

The Return of Population Control: Incentives, Targets and the Backlash against Cairo

by Betsy Hartmann

Editors' Note: Worldwide political upheaval, financial crisis, and urgency around climate change inspire hope for radical change and reform in some, while others see an opportunity for a return to the old days of coercive population policies. In the latest issue of *DifferenTakes*, PopDev director and longtime international women's health activist Betsy Hartmann calls on the reproductive health community to stand strong against incentive programs in family planning, long proven to be harmful to women and to the cause of reproductive freedom.

— Co-editors Katie McKay Bryson and Betsy Hartmann

In January, the U.S. Agency for International Development (USAID) sent out an electronic bulletin about strengthening family planning services with performance-based incentives. These include "reducing financial barriers for voluntary sterilization" through compensation payments to clients.¹ The use of such incentives in the population field raises troubling ethical concerns. Paying

poor people to be sterilized or to use a certain form of contraception distorts the whole notion of reproductive 'choice.' Topping up the salaries of poorly-paid health workers on the basis of their ability to meet sterilization and contraceptive quotas or targets does the same. Sterilization, for example, should be one option among many and not promoted over other methods, especially given its permanence. USAID's bulletin, and the longer report on which it is based, represent a potential backslide away from reproductive health and freedom toward the top-down population control programs of the past. It is time to take action before history repeats itself.

Lest we forget that history, recall the experience of Bangladesh. In the mid-1980s, Bangladesh's then martial law government instituted a crash program to reduce the country's birth rates. In addition to enhancing incentive payments for sterilization, it introduced punitive measures against family planning and health personnel who failed to meet monthly sterilization quotas. Abuse was rampant. In the flood season of 1984, for example, relief workers uncovered a pattern of destitute women being denied food aid unless they agreed to be sterilized.²



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The government's policies did not occur in a vacuum. In 1983 major donor agencies, including USAID, the World Bank, and the UN Fund for Population Activities (UNFPA), put pressure on Bangladesh to achieve a "drastic" reduction in birth rates, primarily through sterilization incentives. Despite a law prohibiting the use of American funds for incentive payments, USAID financed 85 percent of the Bangladesh program's incentive costs. It got around the law by calling the incentives "compensation payments." Sterilization 'acceptors' received a cash payment equivalent to several weeks of wages and a new sari for women or sarong for men at a time when many villagers only owned one piece of clothing. Doctors, clinic staff, health workers, traditional midwives and even members of the public received a fee for each client they "referred" or "motivated" to be sterilized. As a result, the whole health care system was skewed toward sterilization and access to temporary methods of contraception was severely curtailed. Sterilization rates rose especially high in the lean season before the harvest when peasants were desperate for cash to buy food.³

What happened in Bangladesh in the 1980s was nothing out of the ordinary. It was old-school population control with its typical callous disregard for poor women's health and rights in the war to reduce their fertility. Fortunately, by the end of that decade an international campaign against the incentives managed to stop the worst of the sterilization excesses in Bangladesh. At the same time, women's health and reproductive rights activists were organizing across the globe to reform population policy, and achieving a number of successes, particularly at the 1994 UN population conference in Cairo.

The Cairo Plan of Action, endorsed by most of the world's governments, came out against the use of coercion and incentives and disincentives in family planning programs and instead called for the provision of broader, voluntary reproductive health services. Although the Cairo agreement provided important tools for feminist reform of the family planning field, it did not go far enough in challenging population control. It left intact the assumption that population growth is a major cause of poverty, political instability and environmental degradation, thus obscuring the role of powerful corporate, military and government interests. Importantly, while it discouraged contraceptive acceptance targets at the local level, it endorsed national-level targets to reduce population growth by a certain percentage in a specified period of time.⁴

Several years after the Cairo reforms, the Fujimori dictatorship in Peru followed in Bangladesh's footsteps,

launching a crash program to reduce birth rates from 3.2 births per woman in 1996 to 2.5 by 2000. While USAID noted the challenges of meeting such a target "in a quality way," it was still willing to fund the Peruvian program.⁵ In 1997 Fujimori began a brutal mass sterilization campaign primarily targeting indigenous Quechua women. Over two hundred thousand women were sterilized, many against their will, or without prior knowledge of the operation, as is documented in Mathilde Damoiseil's recent documentary, *A Woman's Womb*.⁶ Although USAID was not directly involved, its acquiescence to the government's unrealistic demographic targets and its failure to monitor the program helped set the stage for abuse.

In the wake of the Peruvian scandal, Congress approved the Tiahrt amendment in the 1999 Foreign Operations Appropriations Act. Among other stipulations, the amendment directs that in family planning (FP) projects supported by US government funds:

- "—service providers and referral agents cannot implement or be subject to quotas relating to numbers of births, FP acceptors, or acceptors of a particular method;
- there be no incentives to individuals in exchange for becoming acceptors or program personnel for achieving targets or quotas for numbers of births, acceptors, or acceptors of a particular FP method."⁷

Why then, after ample documentation of the harm caused by such incentives, is USAID considering reintroducing compensation payments for sterilization and other problematic incentive schemes?

The answer is twofold. First, performance-based incentives, commonly called pay-for-performance (P4P), refer to the current trend in international health and development programs to reward people and providers with money or goods for achieving performance targets. In the case of childhood immunization, for example, P4P programs might pay parents for bringing their children to be vaccinated and providers if they reach their quota of children immunized. USAID appears worried that if it doesn't embrace P4P, family planning may decline in perceived importance as other health activities are increasingly incentivized.

Second, the reconsideration of incentives reflects a backlash against the Cairo reforms. For the more hardline proponents of population control, driving birth rates down still remains a higher priority than providing a broad array of reproductive health services

or empowering women. The Cairo approach is too slow for their certainty that population growth is a primary cause of social and environmental ills. These proponents want immediate, quantifiable results, especially in countries where birth rates remain relatively high—such as those in sub-Saharan Africa.

USAID funds a diversity of programs, some more attentive to reproductive health and rights than others. The current foray into incentives may well represent an attempt by population hardliners within the agency to gain the upper hand over feminist reformers.⁸ To give the agency its due, it has acknowledged some of the potential pitfalls of family planning incentives, such as “coercive behavior by managers and providers.” In the case of compensation payments, USAID recognizes that, “without clear communication, clients may incorrectly interpret the offer to cover transportation costs to access counseling or specific services (e.g., voluntary sterilization) as payment to accept a method.” Yet the agency still asserts that these pitfalls can be overcome with “smart design,” and “ongoing monitoring and assessment.”⁹

No amount of smart design or monitoring can correct an approach that is fundamentally flawed. To pay, pressure or force poor people to make certain reproductive decisions over others is a violation of human rights. A careful reading of the longer USAID-commissioned report, *Performance-Based Incentives: Ensuring Voluntarism in Family Planning Initiatives*, sheds unsettling light on the agency’s motives. While the report is produced by a consulting firm, Abt Associates, Inc., and bears the proviso that “the author’s views do not necessarily reflect the views of USAID,” it is published with the agency’s imprint and is clearly the source for its January bulletin.¹⁰ What is most striking about the report is its failure to criticize current incentive schemes financed by other agencies that would clearly violate the Tiahrt amendment. For example, the report speaks positively of Burundi, where health centers receive fees based on new family planning acceptors and for the insertion of IUDs and implants, thus skewing contraceptive distribution toward long-acting, provider-controlled methods over pills or condoms. It also offers no critique of Congo, where a European Union-funded project pays health centers fees on the basis of the number of sterilizations, IUDs and implants they provide. Nor does it question the approach of the National Rural Health Mission

program in India, which pays sterilization incentives to clients, community health workers and doctors, with the scale of fees rising in “low-performing” states. Moreover, the report tries to rewrite history by claiming that compensation payments in Bangladesh did not promote reliance on sterilization.¹¹

USAID’s drive to reinstitute incentives is taking place at a time of great global uncertainty. Elites in many countries are looking for scapegoats for the financial crisis, climate change, and widespread political upheaval. In the media, as well as many policy circles, blaming ‘overpopulation,’ and hence the fertility of poor women, especially women of color, is back in vogue. Neoliberalism’s vicious assault on social welfare has also intensified the view of poor people as unworthy burdens on the state, economy and society. The political mood is turning toward a re-embrace of population control.

If there is a proverbial canary in the coal mine, it is increasing reports of the forced sterilization of HIV-positive women, who are among the most vulnerable to social and medical oppression. According to Lydia

Guterman of the Open Society Foundations, “Community-led documentation efforts in Chile, the Dominican Republic, Mexico, Namibia, South Africa, and Venezuela — as well as anecdotal reports from countries in Eastern Africa, Central America, and Southeast Asia — indicate that the forced sterilization of HIV-positive women is an increasingly global abuse.”¹²

Optimistically, one can view USAID’s recent publications on incentives as a sort of trial balloon sent up to gauge the reaction of the reproductive health community. If that is the case, the sooner it’s popped, the better. More pessimistically, it represents a calculated decision to undermine the Cairo reforms and reinstitute population control as a central motive and tool of family planning programs. If that is true, a broad, global mobilization of reproductive health and rights advocates will be urgently required.

We can draw an important lesson from the past by recognizing that, if the reproductive health community does not quickly seize the moral high ground on the incentive issue, the anti-abortion movement will surely try to do so for their own narrow purposes. They were quick to latch on to the Bangladesh and Peruvian sterilization

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scandals, for example. More recently, anti-abortion groups have been the most vocal source of public outrage regarding reports that the authoritarian Rwandan government intends to sterilize 700,000 men in the next three years in order to reduce population growth.¹³ USAID will be playing with fire if it seeks to circumvent the Tiahrt amendment: giving further ammunition to the anti-abortion movement could set funding and support for international reproductive health back severely.

The days ahead are critical. The reproductive health community must put pressure on USAID and other international agencies not to embrace incentives. It is also important to monitor and resist the activities of private organizations such as Project Prevention. Supported by right-wing, eugenicist interests, Project Prevention pays poor people with drug addiction problems in the U.S. and U.K. to be sterilized or use long-term contraception. It has recently expanded into Kenya where it is paying HIV-positive women a \$40 incentive to get an IUD

inserted, despite evidence that this may be detrimental to their health compared with other contraceptive measures. The rapid mobilization of HIV/AIDS and reproductive rights activists against Project Prevention serves as a positive example of what can be done.¹⁴ The time to act against the reinstatement of population control incentives is now.

About the Author

Betsy Hartmann is the director of the Population and Development Program and Professor of Development Studies at Hampshire College. A longstanding activist in the international women's health movement, she is the author of *Reproductive Rights and Wrongs: The Global Politics of Population Control* (South End Press, 1995) and other non-fiction and fiction books. Read more at <http://www.BetsyHartmann.com>

Notes

1. USAID, "Strengthening Voluntary Family Planning Services with Performance-Based Incentives: Potentials and Pitfalls," *Repositioning in Action*, E-Bulletin, January 2011.
2. See Betsy Hartmann, *Reproductive Rights and Wrongs: The Global Politics of Population Control* (Boston: South End Press, 1995) for an analysis of the Bangladesh sterilization program and other incentive schemes. Also see Matthew Connelly, *Fatal Misconception: The Struggle to Control World Population* (Cambridge: Harvard University Press, 2008) for more on the history of population control.
3. Hartmann, *ibid.*
4. See Betsy Hartmann, "The Changing Faces of Population Control," in Jael Silliman and Anannya Bhattacharjee, eds., *Policing the National Body: Race, Gender and Criminalization* (Boston: South End Press, 2002).
5. USAID, "Coverage with Quality," *Limited Scope Grant Agreement 527-0375*, signed in Lima, Peru, September 26, 1996, p. 4.
6. See Latin American and Caribbean Committee for the Defense of Women's Rights (CLADEM), Center for Reproductive Law and Policy (CRLP), and Estudio para la Defensa de los Derechos de la Mujer, *Women's Sexual and Reproductive Rights in Peru: A Shadow Report* (New York: CRLP, 1998) and the recent documentary on Peru by Mathilde Damoiseil, *A Woman's Womb*, now available to watch for free on <http://www.cultureunplugged.com/play/4623/A-Woman-s-Womb>
7. USAID, "Guidance for Implementing the "Tiahrt" Requirements for Voluntary Family Planning Projects," April 1999, http://www.usaid.gov/our_work/global_health/pop/tiahrtqa.pdf
8. The different motives for USAID family planning funding are evident in the agency's descriptions of its priorities. For example, it allocates resources on the basis of "a strategic budgeting model that includes factors of unmet need, high-risk births, contraceptive use, and population pressures on land and water resources." http://www.usaid.gov/our_work/global_health/pop/countries/index.html
9. USAID, "Strengthening Voluntary Family Planning Services with Performance-Based Incentives: Potentials and Pitfalls," *Repositioning in Action*, E-Bulletin, January 2011.
10. USAID, *Performance-Based Incentives: Ensuring Voluntarism in Family Planning Initiatives*, September 2010, <http://www.healthsystems2020.org/content/resource/detail/2686/>
11. In regard to Bangladesh, the report claims that "there is little evidence supporting the concern that such compensation schemes have promoted reliance on sterilization," and cites a 1992 study that shows a steady decline in sterilization rates despite the persistence of incentives. What it fails to note is that as the result of the international campaign against sterilization abuse in Bangladesh and pressure from more progressive international donors, the government finally began to offer poor women more access to temporary contraceptive methods which helps explain the decline in sterilization.
12. Lydia Guterman, "Women in Namibia Fight Back against Forced Sterilization," November 22, 2010, <http://blog.soros.org/2010/11/women-in-namibia-fight-back-against-forced-sterilization/>
13. Edwin Musoni, "700,000 men expected to undergo vasectomy," *The New Times*, Feb. 2, 2011, <http://www.newtimes.co.rw/print.php?issue=14524&print&article=3795>
14. The anti-abortion Population Research Institute has been one of the first to respond to the news, <http://www.pop.org/content/rwanda-sterilize-700000-men-pri-pledges-work-tirelessly-against-it>