Sociocultural factors and fertility

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INTRODUCTION

Everything affecting the demographic character of a population—its size, rate of increase, geographic distribution, age and sex structure, life expectancy and family composition—has to reckon with one of three demographic variables, namely fertility, mortality and migration. Of these, fertility is the major dynamic element. "To understand fertility is, therefore, to understand not only a major portion of all demographic behaviour, but a fundamental element in social structure and the human condition, generally" (Day 1983: 2).

With fertility levels below replacement level in several countries, and high fertility levels resulting in high population growth, high dependency rates and a compounding of impediments to development in many of the poorer developing areas of the world, understanding fertility behaviour—that is monitoring trends and identifying "factors" and "conditions" that influence fertility behaviour—has become a major concern in many countries and, indeed, the world.

Changes observed in fertility patterns over time or fertility differences between societies at any point in time can only be a function of variations associated with three variables: sexual intercourse, conception and gestation (Davis & Blake 1968: 197). This does not mean that physiological and biological factors are paramount in explaining fertility levels. Most of the variations and changes in fertility behaviour, whether occurring in or between societies, cannot be accounted for by biological or physiological factors. Fertility behaviour is eminently social behaviour (Kammeyer 1971: 94).

Sexual intercourse, conception and gestation should be seen as "intermediate" or "proximate" variables. Sociocultural factors, social structure and social organization act through these variables to influence fertility. Even if we know that contraceptive usage (an element of the conception variable) has been the primary mechanism of fertility control in the United States and other Western communities as well as among white South Africans; even if we know that abortion (a component of the gestation variable) was largely responsible for the rapid reduction of the Japanese birth rate after World War II and even if we know that delayed marriage and celibacy (a component of the sexual intercourse variable) have been important means of fertility control in Ireland and in some other Western communities, we still know very little about fertility behaviour. The questions why the contraception, why the abortion and why the delayed marriage and celibacy, still need answering (Goldshneider 1971: 138-139).

In spite of large amounts of money invested in research—over 330 000 women in more than 60 developed and developing countries in the reproductive age range were interviewed from 1974-1982 during the WFS (World Fertility Survey) alone—many questions in respect of the social factors or conditions that influence fertility still cannot be answered conclusively, or the data suggest that one set of factors may be important in one configuration of social conditions but not in others.

In this contribution no attempt will be made to list and discuss social or cultural factors or conditions that may influence fertility. Attention will rather be focused on three (somewhat disjointed) themes that may tentatively illustrate the relation between sociocultural factors and fertility. These themes are:

- The transition from high to low fertility—a theme that has dominated social demography during this century.
- Fertility trends in South Africa.
- Differential fertility, with special reference to South African data.

THE TRANSITION FROM HIGH TO LOW FERTILITY: THE INFLUENCE OF SOCIOCULTURAL FACTORS

Freedman (in Nam 1968: 216-225) explains fertility levels in premodern communities on the strength of social norms which were moulded by high child mortality and the dependence of the individual on family structures, and particularly on children, in areas such as production, consumption and care in times of sickness and old age. Goldscheider (1971: 135-181) also stresses the value of children in premodern communities in which kinship and family structures are the basic and comprehensive social units. In such communities children help family or kinship groups to attain socially appreciated aims.

Modernization has, directly or indirectly, placed the value of large numbers of children in doubt. Freedman (in Nam 1968: 222-225) and Goldscheider (1971: 160) lay particular emphasis on the changed role of the kinship group as a result of modernization. The latter points out that functional specialization and structural differentiation have disengaged the family from many economic and social institutions, thus narrowing its function. The shift of orientation from extended to nuclear units has had important repercussions for family size since, with the disruption of many ties between the individual and the kinship structures, parents have been compelled to assume responsibility for the care of their children themselves.

The shift from agricultural to industrialized structures, with the accompanying urbanization, has further weakened the influence of kinship structures and has created opportunities for social mobility.

Dumont and other Frenchmen developed the idea of
social capillary in the previous century and Banks and others contributed to the idea. They argue that people desirous of upward mobility will curtail their fertility because of the costs involved. These people need to conserve their resources for the upward climb and, perhaps, by means of conspicuous consumption, to demonstrate their newly acquired status (Petersen 1971: 501).

The economic value of a child has also declined. In a rural environment, typically, the son is able to assist his father at a youthful age and can render such services for two decades or longer. In the modernized urban environment the child, typically, is not a production unit. His potential, which is often developed at the cost of great sacrifice on the part of his parents, is utilized on behalf of his family of procreation and not for orientation. In short, an environment in which style lives and aspirations with regard to mobility were in conflict with high fertility and large families, came into being in urban areas (Goldscheider 1971: 150). Caldwell and Ruzicka's explanation of the transition from high to low fertility, lends support to this view: "They argue that institutional changes that reverse the traditional flow of wealth from the younger to the older generation increase couples' motivation to have fewer children" (Quoted by Cutright 1983: 101).

Freedman (in Nam 1968: 225) lays particular emphasis on the role of education in the process which leads to an orientation towards larger social units instead of the tradition-bound relationship structures.

A few cautionary comments are needed at this stage: Goldscheider (1971: 160-161) states: "It is clear on both theoretical and empirical grounds that fertility reduction does not result automatically and mechanically from the shift to industry from agriculture... The pressure toward a size reduction in the family can result directly through the breakdown of kinship domination, improvements in standards of living and rising aspirations for socioeconomic mobility. Some conditions—urbanization, development, labor force participation of women, stabilization and reduction in mortality levels, (and) education, among others—may bring about these institutional changes, thereby generating pressures indirectly toward family size control... If urbanization reflects the relocation of kin groupings and does not disengage effectively kin control and power, if industrial development does not result in rising aspirations for mobility, if labor-force participation of women does not provide alternative sources of prestige and status to women and does not result in releasing women from male or kinship domination, if educational advances are focussed on specialized socioeconomic groups and not dispersed more widely throughout all segments of the population, if mortality reduction is brought about through medical and technological diffusion without changes in living standards, then it is likely that these specific changes will not result in the necessary pressures engendering fertility reduction."

Nowadays the historical relationship between macro-development variables such as urbanization and industrialization and the fertility transition is often questioned. It has been shown, for instance, that while Britain was the first to industrialize, fertility reductions had occurred in several European countries before a similar trend was observed in Britain. Moreover, a decline in fertility in Britain only became evident several decades after the advent of the Industrial Revolution. France led the way to lower fertility in Europe in modern times and as early as 1801-1805 parts of France had crude birth rates of not much higher than 20 (Van de Walle in Tilley 1978: 263). Industrialization could have had little to do with this trend. Van de Walle and others rather link the emergence of the small family norm in France to changes in inheritance customs, changing employment opportunities, the diffusion of contraceptive practice and the decline of moral opposition to contraceptive practice (Tilley 1978: 343). It is also important to note that the greater part of the French fertility transition originated in rural rather than in urban areas.

In developing countries—with notable exceptions particularly in African and Moslem countries—fertility declines have been recorded during the last decade or two. These declines have not always been in response to factors such as industrialization. Freedman, among others, has noted that several low-income and predominantly rural populations, such as those of China, the Kerala district of India, areas of Indonesia and Sri Lanka and Thailand have experienced substantial declines. Freedman studied similarities in these countries. His findings suggest that "in countries at low levels of economic development, real improvements in health and education may provide a massive change from traditional parent-child roles to new roles that are compatible with smaller family size" (Cutright 1983: 102). It seems then that the relation between development and fertility decline is not at all clear. In a summary of the major findings and implications of the WFS, it is stated: "Fertility decline can and does occur in widely differing socioeconomic contexts. Its onset appears to be determined more by ill-understood cultural factors than by any objectively ascertainable development factors" (World Fertility Survey 1984: 40).

**FERTILITY TRENDS: RSA**

South Africa's population groups have displayed greatly varying fertility trends and patterns during this century ranging from what is typical of developing nations in Africa to what is typical of the highly developed nations of Europe and elsewhere.

**Indian South Africans**

Crude birth rates (CBRs) for Indian South Africans have been available since 1938 when the rate stood at 37. The CBRs for this group declined very slowly in the next few decades and still stood at above the 30 level in 1970. Subsequently the CBR declined to 24 in 1978. With CBRs well above the 40 mark in many developing nations even up to the present, earlier South African Indian CBRs seem moderate. However, since the CBR is calculated on the basis of total population and since males preponderated in the Indian population, earlier "moderate" CBRs concealed high fertility rates of Indian women. Had the male ratios been normal, the CBRs of the Indian population would probably have been above the 45 mark until 1951 (Lettev & Van Tonder 1975: 13-22). Recently Mostert et al. (In: Marius 1988: 80) stated that the total fertility rates (TFRs) of Asians fluctuated round the 7.0 mark during the thirties and early forties before declining to 2.6 in 1979.

The high historical fertility levels of Indian South Africans were supported by cultural norms. These norms still influence fertility levels in the countries of origin, namely India and Pakistan. Dubey (1967: 6) states: "For centuries Indians have been emphasizing and blessing norms of high fertility and large families as prime values." This orientation is strengthened by Hinduism: "There are strong pro-fertility elements in Hinduism... The malecentred view of life, combined
with the belief in reincarnation, makes sons important to pray for their ancestors and deliver them from hell, and tends to relegate woman chiefly to her child-bearing function” (Fagley in Stanford, 1972: 217). “An act of lesser importance than raising a son, but still of high religious merit, is the giving of a daughter in marriage” (Mandelbaum 1974: 22). The Koran is even more explicitly pronatalist than Hindu doctrines: “The Koran forbids celibacy and advocates large families, particularly of sons. The Koran permits contraception only where the birth of a child would clearly endanger the mother’s life . . .” (Kozlov in United Nations 1967).

Pronatalist influence has remained strong in India and Pakistan. In India a most vigorous family-planning campaign has been conducted since the fifties is only now showing limited success with the CBR down to 54 in 1984. In Pakistan fertility rates are still very high and the CBR was indicated at 43 in 1984 (Population Reference Bureau 1984).

Why did Indian fertility in South Africa decline—seemingly by itself—even before a vigorous family-planning programme was established in this country? The answer seems to lie in the fact that South African Indians were—to a much greater extent than the present-day populations of India and Pakistan—exposed to factors that tended to weaken pronatalist cultural forces, bring pressure to bear on institutions such as the extended family that may find high fertility functional and, generally, bring about a re-orientation of fertility ideals. The conditions in question include large-scale urbanization (in 1986 approximately 90% of Indian South Africans (Bureau for Information 1986: 32) were urban whereas respectively only 23% and 28% of India and Pakistan's population are indicated as urban (Population Reference Bureau, 1984)); the near eradication of illiteracy; women entering the labour market and freeing themselves of traditional roles; exposure to Western or modernizing influences through close contact with other cultures; gaining opportunities for social mobility; economic progress; and low infant mortality rates (20 for South African Asians in 1983 (Bureau for Information 1986: 29) as against approximately 125 for India and Pakistan (Population Reference Bureau 1984)) thereby lessening the need to compensate for likely deaths by means of “surplus-fertility.”

Coloureds

Official statistics reflect a sharp decline in fertility during the 1960s and 1970s. According to Mostert (In: Marais 1988: 80) the TFR stood at 6.7 in 1960; 5.6 in 1970; 3.2 in 1980 and 2.8 in 1985. It seems as if “determinist fertility” — supported by notions such as the benefits of “uitteel” (“breeding out”) — was supplanted by controlled fertility adjusted to a modern urban life style. Factors usually associated with the fertility transition —urbanization, industrialization and improved education—probably put the fertility transition in motion. This downward trend was facilitated by an energetic family-planning programme.

Unlike white or Indian fertility, much of coloured fertility is illegitimate. Illegitimacy is often associated with social disorganization or adverse social conditions such as poor housing and poverty.

Blacks

It is usually assumed that fertility was high in traditional society and that people desired large families. Large families benefited the father and the kinship group on political, social and economic grounds. According to Mönning a large number of descendants was even advantageous after death: “The more descendants a man leaves behind to worship him, the more important an ancestor spirit he becomes.” (Mönning 1967: 98).

However some factors—mores, customs and taboos—had an antinatalist effect.

Thus, at one time among the Zulu, premarital sex was strictly regulated and was limited to external intercourse that precluded the possibility of conception. In Chaka's time, men were allowed to marry only after proving themselves on the battlefield and girls of a particular age group were not allowed to marry until all the girls of an older group had been married (Kies, 1987: 16-19). Consequently men and women commenced reproducing at a relatively late age. After marriage, breast-feeding and sexual abstinence—which continued for possibly three years after each birth (Kies, 1987: 16-19)—slowed the family building process. Customs such as these were not confined to the Zulu.

“In all the Southern Bantu tribes the birth of a child out of wedlock is frowned upon as an offence, and sexual morality consists in avoiding this and in observing sexual taboos . . .” (Krige in Schapera 1950: 108-109).

As these customs, and the norms that underpin them, eroded, fertility probably increased. There was certainly an increase in illegitimacy and teenage pregnancies.

Development in the form of industrialization and urbanization have affected fertility. However, since the black population is still predominantly rural, large segments of the population have been isolated from those conditions which have so profoundly influenced Indian fertility in South Africa.

Large families have remained the norm in the poorer rural areas and children are still seen as economic assets. This view is not irrational since large families often seem to cope better in the struggle to survive (Poultney 1982). Sons working as migrant workers also provide much needed cash.

Mostert et al. (In: Marais 1988: 80) estimate the TFR of blacks at the middle of the 1960s at 6.8. Subsequently a very gradual decrease set in and in 1985 the rate stood at approximately 5.5. However the TFR in the black states was calculated at 6.3 as against 3.9 in the “white” areas. Thus, as more blacks are exposed to urban living, modernization, and development in the form of better education, medical and other facilities, more can be expected to want to limit family size with the result that the TFR should continue to decline.

Whites

Overall patterns of and trends in white fertility in South Africa resemble those of Western nations. White fertility is low at present and — as in many other Western and developed nations—oscillating just below replacement level. Historical trends also seem typical, with a sharp fertility decline in the first decades of this century, a marked drop during the depression years of the thirties, a slight post-depression recovery, a moderate baby boom after World War II and then sharp declines which occurred during the 1960s and 70s.

It seems fairly easy to explain most of the trends noted above. The decline in fertility noted at the beginning of the century was probably part of the general downswing in fertility that came to be known as the demographic transition. Factors often associated with the demographic transition such as macrodevelopment variables—urbanization and industrialization—probably contributed materially to this trend. Subsequently
Poor economic conditions caused the sharp drop in fertility during the thirties whereas increased fertility in the forties—the baby boom—was caused by more people marrying and to the fact that many people could only then start the family-building process—or could resume with family building—after the disruption of the war years.

It is more difficult to explain the more recent declines in fertility of the sixties and seventies among South African whites. With the secular fertility decline among whites during the previous century and first decades of the present century long past, with low mortality levels, considerable contraceptive technology already available for some time, a high degree of homogeneity in fertility behaviour, a high level of prosperity, literacy and urbanization, demographic transition theory has little to offer. If its explanatory power has been exhausted.

In some quarters the National Family-planning Programme which was introduced was blamed for the drop in white fertility—as if whites all along wanted smaller families than they actually had and now eagerly availed themselves of the new service to adjust actual fertility to desired fertility. However the causes went much deeper. Research suggests that the drop in fertility was accompanied by a sudden and radical change in orientation towards fertility. During 1966-1967 Mostert (1970) researched fertility and fertility norms in a sample of newly married Afrikaans-speaking white women in Pretoria. The mean number of children desired was 3.6 (Mostert 1970: 11). The same sample (with the exception of losses from various causes) were again interviewed in 1970 (after three years of marriage and before the fertility decline became noticeable). Little change had occurred in desired fertility and the mean number of children desired was 3.7 (Mostert 1974: 64). The third phase of the study, which was conducted in 1974-1975 (when the decline in the birth rate became marked) revealed a mean desired number of only 3.1. The ideal number of children was 4.5 in the first phase of the study, 3.8 in phase two and 3.2 in phase three. It is even more noticeable that only 2% of the women in 1966-67 considered a family of four children to be large whereas 12% felt that five children constituted a large family. By 1974-75 no fewer than 37% of the women viewed a family of four and 66% a family of five as large (Lotter 1981: 7). So it seems that married couples—within a relatively short period of time—changed their orientations in respect of ideal family size and fewer children became the norm.

There were also other factors. Since 1960 a slight downward trend in the percentage married in the younger age groups has become apparent while the incidence of single-parent families, divorce and couples living together has increased.

The trend described above has not occurred only in South Africa. The downturn in fertility begun in 1960 in the United States and 1964 in Europe. All developed Western nations have been affected. Tabah (1980: 361) comments as follows on this trend: "Many authors have looked to social forces for an explanation of the fertility decline. Almost all have arrived at the same conclusion, the Western world is experiencing a revolution in customs, which propels it toward new forms of social organization. The life style of the family participates in the uncertainty that surrounds the general upheaval of society. The rhythm and the conditions of life, notably urban, the mores, all have changed more profoundly in the last 30 years than in the course of the three centuries preceding the advent of the nuclear family.... The traditional style of marriage appears to be, if not outmoded, certainly on the decline... Childbirth will be avoided if it appears to pose material or psychological obstacles to the couple's relationship. And, as is obvious, this relationship has little need of many children in order to flourish".

**DIFFERENTIAL FERTILITY**

An interest in differences in the fertility behaviour of groups or categories of people in populations has for long been evident and can certainly be traced back to pre-Malthusian writings (Thomlinson 1963: 51). Locating groups or categories in society that have different fertility levels provide clues to possible determinants of fertility. Knowing for instance that urban living depresses fertility levels and rural living does not, would thus provide valuable direction in a search for factors influencing fertility behaviour. Analyses of differential fertility may therefore be a search for theoretical understanding and a test of the validity of emerging theory (Kammeyer 1971: 98). Group fertility differentials are also important since they hint at the future composition of populations.

As we have seen race or ethnic group differences in fertility occur in South Africa. In the past considerable language group differences were also noted between white Afrikaans and English speakers (Kommissie van Onderzoek inske die Gesinslewe 1958: 18) but by the mid-1970s differences seem to have contracted (Lotter 1976: 12-15). It seems that the declines of the 1960s and 1970s affected Afrikaner fertility more than that of English speakers and brought the fertility behaviour of the first group more in line with that of the latter group. One would, of course, not link fertility to language per se but rather look for social or cultural factors or conditions operating within a language group that may influence fertility.

Rural and urban residence is also often used in fertility analyses. It seems that rural fertility has generally exceeded urban fertility in European countries and in the Latin American area. In some Asian countries (Indonesia and Pakistan) and in Africa findings have not been clearcut and urban fertility sometimes exceeds rural fertility (United Nations 1982: 49).

According to Mostert et al. (In: Marais 1988: 81) black fertility in "black states" are now appreciably higher than in "white areas" (6.3 as against 3.9). Older surveys, however, indicated little difference between black rural and urban fertility (Lotter & Van Tonder 1976: 42) when age is held constant.

Lotter (1976: 19) found that white fertility on farms was higher than in towns and in towns higher than in cities. However, the variation largely disappeared when the influence of language group was eliminated and the analyses confined to particular age groups.

A great deal of attention has been given to differential fertility by religious groups. Older studies for instance indicated that the fertility of Roman Catholic families was higher than that of Protestant families. Recent studies in the USA and elsewhere suggest a narrowing of this gap. In South Africa few studies have focused on this issue. An early example (Kommissie van Onderzoek inske die Gesinslewe 1958: 64-66) has for instance shown that Afrikaans Protestants have larger families than English-speaking Protestants. The author—quite rightly—feels that sociocultural factors and not religion as such would explain the difference. Surveys conducted in the 1970s in Natal revealed that Hindu women reported somewhat smaller number of live children than Indian Muslims (Lotter & Van Tonder 1975: 24-25; Mostert & Malherbe 1974: 71).
Socioeconomic class—or its components as reflected in for instance indices of occupational or educational status—has often been used as an independent variable in analyses of fertility. It is also useful for explaining present and historical trends in differential fertility and is closely linked with theoretical formulations on the mechanisms of changes in fertility patterns.

Let us consider the historical development of differential fertility by social class in Western countries. Amos Hawley (as quoted by Thomlinson 1965: 175) stated that the classes in pre-industrial times had either identical fertility or, possibly, that a direct correlation between status and fertility occurred. During the industrializing nineteenth century, the birth rate of the high status groups declined, which produced an inverse pattern of fertility differentials. This traditional phase was then replaced in Western communities by a final phase in which a direct correlation between birth rate and socioeconomic status became evident. Of course, developments did not always follow the Hawley model. Sometimes the middle or upper-middle classes initiated the downward slide in fertility and a positive correlation between fertility and social class has been observed in some communities, if not in others. It has become evident that the fertility behaviour of the different classes in developed Western countries has become more homogeneous. During the first half of this century there was still a general tendency for the lower classes to have more children but many exceptions were noted. As early as 1918 a positive correlation between fertility and class was for instance noted in Stockholm. Often an inverse J-shaped pattern emerged with an inverse pattern between all classes except the highest. The higher fertility of the upper classes causes the upturn, thus resulting in the inverse J-shape. This pattern applied for instance to the US urban population in 1940. A U-shaped curve, with the lower and upper classes having the highest and the middle classes the lowest fertility, was observed in Oslo, Norway, in the 1930s. Since the upper classes in the industrial societies have increased their fertility after the Second World War and the fertility of the lower classes has fallen considerably since the early stages of industrialization (Hawthorn 1970: 84) U and inverse J-curves have prevented or postponed the convergence of fertility by class.

What caused differential fertility by social class in Western industrialized communities? Earlier Dumont and colleagues developed the idea of social capillary. This idea was later refined and enriched by Banks and others. They argue that people desirous of upward mobility will curtail fertility because of the costs involved. Such people need to conserve their resources for the upward climb and, perhaps by conspicuous consumption, need to demonstrate their newly acquired status position. Earlier studies gave considerable support to this hypothesis. It was indeed found that the upwardly mobile had fewer children than those just maintaining their position or of those that were downwardly mobile. Becker’s proposition that the number of children will increase as income increases may help to explain direct correlations between status and fertility, but as we know, this relationship is not generally found. The Becker analogy of having children and buying consumer durables has also been criticized (Kammeyer 1971: 111).

Up to now we have referred to status and fertility in industrialized communities. In developing countries—and especially those with declining fertility—it seems that, generally speaking, the upper classes have led the way to lower fertility levels. The picture, however, seems unclear in African countries where there seems to be little indication that fertility is on the decline.

Let us now consider differential fertility according to educational level. Although educational level is linked to status, it may be more relevant than class which, in many communities, is still largely ascribed and not achieved.

A report of the United Nations published in 1983 notes that the educational attainment of parents has consistently been shown to be an important factor in explaining variations in the level of fertility. The relationship usually noted in surveys covering all regions of the world has been a negative one in which subgroups with high educational attainment have lower fertility than groups with little education. However, within this overall tendency many variations and even contrary patterns have been recorded (UN 1983: 66). For instance, in developed countries the U-shaped relationship is now common and occurs in Finland, France, Italy and Holland. In countries such as Kenya and Indonesia slight increases in fertility are registered with higher education and consequently the more common opposite trend does not apply.

Differentials seem to be largest, on average, in Latin America and smallest among the countries of Africa. The UN report notes that the “effect of education on the number of children ever born appears to be sharpest in relatively developed countries; among the least advanced, it exerts less positive influence; sometimes . . . it even has a negative effect” (UN 1983: 75). It appears therefore that it is not so much education—but education to higher levels—that will bring about marked fertility declines. What is it about education that affects fertility? Freedman, among others, stresses the role of education in the process which leads to an orientation towards larger social units instead of the tradition-bound kinship structures in which large families are often the norm and experienced as “good”.

Both the “traditional” and the “modern” relationship between fertility and educational level have been shown to exist in South Africa. For instance Lüther and Van Tonder (1976: 42) found that black women with “higher education” (nine years of schooling or more) had fewer children than those with “low education” (no schooling or up to three years) in each age category and for both the rural and urban samples.

In 1958 (Kommissie van Ondersoek inkaap die Gesinselewefterwyse) an inverse relation between education and fertility was noted for white women with completed fertility. A HSRC study conducted in the 1960s among Afrikaans-speaking white urban women who had been married for approximately eight years showed an overall negative relationship but also suggested that a U-shaped relation between fertility and educational level was emerging (Engelbrecht 1968: 47). A few years later in 1975 another HSRC study clearly showed that women with completed fertility with a medium level of education had smaller families (mean = 2.6 children) than those of either low (mean = 3.1) or high (mean = 3.2) educational status (Lüther 1976: 29).

Women’s work has generally been found to be negatively associated with fertility in all regions and at all levels of development. The relationship is often not strong. In developing countries it is argued that work, in certain circumstances, competes with child-rearing activities for women’s time. The same argument is made for developed countries. But apparently it is not work as such, or any kind of work, that affects fertility. Work will have a greater impact on fertility when it takes the women away from her home (as against work
in and around the house) and when there are no older children or relatives to care for babies, which is often the case in developed communities.

CONCLUSION

Population—and therefore fertility—is a key issue in development and the enhancement of the quality of life. This is particularly true in Africa where high population growth often goes hand in hand with dwindling per capita food production and—at best—stagnating economies.

“...to succeed in the provision of social services to all regardless of any existing differences based on biological difference, social class and geographical outlook we need a viable economy and a healthy population. The correlation between economic growth and population growth is... vital and should be taken seriously in trying to find solutions for the economic crisis Africa is facing now in relation to the provision of social services to all” (Omari in Hepworth 1984: 74–75).

In order to control population growth, some countries had previously laid heavy emphasis on family planning programmes. Others were not greatly interested in family planning, arguing that development itself would bring about a fertility transition. However development often did not materialize.

Nowadays family planning is usually considered to be part and parcel of population development strategies. This approach seems to be the best approach to lower fertility: “Studies of less developed countries provide evidence that recent fertility declines are at least partially attributable to family planning program efforts as well as to improvements in education and health services in these countries” (Cutright 1983: 101).

It is important to note that “macro-development” in the form of industrialization and urbanization is no longer seen as a prerequisite for fertility declines in high fertility areas. Improvements in education, health and communications may also have this effect—even in predominantly rural areas.

REFERENCES


