POPULATION AND DEVELOPMENT

HEARING

BEFORE THE

SUBCOMMITTEE ON AFRICA

OF THE

COMMITTEE ON FOREIGN AFFAIRS
HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

SECOND SESSION

AUGUST 4, 1994

Printed for the use of the Committee on Foreign Affairs

U.S. GOVERNMENT PRINTING OFFICE

85-046 CC WASHINGTON : 1995

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-046505-2

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CONTENTS

WITNESSES

APPENDIX

POPULATION AND DEVELOPMENT

THURSDAY, AUGUST 4, 1994

HOUSE OF REPRESENTATIVES,
COMMITTEE ON FOREIGN AFFAIRS,
SUBCOMMITTEE ON AFRICA,
Washington, DC.

The subcommittee met, pursuant to call, at 2:01 p.m. in room 2200, Rayburn House Office Building, Hon. Harry L. Johnston (chairman of the subcommittee) presiding.

Mr. JOHNSTON. I would like to welcome everyone today to the Subcommittee on Africa's "Population and Development in Africa" hearing.

The Africa Subcommittee meets today to discuss the topic of population and development on this continent. Africa is the continent with the lowest population density in the world, with the exception of Antarctica, and the most rapidly growing population in the world. It is also the continent in which economic development results have been the lowest.

One of the main themes I wish to explore today is the relationship between the high rate of population growth and weak economic performance. While in most of the developing world the average number of births per woman has dropped precipitously in the past three decades, such a demographic transition has been much slower in sub-Saharan Africa. Indeed, the average number of births per woman in Africa is still around six. I might say, it is higher in Burundi and Rwanda. Only 20 percent of the couples in Africa use any type of contraception.

The high rates of population growth in Africa are associated with a range of health and social problems for both mothers and children, with continuing endemic poverty and with environmental degradation. I hope that we can learn more about the linkage between high rates of population growth and the low status of women within society and how enhancing the status of women can be a part of our overall population strategy.

High rates of population growth also wipe out the effects of modest economic growth on per capita income. They also put a tremendous strain on public services, which are already woefully stretched in most African countries.

I find it hard to believe that there is not a connection between the recent tragedy in Rwanda and that country's high population density and rapid rate of population growth, and I worry about what will happen in other densely populated African countries that have both high rates of population growth and ethnic and other so-

cial tensions. Nigeria, with at least 90 million people and 3 percent annual population growth, comes to mind.

Yet, as in most issues, there are success stories. Kenya, Botswana, Zimbabwe, and several other countries have had significant drops in fertility in recent years. I am interested in learning from our panelists what lessons can be drawn from these experiences by other African countries and by the donor communities.

In September the International Conference on Population and Development will take place in Cairo. How will African population issues be addressed at the conference? Will the United States take a leadership role in ensuring that African population issues are effectively addressed at the conference?

Today we will hear from two panels. On the first panel, Carol Peasley, the deputy assistant administrator for African affairs in AID, will present the administration's view. On the second panel we will hear from Dr. Steven Sinding of the Rockefeller Foundation; Nicholas Eberstadt of the American Enterprise Institute; and Dr. Adepeju Olukoya of the Women's Health Organization in Nigeria, who, I might say, came to the United States from Nigeria specifically for this meeting at her own expense; and Peggy Curlin of the Center for Development and Population Activities.

Ms. Peasley, before I call upon you, if Congressman Payne comes in, I have agreed that, since he has a very tight schedule, we will interrupt for him to make a report to the committee on his trip last weekend to Zaire and Rwanda. So I apologize now in advance, and he should be here shortly, but in the meantime I would ask you to go ahead with your statement please.

STATEMENT OF HON. CAROL PEASLEY, DEPUTY ASSISTANT ADMINISTRATOR FOR AFRICA, USAID

Ms. PEASLEY. Thank you, Mr. Chairman. I am pleased to be here today to discuss USAID's program ON population in sub-Saharan Africa. This is my first time to appear before you, and I am glad to be able to address an issue of such importance and one for which I have developed great personal interest during my career with AID. In many ways what happens in this arena will determine the future of development in Africa for the next 50 years.

It is difficult to see how poverty can be reduced and development progress sustained without substantial declines in the rate of growth of Africa's population. Fortunately, there are a number of hopeful signs that suggest Africa may be on the verge of a demographic transition. The last 5 years have seen the broadest and deepest shift in attitudes and in behavior and family planning in Africa in history. Our investments are having a measurable impact.

I would like to address four issues in my remarks: First, to very briefly discuss the nature of the problem of rapid population growth in Africa and how population fits in the administration's foreign policy and development objectives for Africa.

I would like, however, to focus on what USAID is doing in the population family planning arena and the impact of our assistance programs. I would ask that my written statement which addresses these issues in more detail be included in the record.

Mr. JOHNSTON. Without objection.

Ms. PEASLEY. First the demographic problem.

Sub-Saharan Africa has the fastest growing population of any region of the world of any time in history. The population is doubling every quarter century, and the momentum of population growth is such that even if fertility levels were to drop to replacement level today, Africa's population would still double within a lifetime.

There are a complex mix of social, economic, and political factors which contribute to Africa's high fertility rates including high social regard for fertility and to large families supported by age-old family clan and tribal traditions, early female marriage, low levels of female education, high levels of child mortality, low levels of urbanization, a history of policies hostile to family planning, rudimentary delivery systems for contraceptives, and slow economic growth, and no broad system of social security.

Given Africa's current level of underemployment and poverty, its precarious food security situation, fragile ecosystems, already inadequate social services, and the tenuous grip many societies and governments have on maintaining civil order, the prospect of doubling population in two decades is a sobering call to action.

Slowing Africa's high population growth has taken on increased significance and urgency as the Clinton administration has redefined our foreign policy and development objectives for Africa. The current leadership in both USAID and the State Department recognizes the devastating impacts which high fertility has on African women and the threat which unabated high population growth poses to sustainable development and political stability.

The growing importance of family planning and population to the administration's foreign policy and development objectives is manifest in a number of ways. It is an explicit U.S. foreign policy objective for Africa. It is a high priority in the administration's foreign assistance reform legislation and USAID's new sustainable development strategy. It receives increased attention in public fora such as the recent White House Conference on Africa.

We are increasing funding for family planning and population activities in Africa, and we seek to leverage other donors to commit more resources for family planning in Africa. Our enhanced family planning and population efforts are an integral part of an overall sustainable development strategy for Africa which is premised on generating broad-based economic growth.

Economic growth is necessary both to increase demand by women for contraception and to sustain and expand public and private services to meet that demand. Conversely, giving women choice and control over reproduction is in itself empowering, and reduced fertility enables them to be more active economically.

We are complementing and reinforcing our family planning efforts through investments in other key areas such as basic education for girls, child survival, and family health.

USAID is the largest bilateral donor in the population field in sub-Saharan Africa and has been active there since 1968. USAID has supported voluntary family planning programs in 38 countries. Today large bilateral programs are under way in 21 countries. All of the Africa Bureau's major sustainable development programs include family planning, often coupled with child survival and HIV-AIDS prevention as a strategic objective.

The combination of bilateral and central funds for population and family planning in Africa has exceeded $100 million annually for several years. Between 1988 and 1993 USAID provided $332 million from the Development Fund for Africa for this purpose, and we anticipate providing $73 million more this fiscal year. Central Office of Population funds also have provided important technical assistance and financial support.

USAID is a recognized leader in providing population assistance in Africa. We have a clear comparative advantage in this sector because of USAID's strong field staff and an excellent network of cooperating agencies. We have been at the forefront with innovative programming, including computer simulations to stimulate policy change and mobilization of the private sector in contraceptive social marketing and employer-based provision of services.

Our programs have focused in four areas: Changing Africa government policies; support for voluntary family planning programs; support for education, information, and communication; and development of channels for distributing contraceptives.

Our family planning programs are built to encourage demand and to expand supply. However, since the demand for smaller families is correlated with female education, child health, female employment out of the home, urbanization, and overall economic growth, our family planning efforts are always part of an integrated program of assistance for broad-based sustainable development.

Recognizing that no single donor has enough resources to meet the expanding demand for population assistance, donor coordination is an important part of our approach to family planning in Africa. At an individual country level a division of labor typically emerges in which, for example, a British ODA or USAID procures contraceptives, the World Bank funds construction and facilities rehabilitation, and USAID provides technical assistance.

In my written statement I have outlined some more specific success stories of donor coordination, including engagement of the Japanese in this critical area.

USAID has contributed to four major changes over the past decade: First, African government support. Since 1985, USAID has demonstrated through computer modeling, what is known as a RAPID model, the impact of unrestricted population growth on economic well-being, education, health care, and agriculture to policymakers in 28 countries.

Today most African governments have changed from pro-natalist positions to supporting birth spacing and in some cases smaller families. In addition to working to change the basic attitudes of policymakers about family planning, USAID is now working to change policies that impede the effective delivery of contraceptives, and we are seeing success in a number of countries.

Second, increased demand for contraceptive services. USAID-financed education, information, and communications programs have heightened the awareness of parents, particularly mothers, to the need to space births for the welfare of their children. They have also communicated the availability of modern contraceptive methods, and they have resulted in an increasing demand for contraceptive services.

Third, USAID continues to develop and strengthen the service delivery infrastructure. Three channels for distributing contraceptives have been created or supported. First, we have pioneered social marketing, the provision of contraceptives through private sector outlets at subsidized rates. In addition, USAID provides contraceptives for distribution through the public health system. We also support the use of local communities and nongovernmental organizations to deliver contraceptive services. Family planning services are now much more accessible in Africa including in rural areas.

These improvements in service delivery, coupled with increased demand by women, have resulted in increased contraceptive prevalence rates in many countries; for example, in Ghana from 5 percent in 1988 to nearly 15 percent in 1993.

Fourth, lower fertility rates. Fertility rates have dropped markedly in Kenya, Zimbabwe, western Nigeria, and Botswana, and smaller declines have occurred in several other countries. Kenya is the most shining success which shows the results of a multifaceted approach and intensive investment sustained over time.

During the 1970's, USAID's assistance had little measurable impact on Kenya's 4 percent population growth rate, one of the highest in the world. However, even during this period when many were undoubtedly frustrated by the slowness of change, the foundation was being laid for an impact of unprecedented magnitude in Africa. The use of contraception has almost quintupled over the past decade, and the fertility rate dropped by about one-third from about eight children per woman in 1979 to about 5.4 in 1993.

We are having success, but challenges remain. Most notably, male attitudes still constrain women's increased contraception, and slow economic growth and social service expansion also limit impact.

The impact of HIV–AIDS on overall population levels and growth rates is also a great unknown, although current estimates show that it could temporarily half population growth rates in some countries.

There are many positive signs. The policy environment is right, the incentive structure for large families is changing, information is more broadly available than ever before. Consequently, we are confident that the time is now for major declines in fertility throughout Africa.

We are dedicated to maintaining our leadership position and to using our knowledge and resources to continue to push reforms that encourage the empowerment of women and the expanded access to contraceptive, to expand knowledge of family planning practices, and to strengthen delivery systems.

At the same time, our programs in economic growth and female education and child health will continue to lay the foundation for sustained increases in demand for modern family planning. We believe this area is fundamental to development. We intend to make every effort to push forward the demographic transition, and we are confident of our future success.

[The prepared statement of Ms. Peasley appears in the appendix.]

Mr. JOHNSTON. Thank you very much.

Before we go to questions, I was going to ask Congressman Payne to give us a brief overview on his visit to Goma last weekend and to Rwanda.

Congressman Payne.

Mr. PAYNE. Thank you very much, Mr. Chairman.

First of all, let me say I am delighted that the Subcommittee on Africa is focusing on one of the most important aspects of sustainable development, population, where we can take an overview rather than to deal on a country-by-country issue in a crisis way, and so I commend the chairman for calling this very important hearing.

Also, after saying this, I am mindful of the fact that, as the chairman mentioned, he asked me to give a brief report on my trip to Uganda, Rwanda, and Zaire this weekend with the Secretary of Defense Perry.

Let me say, however, as relates to the question of development and population and the issues we are going to be dealing with today, it is going to be important, and as we just heard from our first witness, we have to sufficiently focus on the impact of women in the African society, and we are aware of the fact that there have been changes made and changes are happening, but we feel that the rate of change is not commensurate with the need, and we know that African women are speaking out on their own, there is no question about that, but I think that we as a Government and with policies should certainly support the women who are, in their indigenous way, making a difference in their lives.

The health, education, and reproductive rights of women are so important that every program should be examined to make sure that these aspects are fully funded and implemented. So I just think that the total success of what we are going to try to do as relates to population development and so forth will depend more so on women.

Briefly, let me say a few words about my recent visit to Uganda, Rwanda, and Zaire during the past weekend. First of all, let me thank the chairman once again for his continuing interest in the problems in Africa and the particular problem in Rwanda.

On June 16 we had a very important hearing where we had representatives from the National Security Council, the Organization of African Unity, Mr. Gomez, we had a representative from the RPF who was present, and we heard about the problems, and we had discussions and made recommendations.

As a matter of fact, at that point the chairman mentioned the fact that the term "genocide" had never been uttered, and at our hearing it was danced around by some of our State Department officials, and we think that is very sad, because I feel that we should have called it what it was earlier on and could have gotten international courts of law to start to move more aggressively. But as you know, I have been very highly critical of the administration and the lack of action on their part.

Shortly after the downing of the plane carrying the two Presidents on April 6, we started to have concern, and during April, and May, and June, and much of July while this genocide was happening, we could not really get the proper attention, we felt, the need for logistical support from the request from the U.N. Secretary General.

In my mind, if we had fully implemented some of the requests, perhaps there could have been corridors where protective corridors could have been developed within Rwanda and that this situation would not have occurred. But we supported the reduction of U.N. forces from UNAMIR in Rwanda rather than to strengthen and change the scope of their original mission.

But now, when the TV screens are full of people dying in Zaire and the flood of refugees is unprecedented, our country has taken a very positive role, and so therefore I would like to commend the President and the administration for acting as aggressively as it did when it decided to move. We just felt that perhaps much of this could have been avoided had we moved earlier. But the response has been overwhelming, and I really commend the administration for that. The whole issue—and if you had been there with me, you would have really been proud of our young servicemen and women with what we call their "can do" attitude.

In Kigali we saw an airport that had been closed for 3 months open in 24 hours by our U.S. military putting in an air control system, maintaining the security of the perimeter, and putting everything into the Kigali Airport that it needed, because the Goma Airport was the only one that was open and it was very difficult to get flights into Goma because it is a very small and inadequate airport. For a very small city in the past, they didn't need a great big airport, but with a million and a half people there now it made it very difficult.

So the reopening up of the airport in Kigali was very important, and that was done by our U.S. troops that flew in and immediately turned that airport around.

The other situation that was very encouraging was to see our young men turn around the water supply in 2 to 3 days—really, in 48 hours. They had meshed a U.S. system with a French system where they pumped water from the lake, and they were able to purify over a million and a half gallons of water a day, and the problem was not the fact that there was purified water but the problem was the distribution of the water.

We were able to have water distributed in the city of Goma, and we saw when, 5, 6 days before we got there, the road from the airport to the pumping station was just a one-lane road because the bodies were all put between the street and the sidewalk, and it was just littered with bodies. When we went this time, there were bodies there but nowhere near the amount. We turned it around.

By putting in that system, the death toll of 3,000 to 4,000 a day was immediately turned around in about 48 hours to 900 and 800 a day, and it is still declining, and so once again it made us very proud to see our U.S. soldiers hook up this system, as a matter of fact, with a couple of retired firemen from San Francisco who were flown to Goma and really were the ones that put the system together, because they had done it before in the earthquake in California. They were called upon, and so their ingenuity with the experience of our forces really saved thousands and thousands of lives.

We had the opportunity to meet with the new Government of Rwanda. As you know, it was a situation that started when the Presidents of Rwanda and Burundi were killed in a plane accident.

A group of militant Hutus went on a killing binge, and it originally started about power. It was not originally an ethnic problem, it was those who were in power wanted to retain power, and the initial killings were moderate Hutus as well as Tutsis, and I think that is important because it did not begin—it began with the people who were in power wanting to remain in power because the Arusha cause dealt with an expanding of the power from Hutus to Hutus and Tutsis, and there were just people who were not in concert with that, and so with this radio station that continued to spew out hatred, it then digressed into strictly an ethnic problem, and so as we saw it move through the week, we then saw it turn on from just staying in power to long-standing ethnic hatreds.

The unfortunate part is that, as I indicated, we waited, I think, too long, but the good news is that the new government, although the RPF, which is the Tutsi Army of the Rwanda Liberation Front won the civil war, the Tutsi military leaders decided that the President of Rwanda should be a Hutu because the Hutus still are the majority people and the prime minister is also a Hutu, which, in their government, is a very important position and the vice President is a Tutsi and the minister of defense.

But I think that the first move to show that there was an interest in expanding the Government and that Hutus were welcome and there would not be retribution I think was a very key and important move.

We are attempting to bring in radio facilities so that messages can be beamed to the people in Goma in the camps to ask them to come back to Rwanda, and that is a very important issue, and it is very difficult. They have also asked to have an international court come into Rwanda to have war crime trials. The Government of Rwanda does not want to take on that responsibility, because they want it to be impartial, and they want a third party to come in from the United Nations to conduct the trials, and they are asking support from the United States and U.N. to set up that system.

One problem is that the murderers who pushed the genocide are also in the refugee camps in Tanzania and in Zaire, and these murderers are telling their people not to leave. As a matter of fact, it was the radio station that encouraged the Hutus to leave Rwanda, and that 1.2 million went across the border to Zaire because of the radio. The same one that pushed the genocide, and the killings, and the murdering pushed the people to leave Rwanda to create this terrible situation, and so we finally, I believe, have silenced the radio system, which should have been done 3 or 4 months ago, and we are trying to get across another message.

Finally, the cholera has ended, but, as I indicated, there are Hutus who are almost forcibly keeping people from returning because they want to keep a country in exile perhaps with dreams of reorganizing and coming back. Their argument was that if 250,000 people, Tutsis primarily, living in Uganda could come up with a military force of between 10,000 and 15,000 and defeat the Hutu military, that with a million and a half Hutus outside of the country and many of their former military men this, that perhaps it could be done in reverse since they have 10 times the numbers, and so we need to diffuse that to attempt to segregate those murderers from the general population, and there is a list, and these

people are known, but they are being successful in discouraging people to leave the refugee camps, and so we have a lot of work to do:

The difficulty of burying people because they are in a lava area, a former volcano, and there is hard rock, therefore making it almost impossible even for some of our equipment to dig latrines and to dig graves, and that is a very, very serious situation that we are confronted with.

Also, there is an active volcano that is sort of becoming active, and if that becomes a real situation, I don't know what will happen there.

Finally, the rainy season comes in about a month, and if we don't have these camps cleared or at least reduced by 50 percent, we will of course have very serious problems—the mud, the whole denuding of the area. It was a lush area with trees and vegetation, which of course, when 1.2 million people go in and the only fuel is wood, the whole area has been denuded and will take a long time to come back. So we are hoping that we can get most of them out so that we can move along with the whole reconciliation in Rwanda.

So once again, Mr. Chairman, thank you very much, and I commend Secretary Perry who took the leadership to go and see things firsthand. We had the entire command. General Gowan from our NATO forces flew down with us. As we picked him up in Belgium, we stopped in Cairo and even talked about the population conference and some of the problems. With so many Americans wanting to attend it, I don't know where they are going to stay. The last I heard, they are staying on the Nile River in boats.

And then to have the opportunity to meet with the President of Uganda, who is a very impressive man, President Museveni, and he is certainly willing to assist the new government in Rwanda and has been very helpful and indicated that he was at a meeting of African heads of state when President Clinton announced that they were going into Rwanda, and he said the heads of state were very appreciate of what the U.S. Government was doing, and the Government of Rwanda made it very clear before we even brought the question up, they said this is not Somalia, that we are inviting the U.S. troops to come in, we want them here, we have a government, Somalia had no government nor were the troops welcomed by the so-called rump government, but they are welcoming us. The people in Somalia welcomed the troops, but the leaders didn't. In this instance, the people and the leaders are welcoming our help.

So I took a little longer than I anticipated, Mr. Chairman, but thank you for the opportunity.

Mr. JOHNSTON. Thank you very much, Congressman Payne.

Ms. Peasley, bear with us just a second longer.

At the briefing the day before yesterday that you and Secretary Perry, Brian Atwood, and Senator Wirth gave to the leadership—and I was pleased to be invited—one thing you brought up, and Perry did not have a chance to respond to, was our lack of support for UNAMIR. To go back in chronological order: The plane crashed in the first week in April. I think in May the United Nations authorized and established UNAMIR, a military force that would go in there and try to set up safe zones. Three African countries vol-

unteered 4,000 troops to go in there. All they needed was some logistic support.

Sitting on the plane with Secretary Perry for 30 hours, did you ever have a chance to ask him why we did not supply that logistic support and literally save millions and millions of dollars and probably several hundred thousand lives?

Mr. PAYNE. I did ask the question.

Mr. JOHNSTON. I figured you would.

Mr. PAYNE. The whole question that they continually bring up about the United Nations not having the capability to do things, I think that I have been very critical of our U.S. Ambassador to the U.N. because there were a number of plans that were put forth, but we were uncomfortable with the plans.

We actually said on a McNeil-Lehrer report—the Ambassador talked about the cost, and we had to make sure that we were able to take care of our percentage of the cost for peacekeeping for Rwanda, and that there would have to be a couple of weeks study. This is as people were just being massacred. He never answered the question that I did pose to him but talked about the bureaucracy of the U.N.

When we got to Rwanda, and we met with the UNAMIR commander, he indicated that we could start with Ethiopia that has a whole battalion of 800 ready and waiting. The Secretary of Defense said that they will immediately work out the logistics to bring those troops from the various countries that—to Rwanda and to Zaire, and so, as I have been bringing up many times, preventive programs seem to be the most difficult because we all anticipated what would happen if we didn't act and if we had sent in those troops that could have had protective corridors to prevent the innocent people from being murdered by the warring factions.

We didn't even ask them to intercede in the war but simply have the kind of protective corridors as we see the French have done in the south of Rwanda, or in the West, where there are 2 million people, and had the French not been there these Hutus may have gone over into Burundi, and if in fact we don't get the peacekeeping people in there, they in fact still may go out into Burundi, which would then really—that democracy there would be in jeopardy.

It made no sense. There is no answer for why we did not send the logistical support simply asked by African nations, and Salim Salim, the head of the OAU, said that he made pleas but they went unheeded, and as a result we have this disaster where we have tremendous loss of life and a tremendous amount of cost when we feel it could have been prevented had we taken the first steps .

Mr. JOHNSTON. Thank you. They were throwing out some big figures the other day about what is going to cost, about $300 million.

Mr. PAYNE. Yes, $320 million.

Mr. JOHNSTON. Four thousand American troops in there, $2 million a day after startup costs. The only thing I disagree with you on, a minor technical point, I would not call Burundi a democracy. That is in the eye of the beholders.

Mr. PAYNE. Yes. That did slip up. I mean I am glad you brought it to my attention so I don't make that same mistake again.

Mr. JOHNSTON. Ms. Peasley, a follow-up on Congressman Payne. Do you think it is a coincidence that the recent massacre and/or

massive civil conflict in Rwanda, in a country with the highest density of any country in Africa and one of the highest rates of population, is there any coincidence there or is there a direct correlation?

Ms. PEASLEY. No, I don't think it is a coincidence. I think that there is a strong correlation between population density and the level of resources and the pressure that that puts across the board on society, on all aspects of economic development, on job creation, on society in general.

So, I think there is a very strong correlation. I would like to add that we have always recognized the population growth rate in Rwanda as a serious development issue, and since 1981 it was a critical part of the U.S. aid program in Rwanda.

And ironically, it was becoming a success story until the tragic events in Rwanda. U.S. assistance was instrumental, along with other donors, in helping to increase contraceptive prevalence, to decrease fertility, and to make maternal and child health services more available.

According to 1992 demographic health survey data, modern contraceptive methods had increased in Rwanda from about 1 percent in 1983 to 13 percent by 1992, and fertility had begun to decline from an average of 8–1/2 children per woman in 1983 to 6.2 percent in 1992, so we were really beginning to see very substantial change, almost to the level of change in fertility that we have seen in Kenya.

So, it was a critical problem. I think it did substantially contribute to the problems in Rwanda and to considerable out-migration as well so that it was very destabilizing to neighbors, to Zaire and Burundi in particular.

Mr. JOHNSTON. There is another success story that hasn't been publicized too much. In talking to one of the relief organization persons in Goma, they were waiting for measles to break out with a couple of hundred thousand children there. If it had broken out many would have been dead within a matter of hours. You all got in there and immunized all the children in Rwanda.

Ms. PEASLEY. Right. Apparently, there was 90 percent of vaccination coverage in Rwanda.

Mr. JOHNSTON. So that obviously saved thousands and thousands of lives.

What is the criteria for AID or the Africa Bureau to decide whether or not and to what extent to become involved in the population arena in specific African countries?

Ms. PEASLEY. Well, as part of our strategy development process in an aid office we would be looking at the whole array——

Mr. JOHNSTON. Would you move that mike just a little closer to you.

Ms. PEASLEY. We would be looking at the entire array of development problems in the country. In fact, I think as I had said, in all of our 21 major bilateral programs we do have a family planning program as an important part of our country development program.

But stepping back from that, as we look at the development problems, we will be looking at the population growth rate and at density. We will be looking at economic growth rates and the major constraints to increasing economic growth, particularly to the ex-

tent that population is an important issue in that country. If so, we would be incorporating a family planning program in our country strategy.

Again, I think it is fair to say that in almost every one of our bilateral programs, one of the strategic objectives relates to reducing fertility in part because the policy environment has changed so substantially in Africa.

Obviously, when we develop a country program strategy we do it collaboratively with the people in that country. In fact, the governments themselves have changed their own policies. This has facilitated our own access to provide much more substantial services and support.

So, we are looking analytically at the development problems. We are looking at the environment and the receptivity of the people themselves to have support in that area, to be requesting support. Again, I think it is fair to say that whenever there is a country in which we feel we can really contribute, we are there providing significant support.

Mr. JOHNSTON. Why do you think, though, Africa is behind the other developing countries in this area, the fertility area?

Ms. PEASLEY. Well, I think again much of it is the link to overall development. The fact that economic growth, economic development in Africa has lagged. And I think there is a strong correlation between economic development and population growth. It is a very difficult relationship because it is a correlation that goes in both directions. So, as economic growth has not been as robust in Africa as in other parts of the world, that has hurt.

There have also been traditions. There have been cultures that supported higher fertility rates, having more children. It has been valued. Education levels have been lower, particularly for women. That has been a contributing factor.

Child mortality rates are dropping in many, many countries, but the fact that that has taken time to happen has also influenced fertility rates. There is less urbanization in Africa than in Latin America and Asia, so that has contributed to the difficulty. So, it is a variety of different factors.

Mr. JOHNSTON. In your written testimony you said you were going to increase the amount of population and family planning funds, but your table kind of belies that a little, doesn't it? You start out in fiscal year 1993 with $74.6 million and in fiscal year 1994 you drop almost a million and a half dollars from that. And the irony of it is 1993 was probably George Bush's budget and 1994 is Clinton's and his is less.

Ms. PEASLEY. I believe that some of this is, again, looking at obligations, where there could be very significant obligation——

Mr. JOHNSTON. It is already in the pipeline?

Ms. PEASLEY. It is in the pipeline. So I think, in fact, I was looking at those numbers myself this morning and was surprised. And I believe one of the reasons it was very high 2 or 3 years ago——

Mr. JOHNSTON. Where Jerry comes to the rescue? [Laughter.]

Ms. PEASLEY. OK. Right. There is a—no, it is a different point.

Mr. JOHNSTON. Is that right? To bring home eggs and bacon for dinner or something?

Ms. PEASLEY. In Ghana it was a very substantial obligation because it was a very large program, including some nonproject assistance or sector assistance, so it had a very large obligation.

But it is also important to remember that the $73 million is DFA only and we are also getting substantial support.

Mr. JOHNSTON. Yes. But the chart is only DFA also.

Ms. PEASLEY. That is right. And it is showing——

Mr. JOHNSTON. But it does show an increase from 1988 of $32 million to today of $73 million.

Ms. PEASLEY. Right. And it has somewhat stabilized around the $70–$75 million level.

But again, we see this as part of an integrated package of programs. We have had an increase during this same period in basic education programs, particularly girls' education. So, there are other complementary investments that are supporting our population objectives.

Mr. JOHNSTON. On page 9 of your testimony, you allude to the fertility rate as dropping in South Africa. That surprises me. Mr. Payne and I were in South Africa twice last year. Some of the stories told us by women were that black South African women before they got married would become impregnated in order to prove to their potential spouse that they were capable of having children, after which they would probably have six, seven or eight children.

Now, has that turned around in South Africa? I know it is very sensitive in South Africa, because for years the whites wanted the blacks to have birth control and they did not want to have any, and I was just wondering.

Ms. PEASLEY. I must confess I need to look at that figure more carefully. I suspect that some of that reduction is actually from the modernized, the European aspects of South Africa where you may be seeing the same phenomena that you are seeing in the United States and Europe with declining rates. I have also talked to South African women who are eager to have family planning services, and we will be discussing that with the new government, with our expanded package to discuss their interest in family planning services support.

Mr. JOHNSTON. The other thing that is kind of interesting is on average only one-quarter of the married women in the countries such as Uganda use contraception. I have had several debates with President Museveni about contraceptives, and he stonewalls me every time and I can't figure out why.

At first, I thought it was the Catholic influence but it is not. It is male ego that I find is probably the biggest impediment to teaching them contraception, because apparently African men feel that there is a direct relation between the number of children they have and their virility.

How do you seem to get over that? You don't have to answer that.

Ms. PEASLEY. I won't comment. [Laughter.]

Mr. JOHNSTON. Mr. Payne.

Mr. PAYNE. Thank you. I saw the President again, I didn't want to ask him again about that issue. Well, he did mention that, you know, the contraceptives were so costly for a typical villager that he said, I think even on this last trip where we raised the issue

again, that to introduce that and for the average person to be unable to afford to buy contraceptives, he thought, didn't make good policy. And I wonder whether—I know in some countries there is distribution. But how wide is distribution a part of the family planning program and in particular in the rural areas where I would imagine the problem is greater once we, you know, urbanize and there is an easier communication and access.

Is the problem basically in rural areas? And what is an answer for the President who says that a typical villager cannot afford to pay for that?

Mr. JOHNSTON. Would you yield and let me add on another question? Museveni's argument is, which I think is a little spurious, that 90 percent of his population is illiterate, and if you try to teach a man to use a condom that he thinks—and when you refer to it as a rubber, that it is an inner tube of a tire. But to me, you know, it is—excuse me for being crass—a rubber is a rubber is a rubber, worldwide.

And so I just think he rather took the intellect of his population and denigrated it. Excuse me.

Ms. PEASLEY. Well, obviously, it is more challenging in a rural population, but there are very comprehensive information, education, communication campaigns that are used in, I think, in all countries in which we have family planning programs. Much is through the radio.

We are funding social marketing programs which have been focusing primarily in the early stages on distribution of condoms. They are sold at a subsidized price through commercial marketing channels, and this has been extremely successful.

Zaire is one of the earlier examples of social marketing program that had been extremely effective. I had worked in Malawi. I just recently returned from 5 years in Malawi, and we had a social marketing program that was, again, beginning to have a real impact in rural areas as well.

So they do, in pricing the condoms, they try to be very sensitive to what is affordable. The level of subsidy depend upon the economic well-being of the people in that country. There is also free distribution of contraceptives as well. There are multiple channels. I think that is the important thing to remember. Some through commercial channels, some through public health facilities, some community-based distribution that is going on, again at the village level, which has been extremely effective.

I think this is one of the things we have learned from other parts of the world where community-based distribution has been extremely effective, particularly in Asia a number of years ago, and we are beginning to adopt those techniques for Africa.

So, you know, again I think that there are opportunities for success. I might just add one, because I think it is a wonderful little anecdote of social marketing, particularly in trying to reach men.

There are a number of social marketing programs in Africa where the product, the brand of condom might, for example, sponsor a football game, a soccer game, and you will have 20,000 or 30,000 men at the soccer arena and there will be a lot of promotion for condoms.

I think one of the most creative things was for the World Cup soccer. There were family planning spots that were put on for the broadcast of World Cup soccer as it was going to all of francophone Africa. We funded some family planning spots, and more reaching 200 million men probably at any given point in time, talking about family planning principles.

So, there are a lot of very creative things that are being done to educate people to let them know about what is available.

Mr. PAYNE. I don't want to ask how much it cost per second.

Ms. PEASLEY. It wasn't Superbowl prices.

Mr. PAYNE. But, you know, you had 100 times and 1,000 times more people watching the World Cup. They just say it was unbelievable.

Are you involved much in the Population Conference?

Ms. PEASLEY. I haven't personally been very involved. I know that AID has been actively involved with preparations, and we have been trying to help to facilitate African participation in the conference.

Mr. PAYNE. I was just wondering if you know about the level of participation by women. Will that be a heavy focus or that be the overriding theme, perhaps?

Ms. PEASLEY. Yes, it will be. My understanding is that the African delegations met in Dakar in late 1992 and I believe one of the recommendations that they laid out was that empowerment of women and the status of women be an important subject for the Cairo conference. So, I think that the African nations are fully behind that.

Mr. PAYNE. Just a last question. I know it may not directly be in your jurisdiction either. What with the tragedy in Rwanda and the problems going on now in Tanzania and in Zaire, there is going to be a tremendous number of orphans, unaccompanied children.

As a matter of fact, it is very difficult now. I mean we hear stories of mothers whose child just got separated in this massive thing, and with 1.2 million people around you have got mothers walking through camps of tens of thousands of people trying to see if they can see their children, or their child.

And, of course, with so many parents, women dying, when the men were separated because they were fighting and with the mother dying the child is just unaccompanied. There is going to be a tremendous number of children, infants and young children without parents.

Have you all thought about that? And what if they don't get—and what happens when they get back? Perhaps while these children are there maybe somebody will look over them. You know, the extended family concept in Africa is very positive because people are accepted more readily than in Western culture.

But it is something I think that you need to think about as the reconciliation start and people start returning back. Or even if, in fact, they don't and they are there at some point in time someone is going to have to raise this as an issue?

Ms. PEASLEY. I think that is a very important point, and I think it is something that we have some, a little bit of experience on vis-a-vis, our activities with Mozambique and refugees. I know that there were some activities for orphans and traumatized children

there that were being done by American PVO's, and again we throughout Africa have been doing some work with orphans, AIDS orphans.

So, again it is a subject that at least we have a tiny bit of experience in, and some organizations that are gaining experience in. So, I think that is something we will need to follow-up on.

Mr. PAYNE. Thank you, Mr. Chairman.

Mr. JOHNSTON. One other debate I have had with President Museveni is that there is one out of every four males between the age of 18 and 42 have AIDS in his country.

Going back to educating men, Alice Walker brought the spotlight on this rather neanderthalic procedure that goes on in Africa of female circumcision. Is AID doing anything to try to stop this procedure?

Ms. PEASLEY. Yes, we are. There are activities in several different countries, but it is a very, very sensitive subject, obviously, bound up with tradition and customs.

What we are primarily doing is where there are women's groups in various countries who are taking on this issue we have been there trying to provide support to them to help them deal with the issue. And I believe in a couple of countries there are ongoing activities right now. But it is of very serious concern to us.

Mr. JOHNSTON. Well, how about having it outlawed or making it a criminal offense? Is there any move to try to do that?

Ms. PEASLEY. I think within countries, as the people within those countries want to take an aggressive stand on that, but again I think it would be very difficult for an external party, other than that we have, I believe, formally categorized it as a human rights abuse.

Mr. JOHNSTON. Have you? OK.

Ms. PEASLEY. I think Dick McCall, Chief of Staff of USAID, has referred to it formally as a human rights abuse.

Mr. JOHNSTON. You refer to your success stories as Kenya, Botswana, Zimbabwe. Are you able to transfer that to the other countries and use the procedures in developing them in these other countries?

Ms. PEASLEY. No. I think there is a lot of learning and carrying on examples. I think that since there is such a vast array of factors that influence the success of family planning programs, it is very difficult to take something from one place to another and hope for success. But I think we are applying the lessons, and I think we are beginning to see increased contraceptive prevalence in a number of countries, and I would suspect that in 3, 4, 5 years we will begin to see much more dramatic results.

Mr. JOHNSTON. Ms. Peasley, your debut before the committee was very helpful and very informative, and we appreciate it.

With the bell going off, I have to go vote, so the committee will stand in recess for 10 minutes. And I would ask the second panel to be prepared to come up. As soon as I get back, we will start.

We are in recess 11 and a half minutes.

[Recess].

Mr. JOHNSTON. If I could call the hearing back to order.

On panel two, we will go in the order in which they are listed on the witness list. So, Dr. Sinding from the Rockefeller Foundation, we will start with you, sir.

Incidentally, those of you who have prepared written statements, we will put them in the record in full, without objection.

STATEMENT OF STEVEN W. SINDING, M.D., ROCKEFELLER FOUNDATION

Dr. SINDING. Thank you very much, Mr. Chairman.

Because I was able to submit my statement for the record a couple of days ago, I, with your permission, will not read it.

Mr. JOHNSTON. All right.

Dr. SINDING. And would like to rather focus on a few points in the testimony that I would like to highlight and then, if I may, follow up on a couple of the issues that were raised during the first panel.

The five questions I was asked to address basically follow the track from: "Is population a problem?" to "What is being done about it?" to "What more can be done about it?" to "What are the implications of this for the United States?" to "What does all this mean for the International Conference on Population and Development coming up in Cairo?"

The principal points I tried to make in my written statement are as follows: that rapid population growth and high fertility in Africa are a significant problem for some countries and in some circumstances, both at the macrolevel and at the microlevel, and especially in the short to medium term.

I argued that at the individual level high fertility has important negative consequences for both the health and the educational opportunities for individual families, and at the societal level rapid population growth places heavy burdens on government budgets, particularly in the area of social services like education and health, but also with respect to the capacity to invest in agriculture, and most important the capacity of an economy to produce jobs rapidly enough to absorb very rapidly growing labor forces.

In Kenya, I said in the testimony, a country I know best from my 4 years there as USAID mission director, the modern sector was able to produce only 1 job for every 10 job seekers coming into the labor force and that situation has not improved since the late 1980's.

Basically, what I argue is that while it is difficult, and economists have debated vigorously the question of the long-term macroeconomic consequences of rapid population growth, the evidence seems very much to suggest adoption of what I call the "precautionary principle"—that in the absence of absolute certainty about this issue it would seem prudent for governments to invest in efforts to moderate population growth rates in the face particularly of the negative consequences at the family level and in terms of the capacity of the economy to respond to these very rapidly growing numbers of people.

Now, as to what is happening demographically in Africa and what can happen, I would echo very strongly the comments made by Ms. Peasley during the first panel. The policy environment in Africa is changing very rapidly. Since the 1984 Arusha conference,

which was the African preparatory conference for the International Conference on Population that year in Mexico City, African governments have increasingly articulated a commitment to reduced population growth rates, and to do this largely through voluntary reproductive health and family planning programs.

That commitment was reaffirmed at the 1994 Dakar meeting, which was referred to in Ms. Peasley's testimony. And, as she said, the demographic transition is now clearly underway in three African countries and there is strong evidence that it may have begun in four or five others.

The three countries in which the demographic transition has begun are countries which are significantly different from other sub-Saharan countries on other social and economic indicators, and that is very important to understand that in answering the question you asked, which is how much of a model are these first three countries for the rest of Africa.

Kenya, Zimbabwe and Botswana have significantly higher literacy rates, rates of female education and female literacy, and significantly lower rates of infant and young child mortality than is true for the region as a whole. And it is not coincidental therefore that fertility decline has begun earlier in those countries and has proceeded further than it has in the others.

I am very much of the school that believes that development does establish the parameters within which fertility decline will occur. I also believe, and the evidence is now increasingly strong that in all countries of the developing world, including all countries of Africa, there are a certain number of couples, women in particular, who, given the opportunity to reduce their fertility, would do so.

While development establishes in broad terms desired family size, family planning can make a very important difference in how efficiently and rapidly that aspiration is achieved. And in most of Africa, and we now have data for a very large number of countries in Africa, there is a significant proportion of women who say they want no more children or would like to space the next birth who are not presently practicing contraception and who would, if given access to good information and good services, in all likelihood adopt the use of contraception.

That means that population growth rates would decline somewhat if contraceptive services were expanded. It does not mean that replacement level fertility or population stabilization is around the corner. That won't happen until substantial further improvements in development, particularly development that has to do with the status of women, with health status, with general education levels and with equity proceeds.

The implications of this for the United States in my view are very much along the lines of the approach that Carol Peasley outlined in her testimony. AID has a very strong track record, and I would say a strong comparative advantage, in the expansion of contraceptive services and the expansion of family planning service delivery systems, including the information and communications activities that reinforce those service delivery programs and the research and development that needs to accompany them.

AID also a strong track record, particularly over the last decade, in child survival and in child survival programs, which are abso-

lutely fundamental to reducing infant and young child mortality, which is itself so strongly related to declining fertility. These are two areas in which I think the comparative advantage and strong track record of the U.S. need to be reinforced.

On the other hand, the United States has not in recent years done very much in the area of basic education or primary education. It is not an area in which AID at this stage, in my view, has a strong comparative advantage, and yet basic education, particularly for girls, is such an important, in fact, critical, factor in reducing population growth rates and desired family size that it is a reasonable question for this committee whether more attention should be given to primary education in AID programs.

At a minimum, I would argue that the United States should press hard at the World Bank to see that that institution substantially increases its investments in basic education, particularly education for girls in Africa. The Bank has a commitment in that area. It has something of a track record. And it certainly has the resources, which may not be available to AID to do more in that area.

But beyond education, we know that other investments in women, investments that empower women and strengthen their capacity to participate fully in the life of a country are important. And I would underline here microenterprise and microcredit programs, areas in which AID has been involved where the U.S. Government has some experience and where an expansion of programs to expand the economic participation of women would pay very large dividends, I believe, in their future reproductive behavior.

Finally, I would argue that AID needs to give more attention to the quality of care in the programs that it supports. AID has been a pioneer, has pushed harder than other donors and earlier than other donors on the family planning front in Africa, but sometimes to the exclusion of other services that are essential to the health and well-being of women.

And I think that the time has come, the administration has made a strong rhetorical commitment to improving the quality of care and expanding the definition of its programs to include sexual and reproductive health. The time has come to give real substantive meaning to that rhetorical commitment.

That brings me finally to the Cairo conference. I happen to be a member of the U.S. delegation to that conference. I worked very closely with Under Secretary Wirth through both the Second and the Third Preparatory Committee meetings at Cairo. I am very proud, as a member of the delegation and as an American, of the position the United States has taken, and the broad definition it has given to population issues in preparing for that conference.

I think that what the United States stands for and what the United States has committed itself to in terms of the Cairo conference is a very good blueprint for what the AID program in population and reproductive health should be, and not just in Africa but throughout the world.

Thank you, Mr. Chairman.

Mr. JOHNSTON. Thank you very much, Doctor.

[The prepared statement of Dr. Sinding appears in the appendix.]

Mr. JOHNSTON. Our next witness is Dr. Olukoya, who has come to us from Nigeria at her expense, and we are very indebted, Doctor. And we admire your tenacity and your stamina.

STATEMENT OF ADEPEJU OLUKOYA, M.D., WOMEN'S HEALTH ORGANIZATION OF NIGERIA

Dr. OLUKOYA. Good afternoon, Mr. Chairman, honorable members of the committee.

Mr. JOHNSTON. If you could move the mike just a little closer to you.

Dr. OLUKOYA. All right.

Mr. JOHNSTON. That is good.

Dr. OLUKOYA. I am Adepeju Olukoya, founder and coordinator of the Women's Health Organization of Nigeria, a nongovernmental, nonprofit organization dedicated to strengthening the capacity of Nigerian women's groups at a grassroots level in responding to women's health needs.

I am a medical doctor, a public health physician, educated in your great country, at Penn in Philadelphia, who has been involved with teaching, providing health care services, conducting research on women's health issues as well as working with women's groups for the last 16 years.

On behalf of my colleagues at home I thank you for this opportunity to testify today.

First of all, I must acknowledge that AID support has been very important in providing a lot of the reproductive health care infrastructure that exist in my country. My comments are therefore directed at how we can build on these to better address women's reproductive health needs.

Mr. Chairman, you asked that I address local perceptions of the so-called population crisis. In my view, the problem is not population but economic and social development and lack of improvement in quality of life for all Nigerians. Women will have fewer children if they also have reduction in poverty, basic right to a secure livelihood and good quality basic services.

Population is not an isolated problem but can be fixed simply by controlling women's fertility. Contraceptive distribution alone simply cannot solve the population crisis. In spite of the resources that have been expended on this approach, the majority of women in my country still do not utilize modern contraceptive methods and the community at large still does not identify with the notion of fertility regulation as it is currently propounded. We must look at population within a broader context of women's reproductive health and social and economic development.

The reasons people have large families are numerous. I will mention just three:

Lack of access to quality reproductive health care, including family planning services.

Second, the high infant and child mortality rate. Large numbers of children ensure that at least some of the children will survive to adulthood and in some cases supply the needed manpower for income generation and old age security.

Thirdly, low social and economic status of women which often prevents them from having any say in the size of their families or

other issues related to sexuality and reproduction for that matter. I would like to direct most of my comments to the needs for a reproductive health care approach.

Among Nigerian women pregnancy and childbirth are the leading causes of illness, disability and death. One Nigerian woman dies every 10 minutes due to pregnancy or related causes. That means by the time we finish this hearing maybe about 20 will have died.

Many more suffer from reproductive tract infections, infertility, AIDS, cervical cancer, to name a few. We need a reproductive health approach that will include at least the following four things:

First, a reproductive health approach will expand the range of contraceptive methods and develop several delivery options that are especially suited to helping reduce the epidemic of sexually transmitted diseases, including HIV. This is especially important in a scenario where there is high prevalence of infertility and where many people associate contraceptive use with infertility. We need new women-controlled contraceptive methods which protect them against both pregnancy and STDs, including HIV.

I am troubled by the use of contraceptive methods that provide no protection whatsoever against STD. Furthermore, some methods such as IUDs when used in women with active infection can be harmful to their health.

Second, a reproductive health approach will integrate STD prevention and control with family planning services to ensure the safety and efficacy of those services.

There are many substantial benefits to combining family planning and STD prevention and control. Recognition and management of women's reproductive tract infections require access to the same client population, that is, sexually active men and women, and provide us with similar skills, such as being able to conduct pelvic exams and being able to communicate on sensitive issues of sexuality.

And women are more likely to respond positively to and utilize services that care for their whole bodies rather than focus on one organ or function of one organ.

Thirdly, reproductive health programs should provide humane treatment for women who suffer the consequences of unsafe abortion. Contraceptives can and do fail, and contraception is not always possible for all sexually active people. Forty to 50 million abortions occur worldwide annually and as many as half of these may be illegal and involve extreme hazard to the health of women.

Women suffer serious long-term health problems such as chronic infection, pain and infertility. Humane services for abortion complications are urgently required and can be an effective means of preventing repeated abortions.

Finally, a reproductive health program should provide services for infants and children. The health of women and their children are inextricably linked. High fertility takes a toll not only on women themselves but affects their children's lives as well. A program that provides service for infants and children can become a point of entry for reaching women.

QUALITY OF CARE

Many policymakers have argued that high quality reproductive health and family planning services are too expensive or too difficult to provide. I would say that the cost of not doing so is higher in the long run.

Services are used more frequently and clients remain in the programs longer if the quality of care is good. Unfortunately, clinics often fail to follow generally accepted practice.

According to recent UNFPA reports on family planning clinics in eight countries there was inadequate screening of patients who may have come to the clinic with existing infections. Health care providers often fail to prevent infection by use of infection control measures during the examination of the patients.

The service providers did not follow infection control procedures during IUD insertions. Some of the health workers did not wash their hands between patients. In my country, even if health workers want to wash their hands there often is water shortage, especially in the rural areas where the majority of the people live.

A high quality family planning program also offers counseling and referral services. Women often receive inadequate counseling about potential side effects associated with each of the various contraceptive methods.

The UNFPA survey revealed that fear of side effects was one of the key reasons many people rejected modern contraceptive methods. Last, but not least, a quality family planning program treats its clients with respect and compassion.

Finally, there is a newly emerging and urgent need to reach young people who have been traditionally excluded from family planning programs. In the countries of sub-Saharan Africa births to adolescents constitute between 15 and 20 percent of overall births.

ACCOUNTABILITY

In our program women are truly being involved every step of the way in identifying and helping solve their own health problems. I think all family planning or reproductive health programs must be responsive to the people they serve. This can only be achieved through active client participation and evaluation by objective third parties.

Mr. Chairman, I acknowledge the deep commitment that this administration has shown in matters relating to the health of women, especially the efforts of Under Secretary Tim Wirth, and I think he was previously commended on that.

I will be pleased to answer any questions and expatiate further on some of the points I have raised.

Thank you very much.

Mr. JOHNSTON. Thank you, Doctor. And I noticed you condensed some of your prepared statement, so your entire statement will be a matter of record.

Dr. OLUKOYA. Thank you, sir.

[The prepared statement of Dr. Olukoya appears in the appendix.]

Mr. JOHNSTON. Mr. Eberstadt.

STATEMENT OF NICHOLAS EBERSTADT, AMERICAN ENTERPRISE INSTITUTE

Mr. EBERSTADT. Mr. Chairman, honorable members of the committee and distinguished guests, it is a pleasure and a privilege to be here before you today. With your permission, I will submit a statement for the record and some other materials later on.

Mr. JOHNSTON. All right. Fine.

Mr. EBERSTADT. I would like to emphasize that while I consider it a deep honor to be affiliated with the American Enterprise Institute and with the Harvard Center for Population and Development Studies, the opinions which I will express are mine and mine alone.

Mr. JOHNSTON. All right. A disclaimer then.

Mr. EBERSTADT. In the time before us I would like to make five quick points.

The first is that the state of demographic data for sub-Saharan Africa is very poor today. There are no vital statistical systems on the Continent itself with near complete registration, which is to say that it is impossible to get an idea from the vital registration statistics systems that exist today of levels or trends in births and deaths.

The recent example of Nigeria's census, I think, gives us some example of the margins of error that we are speaking about in the region. In 1992, the World Bank and other international organizations guessed that Nigeria's population was around 110 or 120 million people. But when the count was actually taken 88½ million people were enumerated. That was probably an undercount. But there was still a big gap between what was believed and what was found in reality. Our knowledge of levels and trends is just much less than what is sometimes suggested.

Secondly, as someone who has followed what is sometimes called population studies for the better part of the last two decades, I would like to emphasize a big caveat emptor. There are some things which the corpus of knowledge which is known as population studies is not capable of doing. It is not capable of unambiguously explaining population change in the past. It is not capable of predicting population change in the future. It is not capable of predicting even the onset of fertility decline in specific countries.

Moreover, our understanding of the relationships between demographic change and socioeconomic change in particular localities or even for the world as a whole is rather more distinctly limited than is sometimes suggested. For an indication of this, we can compare the National Academy of Science studies on population change and economic development from 1971 and 1986.

In 1971, the National Academy of Sciences attributed all manner of ills and risks to rapid population growth in developing countries. Fifteen years later, in a fresh look at the problem, a much more qualified and in some ways substantially different assessment came out of the National Academy of Sciences. The latter study argued that rapid population growth probably was associated with a number of socioeconomic problems, but that they were much smaller than previously stated, and small in comparison to problems caused by injurious governmental economic policies and practices.

One of those two assessments may be correct. They cannot both be simultaneously correct. And if they are not both simultaneously

correct, it follows that our leading scientific institutions do not possess a stable corpus of knowledge about population and socio-economic change—or the impact of policy interventions in this area.

Third, one of the things that we do know is that local fertility levels in the sub-Sahara and in the rest of the developing world fairly closely reflect the expressed desires of local women with respect to family size. An interesting and important study on this issue was published in one of the leading demographic journals earlier this year. I will put it into the record.

Without going into a great deal of detail on this study, it showed that a very tight correlation between the expressed fertility desires of local women in various countries in sub-Saharan Africa, Latin America, and Asia, and the actual total fertility rate in those countries.

The study looked at the often-discussed concept of "unmet need" for contraception had a very skeptical reaction to this with respect to its impact on fertility levels.

What that study seems to suggest is that the potential demographic impact of voluntary family planning programs is distinctly limited barring changes—this is an important exception—barring changes in the preferences of local mothers and fathers.

A fourth point is that the antinatalist thrust population programs sponsored by the United States and other foreign governments is in some ways inconsistent with the claims by representatives of those same governments that they respect the mores and preferences of local people.

But there is a practical problem as well. In many, possibly in most countries in the sub-Sahara, ethnic or tribal groups living together within the same country are separated by current or historically based hatreds and animosities. Implementing an antinatal policy in such a context raises the risk of divisive and even explosive political tensions—tensions which could easily set development efforts back very significantly.

Rwanda is much in the news these days. It might be a case in point to consider. When one imagines an antinatalist population program for Hutus that was administered by a government of Tutsis or an antinatalist population program for Tutsis that was administered by a government of Hutus, one begins to appreciate the possible repercussions that antinatal population policies could induce.

Finally, one may note that sub-Saharan Africa's economic problems, which are pervasive, have been extensively studied by economists and others. Many of those studies have detailed widespread state policies and government practices which have had predictable and adverse consequences for local economic performance.

With such poor practices and policies so widely enforced in the past decade or so, it does not seem necessary to invoke demographic forces to explain a great many of the region's agricultural, urban and external debt difficulties.

Proponents of antinatalist population programs for the sub-Sahara risk encouraging the perception that they view bad government as fixed and immutable, but see the family size of African parents as something that is open to policy adjustment. It is in-

cumbent upon those who favor interventions to reduce fertility in the sub-Saharan region to demonstrate that this is not the case.

Thank you very much.

Mr. JOHNSTON. Thank you very much, Mr. Eberstadt, for giving us a different perspective.

Ms. Curlin.

STATEMENT OF PEGGY CURLIN, CENTER FOR DEVELOPMENT AND POPULATION ACTIVITIES

Ms. CURLIN. Thank you, Mr. Chairman. I would like to thank you and the committee, Mr. Chair, for the opportunity to share my perspectives on population in Africa. These perspectives have been developed based on 20 years of experience in enhancing women's potential through sustainable development, family planning and health programs. CEDPA, the Center for Development and Population Activities is an international women-focused organization with outreach to women leaders and women's organizations in 105 countries around the world.

I am joined here today, Mr. Chairman, by a small sampling of these CEDPA alumni representing partnership projects in Ghana, Kenya, Nigeria, South Africa, Tanzania, Uganda, India and Romania. I would like to offer to the Chair a listing of these special guests' names and organizations.

[The information appears in the appendix.]

Mr. JOHNSTON. Would you have them stand up so we can see them?

Ms. CURLIN. Thank you, Mr. Chair. Certainly.

Mr. JOHNSTON. Well, thank you very much for coming today.

Ms. CURLIN. Mr. Chairman and committee, the agenda for the International Conference on Population and Development, ICPD, has for the first time put the concerns and needs of a grassroots community of women before those of policymakers. This is welcome news.

Poor health conditions and rapid population growth are closely associated with low status and limited rights of African women. Without significant improvement in the coming decade in women's reproductive health care and economic and educational opportunities as well as legal rights, rapid population growth in Africa will continue and the quality of life in all countries may be irrevocably damaged.

Yet, as the ICPD program of action recognizes, investing in the lives of women enable countries to stabilize population growth and meet sustainable development goals. I am here to underscore that the single best foreign policy investment the United States can make toward stabilization of population in Africa is the empowerment of women. I am certain that the committee is very familiar with the statistics of African women. In my written remarks I have outlined these issues.

In order to reverse the trend of this downward spiral we need to eliminate the existing barriers to women's full participation in society and highlight women's contributions rather than their victimization. In promoting a more positive image of women as leaders, teachers, development and health professionals as well as their contribution to nontraditional roles, we can help to overcome the

image that women are unable to help themselves and their families, but rather we can empower them to make changes in their lives.

Let me share with you an example of empowerment from the CEDPA alumni network. In Mali a local nurse-midwife decided that women and men should have more information and services in family planning. The government ministry policy had traditionally provided family planning only in clinical settings which had the unintended result of excluding services to women and men living in rural areas.

This nurse-midwife recruited local women and men as organizers and deliverers of community-based services. This innovative act contributed to a policy change that has enabled tens of thousands of rural women to obtain safe contraception so they can plan and space their families.

Once family planning became available, women decided that they can do more with their lives. Now, income generation projects and small industries flourish, and many women are using credit and loan services for the first time. Men are supportive of women's rights and are beginning to take a greater responsibility for their own reproductive behavior.

The contraceptive prevalence rate in this project area was 1.3 percent in 1988. In 1991 it has risen to 57.7 percent, and is greater today.

This did not start as a model project, although it has become one. It began with one empowered woman believing that she could change the system, and she did. As a result she has empowered her community.

To empower women there needs to be a real commitment to unusual business, not business as usual. Lip service to women's empowerment will not bring about the changes that Africa needs. An interrelated web of interventions must be made at the macro and microlevel in order to improve women's lives as well as to have an impact on population growth in Africa.

I have outlined other strategies in my written remarks and I would like to underscore a few that may be critical. Women need access, choice and participation in quality family planning and reproductive health care, and women who want to use family planning but now have no access to it must be the first priority.

Women who are most in need of family planning often face additional hardships: poverty, sick children, a poor self-image, domestic violence, and other related health conditions. Our challenge is to promote integrated family planning services which do not attempt to provide everything at the primary level, but have adequate and knowledgeable referral to other health and social services.

In order to alleviate untold human suffering and health risk, we must address the difficult issue of illegal and unsafe abortions. Unsafe abortion is the leading cause of maternal mortality in Africa and represents a serious and largely unacknowledged public health problem. High quality family planning and post-abortion family planning services reduce the likelihood of unwanted pregnancies and further abortions.

In addition, comprehensive sex education, which includes contraceptive information and services to sexually active youth, is synergistic with community and national goals to reduce abortion.

Grassroots NGO's have a critical role to play in population programs in Africa to ensure women's participation. And finally, economic restructuring must take women's concerns seriously. Economic policies such as Structural Adjustment Programs without social safety nets allow the burden of poor governance to fall too heavily on the shoulders of women and children.

Resources to women are a critical factor to women in their empowerment. Existing resources need to be reprogrammed so that women receive their fair share and that fair share is half.

Credit institutions must reexamine women's access to loans. They have a remarkable repayment record. Educational institutions must recruit girls by working with their families to assure that girls are not left behind to work on the farm while boys are sent to school. More NGO's and women's groups must be recruited to provide family planning and reproductive health services to women where they live and work.

Lastly, the foreign assistance cannot be business as usual either. Bryan Atwood, AID Administrator, has said attention to gender roles is fundamental to the success of programs we assist. We must support full participation of women at all levels of family planning, and indeed all health and development programs. Bryan Atwood's belief in democratic principles is a compelling rationale for women's full participation.

However, the danger exists that country level AID missions will find women's empowerment principles too ephemeral, too difficult to sell to government counterparts, and based on the comfort level with traditional family planning programs too risky.

If this congressional committee believes as I do that women can make a difference between success and failure in Africa, you can help Administrator Atwood and his very capable team by sending a message to the country level that policymakers at the highest level of this country expect women to play a greater role in designing, implementing and evaluating USAID-assisted programs.

This committee should encourage USAID to incorporate women's empowerment in all sectors, particularly in population programs and to ask for and receive a periodic report of the results of these strategies.

Mr. Chairman, I would like to leave the committee with the knowledge that empowerment is contagious, that it is the responsibility of us all and this committee to see that it spreads to women in Africa.

You have here today a sample of the inspiring talent that is available to this committee and to policymakers. Thanks to the empowering process of the ICPD each of us is renewed in the struggle to overcome the historic barriers to women's equality.

Family planning is only a beginning, but an important beginning to women's empowerment and development. However, each of us knows that family planning programs targeting women will not be an acceptable substitute for women-owned and designed programs. The sooner this message reaches policymakers and resource allocators the sooner the fertility rates in Africa will begin to fall.

Mr. Chairman, increasing the role of women will create good news about Africa. Along with thousands of African women leaders in the CEDPA network, I believe that African population and sustainable development programs are success stories waiting to happen.

Thank you.

Mr. JOHNSTON. Thank you very much.

[The prepared statement of Ms. Curlin appears in the appendix.]

Mr. JOHNSTON. If you don't mind, we will ask you a series of questions.

Dr. Sinding, you stated that there was a strong rhetorical commitment by the United States and what we needed now was a substantive commitment. In other words, we are doing a lot of talking and not enough action?

Dr. SINDING. I certainly didn't mean to imply by that comment, Mr. Chairman, that there was no intention to take action. The articulation of U.S. policy is relatively new—it began, really, only with this administration—along the lines of a broader approach. It takes time to take a program that has been operating one way for 25 years and begin to make it operate in another way.

And the resources are extremely constrained. The foreign assistance budget is in terrible shape. It should, in my view, be in much better shape.

But given the constraints on the budget, it is not easy, even if you say that you are going to expand the definition of services to include reproductive health, to do that when you don't have any more money to do it.

So, my message was not to impugn the integrity either of the Congress or the administration with respect to what is desired.

Mr. JOHNSTON. No. You can do that with impunity here.

Dr. SINDING. But rather to say that unless the resources become available to turn that rhetorical commitment into reality, I worry that it may not happen.

Mr. JOHNSTON. Well, let me talk a little politics. We all know that in the Reagan administration he somewhat suspended the Mexico City Plan. But I am looking at figures here, 1988 and 1989, you know, there was $32 million, $40 million; 1990, starting with Bush, it went to $42 million; 1991 under bush it went to $75 million; 1992 under Bush it went to $66 million; 1993, which I said earlier really was the Bush budget, and it was $74 million.

What was the Bush administration doing that the Reagan administration was not doing? Why did we see the almost doubling in the allocations from the DFA for family planning?

Dr. SINDING. Well, it certainly represented a substantial increase in the commitment of resources to family planning programs in Africa. That was a result of changing policies in Africa and the fact that the Bush administration was less overtly hostile to family planning than the Reagan administration had been.

President Bush made a distinction between family planning programs intended to respond to individuals' legitimate desires to reduce their fertility and abortion. And up to that point the two issues had been more or less indistinguishable in the discussions and it became very difficult to talk about family planning outside the context of the domestic debate about abortion.

In the Bush administration there was a little bit less of an interlinking or confusing of those two subjects, and there was a capacity to respond with family planning programs to the rapidly growing demand for resources in Africa that was a result of the policy process.

My point has less to do with the commitment to family planning programs than it has to do with the definition of those programs. The point I am trying to make is that, as we heard from our Nigerian colleague, we need to think about those programs in terms more broadly than simply the delivery of contraceptives. We need to think about those programs in terms of a much broader range of women's reproductive health needs. And there are significant additional costs associated with doing so.

What I am therefore saying is that you can't do just family planning. You can't do a reproductive health program with a budget that up to this point has only been doing family planning.

Mr. JOHNSTON. Dr. Olukoya, do you agree with Mr. Eberstadt and some of the things that he had said earlier about the fact that there really is no empirical data—correct me if I am wrong—in Africa and you really can't estimate the past or the future population data?

And I would assume that you are saying, Mr. Eberstadt, that there really isn't a population problem in Africa?

Mr. EBERSTADT. That isn't what I said.

Mr. JOHNSTON. OK. All right. You quoted the National Academy of Science as saying that the population growth is not a major problem.

Mr. EBERSTADT. Is a smaller problem than issues of economic mismanagement.

Mr. JOHNSTON. How about it, Doctor? Do you agree with that?

Dr. OLUKOYA. Oh, yes. I agree that there are no reliable data. I also do agree that the number of people are increasing. I don't think there is any doubt about that.

And let me quickly say that just as sure as day follows night, if you have too many people sharing one orange it is obvious that they won't get as much a part of that orange as when two people have to share it. I mean that is very simple. And I hate to be too simplistic.

What I guess is the issue is how can we make a difference? And what I am saying is that to get women to start having fewer children you have to do all the things to do other things that have to be in place, and I think examples abound in some of the testimonies today that in the countries in Africa that have packaged and the success stories there are things like better economic indicators. And I think that is a very important issue.

And frankly, I think the money that is being spent on contraceptive distribution is well spent. But I think you could get more miles for your dollar if attention is paid to these other issues.

I don't want to take more than my time. I want to quickly refer back to Mr. Payne's brief to us earlier on. I think the problem in Rwanda—I would hate for us to simplify it to just a population problem resulting in this. I said it is because the Hutus and the Tutsis have been at each other's throats way back before there was so many Rwandans.

And I also would like to say that I bet you if those children had caught measles in that camp as soon as the mothers got back they are going to throw away their packets of pills and they are going to try and replace those kids, and the prevalence will go right down.

So, I think it is not a simplistic thing. I think we are looking at a total package and I guess that the problem is really the finances of it. You know, who is going to pay for it? How much is it going to cost? I think we probably all agree that these are important things to do.

Thank you.

Mr. JOHNSTON. Congressman Payne.

Mr. PAYNE. Thank you very much. I couldn't agree more that the question of economic development. We have I think similar problems in our country. We have a lot of unwed mothers, young mothers. We have crime in some of our cities.

And sometimes they say the solution is maybe to build the jails for the criminals and cutoff aid for the second child. You know, those are sort of some approaches that have been suggested by some people, rather than to deal with the basic problem of the same thing, economic opportunity, access, because if that is done then what will follow will be a reduction of crime. There would be a better self-esteem therefore there would be a reduction in out-of-wedlock births. And so I couldn't agree with you more that the whole question of development is the situation.

And plus it was—it was Mr. Johnston that said the population, and I agree that the question in Rwanda and Burundi goes back centuries and centuries and centuries and it is not a very simple solution, and I hope I didn't give that as a view.

I just wonder how difficult, as we wait for the economics to improve and other things that we know will do the job, what would be some specific things that you think could be done as we are working on the front of trying to have development, sustainable development.

As a matter of fact, as I brought out in my original statement on Rwanda, we were asking for logistical help, sending some of our planes to bring troops that were committed to go to Rwanda from different countries in Africa, and also to pay a third of the cost of bringing them there, and also equipping any of them who were ill-equipped.

Our government looked at it and studied it and said we need to take a look at what it is going to cost. We need to take a look at where it is in the budget pipeline and so forth. Three months later when 1 million people went over the border we have committed $320 million for the Rwandan situation, and that is only up to October 1.

Now, had we had the $10 or $20 million that it probably would have cost to do that first phase, we wouldn't need all of that $320 million which only goes up to October 1. If things are not over they have got to come back to the Congress.

And I am not sure that they have got the $320 million they were asking for. I think we only got $220 million today, so we are $100 million short already.

If we had gotten into the Horn of Africa, into Somalia, before things got so bad—it cost us $1 billion in Somalia.

Now you can't get $1 billion allocated for Africa in 10 years, but once again, after the fact, and going in once we see the crisis, one thing Americans will respond to is a crisis. When they see the children and they see the horror, then, as a nation we respond, and that is really a terrible way to try to alleviate problems.

But I guess back to my question. What are some of the things you feel could be done indigenously in the countries of Africa to move along this whole question of the development—the message of family planning and all? Are there things that you feel, with support from outside countries to help facilitate it, that you could make some progress?

Yes, ma'am?

Dr. OLUKOYA. Thank you, Mr. Payne.

I think to retreat to what he had said, one of the things that underlie all of this is the crisis in government in many of the African countries, and I think without stability and popular participation we jump forward and then we jump backwards, further back. So to my mind—that may be speaking from the Nigerian point of view—that is a very important thing, and I think if we analyze many of the success stories we will find that this is an underlying positive factor.

On top of that, I would say the education and the increase in the status of women is something that could be done, and, secondly, I believe strongly in the reproductive health care approach with increased awareness about family planning and provision of family planning because, as Mr. Sinding said, there are a lot of women who want family planning but cannot get it.

But there are so many other women there who don't even know they need it because they are not educated, they are not in a position to take the required decisions or they feel the clinic is just meant to control their fertility or to stop them from having children, and so they don't even move near the clinic.

Perhaps the face of this program can be such that it is more friendly to the women and draw them closer to take care of their other needs or some of the overriding problems they have. Then this issue of controlling fertility and so on—and of course the child survival strategies that have been laid in place are very important because this replacement theory, not only is it important in Africa, I think it is also important with some of the friends I have in the West. Some of them think very hard before they have their tubes tied because they say, oh, supposing there is an earthquake or there is a plane crash and I lose all my children? What is going to happen—you know.

So I guess that is my answer to your question. Thank you.

Mr. PAYNE. Thank you very much.

Maybe I should ask Ms. Curlin—and my time is expiring—I see you have a number of women from the various countries that are going through your program. What type of support do they get once they return back? Is there a local group there that assists with what you are doing here? You know, you fire them up over here and then they have got to go back. I hear all this tough talk here. Now they have got to go back home. Now I don't want any of these

women to come back with running into serious problems. But what type of follow-up do you have on the ground?

Ms. CURLIN. We have supported these programs through USAID cooperative agreements and grants and also through private funding from foundations and individuals and corporations.

Some of the work that they are doing is cutting edge in adolescent fertility and services to adolescents, advocacy for girls and young women. Before the new administration, "adolescence" was not a word that one could utter openly in the halls of AID. We now see a change, but, as Mr. Sinding has pointed out, we see a change in the rhetoric but not a change in the level of resources that would make it possible to reach the number of adolescents necessary to be a significant factor in the future population in Africa.

Mr. PAYNE. Thank you. I will yield back the balance of my time and just would like to say on your way back, Doctor, to Nigeria, I attempted to travel to Nigeria with two or three of my colleagues this past Friday, but your General Abacha said that Donald Payne was not welcome and I could not have entrance into your great country.

So we are hoping that your governance will reassess the situation there and allow some of the Members of the Congressional Black Caucus, who as a matter of fact were able to go to South Africa even during apartheid, could go to Nigeria to discuss the human rights issues.

Dr. OLUKOYA. Yes. I hope I can go back.

Mr. PAYNE. Yes. Don't give the message. We want to see you again. Please note that it was your general who did not yell, like your child is being bad or something.

Dr. OLUKOYA. We read about them in the papers.

Mr. JOHNSTON. Judge Hastings.

Mr. HASTINGS. Dr. Olukoya, you hope you can go back. The question becomes—after such actions as yesterday's shootings during the demonstration, a larger question is, do you want to go back, and I know you do.

Dr. OLUKOYA. I do, yes.

Mr. HASTINGS. All right, and we can all appreciate that.

In the limited time that I am here—and I apologize to you all for not being here earlier—I had the good fortune today of being with Brian Atwood at a meeting with close to 300 interns who are working here on Capitol Hill who have formed a new group to work first with Rwanda and then refugees in Africa, and that calls to my absence here. But each of your comments were piercing and scintillating on this subject to me, and I am sure to my colleagues.

Looming over all of the notion of family planning is the role or lack of role that males play in all of this. While we talk in terms of things for reproductive care for females, and rightly we should, and for adolescent girls, and rightly we should, you would be amazed at the hard time we would have to talk about vasectomies in Africa, an even harder time in Harlem, in Washington, D.C., and it poses a larger problem for us, and I hope the conference in Cairo will begin to focus on the role that males ought play in family planning in a larger sense.

One thing we might do, Mr. Chairman—and I'm good at lecturing everybody—one thing we might do is, when we go to Africa, to

follow the line of Dr. Olukoya and Ms. Curlin in seeking to empower women, we might decide to meet with more women than men. That might send a unique signal, and we might encourage the Secretary of State and USAID and others who go there to begin to meet with women as well.

The only time that I have visited Africa was with these two gentlemen, all of the staff that are here, with the exception of one, and my recollection of that visit, even in the southern Sudan and in Mogadishu, women were playing backdrop roles, and as far as governmental entities were concerned, we were doing nothing more than perpetuating those male figures, and we did not seek out any women, and I am not accusing anybody. They were not parts of governments to a large degree in Kenya and Uganda and every place but Eritrea, I might add. At least one Cabinet official was a woman; I was pleased to see that.

So we might do something along those lines by, for example, if we visited Nigeria, having people like Dr. Olukoya plan for us some portion of our itinerary. That is just a casual suggestion.

The only question that I would have is, recently there was an article circulated by Robert Kaplan describing the population and environment nexus as the central source of crime and political unrest in West Africa.

I think I already know the answer to this, but what would be your opinions regarding Kaplan's thesis, or any one or two of you in that regard, and what kind of policy implications does this show up? And having asked that question, I really wanted to talk about what culture and religion in Africa does to world population or population everywhere. But can you give me an opinion on Kaplan's article, either of you?

Dr. OLUKOYA. The whole issue of environment and population and what-have-you is a bit complicated, but I think at the moment in Africa what I would say is that poverty is driving people to exploit the environment more. That is number one.

Two, inequitable economic models and development models really emphasize more profit-oriented production, getting Western ways of production and things like that, and those things we know have not been environment friendly in the West, and there is no reason to believe that in Africa they would become more environment friendly.

Thirdly, of course—and we all know that—as far as destroying the planet is concerned, I think the contribution of the whole continent of Africa is minuscule compared to Federal inhabitants of the planet. However, there is a growing clique of people in Africa as well who emulate the consumption patterns of the West, and the same type of model is continuing.

I personally, as a women's activist, really like to think—and I hate it when women are blamed for the bad environment because I think they are making the best of a bad situation.

And your question of culture and religion. There is no doubt in my mind, especially when I heard I think it was Ms. Peasley that was describing some of the successes they had in southwestern Nigeria, that the indicators—the economic indicators, the social and cultural indicators in that part of the country are different for, let's say, northern Nigeria and 10 years from now they may not have

that degree of success in that part because they are still very tied to religious control and very tied to domination of women, which traditionally in southwestern Nigeria has not been so—the famous women traders and independence; I mean their independence and all that—in spite of the overall patriarchal societal structure.

I think the culture and the—especially in southwestern Nigeria—that is where I come from—appreciates the value of spacing children. I mean my mother has six children, and we are all 3 years apart. I mean that is perfect. That even goes better than what we are teaching people these days, and maybe she shouldn't have had six, but that was what they were doing in her time, and they had the time and wherewithal and the patience to do that, and the men cooperated with them. Things have changed. It is not the same now.

So I think the culture and the religion definitely are pronatalist, but I think there are inroads that we should exploit.

Mr. HASTINGS. Right.

Mr. Chairman, would you permit me just one additional question?

Mr. JOHNSTON. Please, go ahead.

Mr. HASTINGS. Dr. Olukoya, how much research is being done with reference to HIV and sexually transmitted diseases? And when I say how much, I know it is hard to quantify, but is there considerable research being done by, first, African countries, Nigeria specifically, and then other countries in that area?

I know your paper rings out for additional understanding regarding sexually transmitted diseases and the type of contraceptive devices that may be able to assist in that regard, and I am just curious, is there much laboratory work ongoing at this time?

Dr. OLUKOYA. Yes. I was going to say what type of research. If you are talking about clinical research and research that depends on technology and things like that, practically none except to establish prevalence and testing blood for HIV prevalence and so on for monitoring and surveillance.

When you talk about research into the type of contraceptives that can protect women, again, I would say none yet, and I hope there could be some progress in this direction.

When it comes to research into what women have been able to do or their perception of the males' perception about HIV and sexually transmitted diseases and all that, some have been done to throw some light on how people view sexual relationships and things which can be useful in shaping more clinical action-oriented research in the future.

Mr. HASTINGS. Yes, ma'am.

Thank you, Mr. Chairman.

Mr. JOHNSTON. Mr. Eberstadt, let me see if I can do a syllogism here of some type.

Is Rwanda suffering from poverty? Does that country suffer from poverty?

Mr. EBERSTADT. Clearly so.

Mr. JOHNSTON. OK.

Is that country overpopulated?

Mr. EBERSTADT. I don't know how to define "overpopulated."

Mr. JOHNSTON. Well, it has the highest density of any country in Africa. It has run out of agricultural lands because the people move from the Northwest to the East, and the Malthusian theory seems to have taken over in that country. That would be my definition of overpopulation, where your population has grown geometrically and your food supply has grown arithmetically.

Now I will repeat my question. Does that country suffer from overpopulation?

Mr. EBERSTADT. I have a very hard time understanding the concept of overpopulation, and I will tell you why. I understand the concept of poverty, but I can't define overpopulation in demographic terms that are unambiguous.

Bermuda has four times the population density of Rwanda, but I don't think that it probably would be considered overpopulated, and Monaco has the highest population density of any country in the world, but I don't often hear concerns about Monaco's overpopulation.

The United States around the time of our founding as a country had a birth rate that is apparently higher than—estimated to be higher than any of the birth rates that are guessed for sub-Saharan Africa today, but the United States around the time of our founding was not considered, I don't think widely, an overpopulated country.

Population problems that we discuss are problems of people, and of course any poverty problems will be manifest in individual human beings. The question that I am all over is the extent to which population change affects the risk of poverty in countries in the sub-Sahara and around the world, and clearly one of the things that population change is, is a form of social change.

Countries and governments which deal poorly with social change are going to deal poorly, I would guess, with population change as well, but population change is one of the slower forms of social change and one of the more predictable forms of social change that governments and societies have to cope with.

It is a roundabout answer.

Mr. JOHNSTON. You have been to Harvard too long. [Laughter.]

Mr. EBERSTADT. Maybe in Washington too long.

Mr. JOHNSTON. Yes.

I can agree with you on Bermuda and Japan, but in a definition of overpopulation where the economy cannot sustain itself, that it is despoiling the environment and that, because of the number of people, you now have starvation and famine, would you say such a matrix would constitute overpopulation?

Mr. EBERSTADT. Well, you made the premise, you posited the premise because of population. If you premise on that, of course the conclusion follows because it was determined by the premise. But if one wishes to add another couple of ingredients to the mix like governments that could be accountable or could adopt different sorts of policies, international trade so that a population might not have to subsist solely on the resources in its own locale but could trade for things, maybe even trade their labor on the international market, then I think it becomes harder to answer that conclusively.

Mr. JOHNSTON. Do you think, under your own definition of population, that any country in the world is overpopulated?

Mr. EBERSTADT. I think there are a lot of countries that have problems, I think there are a lot of countries that have social and economic problems, and I think that some of them can be intensified by population change.

Mr. JOHNSTON. Hurray. Hurray.

I should quit right about now, I might say.

How about you, Doctor? Did you read Kaplan's article in Atlantic Monthly?

Mr. SINDING. Yes, I did.

Mr. JOHNSTON. Could you comment on it, where he says overpopulation is a problem. And it has become, unfortunately, to a lot the bible, you know, and I think it has hurt my cause in trying to get more money for the Development Fund for Africa, because I need to show OMB and the administration some successes and they keep whipping out the Kaplan article.

Mr. SINDING. Well, in that sense, Mr. Chairman, I agree with you. I think the Kaplan article is seriously overdrawn. I think it overstates the contribution of population growth to the ills that he identifies. In that sense, I agree with Mr. Eberstadt. I agree that population growth—extremely high fertility—seriously exacerbates problems that are already there. But it doesn't cause in many instances those problems in the first place, and I think that in that sense Kaplan identifies population growth inappropriately as a cause where the cause has its roots much more fundamentally in the history of bad policy and bad governance that has characterized much of Africa, as Dr. Olukoya has said and I think several members of the panel and the committee have said.

Mr. JOHNSTON. Let me interrupt you.

Dr. Olukoya, Kaplan's article wants Nigeria—suspects that Nigeria——

Dr. OLUKOYA. Will be the next Rwanda?

Mr. JOHNSTON. No. Will take over all of these countries around it, if you read it very carefully—Benin, Togo, all of those.

Dr. OLUKOYA. No, I didn't read the article.

That Nigeria will gobble all the countries?

Mr. JOHNSTON. Gobble them up.

Excuse me. Go ahead, Doctor.

That is, Kaplan points out that these countries were formed by the Europeans on a vertical basis rather than a horizontal basis and all of your population sits on a horizontal basis over there and it would be much easier for Nigeria just to take them all over.

Excuse me, Doctor. I wanted to talk about her general again.

Mr. SINDING. I have said as much as I wanted to say about Kaplan, but I would like to say one word on the issue of the role of males that Judge Hastings brought up, if you would permit me.

Mr. JOHNSTON. Please do. Yes. We always get very informal after 4:30 in these hearings. Only the interested then are still here, and the reporters have gone.

Mr. SINDING. One of the reasons that I think the education and empowerment of women is such an important factor is because of the relationship that that creates between husbands and wives, between men and women. It is not just the empowerment of women, it is the creation of equality in the negotiation of many aspects of a conjugal relationship, including childbearing, that that implies.

The reason I say this is that I have recently been examining in some detail some survey data from Kenya where, unlike most demographic surveys in Africa which only survey women, they also surveyed the husbands and they surveyed them independently, and what the data show is that where the husbands and wives agree on issues of family size and contraceptive use and so on, there are significantly fewer children and significantly higher probability of contraceptive use, and I think that what that is telling us is that where the relationship between men and women is reasonably equal, the probability of husbands and wives agreeing and therefore of coming to a common position is very high, that where husbands and wives don't agree on family size we know that fertility is much higher and contraceptive use is much lower, and that is true in many parts of Africa.

The existence of a strong family planning program in Kenya now for a decade has created an environment within which women are in a position to talk to their husbands and to, in effect, negotiate with them about family size and to bring them around to what the women themselves would like to accomplish.

I think that is the point that Dr. Olukoya was making, that the women in many cases would like to use family planning but there are many constraints on using it. The availability of services is only one of them. Another one of them is very often the attitudes of their husbands.

So working on the attitudes of males is very important, trying to change male attitudes is very important, but creating greater equality between men and women through the empowerment of women I would submit is just as important or more so.

Mr. JOHNSTON. You have already indicated that you agree with the Clinton's administration views on this.

Ms. Curlin how about you?

Ms. CURLIN. The Clinton administration's views on the empowerment of women or——

Mr. JOHNSTON. No. On how he has turned AID to a point where they are going in with more population activities. Correct me if I am wrong.

Mr. SINDING. That is not what I meant.

Mr. JOHNSTON. OK. Tell me what you meant.

Let me see if we can get a consensus vis-a-vis Reagan-Bush and the Clinton administration's view on what AID should be doing and should not be doing.

OK. You tell me, and we will go forward.

Ms. CURLIN. Well, I think that the policies and the statements coming from AID are very welcome indeed in terms of the more holistic approach to family planning and reproductive health, certainly to women's empowerment.

I think, as I have expressed, these ideas will succeed. However, I worry about the resources that it would take to implement programs that could be successful. We have faith in this administration in these programs. The programs that they envision would be successful, would be suited to women's needs and are programs that women want.

Mr. JOHNSTON. OK. Specifically, should AID educate men and women on birth control and distribute birth control devices?

Ms. CURLIN. Oh, indeed.

Mr. JOHNSTON. OK. Mr. Eberstadt.

It is not a trick question.

Mr. EBERSTADT. I'm thinking about the role of government. As a small part of an overall package of social services.

Mr. JOHNSTON. Is that a yes?

Mr. EBERSTADT. Sure.

Mr. JOHNSTON. OK. They can't hear that.

Mr. EBERSTADT. Yes.

Mr. JOHNSTON. OK. Doctor.

Dr. OLUKOYA. I think I would tend to agree with him if it is as part of a total package, not just as an end in itself.

Mr. JOHNSTON. OK. Dr. Sinding.

Dr. SINDING. Yes. I think that what is so reassuring and encouraging about the position the Clinton administration has taken is the broad nature of it.

Mr. JOHNSTON. Holistic, OK.

Dr. SINDING. The holistic nature too. So say population growth is a problem, it is not the determinative problem of underdevelopment, but it is a significant factor in development, and that the way it should be approached is not just through family planning, pills and condoms, but through a broad set of reinforcing social and economic policies, including particularly policies that empower and strengthen women.

Mr. JOHNSTON. Judge Hastings.

Mr. HASTINGS. You know, some of it too, Mr. Chairman, is like pulling eye teeth. If we look at USAID specifically—and none of you have anything to do with the development of the agency from the standpoint of its process and how it goes forward, but over the years what has happened is, people have risen in the ranks, and it is an old agency, old in terms of who is controlling the agency. They need more new people, and I think Brian understands that, and the sooner we get some more new people and some more cultural diversity, some more women involved in AID, then we are going to be in a better position to address some of these problems.

I would like to hear any of the panelists comment on what and who are the major obstacles to the provision of reproductive rights, and please don't pull any punches in any response because I have a few that I would really like to plaster up against the damn wall in Congress and some of their views, but I will get to them at the appropriate time.

Who is holding us up, as best you can determine? And not just America, maybe the Pope.

Ms. CURLIN. I would say certainly, Judge Hastings, that policymakers can be a big obstacle to going forward. Policy makers control the resources, and policymakers make the policies that can be very limiting to people's access to programs like family planning programs.

The barriers, though, are so multiple that it would be impossible just to say that policymakers are the barrier, you eliminate this barrier and things are going to be perfect. That is not the case. Development is a slow and long and very complex process and needs to be done at the grassroots and the household level face to face,

one on one. It is going to be a slow process, but there are a lot of people dedicated to carrying out that process.

Mr. HASTINGS. On the African continent, I gather then, it is like a country-by-country process as well because there may be some a lot more receptive, a lot more willing than others.

Ms. CURLIN. Well, I also think that the NGO's who are involved in this program are going to be a significant factor in moving programs forward. I think that the more NGO's have the recognition of government as their partners and the more resources are directed to those NGO's and particularly grassroots NGO's, the more quickly we will begin to see results.

Mr. HASTINGS. Thank you, Mr. Chairman.

Mr. JOHNSTON. Let me ask you a little about your organization. How are you funded?

Ms. CURLIN. Mr. Chairman, we are funded both with AID grants and cooperative agreements primarily from the Office of Population but also from the Europe Bureau, and about 40 percent of the funding comes from private sources and multilateral organizations such as U.N. agencies and the World Bank along with various foundations and private donors.

Mr. JOHNSTON. So you are a 501(c)(3).

Ms. CURLIN. We are.

Mr. JOHNSTON. Your youth leadership program—these young ladies that are here, just briefly, what is the program that you have for them when you bring them to the United States?

Ms. CURLIN. These women have been a part of our Women in Management Program, so they have had 5 weeks of training in management, strategic planning, resource development; they have also had communications skills training. We have had a very good evaluation of the program.

They have stayed on this extra week to work on actually skills and techniques to reach young people in the community, both boys around girls, to involve them in the planning of programs meant to provide them with other alternatives to high fertility and high-risk fertility. The African women here are very concerned about not only fertility but death through the contact of AIDS.

Mr. JOHNSTON. How many graduates do you have a year in your youth program?

Ms. CURLIN. In our youth programs we have now about 120 graduates. Of the other programs for women, CEDPA has a network of over 4,000 women in 105 countries.

Mr. JOHNSTON. Dr. Sinding, how would you describe the difference between population control and reproductive rights? Is there an inconsistency in those two concepts?

Dr. SINDING. I actually don't think they have very much to do with one another. I think that population control, which is a term which that comes only with the greatest difficulty to my lips, is about trying to reduce high population growth rates in places where those growth rates are seen as being out of kilter with other national aspirations, usually development aspirations.

Reproductive rights is about giving women and men control over their own reproductive systems, including the capacity to control their fertility, but it is not by any means limited to that. One is

very much focused at the individual level, the other is very much focused at the societal level.

I do think, Mr. Chairman, that where the two come together is often in the debate about whether population control is consistent with reproductive freedom: Will population growth rates come down to desirable levels if people are allowed to do exactly what they want to do with respect to reproduction? That is an issue that bedeviled the Bucharest Population Conference 20 years ago, and that has caused enormous amounts of friction between North and South because when antinatalist policies are propounded, as Mr. Eberstadt has said, that is often heard in the South as the North trying to control their population, and you get these debates between those who push for population control and those who say that the issue really ought to be about protecting the rights of individuals.

What we have discovered over the course of the last 25 years is that the inconsistency between those positions is not nearly what we once thought it was or what some once said it was, that in fact if good programs and good policies and the comprehensive broad approach that we have been talking about are pursued, individuals acting in their own self-interest will usually behave in ways that are consistent with what is considered at the macro level to be demographically desirable and that the inconsistency between the micro and the macro views that once seemed to provide the case for coercive programs is simply not true, that meeting the needs and the aspirations of individuals by respecting reproductive rights among other things will usually lead to demographic outcomes that are sustainable.

Mr. JOHNSTON. Mr. Eberstadt—and I will come to a conclusion because I know you all have to get back. But if I support reproductive rights, am I then an antinatalist?

Mr. EBERSTADT. Not at all, sir.

Mr. JOHNSTON. Do you support reproductive rights?

Mr. EBERSTADT. I certainly consider myself to. I don't know if others do.

May I make a comment?

Mr. JOHNSTON. Please do.

Mr. EBERSTADT. My problem is trying to square the circle between reproductive rights and population targets or desired future trends for the world population. There is an enormous range of differences that are evident in the World Fertility Survey results and the Demographic and Health Survey results in terms of fertility levels with given contraceptive prevalence levels.

For example, Bolivia and Benin both have about the same level of contraceptive prevalence in some of the surveys. Bolivia's total fertility rate and desired fertility rate was about three children per woman. In Benin we were talking about seven as per these surveys. That is a huge difference for a given level of contraceptive prevalence.

This make makes me think that the spread of modern contraceptives will not have the demographic impact that some people who wish to reduce birth rates hope for, at least not voluntarily. And all of this leaves aside a question of some interest to some large portions of the sub-Saharan population—the question of infertility.

The problem of infertility is not an irrelevant one in sub-Saharan Africa even today, despite the improvements in health. And the fate of a barren woman in the sub-Sahara is not an enviable one.

But as you know, from our discussions today, we heard a great deal about one population problem and not much about the other. A comprehensive look at health rights and parental desires would probably incorporate both of those quantities.

Mr. JOHNSTON. Anybody else who would like to make any statements?

Doctor, we all concede that Nigeria has about 90 million people, and it is the most heavily populated country in Africa, and it suffers from poverty. Now from your opinion, what created the poverty?

Dr. OLUKOYA. From my opinion, I think the macroeconomic policies and the crisis of governance are the major creators of the poverty.

Mr. JOHNSTON. Do you think population contributed at all to the poverty in your country?

Dr. OLUKOYA. I think when you have poverty already there, people——

Mr. JOHNSTON. Does it exacerbate the problem?

Dr. OLUKOYA. Yes, it does exacerbate the problem. When there is not enough to go around, people become very intolerant, never mind how many people you have, and then if you have so many people running after the same thing, then you get very intolerant.

So I think the poverty really and the saps have really done a lot to erode and damage some of the progress that was made before the so-called population crisis came into being.

Mr. JOHNSTON. One suggestion that I thought you made was very, very good, and that was to put women's clinics at the same place that the children's clinics are, because they will not take care of themselves but they will always take care of their children.

Dr. OLUKOYA. Well, certainly I think the proximity will help a lot. Women still, in the place I come from, will subsume their own needs.

Mr. JOHNSTON. For their children.

Dr. OLUKOYA. For their children, and the husbands too.

Mr. JOHNSTON. That is not an American trait, I might say.

Thank you very much. It has been very helpful, and I sincerely appreciate all of you giving us your time and your knowledge, and the meeting is adjourned.

[Whereupon, at 4:52 p.m., the subcommittee was adjourned.]

APPENDIX

POPULATION AND DEVELOPMENT IN SUB-SAHARAN AFRICA

STATEMENT BY

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HOUSE FOREIGN AFFAIRS COMMITTEE

AUGUST 4, 1994

Members of the Committee, Good Afternoon.

I am pleased to be able to meet with you today to discuss USAID's program in population in sub-Saharan Africa and its contribution to our overall development strategy.

In many ways what happens in this arena will determine the future of development in Africa for the next fifty years. It is difficult to see how poverty can be reduced without substantial declines in the rate of growth of Africa's population. Fortunately, there are a number of hopeful signs that suggest Africa may be on the verge of a demographic transition. The last five years have seen the broadest and deepest shift in attitudes and in behavior in family planning in Africa in history. To paraphrase Churchill, "we are not at the end or at the beginning of the end, but perhaps we have reached the end of the beginning." If this is so it is the most hopeful news to come out of Africa in the last decade.

I will address four issues in my remarks. I would first like to briefly discuss the nature of the problem of rapid population growth in Africa. Second, I will outline how population fits in the Administration's foreign policy and development objectives for Africa. Thirdly, I will explain what USAID is doing in the population/family planning arena and how these efforts reinforce and link with other development activities in economic growth, education, environment, child survival, and reproductive health. Lastly, and most important, I will look at the impact of our family planning programs, as well as discuss the long-range impacts of our programs in other, related areas.

I. THE DEMOGRAPHIC PROBLEM

Sub-Saharan Africa has the fastest growing population of any region of the world of any time in history. Population is doubling every quarter-century. At independence, in 1960, a country such as Ethiopia had less than twenty-five million people; today it has 55 million; by the year 2020 it will have over 100 million. Although large reaches of the continent are underpopulated, other areas such as the Kenya Highlands, the Mossi Plateau in Burkina Faso, and the Rift Valley areas of Rwanda, Burundi, and Malawi, are experiencing serious population pressure on land-holdings.

Although most of sub-Saharan Africa is still primarily rural, this, too, is changing fast. Today, Africa is roughly 28 percent urban; in 2015 it is projected to be 45 percent urban. This will create major stresses for Africa's burgeoning cities.

Rapidly growing populations create high dependency ratios; in most African countries children under fifteen represent nearly 50 percent of the population. Rapidly growing populations also place unmanageable pressures on education and health services. Moreover, with every female child likely to become a mother of many children and a grandmother of many more, the momentum of population growth is such that even were fertility levels to drop to replacement level today, Africa's population would still double within a lifetime.

For those familiar with current living conditions in sub-Saharan Africa, including its precarious food security situation, its fragile social services structure, and the tenuous grip many societies and governments have on maintaining civil order, this prospect of doubling population size in a little over two decades and certainly within the lifetimes of most people in this room, must loom as sobering, indeed.

Impacts on Development

The negative impacts upon general development and upon households and individuals are well understood in the development community and by members of this committee. These include:

* high dependency ratios, i.e. a minority of producers supporting a majority of consumers;

* unmanageable burdens on public education and basic health services, with the quality of both difficult to sustain;

* severe strains on individual household budgets limiting resources available for food, health care, other necessities, and possible savings;

* division of agricultural land into smaller and smaller plots,

fewer fallow years, and, consequently, land degradation in terms of overuse and less economical methods of cultivation;

* pressures on forests in terms of fuelwood, commercial exploitation, and consumption for housing and other construction, as well as pressure on wildlife habitats and areas of biodiversity;

* reduced savings at the household and national level, because so much of the national product must go for immediate consumption; this is particularly true at the household level, where parents are unable to invest in the health and education of all of their children; and

* increased social unrest, particularly in the cities, as economic growth does not generate sufficient jobs to employ the increased number of school leavers who are unemployed or underemployed, often poorly educated and without hope.

Factors Affecting Fertility and Population Growth

As noted above, fertility rates in Africa are the highest in the world. Among the reasons for this are:

* the high social regard for fertility and large families supported by age-old family, clan, and tribal traditions.

* early female marriage

* low levels of female education

* high levels of child mortality

* low levels of urbanization

* a history of policies hostile to family planning

* rudimentary delivery systems for contraceptives

* slow economic growth and no broad system of social security

II. ADMINISTRATION POLICY

Slowing Africa's high population growth has taken on increased significance and urgency as the Clinton Administration has redefined our foreign policy and development objectives for Africa. Promoting sustainable development, which improves the livelihood of Africans today without compromising the well-being of future generations, is an explicit U.S. foreign policy objective which Assistant Secretary George Moose outlined six months ago to this Committee. The current leadership in both USAID and the State Department recognizes the devastating impacts which high fertility

has on African women and the long-term threats which unabated, high population growth poses to sustainable development.

The growing importance of family planning and population to the Administration's foreign policy and development objectives is manifest in a number of ways:

* it is an explicit priority in the Administration's foreign assistance reform legislation and USAID's new sustainable development strategy;

* it receives increased attention in public fora, such as the recent White House Conference on Africa;

* we are increasing funding for family planning and population activities in Africa; and

* we seek to leverage other donors to commit more resources for family planning in Africa, as is being done with the Japanese under the "Common Agenda" led by Under Secretary Wirth.

In Africa, our enhanced family planning and population efforts are an integral part of an overall sustainable development strategy which is premised on generating broad-based economic growth. As President Clinton recently remarked: "Reducing population growth without providing economic opportunities won't work." Economic growth is necessary both to increase demand by women for contraception and to sustain and expand public and private services to meet that demand. We know that better jobs and higher income for African women contribute directly to reduced fertility. Conversely, giving women choice and control over reproduction is in itself empowering, and reduced fertility enables them to be more active economically. We are complementing and reinforcing our family planning efforts through investments in other key areas, such as basic education for girls, child survival and family health.

III. THE USAID PROGRAM

USAID is the largest bilateral donor in the population field in sub-Saharan Africa and has been active there since 1968. Today, major programs are underway in 21 countries where we have a sizable assistance presence, and all of the Bureau for Africa's major sustainable development programs include family planning, often coupled with child survival and HIV/AIDS prevention, as a "strategic objective." Typically, the designation of population as a strategic objective means that it is one of only two or three sectors receiving priority attention and funding by the USAID mission.

The combination of bilateral and central funds for population and family planning has exceeded $100 annually for several years.

Between 1988-93, USAID provided $331.6 million from the Development Fund for Africa for this purpose, and we anticipate providing $73.2 million more this fiscal year. (See Table 1 below.) Central Office of Population funds also have provided important technical assistance and financial support.

TABLE 1

Population/Family Planning Funding from the Development Fund for Africa, FY 1988 - FY 1993 (millions of US $)

FY 1988	32.0
FY 1989	40.5
FY 1990	42.7
FY 1991	75.2
FY 1992	66.1
FY 1993	74.6
TOTAL	$ 331.2
FY 1994 estimate	73.2

USAID is a recognized leader in providing population assistance in Africa. This is in part because of USAID's comparative advantage, an advantage which is based in great part on:

* **A strong field staff:** USAID is unique among donors with its field presence. We have a dedicated cadre of technical professionals in USAID missions and our two regional offices able to work in host-country environments with government officials, local non-governmental organizations, and other donors to tailor USAID assistance to specific country needs.

* **A network of "Cooperating Agencies:"** The single most distinguishing feature of USAID's population program is its impressive network of cooperating agencies and contractors. These organizations harness the best technical talent in the United States in areas of clinical training, survey research, logistics management, information, education and communications, and technology transfer.

Equally important has been the experience we have gained over thirty years of population programming, which has led to innovative leadership, particularly in:

* **Leadership in engaging the private sector:** USAID in Africa has taken the lead among all donors in mobilizing the private sector in family planning through contraceptive social marketing and employer-based provision of services.

* **Strong technical leadership:** USAID's population staff in Washington and the field possess a combination of expertise in policy dialogue, communications, demographic analysis,

training, service delivery, logistics management, biomedical and operations research, and hands-on program management.

* **Leadership in contraceptive procurement and logistics:** recognizing that "you can't contracept without contraceptives," USAID for years has consistently given high priority to providing contraceptive supplies and related assistance in logistics and quality assurance. Recently, the Bureau for Africa has purchased $18-20 million worth of contraceptives annually, an amount we expect will increase in the immediate future.

USAID programs have focussed in four areas:

- Changing African Government Policies
- Support for voluntary family planning programs
- Support for education, information and communication
- Development of channels for distributing contraceptives

Donor Coordination

Population and family planning enjoys high priority among donors, and coordination among major donors has become a prominent feature in African programs. The driving force for this is the recognition that no single donor has enough resources to meet the expanding demand for assistance and also the fact that no single donor possesses the full spectrum of capabilities that are required.

USAID's principal colleagues in the donor community are the UNFPA, UNICEF (for child survival) the World Bank, the European Community and the U.K.'s Overseas Development Administration. In some countries, such as Tanzania, the Nordic countries are prominent as is the Canadian International Development Administration. At an individual country level, a division of labor typically emerges in which, for example, the ODA or USAID provides contraceptives, the Bank undertakes construction and facilities rehabilitation, USAID provides the technical assistance.

In Malawi, when the country was establishing a family planning coordinating body (named the Family Welfare Council), USAID funded the consulting team that worked with the Malawians to create the legislative framework for the Council. These consultants, in effect, worked for all donors in the sector, as well as the Government of Malawi. This formed the basis for a consolidated funding proposal for the European Community, the World Bank, the U.K. and the UNFPA.

The largest family planning training center in Africa, the Center for African Family Studies in Nairobi, is jointly funded by the

International Planned Parenthood Federation and USAID. CERPOD, the Center for Research on Population and Development in Bamako, Mali, which serves all Sahelian countries, is funded by a host of donors including the Canadians, the U.N., the French, the Belgians, Rockfeller Foundation and USAID, plus, of course, the Sahelian states themselves.

A new initiative is in its early stages which will involve Japan and the U.S. teaming up to address HIV/AIDS prevention and family planning requirements in Ghana and Kenya. This is part of an initiative led by Under-Secretary Wirth, to broaden the base of Japanese-American cooperation in development. In order for the Japanese to provide medicines and contraceptives, they had to change their policy against financing consumable goods. A key area in which we are interested in seeing additional support from other donors concerns commodities, particularly drugs for STD treatment and contraceptives, for which the need is growing rapidly.

Linkages with Other Development Programs

We recognize, of course, that even if Africa's rapid population growth were slowed, even dramatically slowed, it would not automatically guarantee economic and social development. Simultaneously, we also recognize that unless rapid population growth is slowed, the prospects for improving education, health services, creating employment, raising incomes, and preserving the environment, and for economic growth and development more generally, will be bleak, indeed.

The key issue, of course, is that there is a demand and a supply side to family planning outcomes. Our family planning programs are built to encourage demand and expand supply, but it is clear from the literature, that the demand for smaller families is correlated with female education, child health, female employment out of the home, urbanization, and overall economic growth.

Female Education

USAID supports basic education programs in 12 African countries in which special attention is accorded to reaching girls and young women. Countries involved are Benin, Botswana, Ethiopia, Ghana, Guinea, Lesotho, Malawi, Mali, Namibia, South Africa, Swaziland and Uganda.

Out-of-Home Employment

Better education, of course, opens the door to out-of-home employment for women, and when that occurs, fertility drops even further. Education, too, is directly linked to empowerment of women so that they can make their own reproductive health decisions.

Child Survival

Child survival is widely accepted as another key motivation to accepting contraception, spacing births, and limiting family size. If children survive, it will not be necessary to have so many of them to fulfill family goals including assistance in old age. Although the supporting data for this are less robust than for the influence of education, it remains a reasonable assumption. Additionally, child survival programs are worthwhile in their own right and to the extent they support reduced fertility, that remains a plus.

Reproductive Health

A recent and important modification in USAID's family planning and population program approach has been to incorporate significant aspects of reproductive health in our work. In summary form, this means that in addition to promoting access to quality contraception, we will support measures to increase safe delivery, and we will address the neglected area in women's health (and men's health, too) of preventing sexually transmitted diseases; and we will begin to address the reproductive health needs of adolescents with the objective of helping them to protect themselves from STDs including HIV/AIDS.

IV. IMPACTS

Many countries in Africa are beginning to enter the second stage of the demographic transition. Some are entering more rapidly than others. For decades, child mortality rates have been declining, while birth rates have stayed at a very high level. Large families remain the norm and the ideal in much of Africa, with average fertility rates (the number of children a women will bear in her lifetime) of eight children. Rural-urban migration, increased female education and participation in the labor force, and increased survival rates of children are changing the calculus by which families determine how many children to have.

USAID has contributed to four major changes over the past decade. A clear lesson is that achieving impact in this area requires long-term, consistent programming. This is why we have achieved significant success in Zimbabwe, Botswana and Kenya. And why, after fifteen years of limited success in Ghana, we are now beginning to see major changes in behavior.

African Government Support

Since 1985, USAID has demonstrated through computer modelling (what is known as the RAPID model) the impacts of unrestricted population growth on economic well being, education, health care, and agriculture to over policy makers in 28 countries. Today, most African governments have changed from pro-natalist positions to

positions that support birth spacing, and in some cases, smaller families. Much of the change in attitudes among senior policy makers can be attributed to these "RAPID" demonstrations.

In addition to working to change the basic attitudes of policy makers about family planning, USAID is now working in countries such as Tanzania and Senegal to change policies that impede the effective delivery of contraceptives. For example, the Government of Tanzania has agreed to remove a tariff on contraceptives, which should help make them cheaper. In Niger and Zambia, a new policy allows non-medical people to distribute contraceptives.

Lower Fertility Rates

USAID has supported voluntary family planning programs in 38 countries. In Kenya, USAID has promoted family planning since 1972; in Zimbabwe, since 1983; and in Botswana, since 1973. In each of these countries, USAID is the largest donor.

Fertility rates have actually dropped in a few countries and large changes have occurred in Kenya, Zimbabwe, South Africa, Western Nigeria and Botswana. Perhaps the most remarkable and most tragic success is in Rwanda, where before the civil war began, preliminary results from the Demographic and Health Surveys suggest a dramatic decline in total fertility rates of 25%. According to our best estimates, the total fertility rate in Rwanda was among the highest in the world in 1983 -- 8.5. In 1993, preliminary estimates show the fertility rate to have declined to 6.2. Rwanda has long been characterized as having a Malthusian population problem, and undoubtedly, the growing realization that landholdings can be sub-divided no longer, coupled with improved child health and an aggressive family planning program, have all contributed to this change.

Increased Demand for Contraceptive Services

USAID-financed education, information and communications programs have heightened the awareness of parents (particularly mothers) to the need to space births for the welfare of the children. They have also communicated the availability of modern contraceptive methods. According to recent demographic health surveys, the demand for contraceptive services has increased. On average about one-quarter of the married women in the countries of Botswana, Burundi, Ghana, Kenya, Liberia, Mali, Togo, Uganda and Zimbabwe would like to have access to family planning services, but don't currently. About 80 percent of these women would like to put off their next pregnancy, and 20 percent would like to limit the size of their families. (See attached bar chart).

Development of Service Delivery Infrastructure

USAID continues to develop and strengthen the service delivery

infrastructure. Three channels for distributing contraceptives have been created or supported. First, USAID has pioneered social marketing--the provision of contraceptives through private sector outlets at subsidized rates. Second, USAID provides contraceptives for distribution through the public health system. Third, USAID supports the use of local communities and non-governmental organizations to deliver contraceptive services.

The impacts of these programs is demonstrated in Table II. For example, in Guinea, the number of family planning service delivery points increased from 0 to 340 between 1988 and 1992; in Kenya, they went from 762 to 1832 between 1984 and 1993; and in Malawi, they went from 3 to 230 over the same period.

It might be well to look at the Kenya case more carefully.

Since 1972, USAID has been supporting and promoting voluntary family planning programs in Kenya (providing more than $53 million since 1983 in bilateral assistance). During the first ten years of USAID assistance, little change in either contraceptive prevalence or fertility could be perceived. Kenya had one of the highest population growth rates in the world--nearly 4.0 percent per year.

USAID focussed on expanding family planning services and improving their quality. Activities included:

- **Fertility surveys** that drew attention to the magnitude of the problem and also monitored progress;
- Family planning **training** for health workers;
- **Community-based** family planning;
- **Businesses** adding family planning to health services for their employees;
- Introduction and wide acceptance of **voluntary surgical contraception**;
- Better **contraceptives logistics** management;
- **Improved management** of non-governmental organizations (NGOs);

Our multi-faceted program in Kenya has helped to change family planning behavior in a magnitude unprecedented in Africa.

- The use of contraception has almost quintupled over the past decade. In 1978, 7 percent of married couples of reproductive age used family planning. By 1993, the figure had jumped to 33 percent.
- The fertility rate dropped from about 8 children per woman in

1979 to about 5.4 in 1993.

In Zimbabwe, while contraception rates have increased, the financial viability of the expanded service delivery systems is also improving. In 1993, the Government of Zimbabwe purchased, from its own budget, 21% of all family planning commodities; this rose to 25% this year. About half of the cost of commodities is recovered through sales to those who can afford them.

V. THE FUTURE

Research is now suggesting that the demographic transition in Africa may be very different from similar transitions in Asia and Latin America. Much of the demand for modern contraceptives is coming from unmarried or recently married women, and from married women interested in increasing the time between births. Although the desired size of family has declined, relatively little of the demand for modern contraceptives comes from women who do not wish to have any more children. These findings have important implications for the impact of various types of family planning. The policy environment is right. The incentive structure for large families is changing. Information is now more broadly available than ever before. Thus, USAID believes that substantial progress can be achieved during the next decade.

Two broad constraints remain:

- **Male attitudes.** Many women are ready to practice birth control and limit family size, but many men still subscribe to the cultural norm of large families as both a social security network and a sign of virility. Without changes in male attitudes, the decline in fertility rates will soon plateau.

- **Slow Economic Growth.** Everywhere in the world where the demographic transition has occurred it has been accompanied by economic growth and urbanization, or major increases in the provision of social services, particularly female education. These changes are occurring very slowly in Africa.

There remains one great unknown in Africa's demographic equation--the impact of HIV/AIDS on overall population levels and growth rates. Projections have varied dramatically, but the U.S. Bureau of Census now estimates that in heavily infected countries, the annual rate of population growth may be halved by the year 2010; in other countries, it may be reduced by one third.

VI. CONCLUSION

We are confident that the time is now for major declines in fertility throughout Africa. We are dedicated to maintain our leadership position, and to use our knowledge and resources to: (1) continue to push reforms that encourage the empowerment of women and expanded access to contraceptives; (2) expand knowledge of family planning practices; and (3) strengthen delivery systems.

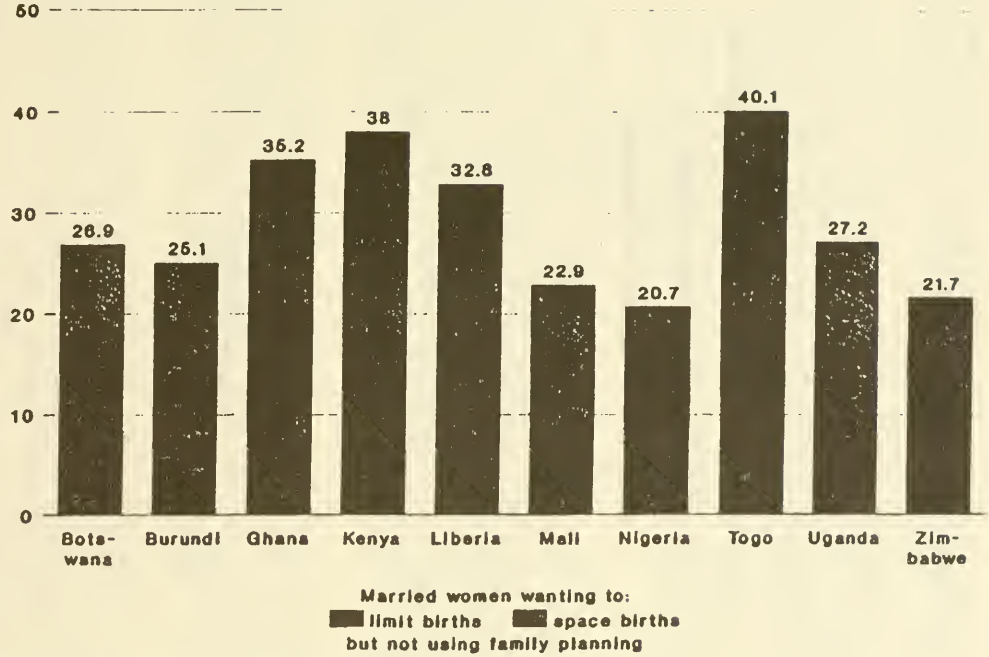
At the same time, our programs in economic growth, in female education, and in child health, will continue to lay the foundation for sustained increases in demand for modern family planning. We believe this area is fundamental to development, we intend to make every effort to push forward the demographic transition, and we are confident in our future success.

TABLE 2: EFFECTIVENESS OF SELECTED USAID FAMILY PLANNING PROGRAMS

COUNTRY	Change in Couple Years of Protection (CYP)[1]	Change in Service Delivery Points	Change in Contraceptive Prevalence Rate (CPR)[2]	Change in Total Fertility Rate (TFR)[3]
Cameroon (1990-91)	from 30,000 to 33,000	from 21 to 30	n.a.*	n.a.*
Ghana (1988-92)	n.a.*	n.a.*	from 12.8% to 18.0%	n.a.*
Guinea (1988-92)	from 0 to 18,745	from 0 to 340	n.a.*	n.a.*
Kenya (1984-92)	from (in 91) 564,998 to 638,302	from 762 to 1832	from 9% to 27% (1978-1989)	from 7.7 to 6.5
Malawi (1984-92)	n.a.*	from 3 to 230	from 1.0% to 5.5%	7.6 (no change)
Mali (1987-92)	n.a.*	n.a.*	from 1.3% to 3.5%	n.a.*
Niger (1990-91)	from 29,948 to 52,533	from 114 to 201	n.a.*	n.a.*
Rwanda (1983-1993)	n.a.	n.a.	less than 1% to 21%	from 8.5 to 6.2
Senegal (1988-91)	from 54,400 to 101,000	n.a.*	urban from 6.7% in 1986 to 10.4% in 1991	n.a.*
Uganda (1990-92)	n.a.*	from 152 to 1566	n.a.*	n.a.*

*n.a. not available
[1]CYP the quantities of contraceptives (varying by method) needed to protect a woman from pregnancy for one year
[2]CPR percentage of fertile women (age 15-49) using any form of contraception, traditional or modern
[3]TFR average number of children a woman will bear during her lifetime

Unmet Need for Family Planning



Source: Westoff & Ochoa, in *Demographic and Health Surveys Comparative Studies* 3 (Columbia, MD: Institute for Resource Development, 1990) Table 4.2.

Testimony of Steven W. Sinding, The Rockefeller Foundation,

Before the Subcommittee on Africa

of the House Foreign Affairs Committee

August 4, 1994

Mr. Chairman, members of the Committee, I am very pleased to have been asked to speak to you this afternoon on the subject of population and development in sub-Saharan Africa.

My name is Steven Sinding. I am the Director for Population Sciences at The Rockefeller Foundation. I spent over twenty years with the US Agency for International Development during which I served for 4 years as Agency Director for Population in Washington and at the end of my AID career, for 4 years as the Mission Director in Kenya. In addition, I was the Senior Population Advisor at the World Bank before joining the Rockefeller Foundation.

In my brief remarks, I would like to deal with 3 questions: Is rapid population growth a serious deterrent to African social and economic development? If so, are there effective measures available to slow it? What should the U.S. do?

The Consequences of High Fertility

As the Committee is aware, there has been considerable debate over the last quarter century, and indeed, since the time of the Reverend Malthus himself, about the relationship between population growth and development. Views on this question range from the apocalyptic to the sanguine. Economists and other social scientists bring carloads of data to support these different points of view, each able to marshall evidence to support their positions. You are all familiar with the writings of Paul Ehrlich from the publication in the 1960's book *The Population Bomb* onward, and the writings of Julian Simon and his book *The Ultimate Resource*. Ehrlich and Simon define the endpoints of a continuum along which various scholars and analysts are ranged between what I have called the apocalyptic and the sanguine.

In recent years, several efforts have been made to find a "golden mean" among the various points of view by convening leading demographers and other population scientists to sift through the evidence and declare a common position. The National Academy of Sciences has twice attempted this task, once in 1972 and again in 1986. On the first occasion, the Academy found itself leaning toward the apocalyptic end of the continuum. Fourteen years later, the position had shifted toward the more sanguine.

Now, in 1994, a new effort has been made, this time by the Overseas Development Council in collaboration with Prof. Robert Cassen of Oxford University and a group of leading economists and other social scientists. They have produced a new volume entitled *Population and Development: Old Debates, New Conclusions*. I would like to quote just one passage from Cassen's introductory essay to this new volume to try to characterize where academic and scientific opinion stands today. Cassen says, "It seems fairly clear that population growth is not the overwhelming affliction for developing countries that some have claimed, and certainly not the prime cause of difficulties for development; but it also should not be regarded with equanimity. ...the balance of the assessments in this volume is that there are clear negative effects at the individual and

household level of population growth under conditions of high fertility. These effects include impacts on the health and education of children and mothers' health and life opportunities. Women of all generations tend to be disadvantaged in these circumstances. The household level effects will be compounded when rapid population growth puts pressure on public resources for health and education."

But Cassen goes beyond the household level when he speaks of Africa. I would like to read two paragraphs that Cassen includes on Malawi to illustrate a fairly typical African demographic and development scene.

> Malawi is an example of a low income country with fast-growing population and high fertility. In 1990, its labor force was 3.4 million. By 2010, the labor force will double to about 6.8 million. Only a quarter are currently employed in the formal sector or the urban informal sector; even at optimistic rates of economic growth, those sectors will employ only a third of the labor force projected for 2010. The remaining 4.5 million workers will presumably have to be absorbed in small-holder agriculture. But each small-holder already cultivates just two-thirds of an acre -- barely enough to support a family. To absorb increased agricultural labor, additional land will need to be brought under cultivation, but since the best land is already in use, much of the new land will be marginal. Malawi has had a good record of increasing agricultural productivity in the last two decades, but very large investments in levels of modern agricultural inputs will be needed to maintain crop yields and prevent a decline in farm incomes. At the same time, Malawi is finding it difficult to improve present educational standards and will continue to do so as long as its population is doubling every two decades.
>
> Even if fertility declines soon in Malawi, the declines will have little impact on employment problems in the near term; most of the labor force of 2010 is already born. However, projections of labor force growth to 2045 illustrate that near term fertility declines could make a large difference. With no fertility decline, the working age population would number 37 million in 2045; with moderate fertility declines, it would reach 22 million; and with rapid declines, only 15 million. Without declines in fertility, it seems unlikely that Malawi will be able to increase the amount of capital per worker enough to produce significant improvements in productivity, wages, and living standards in the foreseeable future. One cannot exclude the possibility of improvements on an individual basis in Malawi even under the high population growth scenario. But such improvements have been fairly exiguous in the last twenty years, and the challenges ahead seem enormous in the absence of significant fertility decline."

In this passage, Cassen goes beyond the effects at the individual or family level to assert that at very high levels of growth, the macroeconomic effects are also clear. Cassen's overall message, and the conclusion which I have drawn from many years of work in this field, including four in Africa in the recent past, is that while it is difficult to

separate the effects of population growth from the many other factors which influence economic performance in the long term, there are some short to medium run consequences of rapid population growth which are serious and clearly negative. These include the capacity of societies to properly feed, educate and provide health services for the rapidly growing numbers of people during periods of population growth that exceed 2% or 2.5% per year. At such high levels of population growth, it is virtually impossible for governments to secure the resources to expand classroom space, train teachers, provide health facilities, purchase medicines and the other requirements of good health systems, and provide the incentives and inputs to the agricultural sector that permit food production to keep pace with population growth.

Many African countries have had to turn to substantial food imports over the past decade to keep pace with population growth, even in the cases where agricultural output has grown at reasonable rates. Just to give one example, in Ethiopia which has enjoyed bumper harvests for the past two seasons, population growth has made it necessary for the government to import food on both concessional and commercial terms at levels comparable to those of the severe drought years of 1984 and 1985.

In addition to education, health and agriculture, rapid population growth implies a growth in the size of the labor force, as Cassen points out, that makes it virtually impossible for African economies to absorb new entrants and claimants for jobs. When I was living in Kenya in the mid- and late-1980's, the economy was producing about one new job per year in the formal sector for every ten new entrants to the labor market. Clearly, such a situation is not sustainable and contains the seeds for massive social and political disruption. In Africa, the economic stagnation or deterioration of the last decade has made a serious situation disastrous. The spectacular economic performance of such East Asian countries as Korea, Taiwan and Thailand, which produced the so-called "Asian Miracle," enabled them to begin to absorb the very young and aggressive labor force entrants, but only after years of effective population policies had been in place.

In Africa, most countries have neither spurred economic growth to the point that the job base is expanding nor implemented population policies which reduce the size of the cohorts entering the labor force. The result is growing pressure for jobs on a declining employment base. If you add to this mix the efforts that African countries have made to expand educational opportunity, you have the makings of a particularly volatile mix as upwardly mobile aspirants for jobs, educated at least through the primary level, find their way blocked by economic performance that simply does not generate the jobs they have come to expect. The lid can be kept on such a situation for a while, but not indefinitely.

I conclude my discussion of consequences by advocating the precautionary principle. Although the relationship between population growth and economic performance is complex and mediated by many other factors (most importantly,

economic policies), in situations of sustained high population growth, there is sufficient evidence of short to medium term pressures and problems that governments are well advised to adopt policies which bring about a slowing of population growth in a voluntary and humane manner. The failure of governments to do so in the short run can lead to a requirement in the future to try to control population growth rates in more Draconian ways. We are living through the most rapid expansion of human numbers in history. This expansion is by consensus not sustainable. We have it within our power to hasten the return toward balanced population growth. Many deaths and much suffering can be averted if we exercise these options rather than letting nature take its otherwise inexorable course.

Policy Responses to High Population Growth

I would like to turn now to the question of what can be done by governments which choose to reduce population growth.

For many years, demographers predicted that the fertility declines that have been seen in Asia and Latin America would not be seen soon in Africa. They asserted that for a variety of cultural, social, and economic reasons, Africa was "different." Until quite recently, there was an air of great pessimism about the demographic transition occurring any time soon in Africa. However, beginning in the mid-80's, evidence began to accumulate that in at least three countries, the demographic transition was underway. These are Botswana, Kenya, and Zimbabwe. By 1984, and particularly by 1986, it had become clear that fertility was beginning to fall in all three countries and that family planning programs were beginning to have a significant impact on population growth rates.

To take the example I know best, in Kenya the total fertility rate declined from 8.1 in 1978 to 7.7 in 1984, to 6.7 in 1989, and to 5.4 by 1993. During this time, the prevalence of contraceptive use increased from about 7% of all women of reproductive age to 33%. In Zimbabwe, where the population growth rate was slower at the beginning of the period, contraceptive prevalence rose even higher -- to 45% by the late 1980's. Comparable increases in contraceptive use and decreases in fertility were also observed in Botswana. In 1993, a special panel on African demography commissioned by The National Academy of Sciences concluded that the demographic transition is clearly underway in these three countries. This suggests that fertility change throughout Africa is possible in a much shorter time frame than had been thought possible less than a decade earlier. Indeed, the report says that fertility decline is now underway in at least seven countries.

To have confidence that the three cases just mentioned can be generalized to the continent as a whole, it is critical to understand the factors that have led to the fertility declines in these three countries.

As the Committee on Foreign Affairs heard from Margaret Catley-Carlson earlier this summer, there is now widespread consensus that three factors in particular are crucial to reducing fertility in developing countries. These are the provision of family planning and reproductive health services that permit men and women to realize their desired family size; investments in the empowerment of women, particularly through education, which leads to a reduction in the number of children they desire; and reductions in infant and young child mortality in order to assure couples of the survival of the children they have already borne. The essential package which has been broadly ratified in the three preparatory meetings for the 1994 International Conference on Population and Development in Cairo this September includes family planning and reproductive health services, child survival programs, and a major expansion in basic education, particularly for girls.

In looking at Africa, it is striking that Kenya, Zimbabwe and Botswana enjoy significantly higher levels of female literacy and educational attainment and lower levels of infant and young child mortality than virtually any other country, except South Africa. This has led many to conclude that while the conditions for rapid and sustained fertility decline may be favorable in these three countries, efforts to reduce fertility in much of the rest of sub-Saharan Africa are likely to prove far more difficult until the requisite improvements in educational and mortality statistics have been achieved. Family planning and reproductive health programs alone, it is argued, are unlikely to have the same impact elsewhere that they have had in the initial three.

While this generalization is probably broadly valid, there is evidence from the Kenyan case and also from the recent significant fertility declines in Bangladesh, that substantial progress can be made in very poor countries, including many African countries, simply by focusing on the issue of unwanted fertility.

To pause for just a moment on this distinction between wanted and unwanted fertility, in broad terms it is possible to say that in looking at the family planning versus development debate, we have now come to understand that family planning programs can help couples to eliminate unwanted fertility but only development will cause desired fertility to fall to the replacement level of 2 children. Are there high levels of unwanted fertility in Africa? The answer from surveys in many countries that have been conducted over the last decade or so, is yes. In virtually all African countries, there are significant numbers of women and men who are having more children than they desire (see attached chart). While there is considerable debate about the accuracy and validity of this measure, it is nonetheless true that historical studies of the issue of unwanted fertility have shown that it is an excellent predictor of future fertility declines. Furthermore, unwanted fertility becomes something of a "moving target" -- as fertility begins to decline, desired family size in many cases falls just as fast, so that the gap between desired fertility and actual fertility often remains constant through much of the fertility transition.

This is illustrated by the case of Kenya, where desired fertility fell from six children to four children between 1978 and 1993 while actual fertility has fallen from eight children to slightly over five. Kenya is beginning to close the gap between actual and desired fertility, but the faster fertility declines, the more desired family size seems also to fall. This same phenomenon can be observed in virtually all countries which have entered the demographic transition.

The NAS study concludes that in the 3 countries in which sharp declines in fertility have occurred, most of the decline is due to rising levels of contraception (as opposed to rising age of marriage, abortion, etc.). This rise in contraceptive use is, in turn, due largely to organized family planning programs in both the public and the NGO sectors -- the commercial sector is not a significant source of services in any of the 3 countries. Thus, it seems fair to conclude that where fertility has declined sharply so far in Africa, organized family planning program efforts have been an important part of the story -

along with rising educational levels, especially for girls, and declining infant and young child mortality.

Does the U.S. deserve some of the credit for this? Yes, definitely. As the earliest and the largest bilateral donor to each of these countries' population programs, USAID deserves a great deal of the credit for a) raising awareness about population among leadership groups, b) finding early NGO projects; c) supporting the development of government programs and d) supporting research that documented and reinforced program efforts. Other donors, especially the World Bank, UNFPA, and the British ODA, also deserve credit as external agents of support.

So, what can we conclude? Simply this. Development, particularly such aspects of development as raising basic health and educational levels and improving equity within societies, is the crucial determinant of desired fertility. Without development, fertility and, by extension, population growth rates will remain high. Family planning and reproductive health services can help individuals and couples to bring their fertility in line with their desired family size, but by itself, family planning probably does not reduce desired family size. Thus, population stabilization in Africa, as elsewhere, will require a comprehensive approach that focuses on the essential package that is embodied in the Cairo document: family planning and reproductive health; basic education, particularly for girls; and child survival. We have seen that even at very low income levels, such as those of South India and Sri Lanka, investments in human development with equity can bring about very low levels of fertility and population growth.

Implications for the United States

Finally, turning to the implications of all of this for the United States, it seems to me quite clear that from a population perspective alone, the highest priority for U.S. assistance to Africa should be in the realm of human resource development. However, there are many other reasons why such programs should be a high priority for the United States, including the fact that human resources development is one of the fields in which USAID programs have traditionally been strongest and where US capacity and commitment have historically run deepest. USAID has particular strengths in family planning and child survival, less in basic education. It should reaffirm its commitment to these two critical program areas; broaden its support for family planning to incorporate critical reproductive health services such as prevention and treatment of sexually transmitted diseases and treatment of unsafe abortion; and press host governments and The World Bank to commit substantially increased resources for basic education.

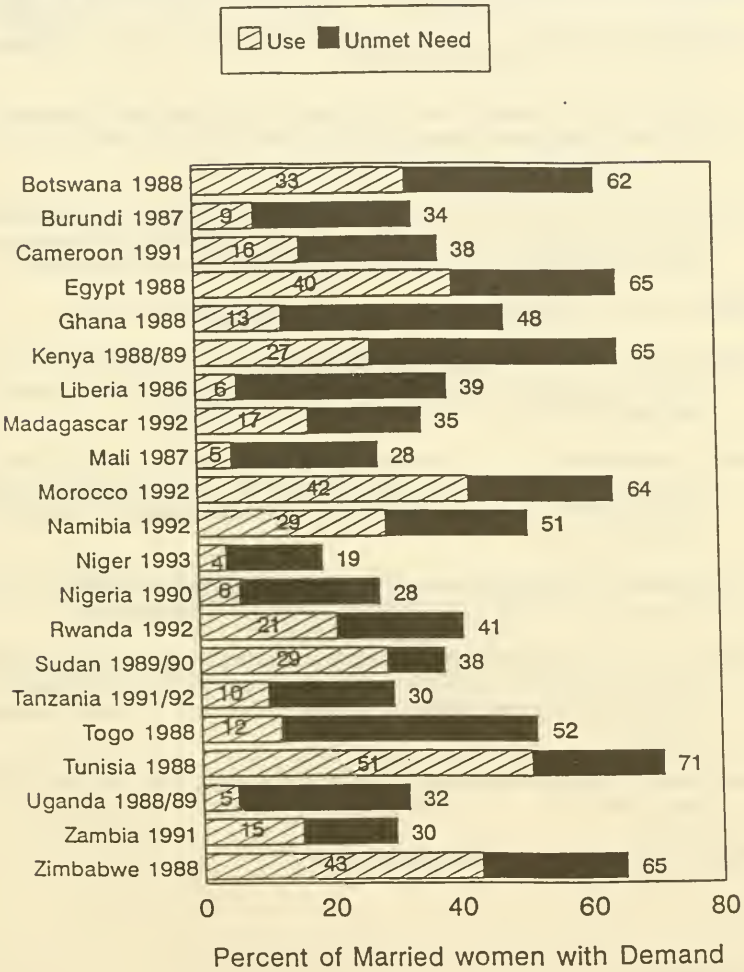
But how high should Africa's claim be in the ranking of U.S. population assistance? After all, Africa's population is relatively small in comparison with Asia's, and only Nigeria ranks as a really large country by global standards. True, but Africa as a whole has a population growth rate that is nearly twice as high as any other region's -- around 3 percent a year. Also, other regions, especially most Latin American countries, are now experiencing falling fertility and expanding commitments on the part of their own governments to provide the resources for family planning, education, and child

survival programs. Africa stands alone in its clear dependence on the international community for help.

Finally, the comparative advantage of the United States, as opposed say to the World Bank, is in providing flexible grant-based, technical assistance and commodities that are so crucial at early stages of program development. USAID's highly differentiated assistance mechanisms, including closely supervised bilateral assistance and the several imaginative channels represented by the centrally-funded cooperating agencies far exceeds in sophistication, flexibility, and scale what other donors can provide. Thus, USAID has a clear comparative advantage over nearly all other donors in Africa and should play a major role in population assistance there.

Mr. Chairman, members of the Committee, I thank you very much for giving me this opportunity to testify and I look forward to answering your questions.

Total Demand for Family Planning: Use and Unmet Need



Source: Charles Westoff

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WOMEN'S HEALTH ORGANISATION OF NIGERIA

TESTIMONY OF DR. ADEPEJU OLUKOYA

FOUNDER AND COORDINATOR

WOMEN'S HEALTH ORGANISATION OF NIGERIA

HOUSE FOREIGN AFFAIRS COMMITTEE

SUBCOMMITTEE ON AFRICA

AUGUST 4, 1994

Good afternoon, Mr. Chairman. My name is Dr. Adepeju Olukoya. I am the founder and Coordinator of the Women's Health Organisation of Nigeria. WHON is a non-governmental, non-profit organization dedicated to strengthening the capacity of Nigerians, particularly women's groups at the grassroots level, in responding to women's health needs.

I am a medical doctor, a Public Health Physician, educated in your great country. For the better part of the last sixteen years, I have been involved with teaching, providing health care services, conducting research on women's health issues, as well as working with women's groups.

On behalf of my colleagues, I would like to thank you for this opportunity to testify today. I am delighted to be here.

My Organisation does not receive AID funding, so I can speak as an objective observer. I must, however, acknowledge how important foreign aid, especially AID support, has been in providing a lot of the reproductive health care infrastructure that exists in my country. My comments today are directed at how we can build on these to better address women's reproductive health needs.

In your letter of invitation, Mr. Chairman, you asked that I address local perceptions of the so-called "population crisis." In my view, the problem is not population but lack of economic and social development, and improvements in the quality of life for all people. Women will have fewer children if there is reduction in poverty, basic right to a secure livelihood and good quality basic services, guaranteed through democratic, people-centred and participatory processes.

For years the perception has been that population is an isolated problem that can be fixed simply with the proverbial magic bullet of controlling women's fertility. My experiences show that approach simply does not attack the problem at its roots. This is manifest in the reality that in spite of the magnitude of resources that have been expended on this approach, the majority of women in my country still do not utilise modern contraceptive methods, and the community at large still does not identify with the notion of fertility regulation as is currently propounded. Contraceptive distribution alone simply cannot solve the "population crisis". We must look at population within a broader context of women's reproductive health and social and economic development.

The reasons people have large families are numerous and well documented. I will just mention three:

1. Lack of access to quality reproductive health care, including family planning services;
2. The high infant and child mortality rates--large numbers of children ensure that at least some of the children will survive to adulthood and in some cases, supply the needed manpower for income generation and old age security in scenarios where basic health care services continue to deteriorate, and poverty continues to rise, primarily as a result of macroeconomic policies and crises of governance.
3. Low social and economic status of women, which often prevents them from having any say in the size of their families, or other issues related to sexuality and reproduction for that matter.

I would like to direct most of my comments to the first reason. Why do we need a reproductive health approach?

Among Nigerian women, pregnancy and childbirth are the leading causes of illness, disability and death. Nigeria has one of the highest maternal mortality ratios in the world. It is estimated that up to 1,800 mothers lose their lives for every 100,000 live births especially in the rural areas.

Estimates are that one Nigerian woman dies every 10 minutes due to pregnancy and related causes. And for every one that dies, 20 more are sick and disabled, often for life with illnesses such as reproductive tract infections, infertility, AIDS, cervical cancer.

What do we mean by reproductive health care? A reproductive health approach should:

1. Expand the range of contraceptive methods and develop service delivery options that are especially suited to helping reduce the epidemic of sexually transmitted diseases (STDs), including the Human Immunodeficiency Virus (HIV).

   This is especially important in a scenario where there is high prevalence of infertility, and where many people associate contraceptive use with infertility.

   We need new women-controlled contraceptive methods which protect them against both pregnancy and STDs, and if possible, HIV. While we now have a choice among several methods of contraception, such as IUDs and the pill,

there are currently no methods that women control and that protect them against both pregnancy and STDs.

I am troubled by the use of contraceptive methods that provide no protection against STDs in communities where such diseases are highly prevalent. Furthermore, some methods such as IUDs, when used in women with active infection, can be harmful to their health. The Centers for Disease Control (CDC) has clear guidelines for addressing this situation.

2. Integrate STD prevention and control with family planning services to ensure the safety and efficacy of those services.

Contraceptive safety and use can be compromised by the presence of STDs. There are very substantial benefits to combining family planning and STD prevention and control. For one thing, recognition and management of women's reproductive tract infections require access to the same client population, that is sexually active women, as well as providers with similar skills, for example, competent pelvic examination and the ability to communicate concerning sensitive issues of sexuality. From research that we have done, men and women appreciate this ! Women are more likely to respond positively to, and utilise services that they perceive as catering to their whole bodies. rather than focus on one organ or a function of one organ !

However more research is needed to determine how to:

- integrate STD diagnosis and treatment with family planning services and at what cost;
- develop simpler and cheaper STD diagnostic techniques for use in family planning services;
- promote the use of condoms through all family planning services; and
- research behavior to help design effective counselling and service delivery that will increase client awareness and shared male-female responsibility.

3. Provide humane treatment for women who suffer the consequences of unsafe abortion.

Contraceptives can and do fail, and contraception is not always possible for all sexually active people. 40-50 million abortions occur worldwide annually. As many as half of these are estimated to be illegal and this usually implies extreme hazard to the health of women. Many women suffer serious long-term health problems such as chronic infection and pain, and infertility. Humane services for abortion complications, including contraceptive information and services, are urgently required and can be an effective means of preventing repeat abortions.

4. Provide services for infants and children.

The health of women and their children are inextricably linked. Maternal and child mortality is closely associated with lack of adequate family planning and reproductive health care. One of the leading causes of maternal death is postpartum hemorrhage--common among poor women who have closely spaced pregnancies and unsafe abortions. High fertility takes a toll not only on the women's health but affects their children's lives as well. As many as half of the women in the developing countries are anaemic. A child born less than two years after a previous birth is 50 percent more likely to die before his or her fifth birthday.

In general, women are more likely to visit clinics seeking health care for their children than for themselves. A reproductive health clinic that provides services for infants and children can become a point of entry for reaching women.

Quality of Care

Many policy makers have argued that high quality reproductive health and family planning services are too expensive or too difficult to provide especially in countries that are not technologically advanced. The cost of not doing so is higher !

We have found that family planning services are used more frequently and clients will remain in the programs longer if the quality of care is improved.

Unfortunately, clinics often fail to follow generally accepted practices. According to a recent UNFPA report on family planning clinics in three countries, the health care providers often failed to prevent infection by use of infection-control procedures during examination and there was inadequate screening of patients who may have come to the clinic with existing infections. The report also noted that the service providers did not follow infection control procedures during IUD insertions. Some of the health care workers did not wash their hands between patients! In one country, the most frequent reason cited for removing IUDs from patients was the provider's inability to deal with infection.

A high quality family planning program also offers counseling and referral services. Women often receive inadequate counseling about potential side-effects associated with each of the various contraceptive methods. The UNFPA survey revealed that fear of side-effects was one of the key reasons many people reject modern contraceptive methods. With proper counseling women can make informed choices as to the right method for them.

Last but not the least, a quality family planning program treats its clients with respect and compassion. People are treated with dignity and courtesy, instead of as objects that must be dealt with. For example, in many instances, women are not informed about procedures being performed on them, and their implications!

Finally, this statement would not be complete if I did not address the newly emerging and urgent need to reach young people, who have been traditionally excluded from family planning programs. In the countries of sub-Saharan Africa, births to adolescents constitute between 15-20% of overall births. As traditional sexuality education systems break down, more and more young people become sexually active at increasingly younger ages, often

through no choice of their own. We have to develop new strategies for reaching this group.

Adolescents and young adults are particularly vulnerable to sexually transmitted diseases.

Accountability

One of the key strengths of our program is that women are truly being involved every step of the way in identifying and helping resolve their own health problems. I believe all family planning and reproductive health programs must be responsive to the people they serve. This can only be achieved through active client participation in all stages of program design, implementation, monitoring and research. Programs need to be evaluated by objective third parties.

In the final analysis, we are only as successful as the people we serve.

Mr. Chairman, I acknowledge the deep commitment that this administration has shown in matters relating to the health of women. I would specifically make mention of the efforts of under-Secretary Tim Wirth.

I was also delighted to learn that the Senate Report accompanying the Foreign Operations Appropriation bill calls for AID to set up an advisory committee on women's health and population activities. I understand that this advisory committee will consist of experts in family planning and women's health issues who will be actively involved in the design and implementation of family planning and reproductive health programs. I applaud this effort to make family planning programs more responsive to the ultimate recipients of their services. I would urge your committee to include credible international experts in this committee.

I would be pleased to answer any questions Subcommittee members may have.

TESTIMONY TO THE HOUSE FOREIGN AFFAIRS COMMITTEE
BY PEGGY CURLIN
PRESIDENT
CENTRE FOR DEVELOPMENT AND POPULATION ACTIVITIES
AUGUST 4, 1994

Mr. Chairman, I appreciate the opportunity to appear before the House Foreign Affairs Subcommittee on Africa today. My name is Peggy Curlin and I am the President of the Centre for Development and Population Activities in Washington D.C. I would like to thank you and the committee for inviting me to share my perspective on population and Africa, which is based on 20 years of experience enhancing women's potential through sustainable development, family planning, and health programs.

CEDPA is an international woman-focused organization with a network of 900 partner organizations in Africa, Asia, Eastern Europe, the Middle East and Latin America. Since 1975, we have worked with women leaders and women's organizations who have an enormous outreach in 105 countries around the world. I am joined here today by a small sampling of the CEDPA alumnae network in Africa. These women are in Washington, D.C. as part of CEDPA's Youth Leadership Program and represent CEDPA partner-projects in Ghana, Kenya, Nigeria, South Africa, Tanzania and Uganda.

Mr. Chairman, in the United States we are too often presented with a bleak picture of Africa. The haunting images of Rwandan refugees dying of cholera, Somali mothers trying to feed their children or tribal violence in the Sudan. The oft-quoted Atlantic Monthly article The Coming Anarchy, suggests that burgeoning population in Nigeria will doom millions to a life that is "nasty, brutish and short."

When faced with these harsh realities, we tend to look away from individuals and turn to statistics for explanations. A recent Population Reference Bureau Data sheet, for example, characterized the population dynamics of sub-Saharan Africa as a series of highs and lows: the highest crude birth rate of any major world region, the highest infant mortality, the lowest life expectancy, the lowest contraceptive prevalence. These demographic highs and lows have become the focus of concern to African policymakers struggling to improve the quality of life for Africa's people. This is a focus that, while valid, is also misplaced. If I may borrow the title of a recent publication, when addressing the issue of population in Africa, we need to move "beyond the numbers" and begin to look at the needs and roles of individuals, particularly women.

The agenda for the International Conference on Population and Development (ICPD) has for the first time put the concerns and needs of grass roots community women before policy makers. This is welcome news. Poor health conditions and rapid population growth are closely associated with low status and limited rights of women. Without significant improvements in the coming decade in women's reproductive health care and economic and educational opportunities as well as full legal rights, rapid population grow in Africa will continue and the quality of life in all countries may be irreparably damaged. Yet, as the ICPD Programme of

Action recognizes, investing in the lives of women enables countries to stabilize population growth and meet sustainable development goals. I am here to underscore that the single best foreign policy investment the United States can have towards stabilization of population in Africa is the empowerment of women.

I am certain that the committee is very familiar with the status of African women. Throughout Sub-Saharan Africa, women have been marginalized and constitute the majority of Africa's poor adults. They lack the power and resources to change their role and status in society. It is a familiar statistic but well worth repeating that women in Africa perform 60% of the work and in some areas grow 60 to 80% of its food. In every country in Sub-Saharan Africa, households headed by women are the poorest.

Most women in Africa lack access to quality family planning services. In Sub-Saharan African, at least 85% of married women are not using contraception, largely due to the lack of availability, even though they wish to avoid pregnancy. In Kenya, for example, a recent Demographic and Health Survey (DHS) study indicated that 52% of the married women do not want any more children. In addition, 26% would like to postpone subsequent births.

Women's health is viewed almost exclusively in relation to their childbearing role throughout Africa. Yet more than two-thirds of pregnant women receive no formal prenatal care, and at least 150,000 women die each year from pregnancy-related causes. Moreover, for every maternal death, there are more than 100 women who suffer complications that threaten their life and the life of their child. This means that more than 1.5 million African women annually suffer pregnancy-related complications before, during, and after birth, including hemorrhage, sepsis, anemia, hypertension, and obstructed labor. In addition to the negative impact on women's lives, this has a disastrous impact on family life, economic well-being, and the health and welfare of children.

African women lack the same economic and educational opportunities that are afforded to men. Gender bias is a primary cause of poverty because it prevents women from obtaining education, training, health services, child care, employment and legal status needed to escape from poverty. The overriding preference for male children leads to poor nutrition for girls, limited or no educational opportunities, and a host of more subtle discriminatory actions that together deny girls a sense of their own worth and the option to fulfill their potential beyond being a wife and mother.

Moreover, the gender gap in education has a devastating effect on the aspirations and opportunities of young women. Almost two thirds of the illiterate people in Africa are women. In all of the sub-Saharan African countries, women's literacy lags behind men's, in most cases by a significant percentage, and far fewer girls than boys attend schools.

In order to reverse the trend of this downward spiral, we need to eliminate the existing barriers to women's full participation in society and highlight women's contribution rather than their victimization. Ordinary African women can and should be empowered to do extraordinary things. African women can and should be seen as contributing to development, not as victims of poverty and ill health. In promoting a more positive image of women as leaders, teachers,

development and health professionals, as well as their contributions in non traditional roles, we can help to overcome the image that women are unable to help themselves and their families, but rather empower them to take charge of their lives.

Let me share with you an example of empowerment from the CEDPA alumnae network. In Mali, a local nurse midwife decided that women and men should have more information and services in family planning. The Government Ministry policy had traditionally provided family planning only in a clinical setting, which had the unintended result of excluding services to women and men living in rural communities. This Nurse Midwife recruited local women and men as organizers and deliverers of community-based services. This innovative act contributed to a policy change that has enabled tens of thousands of rural women to obtain safe contraceptives so they can plan and space their families. Once family planning became available, women decided that they could do more with their lives. Now income generation projects and small industries flourish and many women are using credit and loan services for the first time. Men are supportive of women's rights and are beginning to take greater responsibility for their own reproductive behavior. In 1991, the contraceptive prevalence rate (CPR) in this project area was 57.7% in contrast to the all country rate of 1.3%, one of the lowest in the world. This did not start as a model project, although it has become one. It began with an empowered woman believing that she could change the system, and she did. As a result, she has empowered her community.

To empower women there needs to be a real commitment to unusual business, not business as usual. Lip service to women's empowerment will not bring about the change that Africa needs. Any of these women here today can tell you in great detail what an empowerment program looks like. It is not a sector, but it is an important component of any sectoral program. To be effective empowerment programs must reach large numbers of women. This is possible through use of existing channels and programs such as agricultural extension agents, vocational training and managerial programs. By opening these programs to women, the benefit is multiplied many times over with little added expenditure.

In order to succeed at global women's empowerment, the United States must underscore and reinforce a common global plan of action that addresses women's roles and needs. An inter-related web of interventions must be made at the macro and micro-level in order to improve women's lives as well as have an impact on population growth in Africa.

Specifically:

* **Women need access, choice and participation in quality family planning and reproductive health care.** By enhancing the potential of individuals, family planning contributes to achieving development goals: the advancement of women, the stabilization of population growth, preservation of the environment, and democratic processes which leads to an improved quality of life and sustainable development. The women who are most in need of family planning, however, often face additional hardships; poverty, sick children, a poor self image, domestic violence and other health related conditions. Our challenge is to promote integrated family planning services, which do not attempt the provide everything at the primary care level, but have adequate and knowledgeable referrals for other health and social services.

* **Women who want to use family planning but have no access must be the first priority.** We cannot assume that all women can be reached by traditional methods of distribution of contraceptives. Women are poor, remote, and often powerless to meet their own reproductive health needs. Moreover, without access to contraception, women are relegated to giving birth and raising children, and often incapable of taking advantage of a wide range of economic and social activities. However, once they have access to family planning services, women are inherently capable to understand and act upon information which will improve the quality of their life and the lives of their families.

* **In order to alleviate untold human suffering and health risks, we must address the difficult issue of illegal and unsafe abortion.** Unsafe abortion is the leading cause of maternal mortality in Africa and represents a serious and largely unacknowledged public health problem. High quality family planning and post-abortion family planning services reduces the likelihood of unwanted pregnancies and abortions. In addition, comprehensive sex education, which includes contraceptive information and services to sexually active youth, is synergistic with community and national goals to reduce abortion. Whether safe and legal abortion is seen as an alternative to death and illness is within the purview of national governments, but women themselves must have the major role in making the policy decisions which affect their health.

* **Universal educational opportunities, especially for girls and women, are an essential precondition to women's economic empowerment.** While universal education may be unattainable in the near future, closing the gender gap between boys and girls education is a realistic goal. This gender gap is closely associated with underdevelopment and if not addressed, will continue to contribute to the cycle of high fertility, low status for women, high infant and maternal mortality and poverty for all.
* **The unique problems faced by adolescent girls must also be addressed.** Without education and earning potential adolescent girls are in a particularly vulnerable position. The double standard for male and female sexuality assures that young women will continue to be married early to protect the family's honor, or worse, to be used by older men as safe sexual partners. The elimination of child prostitution and enforcement of the age of marriage are vital to the protection of young women and girls. Enabling girls to make decisions on information about other options to early marriage and childbirth are demographically and socially effective methods to decrease high fertility and mortality and morbidity in women. Moreover, by changing the image of women, girls will be thought of as more valuable by society as well as their families.

* **Males and adolescent boys also have an important role to play as responsible sexual partners and fathers.** In general, men continue to exercise preponderant power in nearly every sphere of life, including personal decisions regarding family planning and the policy decisions made at all levels of government. Women, however, continue to bear most of the burden of child rearing. We must promote gender equity and empower men to take responsibility for their own fertility. African governments should recognize men as clients for contraceptive information and services, increase research for development of new male contraceptives, and promote the use of condoms and vasectomy through innovative services and information campaigns. The rapid spread of HIV/AIDS is an additional critical factor that supports increased male responsibility as well as early and explicit sexual education for both boys and girls.

* **Grassroots NGOs have a critical role to play in population programs in Africa.** Attention must be directed on increasing the status, ability and participation of women in development and population programs. As women are rarely involved in designing or carrying out these programs, they often do not address the real needs of women or utilize the enormous wealth of practical and experiential knowledge that women have to offer. Community women must be trained and empowered to meet the multiple needs of women through the provision of non-clinical family planning information and services and through referral to secondary and tertiary care. Women must continue to be empowered to work through community development and women's groups to address gender, poverty and environmental issues. Furthermore, women should have equal access to management and policy level positions in both government and NGOs. Such efforts will ensure that programs and policies are more responsive to women's needs as well as contribute to altering gender stereotypes.

* **In order to change laws, policies and practices which discriminate against women, governments and NGOs must take increased responsibility for protecting women's rights.** Advocacy for girls education, equal rights and participation in democratic processes should be a vital part of women's development strategies. Policy makers should be sensitized to gender discrimination and its pervasive effect in all aspects of society.

* **Economic restructuring must take women's concerns seriously.** Economic policies such as structural adjustment programs without social safety nets allow the burden of poor governance to fall too heavily on the shoulders of women and children. Economic reform should be preceded by what development factors will support the provision of basic services, what effect such policies will have in the informal sector where most women derive their economic livelihood, and what food policies are in place to assure basic nutrition for women and children during economic restructuring.

* **Resources to women are a critical factor in their empowerment.** Existing resources need to be reprogrammed so that women receive their fair share - which is half . As they have a remarkable repayment record, credit institutions must reexamine women's access to loans. Educational institutions must recruit girls by working with their families to assure that girls are not left behind to work on the farm while boys are sent to school. More NGOs and women's groups must be recruited to provide family planing and reproductive health services to women where they live and work. Governments must value their NGOs and grassroots women's groups as partners giving them full in decision making and policy development.

Lastly, foreign assistance cannot be business as usual either. Brian Atwood, AID Administrator has said, "Attention to gender roles is fundamental to the success of programs we assist. We must support full participation of women at all levels of family planning and -- indeed -- all health and development programs." Brian Atwood's belief in democratic principles is a compelling rationale for women's full participation. However, the danger exists that country level AID missions will find women's empowerment principles too ephemeral, too difficult to sell to government counterparts and, based on the comfort levels with traditional family planning programs, too risky. If this Committee is concerned that women can make the difference between success and failure in Africa, you can help Administrator Atwood and his very capable team by sending a signal to the country level that policy makers at the highest level in this

country expect women to play a greater role in designing, implementing and evaluating US AID assisted programs. This Committee should encourage US AID to incorporate women's empowerment in all sectors, particularly in population programs, and to ask and receive a periodic report on the results of these strategies.

Mr. Chairman, I would like to leave the committee with the knowledge that empowerment is contagious, and that it is the responsibility of this committee to see that it spreads to the women of Africa. You have here today a sample of the inspiring talent that is available to this Committee and the policy makers in Africa. Thanks to the empowering process of the ICPD, each of us is renewed in the struggle to overcome historic barriers to women's equality. Family planning is only a beginning, but an important beginning to women's empowerment and development. However, each of us know that family planning programs targeting women will not be an acceptable substitute for women owned and designed programs. The sooner this message reaches policy makers and resource allocators, the sooner the fertility rates in Africa will begin to fall. Mr. Chairman, increasing the role of women will create good news about Africa. Along with thousands of African women leaders in the CEDPA network, I believe that African population and sustainable development programs are success stories waiting to happen.

YOUTH LEADERSHIP FELLOWSHIP PROGRAM

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ISBN 0-16-046505-2