

A New Look at the Asian Fertility Transition

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The significance of the Asian fertility transition can hardly be overestimated. The relatively sanguine view of population growth expressed at the 1994 International Conference for Population and Development (ICPD) in Cairo was possible only because of the demographic events in Asia over the last 30 years. In 1965 Asian women were still bearing about six children. Even at current rates, today's young women will give birth to half as many. This measure, namely the average number of live births over a reproductive lifetime, is called the total fertility rate. It has to be above 2—considerably above if mortality is still high—to achieve long-term population replacement. By 1995 East Asia, taken as a whole, exhibited a total fertility rate of 1.9. Elsewhere, Singapore was below long-term replacement, Thailand had just achieved it, and Sri Lanka was only a little above.

The role of Asia in the global fertility transition is shown by estimates I made a few years ago for a World Bank Planning Meeting covering the first quarter of a century of the Asian transition [Caldwell (1993), p. 300]. Between 1965 and 1988 the world's annual birth rate fell by 22 percent. In 1988 there would have been 40 million more births if there had been no decline from 1965 fertility levels. Of that total decline in the world's births, almost 80 percent had been contributed by Asia, compared with only 10 percent by Latin America, nothing by Africa, and, unexpectedly, 10 percent by the high-income countries of the West. Indeed, 60 percent of the decline was produced by two countries, China and India, even though they constitute only 38 percent of the world's population. They accounted, between them, for over three-quarters of Asia's fall in births.

From the end of the Second World War there was a growing movement which held that the quickening rate of population growth, resulting from unexpectedly steep mortality declines had to be constrained by a fall in fertility. If necessary, that fall had to be planned and assisted by governments. There were two problems.

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The first was that no fertility decline—bar a modest one in Japan—had ever been recorded outside the West, and there was a growing body of literature which claimed that the Western experience was unique and arose from a type of family which was found nowhere else. The second problem was that no government had ever set up programmes to intervene in the field of reproduction and many Western observers believed that none were ever likely to do so.

The second problem began to be overcome from 1951 when Prime Minister Nehru announced that India would establish a national family planning programme from the following year. Just how unforeseen this was is shown by the paper published soon afterwards by Frank Notestein in *Population Index* [Notestein (1951)]. Notestein was the leader of the group that believed that fertility decline had to be organised, but, with an experience largely confined to Western governments, he had not anticipated that such an action could be taken by the government of a large poor country where nearly all the population appeared to show by their behaviour that they believed in unrestricted fertility.

Although Nehru made his announcement after having been startled by the unexpectedly large population recorded by the 1951 census, this decision rested on a longer history in undivided British colonial India. Both foreign and indigenous civil servants and other sections of the elite took it for granted that Malthus was at least partly right about South Asia and that there was a race between population and resources, especially food [Caldwell and Caldwell (1986)]. Nehru might not have come to his decision but for the memory of the horrific Bengal famine of 1943-44, which had been the subject of a recent report [Indian Famine Inquiry Commission (1945)]. The likely need for state intervention in the greater India area had been stated in the influential Bhole Report on health published in 1947 [Indian Government, Health Survey and Development Committee (1946)], a theme which was then taken up by the Congress Party's planning committee's sub-committee [Shah (1947)]. All took the non-Western view that there was no fundamental problem in governments intervening to influence their citizens' fertility levels and reproductive habits, except that they might not succeed in reducing fertility. The other part of the old Indian territory, Pakistan, followed only four years later in announcing that it would also employ state intervention to attempt to reduce the rate of population growth.

The other problem appeared more formidable, and perhaps insurmountable. By 1965 there were a range of national family planning programmes in the world, as well as private programmes with government backing [Berelson *et al.* (1966)], and yet Third World fertility remained almost uniformly high, while mortality declined and population growth rates increased. The only exceptions were a few small populations whose cultures had been profoundly changed by long or intensive colonisation. Most were found in the West Indies. In Asia, fertility had fallen modestly in Sri Lanka but this was almost entirely due to the postponement of female marriage, and fertility

decline had begun in the polyglot city populations of Singapore and Hong Kong. Elsewhere, it did indeed look as if the Asian Family was different and gave sufficient support to those of its members who were newly married or had dependent children to counter any other influences towards fertility control.

Then, in the second half of the 1960s, fertility began to fall widely throughout the Third World, in most of Latin America and in significant parts of Asia. By this time it was clear that marital fertility was also declining in Sri Lanka, and elsewhere that the same thing was happening not only in Singapore and Hong Kong but also in South Korea, Taiwan, the Philippines, Malaysia and Thailand. Fertility decline also began in two of what are now new Central Asian countries, Uzbekistan and Turkmenistan. It appears to have begun even earlier in Krygyzstan and Kazakstan, but this may have been largely confined to their considerable European populations. The social research problem now became that of explaining why societies not characterised by nuclear families, and often strongly patrilineal and patriarchal, could experience fertility transition.

Since then, fertility transition in ESCAP Asia has become general. The only countries where the total fertility rate is still over five and where there is no pronounced downward trend in fertility are Afghanistan, Laos, Cambodia, Nepal and Pakistan. In the Middle East, this situation is still found in about half the countries, namely Palestine, Yemen, Oman, Iraq, Syria, Jordan and Saudi Arabia. Except for Libya, this situation is no longer true in the other large Arab area, the Maghreb, where total fertility rates range from 3.4 to 4.4.

What happened? In terms of the economic and social thresholds exhibited in the West at the onset of fertility decline, Latin America's fertility transition was to be expected. It had become richer, more industrialised and more urbanised. But, except in Japan, Singapore, Hong Kong and Brunei, this was not the case in Asia. Real per capita income was much lower than it had been in the West, and so was the proportion of non-agricultural population and the level of urbanisation. Only two indices compared with the West at the onset of fertility transition: child survival and, more generally, mortality levels in East and Southeast Asia, and schooling levels in those two regions. It may, of course, be that child survival and the effect of education, in increasing both the costs of children and the aspirations of parents, are the two key elements in fertility transition. There is a growing body of research that points this way.

But Asia was unusual, too, when its transition was compared with populations elsewhere that had retained high fertility. A comparison of a range of sub-Saharan African countries and Asian countries in the 1960s and 1970s showed that the former would be at least as likely to exhibit early fertility decline if that decline were to be solely determined by economic and health levels [Caldwell and Caldwell (1988)]. In most of these African countries fertility remained high, at least until very recently. Asia's fertility transition remains unique.

The unique element in the surprisingly early Asian fertility decline is undoubtedly the Asian-style national family planning programme. These programmes were invented in Asia, and ESCAP Asia¹ is still very largely their preserve. Where they have existed at all elsewhere, they have only been pallid and much less effective instruments as in Latin America, sub-Saharan Africa and Southwest Asia. The nearest parallel to the Asian experience is in North Africa.

Elsewhere, I have attempted to analyse the success of the Asian programmes in a great arc of countries stretching from India through Southeast Asia and then northward to China and South Korea. The key to their success appeared to be their leadership by elites convinced of the need to set up family planning programmes, and providing leadership in moral terms and not as if they were merely providing a new range of optional services. These elites picked up the message from the West but it resonated with older feelings about large population numbers and limited resources, and some probably saw the growth of large poverty-stricken populations as a threat. The most important aspect of this movement was an old tradition of the nation state and an old tradition of elites providing leadership not merely in political but also in moral terms. The basis for this is obvious in Confucian and Hindu populations and to a lesser degree in Buddhist ones. But these attitudes were also approximated by both independence movements and army regimes. In Indonesian successive colonial and independence regimes have fashioned a relationship between the central government and village authorities which achieves the same end.

This moral leadership succeeded only where there was no strong competition for moral leadership, especially one that had views on fertility control. In Europe and South America the Christian church, especially its Catholic variant, had largely prevented governments from entering this field except to oppose fertility control. In sub-Saharan Africa traditional religion was not organised, but the fact that its central tenet was pronatalism made elites and governments wary of supporting family planning programmes too strongly. In Asia, in contrast, historically not only fertility control but infanticide had been acceptable in Japan, China and significant parts of India. Islam had no specific tenets opposing contraception, but it could be argued that it was opposed to undue pessimism about the future.

In these circumstances, there was little debate among the elites about erecting national family planning programmes. There was merely a need to convince the mass of the people, and this they were willing to do. Indeed, having a moral target meant that a degree of compulsion was not ruled out. That compulsion came in China from the

¹i.e., the Asian Countries belonging to the United Nations Economic and Social Commission for Asia and the Pacific. This region excludes the Middle East and Siberian Russia, but includes all Asian countries from Iran eastward (including the new Central Asian countries previously part of the USSR). The full ESCAP region also covers Australia, New Zealand and the Pacific Islands, but this area is excluded from the region described here as ESCAP Asia.

1970s; in India during the 1975–77 Emergency and to some degree at earlier times; and, arguably, to some extent in Indonesia. These programmes proved beyond doubt that coercion can reduce fertility almost indefinitely and that it is not necessary to wait for sufficient socio-economic change.

Where there was moral opposition, the situation was more complex. The attitude of the Catholic church in the Philippines stalled the success of the programme there. A changed moral and political philosophy in Malaysia brought the Malay fertility decline to a halt. When we were carrying out research in rural South India, village Muslim leaders argued in opposition to the family planning programme that Hindus had always worshipped governments while Muslims had a holy book for guidance [Caldwell *et al.* (1988)]. Muslim acceptance of the programme was weaker and their fertility was higher, but it should be noted that this may have been more the reaction of a minority population than a basically religious position. Indeed, the village Muslim religious leadership found it difficult to define exactly what the religious case against family planning was, and many of their followers did accept voluntary sterilisation.

We and colleagues have studied two Asian experiences of very contrasting types.

The first was in Sri Lanka which is the closest Third World Asian approach to the Western experience. Sri Lanka is a poor country by world and South Asian standards. It has one-fortieth of the per capita income of the United States, but a life expectancy only three years shorter and a fertility level which characterised America until the end of the 1960s. The explanation is to be found in its high educational levels, particularly important in the case of women, and in low child mortality levels, a product both of maternal education and an easily accessible health system. The underlying reason for this situation is an ancient fairly high status of women, the Buddhist belief in enlightenment, the nineteenth century Buddhist Reform Movement which translated this into a need for education, and an egalitarian radical tradition which demanded equal benefits for rural and poor urban populations. The educational situation of women in Sri Lanka's 1921 Census was similar to that of Pakistani women in Pakistan's 1981 Census. As early as the 1930s, there was some control of fertility in Sri Lanka by the so-called natural methods (abstinence, withdrawal and rhythm), and Sri Lankans used these methods so easily that until recently they have explained nearly half of all fertility control.

More recently, we have been part of a group examining one of the world's least likely fertility transitions, that of Bangladesh. Bangladesh has only 70 percent of the per capita income of India and little more than half that of Pakistan. Its level of urbanisation is around half the Pakistan level. Furthermore, its existence as a nation state dates back not millennia but only 26 years, although Bengali cultural nationalism provides something of a substitute. Elite leadership has been confused by a rapid rotation of governments, and the population is very largely Muslim. Yet, the most recent

Demographic and Health Survey shows a total fertility rate of 3.6, close to that of India and only just above the Southeast Asian average. Fertility has declined by 50 percent over the last two decades, and this has been achieved by contraception, with nearly half of all married couples practising fertility control. This achievement is widely regarded as the mere application of an efficient family planning programme in forbidding social and economic circumstances. [Carty *et al.* (1994).]

Our study suggested that the situation has been more complex than this and that it is not a simple situation of the government of the day deciding to adopt an efficient family planning programme. Bangladesh's experience has quite deep historical roots. These go back to undivided India, with the ICS officers apprehensive of fast population growth and famine, and to undivided Pakistan with the first family planning programme starting in the second half of the 1950s [Adil (1966)]. This programme is now regarded as having largely been a failure, yet the officers who organised Ayub Khan's programme in the 1960s report that they built on trained groups surviving from the earlier programme. More importantly, civil servants from the 1950s assumed family planning to be the policy of the land and were trained to think so in the Civil Service College in Lahore; East Pakistani officers had this reinforced by a further period at the Comilla College for Rural Development. The lessons were particularly pertinent in East Pakistan because of the obvious density of the population and they were reinforced by the crises brought about by war and floods. In the 1960s the Ayub Khan programme appears to have been more effective in East than West Pakistan. Certainly, it created a cadre of civil servants who believed in the policy and carried it through into the period of the new Bangladesh state.

The first period of this new state was one of disorganisation and euphoria, where such cautious programmes as family planning were not a high priority and where politics was all. This period passed for several reasons. The new civil service was in fact the old civil service and provided the strongest element of stability. The new state was soon beset by problems and its obviously dense population was easily seen as an aggravating factor. The poverty of the world's largest new country both attracted unusual quantities of international aid and made governments reluctant to reject the aid and the advice that went with it.

There has been a consensus within the civil service, the elite, the army and the government, at least since about 1973, that family planning is a national priority, an attitude that it is above politics. Nearly all educated Bangladeshis now take that view. There has been no religious opposition at the national level. This is partly explained by the fact that the religious leadership took the wrong side in the War of Independence, backing religious cohesion against cultural cohesion. Every survey shows the chief rural resistance to the acceptance of contraception is religious but deeper questioning of what this means suggests that the opposing force is less theological than conservative. Older villagers and their imams are really opposing an attack by modernism on traditional

rural society, and especially on the rights of men over women, and the old over the young. Superficially, politics seems to have been very divisive in Bangladesh, but governments and oppositions are separated by no vast ideological gulfs and there is increasing ethnic and cultural homogeneity in the country. The civil service is surprisingly little affected by political changes and there is a consistency in their development priorities and policies.

Economic change has been limited but social change less so. The War of Independence and subsequent politicisation brought national politics into the village and did much to break down rural isolation. There has been a transport revolution with large trucks on the main roads and bicycle rickshaws using the new paths to bring wheeled transport even into the remotest villages. Bangladesh doubled the proportion of its girls in school between 1980 and 1993 and is approaching universal primary schooling for both boys and girls. Girls' schooling at both the primary and secondary level is now twice the level found in Pakistan [World Bank (1996)]. The new textile industries in Dhaka have a very largely female work force.

Finally, the family planning programme is well developed, does not charge, and provides a wide range of contraception. It is almost certain that, if Bangladesh had followed the Indian example and provided little but sterilisation, its fertility would not be nearly as low as India's. In fact, only a quarter of Bangladesh's family planners are protected by sterilisation compared with almost three-quarters in India. The Matlab experimental area in Bangladesh has shown that new additions to those practising contraception are achieved mostly by making new methods available. [Caldwell and Caldwell (1992)] There is not as much substitution as might have been anticipated. The very high level of family planning now achieved in the Matlab intervention area has been attained by offering injectables, now used by over half the contraceptors there, and by growing numbers in the rest of the country.

The great anomaly in ESCAP Asia's family planning picture is, of course, Pakistan, with a total fertility rate which may still be close to six, and a contraceptive prevalence rate among married couples of 12 percent by all methods and nine percent by modern methods. Pakistan has a much higher per capita income than the few other ESCAP countries with nearly uncontrolled fertility: Afghanistan, Nepal, Bhutan, Laos and Cambodia.

I have come here to learn the reasons for this situation rather than to ascribe them. I seek to have my wilder surmises corrected.

It does appear to the outsider that there have been other political priorities. There are real ethnic tensions of a kind that do not exist in Bangladesh. Changes of Government really do impinge on civil servants and their priorities. There appears to be an unresolved struggle between the more theological and the more secular state of a kind that does not exist in Bangladesh in spite of the fact that one political party might employ more religious symbolism than the other. Foreign affairs and defence are clearly

of greater concern to Pakistan, though they do not seem to give rise to political schisms.

In social and economic terms, the obvious index is the low level of female education in Pakistan. This may be a sign of strong male dominance and patriarchy but it may also be a factor reinforcing that situation.

I am less certain about religious issues. Pakistan is close to the Middle East and may share some of the feeling that family size is not a matter for people on this earth to determine. Nevertheless, it is salutary to realise that not only North Africa but considerable parts of the Middle East have contraceptive levels far in excess of Pakistan's. Syria's level is almost twice as high, Jordan's three times as high and Bahrain's more than four times, while Iran, with a prevalence rate of 65 percent, competes with Sri Lanka and Thailand.

The fertility revolution in Asia is truly astonishing. In the ESCAP region around 45 percent of the population is under or around long-term replacement. The problems of supporting the aged and other issues once experienced only by industrialised economies are now facing much of Asia. At the same time, most of the region is finding it easier to provide sustained education for the relatively small proportion of children they now have. In contrast, Pakistan is the largest Muslim country, and indeed the largest country of any faith in the world, without controlled fertility. There must be sufficient reasons, and I am eager to learn them.

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Comments

It is an outstanding pleasure to welcome Professor Caldwell to the PSDE Conference: we have been trying to invite him for the last several years; I am so glad he could make it given his very busy schedule as the IUSSP President. It is also an honour to be a discussant on his paper, A New Look at the Fertility Transition in Asia. No one has written more extensively and prolifically on demographic transitions in the Third World, especially the Asian region, as him and this paper is a result of several years of experience, research and travel. I feel I can hardly match the profundity of his lecture and I warn you that my comments on his paper will seem very pedestrian in contrast.

Professor Caldwell has highlighted the immense role that the fertility transition in Asia has played in bringing about a stationary population in the world, of preventing the largest proportion (80 percent) of the world's births between 1965 and 1988. This is of course because most of the world's most populous nations are Asian: China, India, Indonesia, Pakistan and Bangladesh. It is worth remembering that despite falls in fertility in most of Asia, due to population momentum and the large sizes of the population, Asia will continue to be the region which will contribute most to the world's population even up to the middle of the next Century. The second point which is worth highlighting and very central to the theme of the lecture is that the fertility transition in Asia has been far from uniform, phased over 20 years and is not over in many parts of Asia.

The fertility transition in East Asia began as far back as the 1960s, followed by most of East Asia in the 1970s and South Asian countries beginning their fertility decline in the eighties and most of West Asia will probably experience their transition in the 1990s. The onset of fertility transition and its speed has been different across sub-regions of Asia, reflecting their distinctly different economic growth, linguistic and ethnic compositions, and cultures. *So right from the beginning it should be said that it is extremely difficult to generalise at all about the Asian Fertility transition.* In a IUSSP Seminar in 1989, many scholars met to discuss the transition in Asia, and the vastly different experience of each sub-region, leave alone regions within large countries like China and India, were a challenge to explain. *There were very few commonalities about the fertility transition in most Asian Countries. I think this is also the conclusion of Professor Caldwell's lecture.*

Professor Caldwell has tried to bring out some of the specificities of the Asian fertility transition, particularly those that might differentiate it from the European transition which preceded several decades earlier. I would like to add to his list, perhaps it would be correct to say that I would be just amplifying some of the points made fleetingly in his paper:

1. Family systems are much more integral part of Asian way of life than most of Europe. Relations between the generations (particularly parents and sons) and gender relations which contribute to very strong preference which continues to exist even in parts of Asia (Korea, Taiwan and China) where fertility has declined cannot be emphasised enough.
2. Women's status is consequently lower in Asia than in Europe.
3. Mortality levels in Asia are much lower than they were in Europe at the onset of their transition.....also we are talking in Asia about much higher fertility levels and large population sizes, much exceeding those found in Europe.
4. The most glaring difference (in my opinion) is that while during the European transition there were no means to control fertility except traditional ones like withdrawal, rhythm and abortion, most of Asia is inundated with modern contraceptive methods. The development of modern contraceptives like the oral pill, the IUD and the injectable *preceded* the Asian fertility transition, and all countries in varying degrees did have theoretical access to these contraceptives.
5. Furthermore, most Asian countries *unlike European ones*, were actively involved at the level of the State in promoting contraception and in reducing fertility. The level of state authority is also greater than in Europe except in Eastern Europe. The main thrust of my comments are based on this difference: how important is this difference when we reflect upon the Fertility transition in Asia and compare it to the widely studied European transition.

The Role of State Policies

Professor Caldwell explicitly ascribes huge importance to the role of policies in bringing about changes in fertility behaviour. Most of the discussion in his paper surrounds differences in policies pursued by various Governments in Asia and their relative successes and failures. *Personally I would like to pose the question of whether policies in Asia have been all that successful and congruously whether change (excepting in the case of China) would not have occurred all the same even if the "growing movement which wanted to hasten the fertility transition" had not been in motion!*

Ultimately fertility fell in Asia, perhaps when per capita incomes were overall lower than they were in Europe at the onset of transition, and perhaps with lower levels of urbanisation and industrialisation. But the general pattern of change was not *all that different*. More technologically advanced countries, those with more modern labour forces and with more women in the labour force, those with higher levels of education and with higher economic growth were the ones to lead the transition. How much of a role can we attribute to population policy *alone in the absence of some basic social and economic development?*

Perhaps the role of policy can at most be that of a catalyst, of advancing transitions by a few years may be a decade at most. But there are equivalent stories of how policy is not uniformly successful (parts of Indonesia, even rural China) and Pakistan and I would go as far as to include India. As pointed out by Caldwell, Nehru adopted an anti-nationalist policy as far back as 1951, and despite this policy, despite the coercive measures of the Emergency and the sterilisation campaign by Sanjay Gandhi, *most of India (with the exception of Kerala and Tamil Nadu) did not experience a decline in fertility until about a decade ago....more than thirty years after the official policy was adopted.* The wide differences in fertility which exist across the Indian states with some like Kerala and Tamil Nadu having achieved almost replacement fertility and others like Uttar Pradesh and Bihar which only recently have shown signs of a fertility decline *demonstrate my point that policy at that level may have had little to do with changes in behaviour.*

I am not arguing that policy has no effect at all. Instead I would like to argue that it is the nature of the State, its fortitude in implementing policies which ultimately matters. I would like to raise the example of Iran. Professor Caldwell points out in the paper the role of “Islamic fundamentalism” in reversing the urban fertility transition. But in his “new look” at the Asian Fertility transition he may find stronger lessons to be drawn from what is happening more currently in the Islamic State of Iran. Iran only adopted a firm policy of bringing down mortality and fertility only as late as 1992, already it has achieved huge declines in infant-child mortality and in fertility. I do not believe that there has been a change in the Islamic mind set of the government of Iran but a clear vision that lower fertility is necessary for survival has been pursued systematically and consistently *at all levels by a strong state and achieving much greater success than the rather ‘unsuccessful’ experiment of one of Asia’s earliest programmes, India and as effective as the Draconian policies followed by China.* Indonesia, Korea, Singapore all share the common characteristics of a strong state, which is not just associated with more rapid fertility transitions but other development and social policies. Sri Lanka and Bangladesh are two countries singled out by Professor Caldwell in his paper in elaborating on the Asian fertility transition. I would like to take up these two cases and make some comments on the role of social, cultural and religious factors in fertility change.

The case of Sri Lanka is unique in its high levels of female education and broad based and more egalitarian social and economic systems. It is also an island and experienced fertility decline the earliest in South Asia. Bangladesh’s success in achieving fertility decline in a poor setting is the development planners ‘dream story’: with most of the achievement being attributed to by an efficient population policy. I would like to argue, perhaps much more strongly than Professor Caldwell, that indeed there were important social changes related closely to economic changes which may have preceded or at least “enabled” this unusual setting to achieve rapid

fertility change. Increasing landlessness leading to migration, women entering the informal labour force, the burgeoning of the garment industry, female headed households, to name a few. Poverty induced or whatever, Bangladeshi society was under extreme economic pressures, to which it was reacting, and the policy and strong family planning programme came alongside.

I do not believe that Bangladesh's family planning programme alone can take the cup away on being the winner of the fertility transition. Though designed better than the Indian programme because of its multiple methods (versus the rather excessive reliance on sterilisation in India) it has in its favour a much more homogenous population than India and Pakistan, much more closely spaced settlements etc.

I would now like to turn to Pakistan. The biggest challenge left in Asia according to Professor Caldwell is Pakistan, "*the largest Muslim country* and indeed the largest country of any faith in the world without controlled fertility. First of all I would like to have reassured to Professor Caldwell that fertility has most certainly begun to decline in Pakistan. The urban fertility transition started at least a decade ago and the transition in rural areas, has begun more recently in the last couple of years. Professor Caldwell's figures need updating: The official figure for the total fertility rate adopted for the beginning of the Ninth Plan early next year is 5.4, though most demographers including Dr Hashmi would argue that this total fertility rate has already been achieved and the TFR is much lower. The contraceptive prevalence survey of 1994-95 found the contraceptive prevalence rate to be 18 percent nationally and about 11 in rural areas and 33 in urban areas. There is ample evidence collected by the National Institute of Population studies and the Population Council that there has been very rapid changes in contraceptive adoption in urban but also in rural areas, at least of Punjab and NWFP.

What is indeed quite interesting about the fertility transition in Pakistan is the predominance of traditional methods, particularly the use of withdrawal. This is reminiscent of the wide reliance on withdrawal as the main method used in the European fertility transition. But more importantly the fact that condoms and withdrawal account for more than 45 percent of contraceptive use in Pakistan, suggests that most of the fertility transition is occurring outside of the Population programme, outside of the purview of population policy. Increased aspirations for schooling, spiralling inflation, rapid urbanisation and migration are the major explanations for the reduced demand for children. But the means being adopted to control fertility present a telling story of a demand driven transition. Despite an official programme since 1965, fertility changes could not be "engineered" easily in Pakistan. I do not think as Caldwell suggests that religious opposition has played much of a role in Pakistan. Religious opposition, if any, has practically dissipated

with the emergence of more immediate and practical consideration of providing for more children. Again Pakistan is following its own unique path to achieving fertility transition, one quite different from to other South Asian neighbours.

To conclude I would again like to reiterate that given the vast variations across Asian societies in social conditions, in levels of economic development, a single model or explanation for fertility decline is not possible. What Asia has proven, much more so than the case of Europe, that there seem to be more exceptions than conformity with any single theory of demographic transition. Almost each individual country has its own unique story about the how, when and wherefore of demographic transition and Professor Caldwell's new look at reinforces that view.

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