edmunds, 1981).

5.2 Population control through family planning

In 1974 the first formal population programme, aimed at lowering the fertility rate of the black population rather than tackling the population 'problem' through removals and homelands, began. Citing the World Population Conference of the same year, this programme considered contraception as the means of lowering the fertility rate. In keeping with the aim of reducing numbers, a vertical 'family planning' service was set up to take contraception to women. Family planning outlets, mostly mobile clinics, were extended to cover most of the country.

While this programme has ensured that the majority of South African women can gain access to contraception, it has been riven with human rights abuses arising out of its conceptualisation as a population control programme rather than a health or sexual and reproductive rights programme.

In particular, as a vertical service it does not offer reproductive health care. Essential components, such as checking for and treatment of sexually transmitted diseases, pap smears for cervical cancer, information about these issues as well as about the full range of contraceptives and their pros and cons, and help for those experiencing infertility, are only offered in a few urban services. Abortion and services to prevent deaths due to unsafe abortions are not provided. Moreover, the mobile clinics in particular offer a very limited range of contraceptives, and often only the injection. Companies are encouraged to let their occupational health nurses offer contraception, with a short training course given by the Department of Health, and contraceptives given by the Department free of charge. Women are under pressure to use contraception given the lack of legislated job protection for pregnant women (except for the few women covered by trade union maternity or parental agreements). At hospitals, nurses refer to the injection as the 'fourth stage of labour' because it is routinely given after the birth of a baby, without necessarily informing the mother or discussing the implications with her. The most basic principles of reproductive health care, including choice, privacy and information, are widely ignored. Finally, the programme focuses on women, reinforcing the unequal power relations between men and women rather than challenging these by offering men information and services and encouraging them to share responsibility for reproduction.

With the next phase of the population policy, which is discussed below, the Family Planning section was at pains to separate contraceptive provision from the ideology of population control. But contraceptive provision was already institutionalised within a population control framework, rather than a women's health or sexual and reproductive rights framework, so that the ideological shift did not improve the actual services.

In the 1990s there has been a move to integrate family planning services with other primary health care services. Although this may solve some problems, it also creates new ones. In particular it limits the accessibility of contraceptive services, instead of upgrading and broadening these into sexual and reproductive health services. Much more research and conceptualisation is necessary before it is carried any further.

5.3 Resources

The shortage of resources argument was used in South Africa in relation to water supply. In 1983 the Report of the Science Committee of the President's Council into Demographic Trends in South Africa was published after a government commission. It argued that South Africa did not have the water resources to maintain a population greater than 80 million people. Other resources, such as food, were not considered at risk. Although South Africa certainly does experience scarcity of water, the analysis did not consider the impact of socio-political decisions in the apartheid era on water availability nor did it take cognisance of the urgent need for water planning and management in achieving equity of access to water supply (Hollingworth et al, 1994). Instead, the conclusion that South Africa faced a future shortage in water resources formed the rather limited (and in many ways ideological) primary scientific justification for the Report's proposal that a Population Development Programme (PDP) be established. On the basis of this report, the PDP was formed with the aim of ensuring that population numbers were brought into line with resource availability.

5.4 Population control through development: the Population Development Programme

As a result of the Report and the shifts in international thinking, the government altered its position that development could not occur rapidly enough and that the focus should be on contraceptive provision. It now argued that development was an essential component for population reduction. It set up the PDP to achieve this goal, and incorporated contraceptive provision into its definition of development. The primary role of the PDP was to ensure intersectoral collaboration in lowering the population growth rate, the target being to achieve a fertility rate of 2.1 children per woman by the year 2010.\

The PDP was institutionalised through two structures. The first, the Interdepartmental Committee for Population Development, meets biannually to discuss how the different government departments can promote the aims of the PDP. The second is the Council for Population Development which was set up to 'advise the Minister from a private sector point of view on population matters' (Gouws, 1992). It is comprised of experts and opinion makers, most of whom are sympathetic to the previous government's population policy, although recently the climate of transition has led the Directorate Population Development, the secretariat of PDP, to approach people from a wider political perspective to join the Council. The Council establishes working groups to investigate issues it identifies as crucial for lowering the population growth rate, and, on the basis of the findings of these groups, advises the government on population policy.

These structures are serviced by the Chief Directorate Population Development, which before the new government took office was one of the Directorates within the Department of National Health and Population Development. It is now in the Ministry of Welfare and Population Development. The Chief Directorate coordinates the overall PDP.

In addition to its secretarial, coordinating function, it has a small implementing role. It has nine regional offices with 44 planning regions, a total of 170 employees and an annual budget of R33 million (CEC, 1993:9). After persuading the leaders of the 'homelands' of the importance of the PDP, offices were set up and liaison officers employed in these areas too, although some of these fall under the Chief

Minister or Minister of Economic Planning rather than the Department of Health. The role of these officers has changed over time. Officially they have two roles: to facilitate development initiatives in local areas, and to popularise the view that South Africa has too big a population for the available resources—encapsulated in the phrase 'the demographic reality'—through information, education and communication (IEC). In fact, the development role has been given less emphasis as its flaws have become apparent (see below) and the IEC role has become more central, although there are significant regional differences.

The Directorate Population Development has identified five development fields which it argues have 'proven demographic impact'. These are education, primary health care (including family planning), economic development, manpower [sic] training and housing. It has five indicators which it uses to monitor the PDP's progress. These are the total fertility rate, the infant mortality rate, the literacy rate, the teenage birth rate and contraceptive usage (DNHPD, 1993).

In keeping with the transitional period, the Directorate is conducting an ongoing assessment of its role, and attempting to locate itself in the post-election South Africa. It is putting substantial effort into making international contacts, especially with population specialists in Africa, in order to learn from African experience and to be able to show how the PDP parallels international experience. As a result the actual activities of its liaison officers are often not consistent with the approach presented by employees of the head office. The programme as it exists at the moment is flawed in a number of ways, as discussed in the sections below. Some of these flaws are recognised by the Directorate.

5.4.1 Acceptance of discrimination

The PDP's existence was based not only on a questionable approach to natural resources, as discussed in 5.3, but on the assumption that the system of apartheid would continue. It did not seek to alter the problematic demographic impact of apartheid by challenging such things as the overall system of migrancy, unequal access to training and jobs, and homelands. Instead, it analysed and developed programmes on the basis of an acceptance of discriminatory racial divisions in society. It focused on the African population, since it had the highest fertility rate, and did not challenge the existing systems of resource distribution or consumption.

5.4.2 Links to the security system

In addition, the PDP was drawn into the National Security Management System, set up in the early 1980s to monitor and undermine community mobilisation against apartheid and specifically the United Democratic Front. The PDP sat on the Joint Management Committees which were set up for this purpose. Situation analyses, ostensibly done to determine community development needs, were used as a means of monitoring community leadership and organisations. The brief of PDP liaison officers included facilitating the development of alternative community structures to those of the United Democratic Front. Thus although the PDP discourse was apolitical, expressing concern for the future survival of the whole population, its approach reinforced the existing racist and oppressive political situation. While it argued for a community development approach and community participation, it acted upon a community which had no vote, and hence no say about the existence of PDP, with the specific aim of undermining burgeoning attempts at community organisation.

5.4.3 Lack of funds and authority in relation to other sectors

The focus on development as a means of lowering population growth was flawed not only because of its sinister political motives, but because of its understanding of community development as community self-help. The PDP had no resources to back up development programmes and has no start-up funds. In a context of extreme poverty, communities are seldom able to take on development projects without an injection of funds and technical skills. A programme which expects a community which has been denied access to land, education and jobs to finance its own development is doomed to failure.

Furthermore, although the PDP was articulated as a national development programme, it was located first in the Department of Health and Population Development and is now in the Department of Welfare and Population Development. From there the PDP, through the Interdepartmental Committee, is expected to motivate other government departments to adopt development programmes which will influence population growth. However, it has no authority over these departments, nor any right to influence budget allocations.

This is clearly an ineffective institutional framework for a national development programme. At the local level, it means that liaison officers can approach other departments to participate in certain projects but cannot insist that they do so, or that they direct financial resources towards these projects.

It soon became clear that the PDP could not actually coordinate or carry out development. Although the objective was still to lower the population growth rate through the development programmes and plans of the Interdepartmental Committee, the Chief Directorate Population Development, with the exception of a few regions, largely confined itself to IEC programmes on the 'demographic reality'.

5.4.4 Information, Education and Communication

Although the literature on population is rich in discussion on IEC programmes, an aspect of the PDP which is very much in keeping with international trends, the exact purpose and content of IEC programmes as part of a population programme remains subject to debate.[1]

There are two approaches to IEC in the PDP. The first is the view that people need to be made aware of South Africa's 'demographic reality'. People need to be made aware of the impending shortage of resources, and encouraged to have fewer children in order to avoid this problem. This approach has a number of flaws. First, it presumes that individuals will change their behaviour for the sake of the nation. There is no evidence to support this except in the case of authoritarian governments which take control of the personal lives of their citizens. People change their behaviour to meet their own needs, whether economic or social. This would include needs that are met by fulfilling broader community needs and aspirations. Second, to appeal to people who are disenfranchised, and therefore explicitly excluded from having a say in the welfare of the 'nation', to act on behalf of that nation is a meaningless and politically naive exercise. People cannot be expected to change their behaviour in order to afford future generations access to resources when the government expecting them to do so has deliberately denied them access to existing resources.

[1] This section does not discuss the use of IEC, social marketing and other related methods for promoting contraceptive awareness and usage. It looks specifically at IEC aimed at demographic awareness.

Finally, the explanation given for the increasing shortage of resources in the IEC programmes is both ahistorical and inaccurate. The Directorate Population Development's rural video, for example, focuses on the overpopulation of rural land. It argues that as each generation had children the land on which the family farmed had to be divided and subdivided, until there was not enough left. Thus families had to move to the cities where they faced problems which included unemployment, pollution and lack of housing. Thus, as discussed under 4 above, the overpopulation approach blames the victims of discrimination, forced removals and land theft for their own poverty, without acknowledging the actual causes of poverty and population pressure in certain parts of the country.

The second approach to IEC, used in some PDP programmes, is to focus on individual behaviour. On radio and television, and in some community drama and school-based education programmes, young people are encouraged to consider the impact of, for example, pregnancy, on their futures. They are given information about how to look after their own environment and to behave responsibly. Role models are used to argue that if a young person wants an education, car or house, this will be possible if they have fewer children. This type of approach has a greater chance of success. But it too fails to acknowledge that having fewer children does not guarantee a person financial success in life. Moreover, it does not address the underlying motivations people may have for having children. For example, until a woman has an education and a career, childbearing may remain the key to her identity as an adult and she may perceive it as a safeguard for her old age.

The IEC programmes differ from region to region. In most regions they are localised. Programmes are run in a few schools or the liaison officers work with a few communities. The reason is that the regions have no funds to pay for their work. They have salaries and cars, but need to raise all money for materials or events from the private sector. As a result, the impact is very small. The failure to institutionalise programmes, by for example building IEC into the school curricula and into teacher training curricula, means that the significant effort of individuals doing IEC fails to have a very widespread effect.

The programmes run on radio and television have a much wider outreach.

5.4.5 The impact of PDP on popular consciousness

The political history of population programmes has permeated the national consciousness. Many black people argue that the government wants to lower black population numbers (Pelser et al, 1992) and there are cases where black women have been exhorted not to play into the government's hands by using contraception. The fact that family planning services, unlike others, are free reinforces this view. The politicisation of the population issue is recognised by many PDP officials themselves. Officials from the family planning services are, too late, at pains to ensure that their services are not associated with the overpopulation message.

This politicisation does not, however, necessarily have an impact on people's use of contraception. There is little research on this question, but it appears that people will use contraception if they want to, irrespective of the political connotations associated with it. Similarly increasing numbers of women are using contraception even when their husbands or sexual partners do not want them to do so.

While regional programmes have won respect from some communities in some regions, they have caused tensions in

others. In some areas too they have antagonised the officials from other government departments who feel that PDP is encroaching on their preserve.

All of these issues need to be taken into account when developing an approach to population issues for the post-election South Africa.

Section III: Placing quality of life and human development at the centre

6. Placing population and demographic issues within a development framework

The central problem with framing population growth as an issue in itself is that reducing population growth is inappropriate as a policy goal. If the primary goal of a government or development agency is to reduce population growth it may lose sight of its ultimate objective, which is to improve the quality of life of the population. If quality of life and not population numbers is the main goal, all other programmes will be judged in relation to a fundamentally human objective, rather than in relation to easily dehumanised statistics.

In my view the overpopulation approach should be discarded along with the apartheid era. The government of a 'new' South Africa should not present the reduction of population growth as an objective in itself. An appropriate starting point for framing policy on population is improvement of the quality of life and development of key indicators for measuring such improvement. This view is consistent with the Reconstruction and Development Programme (RDP) of the new government and the Human Development focus of the DBSA.

The overpopulation and quality of life approaches are not necessarily mutually exclusive, and the indicators they use will by and large be the same. Nonetheless the second, people-centred approach offers greater possibilities for developing programmes which meet the needs of the population in the short and long term.

This paper recommends the adoption of a development framework which focuses on quality of life. It examines the potential for a shared perspective, across all development sectors[1] , of the major quality of life goals and the indicators by which their achievement should be measured. It then considers whether there are 'population' concerns which would be excluded by the quality of life approach.

The population literature suggests that, in addition to the socio-economic changes in areas which make a specific impact on population such as women's literacy and employment rates, and the provision of reproductive health services), specific 'population' activities are necessary to accelerate the decline in the population growth rate. These activities fall into three broad areas: planning based on demographic information, population education or IEC (discussed in 5.4.4), and the provision of family planning within a primary health care approach (discussed in 5.2).

All these are development concerns, and would be addressed within a wider development framework. However, before considering this, the question of data collection requires brief consideration.

[1] The word 'sector' is used here to refer to the various components which comprise development: health, education, labour etc. It incorporates government departments responsible for these areas as well as other stakeholders such as NGOs and the private sector.

6.1 The importance of data collection for development planning

A population programme may simply be a programme which ensures that demographic factors are taken into account in any planning exercise. An understanding of the demographic profile of the area concerned is essential if a development programme is to be effective. Information on population size, age structure, sex ratio, stability and density makes the short-term planning of basic facilities possible. Additional information, such as information about the housing supply, educational facilities and water provision is needed in order to establish priorities.

Other demographic information is necessary for long-term planning. Fertility, mortality and migration, the three major components of a demographic profile of a place, affect its long-term needs. For example, if the fertility rate is high and mortality low, the resulting population growth will place new demands on existing infrastructure, services and economy, in addition to those already placed on them by the need for equity. Similarly ongoing migration into an area may exert pressure on it, and if the numbers of older people in an area are increasing, the existing facilities may not meet their needs.

Development priorities across areas have to be based on data on the overall national quality of life. The basic indicators used internationally are maternal mortality, infant mortality, total fertility rate, literacy and educational status and employment levels, all disaggregated by sex[1] . These data should be available for all provinces and local areas.

In South Africa, however, basic information such as birth and death rates are often estimates since the registration of births and deaths is haphazard in many areas. The census data are unreliable and require substantial reworking by demographers if they are to be at all useful. Systems for data gathering are not uniform across the homelands and much of the data gathered by the various institutions within South Africa, such as the Human Sciences Research Council and the Central Statistical Service, excludes the TBVC states. As a result, even estimates of maternal and infant mortality are likely to be incorrect.

A national system of data collection with an efficient flow of information to and from all provinces and all sectors is essential for national, provincial and local development policy and planning. In order to achieve this, training in demography is essential. The capacity to interpret data in relation to development goals is also essential, which means that the curriculum of demographic training must have socio-economic content and move away from the overpopulation orientation.

In the process of integrating population into development the major method followed is to incorporate demographic insights into every level of development planning. The *Manual for the Integration of Population Variables into Development Plans in African Countries* (ECA, 91:10-11) expresses it thus:

> For macro-economic planners, integration involves taking account of projections of size, age-sex structure

[1] These indicators are the same as those used by the PDP except that the latter includes contraceptive usage and teenage birth rate, and excludes maternal mortality. Contraceptive usage is not a basic indicator, it is reflective of the other indicators. The teenage birth rate is arguably a key indicator of quality of life, since it is high amongst poorer and less settled communities.

and spatial distribution of the population in determining food, employment and basic needs (eg education, health, housing) requirements. For socio-economic demographers, integration involves the formulation of socio-economic policies to influence demographic trends and achieve higher standards of living. For health planners, integration could mean the addition of family planning activities to ongoing development programmes in health, nutrition, education, rural development etc.

IPDP (Integration of population variables into development plans) involves incorporating demographic variables and projections as inputs to sectoral and regional planning; determining the demographic impact of diverse economic and social programmes; and, defining those complementary and specific actions needed to induce increasing balance between demographic dynamics and economic potential. In effect IPDP implies that demographic variables are taken into account in the elaboration of development plans; formulating population policies within the context of development policies; and, integrating the processes of development and population planning with the ultimate goal of eliminating and/or minimising poverty, unemployment and inequality; the three desiderata of development efforts.

This paper thus submits that demographic input into development planning and evaluation is essential. Whether this constitutes a population programme will be discussed later.

6.2 Developing a strategy to meet overall development goals

The integration of demographic data into development planning is perhaps the easiest challenge facing the overall development process, although the exact location of demographic data collection within government, or within a development institution, needs further discussion. A more complex problem is the question of an overall development framework.

The RDP is specifically concerned with the need to determine development priorities, and to allocate budgets accordingly. In addition, it emphasises the importance of those priorities being 'publicly determined', and of the planning and implementation processes being publicly accountable (ANC, 1994: 136-146). The process of establishing the RDP will therefore require input from a wide range of interest groups in order to determine not just the priorities, but the most effective mechanisms for reaching its goals. As a contribution to this process, the following section discusses some of the challenges facing the establishment of a single development framework. Most of the issues raised also need to be considered by large development institutions, such as the DBSA, just as much as by the government.

While in principle sectors may share a common overall goal, in practice each sector has its own goals, plans, time-frames and systems of evaluation. This means that a number of sectors often operate in the same geographical space, without an integrated approach or built-in cooperation mechanisms (Rural Primary Health Care, 1993). In addition, there are often other institutions operating in the same space. This situation can result in the inefficient use of resources, with the duplication of some (financial, human or technical) resources and an absence of others. This

points to the lack of a coherent, community-approved, plan for any particular area.

It is this problem that has led to growing recognition of the need for intersectoral collaboration. The first step is to agree to the same set of goals and overall indicators for measuring their achievement. The next, and much more complex, step is to institutionalise the cooperation.

6.2.1 Developing cross-sectoral development goals

Without presenting any specific model, a number of components will be mentioned.

First, a mechanism for developing a national strategy or, in the case of a development institution such as the DBSA, an institutional strategy is required. This necessitates a structure which can pull together all relevant sectors and facilitate debate about national development objectives. All the sectors would then have to agree on the best way of achieving these objectives and to decide on priorities and time frames. The next component of a national strategy is that priorities need to be translated into the budgeting process. Thus whatever the structure, it must be located in such a way that it can directly influence budget allocation.

The underlying challenge is the creation of national development goals which are accepted by the majority of people in society. Since not all development needs can be met in a short period of time, the painful process of choosing priorities will have to be faced directly. The process of identifying the overall goals will differ according to the institution involved. In the case of government, policy experts and practitioners in all sectors need to engage in the debate about priorities. Ultimately, however, those priorities should be determined by the public's perceptions of their immediate and long-term needs. At provincial and local levels, in addition to the views of the elected representatives of the people, public hearings, research and other mechanisms should be used to identify priorities in order to ensure that the development effort is entirely consistent with the aspirations of the population and that the population is able to come to terms with the fact that choices have to be made, that not all expectations can be met at the same time.

In the case of a specific institution, such as the DBSA, the process would take place within the institution, but would also have to rely on community-based input. Once the DBSA has consensus on its overall goals (a consensus that would have been developed not only within the Bank but also by all stakeholders serviced by the Bank), it could develop consensus across its regions and functional divisions on the sorts of activities which would best achieve its overall goals. Once these have been agreed, budgets would have to be adjusted to allow sectors responsible for priority areas to focus on them. Each sector would need to give priority to such activities, in so far as they were located within the sector itself or intersected with it.

6.2.2 The management of intersectoral collaboration

Once priorities have been identified and funds allocated, the actual planning process would begin. This too raises questions about intersectoral collaboration, since many priorities may not be achievable in any specific sector. The problem of teenage pregnancy, for example, must be dealt with by providing, amongst other things, life-skills and sex education in schools, contraception for young people, recreation facilities for schoolchildren and the unemployed, and job opportunities for school leavers, as well as by creating an environment which makes rape a socially unacceptable act. Furthermore sectoral issues, such as raising levels of literacy and

adult education, need to be interfaced with other factors such as workplaces. Systems for managing such interfaces are difficult but essential, and will probably determine the effectiveness of any overall development strategy.

The model developed in the pre-election period was the location of the RDP within the President's office. Its institutionalisation is a more lengthy process. The RDP should be able to coordinate discussion across sectors, and to influence budgeting. This option is so attractive to many policy makers that it is proposed that a wide range of programmes be located under the RDP, including demographic, gender, health promotion, and adult education programmes. It may well be appropriate to locate a demographic unit under the RDP, to enable demographers to identify demographic information needs in relation to development planning, and offer their expertise in this process. The same could apply to a gender unit, since the improvement of gender relations, and of women's position in society, needs to be considered in all development planning.

The motivation for the location of health promotion and other specific programmes under the RDP is their intersectoral nature. The question is just how many and what sorts of intersectoral programmes should be institutionalised. The RDP or, in the case of a non-governmental institution, the body responsible for coordinating the overall development plan, should not take over the 'line functions' of any sector. Its role should be facilitative. It therefore seems appropriate that support functions be located within the RDP, whereas actual intersectoral programmes could be facilitated by the RDP without being institutionalised within it. Following this approach, the demographic and gender units would be required to provide support and input in all sectors. They would therefore fit institutionally within the RDP, or the body responsible for facilitating an integrated development plan.

Intersectoral programmes, however, require the RDP, or equivalent, to set up a management structure which facilitates collaboration on specific issues, as and when required, by pulling together the relevant government departments and experts and stakeholders from civil society. These task forces would develop policies and programmes on specific intersectoral issues. The work would then be carried out in the various sectors.

At local level, the difficulties of facilitating intersectoral communication and collaboration are often compounded by the absence of community-based organisation. This may, to some extent, be resolved once local representative structures have been developed and elections for these have taken place. It will, however, be some years before there are effective local representative structures at all levels. Moreover, further debate is needed as to whether such elected local structures will be able fully to represent the views of specific interest groups, and particularly of marginalised groups, such as women or pensioners. It may be appropriate to employ a corps of development facilitators to work at implementing the intersectoral approach at lower levels. These facilitators would have no sectoral 'line function' of their own. Their task would be, on the one hand, to build the capacity of communities to organise and to express their views and needs and, on the other hand, to support all sectors in focusing their work to meet the overall development goals. They would have to facilitate communication between the community and the service providers: government departments, statutory bodies, NGOs and the private sector.

Some argue that this would remove the responsibility of each sector to work in a

community-accountable way. Is it, however, appropriate for each sector to take responsibility for building community organisation? The retraining of people in every sector is unrealistic. It is both more realistic and more efficient to support a corps of development facilitators whose role is to facilitate community linkage with those sectors whose services they require. This is the role of NGOs, and the government should support this role, rather than usurp it. Where NGOs cannot play this role development facilitators will have to be trained and employed by the RDP itself.

6.3 A single set of indicators

In the short term, reaching consensus about goals and about activities to achieve these will be a major step forward. In the longer term, the achievement of these priorities or overall development goals should be measured using basic indicators, not just of each priority (such as numbers of people with reticulated water, or secure homes, or educational levels) but using quality of life indicators which measure the overall improvement for society as a whole.

While each sector can measure the attainment of its own goals, such as improvements in percentage coverage of domestic water supply or the extent of community participation in decision making over water supply, achievements in the overall development goals, beyond the sectoral goals, should be reflected in improvements in the quality of life indicators.

International experience has shown the following indicators to be reflective of overall quality of life: the infant mortality rate, the rate of maternal morbidity and mortality, literacy and educational levels (and specifically those of women), the total fertility rate, and improvements in women's legal, social and economic status.

Although the quality of existing data is inadequate, and there are not as yet systems for the national collection of data, the idea is worth considering as a long-term goal for evaluating the effectiveness of the overarching development framework.

6.3.1 The applicability of health indicators

Some of the above indicators may seem specific to the health sector, rather than indicators of overall improvements in quality of life. The health indicators do, however, reach into all sectors. Maternal mortality will serve as an example.

Maternal mortality can to some extent be prevented through effective health services. Effective health services will for example identify women at risk and ensure that they have access to an effective antenatal programme and, at the time of delivery, to a health service which is familiar with their particular situation; will ensure that women have access to facilities for safe abortions; will secure women a high quality of reproductive health care; and will ensure that the service is receptive to young people and supports them in using contraception.

Even these health service-based strategies are dependent on factors outside the health sector: an efficient transport infrastructure; a family and employment system which ensures that women have the time to use health services during pregnancy, and are able to do so because others take responsibility for child care and domestic work.

There are other causes of maternal mortality which are not under the control of the health service. These include, for example, the nutritional status of women, which is a product of the economic and agricultural sectors, as well as of women's

subordinate social status in the family and society; the social and legal status of women which does not acknowledge women's right to control their bodies, and hence their right to safe and effective contraception and legal abortion, nor their right to choose whether to be mothers and how many children to have. Social factors include poor recreation and schooling facilities, few employment options, social pressure to prove fertility as a means of gaining adult status, the breakdown of cultural mechanisms for sex education and the absence of such education within the school system. All of these factors are associated with a high rate of teenage pregnancy, which is directly related to an increased risk of maternal mortality.

Thus an improvement in the rate of maternal mortality reflects an improvement in overall development and specifically in the social and economic status of women, which in turn, has been shown to reflect an improvement in overall social well-being. Maternal mortality is therefore a potential indicator for measuring a general improvement in the quality of life, rather than improvements in any specific sector.

More generally, since health reflects overall quality of life, the indicators which measure improvements in health status may well be the same indicators which measure the impact of improvements across all sectors, improvements which are usually spoken of as 'development'.

6.4 Can achievements in the 'population' terrain be measured through an overall development process?

The question remains whether an integrated system of development planning adequately tackles population issues. This is dependent on two questions: the first is whether the lowering of the population growth rate is retained as an overall development objective; the second is the question of language and what is meant by 'population issues'.

6.4.1 Lowering the population growth rate as a development objective

The basic premise of the 'population establishment' is that the population growth rate will not decline rapidly enough with broad socio-economic development. A specific set of programmes is needed to accelerate this process. The premise is based on the assumption that population issues would not be high on the development agenda without a specific population programme. This may well be the case in certain parts of the world, but experience in South Africa shows that population issues are high on the agenda of most communities. The five 'fields' identified by the PDP are at the centre of any definition of development priorities: education, primary health care, economic development, manpower [sic] training and housing. Women's status has not been high on the agenda until now, but has now gained prominence with the Bill of Rights and the RDP. Teenage pregnancy, which is continually identified as a cause of serious concern within communities, would not be overlooked in a process in which communities determined development goals.

The indicators used to monitor the PDP's progress are the total fertility rate, infant mortality rate, literacy rate, teenage pregnancy rate and contraceptive usage. These are more specifically demographic indicators than those which would be used to measure the broad development field described above. The overlap is nevertheless significant since total fertility, infant mortality and literacy are all generally accepted indicators of a society's overall well-being.

Given the importance of focusing on justice and redistribution as a means of removing past discrimination and rectifying the backlog in services, training and infrastructure, this paper has argued that a human-centred approach to development which focuses on the need to improve the quality of life of the population is essential. Although such a development framework will support the lowering of the population growth rate, making the population growth rate an objective in itself could undermine the credibility and effectiveness of the overall programme. It could be understood as a continuation of racially-bound development goals and as a victim-blaming approach, rather than as an approach which seeks to rectify past injustices. For these reasons, it is inappropriate to include the lowering of the population growth rate in the framework of development objectives for the post-election South Africa.

This does not mean that demographic concerns will not be central (see 6.1 above). On the contrary it will be recognised within the framework for development that demographic trends are the product of a range of development initiatives, and that these should be considered in development planning. There is, however, no place in the development framework for the concept of 'overpopulation'.

6.4.2 The importance of language

Related to this is the question of language. Given the historical association of 'population programmes' with 'population control', and of both of these with racism, there is little logic in maintaining this language in development discourse. A government committed to justice and to ending discrimination should avoid a discourse which may be counterproductive to these aims, whatever the intention.

It may be tempting to accept the discourse of 'population' as used in international terminology in order to show the coherence of South Africa's policies with those of the international community. However, the use of terminology which explicitly describes local thinking and practices will avoid the resumption of old policies or the adoption of international processes which may not be appropriate for South Africa. This is particularly relevant since international policy on population is not based on the experience of countries with South Africa's economic, social and historical profile. While there are many lessons to be learnt from international experience, one should be wary of importing international policies as a package. Some international writing on population, notably the draft paper produced for the International Conference on Population and Development, is consistent with the proposals presented in this paper, though the expression differs to some extent.

Within South Africa, different meanings are ascribed to the term 'population'. Some demographers argue that 'demography' refers to 'facts' about the population; 'development' to 'facts' about the environment, such as the quantity of available fuel; and 'population' to the interaction between demography and development. These definitions remove the human element from development and are contrary to most local and international development discourses which put people at the centre. The term 'population' then becomes interchangeable with the usual meaning of 'development'.

It would therefore seem most appropriate to remove 'population' from the local policy discourse; to retain 'demography', in order to refer to factual information about the structure, distribution and changing shape of the population; and to use 'development' to refer to all those processes involved in improving quality of life, including improvements in people's

access to skills, infrastructure and services, and improvements in people's sense of control over their lives.

6.5 Implications for the PDP

The approach suggested in this paper does not do away with the concerns of the population establishment, but locates demography within an overall development process, and institutionalises demographic concerns appropriately. Essential demographic skills, such as information gathering and analysis and inputting demographic trends into policy and planning processes, are located within a demographic unit which has easy access to whatever system of development planning and intersectoral collaboration is institutionalised. Other dimensions of the 'population' terrain are tackled within the appropriate departments: provision of reproductive health services in the Department of Health, improvements in access to education in the Department of Education and so on.

Although the precise implementation of the proposals of this paper, if accepted, would depend on the general process of transition and negotiation, only a limited staff from the present PDP would remain in a demographic unit. For example, those liaison officers currently providing 'population education' in the schools could go into the Department of Education. The demographic unit would provide a support function, rather than constitute a line function in a Ministry.

6.6 A note about contraceptive services

For the reasons presented in this paper, the provision of contraception should not be tarnished by goals based on population numbers. Responsibility for contraceptive services should be located within the Department of Health. The objectives should not be to reach target numbers of 'acceptors', although they should aim to reach 100% coverage over the next few years, but to empower women and men to take charge of their own fertility through high quality services. Such services need to follow a reproductive health model rather than the vertical service model associated with the promotion of 'family planning' as a means of lowering population growth. The approach being developed in preparation for the ICPD Conference in Cairo emphasises the importance of incorporating 'family planning' into sexual and reproductive health care. However, it often adds family planning to its list of necessities alongside reproductive health care. This would seem to allow for vertical contraceptive provision even though international consensus is against this system. This reflects tensions within the international community, as discussed in section 3 above, and is one of the areas in which South Africa may find itself in conflict with international agencies.

7. The way forward

One of the problems associated with this approach is the assumption that it is possible to make a rational choice of intervention, with the sure knowledge that one intervention will improve quality of life more rapidly than another. Although there are some interventions which have been shown to be essential factors in improving quality of life, such as women's employment and educational levels, there is still not enough information available within these categories of intervention.

Employment is seen as a significant factor in development not only because it benefits the nation as a whole, but also because income provides the employed person with the capacity to ensure the well-being of

herself and her family. The employment of women is emphasised because whereas a man will give some of his income to look after his dependants, a woman will use her entire income to do so and because employment substantially improves women's capacity to take control over their lives and futures and to challenge their subordinate status.

The more specific question of the types of employment called for is not as clear. A job which offers little satisfaction other than the wage earned is not likely to challenge a woman's primary view of herself as a mother, whose task is to support her children. A job which offers opportunities for self-development, for further training and career development may provide an important sense of personal satisfaction; it may give a woman a sense of self-worth, beyond motherhood. In this context a woman may choose to put her earnings into further training; she may be able to spend money on a buying a home and ensuring her own security; she may feel more able to assert her right to make reproductive decisions; she may choose to have children later in life; she may choose to have fewer children. Motherhood would not be her only goal, her only means of achieving recognition as an adult. In contrast a job which keeps a woman isolated, such as domestic work or piece work done at home, is less likely to expose her to new ideas, public debates, and a sense of herself as part of a broader community or to give her a sense of the changes taking place in society, all of which influence her ability to make decisions about her life and her future and to develop her potential in all areas.

Thus if an overall development goal is to improve women's social status, the kinds of job and training opportunities provided may influence the effectiveness of the programme.

The whole question of which sectoral inputs per rand make the biggest difference still needs to be researched.

Although such research should be ongoing, at this stage the key question is still whether it is possible to create a development programme which goes beyond listing the vast range of changes which need to be made without any consensus on priorities, and which avoids competition among the various sectors for funds to implement their line function, without reference to national priorities. With the achievement of consensus on the RDP, the question now is how this will be institutionalised and translated into a focused development programme that effectively meets people's expectations, especially given that difficult choices have to be made.

The harnessing of demographic information to support the national development initiative, and the elimination of racist and victim-blaming notions of overpopulation would contribute significantly to the achievement of this endeavour.

References

AFRICAN NATIONAL CONGRESS, 1994. *The Reconstruction and Development Programme.* Chapter 6: Implementing the RDP. Johannesburg: Umanyano Publications, 136-146.

COMMISSION OF THE EUROPEAN COMMUNITY (CEC),1993. Reproductive Health and Family Planning Consultancy: National Review and Recommendations. Johannesburg.

DEPARTMENT OF NATIONAL HEALTH AND POPULATION DEVELOPMENT (DNHPD), 1993. *The Population Development Programme in South Africa and the Role of the Chief Directorate Population Development.* CDPD Circular Minute 2/93, Pretoria, November.

EDMUNDS, M, 1981. Population dynamics and migrant labour in South Africa, in Michaelson, IC (ed) *And the Poor Get Children: Radical Perspectives on Population Dynamics.* London: Monthly Review Press, 154-179.

GOUWS, N, 1992. Population Policy in South Africa. Paper delivered at a Conference of the Association for Sociology in Southern Africa, Pretoria, 28 June-1 July.

HOLLINGWORTH, BE, JACKSON, BM, & MULLER, AM, 1994. Management in Social Transformation. Paper to be delivered at a conference, *50 Years of Water Engineering in South Africa: A Tribute to Professor Des Midgley,* University of the Witwatersrand, Johannesburg, 14-15 July.

KNOWLES, J, 1993. Implications of changing development paradigms for population policy and planning, *Round Table on Population and Development Strategies* (Expert meeting in Preparation for the International Conference on Population and Development, Cairo, 1994). Bangkok, November.

LAWTON, R, 1986. Planning for people, in Gould, W, & Lawton, R (eds), *Planning for Population Change.* London: Croom Helm, 9-38.

ORIEJI CHIMERE-DAN, 1993. Population Policy in South Africa, *Studies in Family Planning*, 24(1).

PELSER, AJ, BOTES, LJS & VAN DER BERG, L, 1992. Politics as an Environmental Factor in Population Development: Reviewing the South African Situation, *Development Southern Africa*, 9(1).

RURAL PRIMARY HEALTH CARE FIELDWORKERS' PROJECT, 1993. *With our Own Hands: Women Write About Development and Health.* Chapter 6: Working Towards Intersectoral Co-operation in Community Development. Johannesburg: Centre for Health Policy, University of the Witwatersrand, pp49-57.

SADIK, NAFIS, undated (c1991). International Conference on Population and Development (ICPD). Secretary-General, ICPD, No 6 , p3.

UNITED NATIONS ECONOMIC COMMISSION FOR AFRICA (ECA), 1991. *Manual for the Integration of Population Variables into Development Plans in African Countries.* ECA/POP/TP/91/1 1.1(ii):10-11.

Further reading

BERELSON, B, 1990. The great debate on population policy: an instructive entertainment, *International Family Planning Perspectives*, 16(4).

GREADY, M, KLUGMAN, B, BOIKANYO, E, REES, H & XABA, K, *When is yes really yes? The experiences of contraception and contraceptive services amongst groups of women in the PWV area*. Centre for Health Policy, University of the Witwatersrand, forthcoming.

JOLLY, C, 1993. Population change, land use and the environment, *Reproductive Health Matters*, 1: 13-25.

KILIMANJARO PROGRAMME OF ACTION FOR AFRICAN POPULATION AND SELF-RELIANT DEVELOPMENT, 1994. Arusha, United Republic of Tanzania, 9-13 January.

KLUGMAN, B, 1991. Population policy in South Africa: a critical perspective, *Development Southern Africa*, 8(1): 19-34.

KLUGMAN, B, 1993. Balancing means and ends—population policy in South Africa, *Reproductive Health Matters*, 1: 44-57.

MCKENZIE, A, 1988. *The Relevance of the Demographic Transition to South Africa*. Masters thesis in Public Health, Department of Community Medicine, University of Leeds.

MOSER, C, 1991. Gender planning in the Third World: meeting practical and strategic needs, in Grant, R & Newland, K., (eds), *Gender and International Relations*. Milton Keynes: Open University Press, 82-121.

SCIENCE COMMITTEE OF THE PRESIDENT'S COUNCIL, 1983. *Report of the Science Committee of the President's Council into Demographic Trends in South Africa*. Cape Town: Government Printer.

SMIT, J., 1993. Attitudes to family planning and family size: implications for reproductive health policy, *Global Change and Social Transformation*. Conference of the Centre for Science Development, Pretoria, November.

THE INTERNATIONAL FORUM ON POPULATION IN THE TWENTY-FIRST CENTURY, 1989. *Amsterdam Declaration—A Better Life for Future Generations*. Amsterdam, 6-9 November.

UNITED NATIONS POPULATION FUND, 1992. *Population Growth and Economic Development*, Report on the consultative meeting of economists convened by the United Nations Population Fund, New York, 28-29 September.

VAN RENSBURG, E, 1992. Demographic transition in South Africa: Implications for population policy and planning. Paper delivered at the Association for Sociology in Southern Africa Conference, Pretoria, July.