UNITED
NATIONS

DP

Governing Council
of the
United Nations
Development Programme

Distr.
GENERAL

DP/1985/32

20 March 1985

ORIGINAL: ENGLISH

Thirty-second session
June 1985, New York
Item 6 of the provisional agenda
UNFPA

SUPPORT

UNITED NATIONS FUND FOR POPULATION ACTIVITIES

Report of the Executive Director on the use of incentives and disincentives in family planning programmes

Summary

This report of the Executive Director is prepared in response to decision 83/17, I, paragraph 12 of the Governing Council at its thirtieth session requesting a report on the use of incentives and disincentives in family planning programmes. This document represents an overview of the subject of incentives and disincentives based on an analysis of their use in a number of countries. After examining the types of incentives and disincentives utilized and their target groups, the experience with incentives and disincentives to date, their effects on the quality of services, and their relationship to free and informed choice, the report ends with a summary and conclusions section.

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INTRODUCTION

1. At its thirtieth session in June 1983 the Governing Council by decision 83/17, I, paragraph 12, requested UNFPA to provide to the Council at its thirty-second session in June 1985 a report on the use of incentives and disincentives in family planning programmes, describing the various types utilized, experiences in the use of such incentives and disincentives, and the effects of such systems on the quality of services offered and on the individual's free and informed choice.

2. Over the past two years, UNFPA has carried out a number of activities which have formed the basis for the substantive parts of this paper, the most significant of which was an ad hoc technical meeting held in New York from 24 to 26 September 1984, which brought together 15 international experts to review the use of incentives and disincentives in family planning programmes.

3. The purpose of this paper is to present an overview of the subject of incentives and disincentives based on an analysis of their use in a number of countries. The paper, after a brief introduction, examines the types of incentives utilized and their target groups; the experience with incentives and disincentives to date; their effects on the quality of services; and their relationship to free and informed choice. It ends with a summary and conclusions section.

I. THE CONTEXT OF INCENTIVES AND DISINCENTIVES IN FAMILY PLANNING

4. Concern about high fertility rates has led many countries to mobilize both internal and external resources to provide family planning services and information in order to assist all couples and individuals to decide freely and responsibly the number and spacing of their children. Many of these programmes have been successful, but some have not achieved their objectives as quickly as was originally anticipated. As a result, emphasis has been placed on the initiation of motivational methods such as incentives and disincentives in order to achieve national demographic objectives.

5. Family-building is strongly influenced by cultural, religious, and social values, and is closely related to the role, status, education and employment of women; levels of economic development and health, especially infant, child and maternal health; and the perception of present and future quality of life. Examination of family planning programmes has reaffirmed the need to pay more attention to psychosocial, economic and cultural aspects in order to encourage and motivate peoples' desire for specific fertility goals; as well as to operational and managerial issues in providing high-quality services.

6. There is growing recognition that government policies and programmes have an interacting effect on fertility behaviour. This has gradually led to a broader approach to population concerns, complementing the provision of information and services with other measures. Incentives and disincentives can be seen as one aspect of these wider efforts, oriented to the attainment

of specified fertility objectives, within the specific political, socio-economic, religious and cultural context of a given country. Family planning incentives and disincentives are designed specifically to alter fertility behaviour or achieve demographic goals. They should not be confused with traditional social welfare policies which are not designed principally to affect fertility, but to ease the financial burden of child-bearing and child-rearing.

7. Whether for reducing or increasing fertility, whether oriented to individuals, couples or communities, or whether administered by Governments or non-governmental organizations, incentives and disincentives are often perceived as sensitive and controversial means for influencing fertility behaviour in the direction of family size goals specified by a Government. Nevertheless, they have been recognized for some years now as having, at least potentially, an important role to play in family planning programmes. The 1974 World Population Plan of Action, in paragraph 34, stated that "Family size may also be affected by incentive and disincentive schemes. However, if such schemes are adopted or modified it is essential that they should not violate human rights". The 1984 International Conference on Population in Mexico again referred to the subject in recommendation 31, which stated that "Legislation and policies concerning the family and programmes of incentives and disincentives should be neither coercive nor discriminatory and should be consistent with internationally recognized human rights as well as with changing individual and cultural values".

8. In the population field, incentives and disincentives have not been limited simply to the area of family planning. For instance, incentives have been used to encourage participation in population redistribution programmes, and to encourage utilization of maternal and child health services. Incentives have also been paid on occasion to those taking part in information, education and communication programmes. This report, however, will focus mainly on the use of family planning service incentives and disincentives used for reducing fertility in developing countries, since these are currently the most common in use; since population programmes in developing countries are the chief concern of UNFPA; and since many of the issues raised appear to be raised most often in regard to such programmes.

II. TYPES OF INCENTIVES AND DISINCENTIVES, AND TARGET GROUPS

9. While there are many different types of incentives and disincentives, they are all characteristically either a reward or a penalty tied to some kind of fertility behaviour. Incentives can be in cash or in kind, and encompass such areas as gifts, clothing and food; maternity leave, benefits and allowances; low-interest loans and taxation levels; priority for housing, educational and health services; employment opportunities for women and future employment priority for children; land development schemes and eligibility for participation in income-generating activities; social security benefits and old age pensions; and special awards ranging from lottery tickets to certificates.

10. Incentives may be paid to (a) acceptors, that is, individuals, couples or communities who accept rewards for adhering to policy specified fertility behaviour; (b) motivators, that is, persons who on a voluntary or paid basis attempt to persuade others to accept a method of family planning; or (c) service providers, that is, persons providing designated services on a per case or other basis. Disincentives (d) are aimed almost exclusively at individuals or couples.

A. Acceptor incentives

11. For acceptors, both small and large payments have been utilized as incentives. The small payment approach is based on the assumption that the primary purpose of incentives is to attract potential acceptors by offering them compensation for lost wages, transportation and other costs involved in acceptance of a family planning method. The incentive is usually a small, one-time cash payment given the moment a specified family planning method is adopted. The specific sum paid varies within and between countries, often depending on availability of funds and changing circumstances over time.

12. The large incentive approach assumes that couples desire numerous children, especially sons, for social and economic reasons, and that only substantial economic incentives can change desired family size by affecting the costs and benefits of children to parents. This strategy differs from the small-payment approach in that the scale of the incentive must be perceived as being sufficiently large to compensate, at least partially, the "cost" to the family of having fewer children than tradition would otherwise dictate. A variation is payments to acceptors of a sizeable sum for sterilization after two children and proportionately lesser amounts after third or higher-order births. Additional longer-term rewards may include free medical care in the pre-school years, admission to better schools, and higher priority for the parents in qualifying for housing and other loans. The one-child family campaign is an example of the large scale, longer-term approach. In countries with declining populations or low fertility, large incentives may be used to encourage additional births through parity-related birth grants, family allowances, housing loans, maternity and paternity leave, or other inducements.

13. Longer-term, deferred rewards are designed to provide benefits for avoiding pregnancy, while leaving the choice of fertility regulation method to the couple. Examples are the no-births bonus schemes, education grants for having fewer children and increasingly higher payments into savings accounts, which mature at a future date, for attaining a stipulated number of pregnancy-free months in excess of a stipulated period since the last birth. Such incentives require considerable faith on the part of the acceptor in future political and economic stability.

14. Community incentives are based on the assumption that communities, usually villages, are capable of perceiving the need for fertility reduction and economic development, and can be motivated to participate in family

planning programmes linked to visible improvement in the quality of life. Typically, communities are rewarded for improving contraceptive prevalence rates above a base level or for reducing fertility rates in accordance with a pre-determined formula. Rewards are often in the form of village revolving funds, which may be tapped for loans to finance appropriate technology-oriented, income-generating activities, enhancing family and community life.

B. Motivator incentives

15. Motivator incentives are rewards normally paid to individuals who encourage clients to use family planning methods such as sterilization or IUD. However, in some countries, payments to motivators have been classified as reimbursement for travel expenses and not as incentives per se. In other countries they are perceived simply as remuneration for a job and thus not different from any other wage arrangement between an employer and an employee.

C. Service-provider incentives

16. Provider incentives are usually in the form of immediate cash payments on a per case basis. Occasionally, however, priority for further training or promotion within a national health service may be linked to the volume of family planning services delivered. Also, incentives are sometimes given to institutions, to defray hospital and clinic expenses, or to encourage follow-up care of clients. These payments are made to physicians, paramedicals and front-line workers for the provision of family planning services, most commonly sterilization, IUD insertion, and pill and condom distribution. In the case of sterilization, the payment is usually made to a physician, but where the service is provided by a team it may be split according to a predetermined formula.

17. The fundamental idea behind such incentives is simply to encourage health personnel to provide a service which traditionally has not been perceived as an integral component of health care. In many countries such payments are not seen as incentives per se, but simply as fees for services. While such payments probably do ensure the continuing provision of services, they have the disadvantage of requiring a high level of continuing expenditure. In addition, once instituted, it may be difficult to withdraw such payments without affecting the availability of family planning services. Provider incentives may also present a conflict of interest, in that the provider, who stands to gain by carrying out a procedure, may also be providing the client with information on which to base a decision. In such circumstances it should be ensured that the client is informed of all possible benefits and consequences.

D. Disincentives

18. Disincentives or "negative incentives" usually impose costs on large families by reducing or withholding benefits in such areas as, maternity leave and allowances, delivery costs, housing subsidies, assistance for education

and health services and family and tax allowances. Previously earned incentives for example, job promotion or social security increases may also be reduced. Disincentives can also be found in countries that wish to encourage fertility. Examples of these are special taxes which may be levied on single persons, or on couples who are childless after one or two years of marriage.

III. EXPERIENCE IN THE USE OF INCENTIVES AND DISINCENTIVES

19. Although incentive and disincentive programmes are becoming more common, they exist only in a limited number of countries at present. They tend to be found in those countries which have relatively sophisticated infrastructures in regard to family planning information and services; those which have a relatively long history of population policies and programmes; and those which perceive their population situation to be of such importance as to warrant measures beyond the mere provision of information and services. For these reasons, although examples of incentive and disincentive schemes can be found in all regions of the world, they tend to be more common in Asia and particularly so in regard to programmes aimed at reducing fertility. However, even in this region, countries without incentive or disincentive programmes still outnumber those with them.

20. Despite several decades of experience with diverse incentives and disincentives, implemented under varied administrative circumstances, the information available to assess such programmes is too limited to make an objective assessment of their impact. In some countries, the fertility effects of incentives cannot be easily separated from the influence of concurrent societal changes, evolving family planning programmes and shifts in levels of rewards over time. In others, collected data are either insufficient or not reliable enough for rigorous analysis. Nevertheless, several overall observations can be made.

21. Findings from European studies of policies designed to encourage child-bearing suggest that, in countries with very low levels of fertility, incentives result primarily in accelerating the birth of a second child to an earlier time in marriage. However, average family size tends to change very little with usually only a slight increase in the proportion of women giving birth to a third child. Quite often, the appeal of benefits erodes as aspirations for a better life overtake the perceived economic value of incentives. To remain attractive, incentives have to be continuously improved. The success of incentive programmes to increase fertility has been difficult to assess because the simultaneous operation of related programmes has made controlled studies hard to design.

22. Experience with incentives for reducing fertility suggests that relatively small, one-time payments to acceptors result in an initial rise in the level of acceptance. When, however, acceptance of a reversible method is prompted mainly by the desire for a financial reward, the effect of the higher level of acceptance may be offset by a higher level of subsequent discontinuation of the method. Incentives for sterilization, since they

require only a one-time payment and have no need of monitoring for continuation, are likely to be more effective than incentives for reversible methods.

23. While some studies suggest that a higher level of incentives leads to increased use of family planning methods, others note that couples are not solely motivated by incentives and that the success of incentives depend on their being part of a more comprehensive programme to influence desired family size. Such broader programmes often include components to improve the education and status of women, to provide opportunities for economic activity and to raise levels of health. Efforts to encourage child-bearing among certain economic subgroups of some populations are too recent to permit meaningful comments.

24. Deferred incentives are more difficult to implement, requiring continuous monitoring of method use or of women's pregnancy status. The no-baby bonus scheme may be feasible in highly structured work settings, but would involve major reporting problems in largely unstructured villages where registration of births and deaths is likely to be incomplete. While the one child family planning programme has registered initial success, this orientation has created its own problems that remain to be assessed.

25. There are some indications that the private sector and non-governmental organizations may be in a good position to respond to the needs of individuals by building on motivation for longer-term benefits. In this regard, experience with community incentives, linking family planning with economic development, has been especially promising. Availability of revolving funds often stimulates local initiatives for income-generating activities or other community-enhancing projects. All repayments, including interest, remain in the village to encourage continuing development. Each village decides on its own goals, supporting and rewarding fertility-reducing behaviour without penalizing those who do not wish to participate. It appears that, given appropriate economic motivation and technical resources, people will actively participate in endeavours which are perceived to improve their quality of life and which strengthen their self-reliance in needs assessment, planning and implementation.

26. Experience with disincentives for lowering fertility comes primarily from countries where mutual agreement appears to exist between the Government and the people in regard to population policies and programmes, and where all methods of fertility regulation are widely available and accessible. In some countries, implementation of widely publicized disincentives may be more symbolic than real, their main purpose being educational. Elsewhere, implementation of incentives may be quite strict, ranging from reduction or forfeiture of previously earned benefits to payment of penalities for exceeding specified limits on child-bearing. Creation of a cultural environment favourable to reduced fertility may develop attitudes sufficiently constraining on fertility behaviour without imposing undue hardships on children born in excess of desired norms.

27. In general it would appear that policy decisions on the size of payments, to whom they should be paid, and when and in what form they should be paid have been made more on the basis of intuition and the availability of resources than as a result of field experience. However, despite a relatively weak information base in this area, it is possible to suggest certain factors which may tend to improve the effectiveness of incentive and disincentive programmes. These would include: political and cultural acceptability; financial feasibility; a simple design to facilitate administration; and a combination of several incentives or disincentives rather than a single isolated measure.

28. Because incentive measures are likely to impose an additional burden on existing administrative structures, financial procedures should be simplified wherever possible, and regular supervision established. Such procedures are important in order to maintain accountability, which is essential if integrity and public confidence are to be assured, and to ensure a continuous flow of funds to recipients. Recording and reporting systems are needed for identifying problems and monitoring progress. Programme continuation and improvement can then be based on the performance of the organizational mechanism in relation to set goals, with flexibility to make adjustments as needed.

29. Continuing monitoring and evaluation should assess such programmes in terms of contraceptive prevalence and fertility rates; acceptor characteristics in terms of age, parity, and education; effects on service delivery; operational and managerial problems; informed consent; and whether results merit the investment required. Quantitative analysis should be supplemented by investigation of qualitative aspects such as client satisfaction and the effects of incentives on the quality of life.

30. Assessment of cost-effectiveness is an essential component of any programme and should be considered from the very beginning. The recurrent financial burden of individual incentive schemes on existing budgets should be carefully assessed since, once begun, it may be difficult to withdraw at a later date without negative effects on the programme. This is particularly the case for provider incentives. On the other hand, acceptor incentives should become less necessary over time as the small family becomes the desired norm. For these reasons it may be useful to carry out carefully designed pilot studies before embarking on major programmes.

IV. EFFECTS OF INCENTIVES ON THE QUALITY OF SERVICES

31. The question of quality of services appears to be raised most often in regard to individual incentives designed to reduce fertility. As with many other aspects of such programmes, this is one which has not been studied in any detail up to the present time. It is possible, however, to indicate how incentives may affect the quality of services, and thus where future research may be required.

32. Payments to providers of family planning services may create animosity among other health personnel; in some countries, team incentives have helped to reduce this problem. Provider incentives may encourage shortcuts, or place undue emphasis on methods deemed less desirable by acceptors. All methods of family planning should be made equally available to clients, and any incentive should not itself become the reason for choosing or recommending a particular method. When speed is of the essence in earning per case fees, the relationship between the client and provider may be affected. Paying a service-provider on a sessional basis rather than for each individual case may help to avoid this problem, but may also reduce the quantity of services given.

33. Adequacy of follow-up is also a measure of the quality of service. In order to improve this, some incentive programmes pay only half the fee at the time of service provision, and the remainder for a follow-up check. Incentives to distributors of reversible methods may have positive effects on the quality of services. Such persons, who generally work in the community, are able to maintain a close relationship with the acceptor, spending time on the provision of information and the resolution of any problems encountered.

34. Incentives to providers and motivators, particularly those paid on a per case basis, may be associated with some lack of observance of informed consent procedures, since clients may not always be fully counselled and advised as to the benefits and consequences of all available methods. Such instances, though they appear to be rare, may do substantial damage to the credibility of both the incentives and the wider family planning programme when they come to light. This only serves to emphasize the importance of continuous monitoring in order to prevent such occurrences.

35. The quality of services may also be related to the design of a particular programme. For instance, the traditional centralized approach involves the passing of incentive payments through numerous channels. If such payments are delayed for any reason, this may reduce staff morale to the extent that it may affect their work performance in terms of both quantity and quality. On the other hand, the grass-roots approach, emphasizing community participation, may avoid such problems since incentives are often in the form of a fund administered at the village level. Furthermore, involving the community in the planning and management of incentive programmes can improve the quality of services by ensuring that they are tailored to the particular needs of local people.

36. Finally, where family planning is integrated with maternal and child health, it becomes one of a range of activities and services carried out by health personnel. In such circumstances, the provision of an incentive for acceptance of family planning may attract a larger volume of clients who can then utilize a much wider range of services for themselves and their children. It has been suggested that providing an incentive for family planning may lead to downgrading or even neglect of other maternal and child health services. However, no documented evidence for this has been reported.

V. THE USE OF INCENTIVES AND DISINCENTIVES AND FREE AND INFORMED CHOICE

37. In examining issues related to free and informed choice it is useful first to consider the broader field of incentives and disincentives. The theory and practice of altering behaviour through rewards and punishments is not new. Incentives and disincentives are widespread throughout many aspects of daily life and have been used for many years to influence human behaviour in such areas as education, work productivity, consumerism, and law and order. Some government actions such as fines and tax benefits are intended to have certain incentive and disincentive effects. Other actions may have such effects unintentionally, and may have resulted in changed fertility behaviour. What is relatively new is the introduction of incentives and disincentives to intentionally affect reproductive behaviour - traditionally seen as a highly private and personal area in which the individual's wishes and preferences are paramount. For this reason, incentives and disincentives in the field of family planning touch on many sensitive issues, but this sensitivity should not obscure the fact that they are basically neutral and not inherently unethical.

38. Incentives and disincentives to reduce fertility range in degree of voluntarism from those which allow complete free choice to those which appear to place quite heavy pressures on individuals. However, the perception of voluntarism also varies a great deal. The persuasive strength of the same incentive may not be viewed in the same way in different parts of the world owing to different psychological and socio-cultural norms. Furthermore, judgements about what constitutes free and informed choice must be made within both the context of a particular culture and the context of the overall government programme for social and economic development, of which family planning incentives and disincentives are only a small part. Unauthorized resort to coercion on the local level has been reported on occasion, but such deviations from government policy are strongly censured, and policies and programmes should not be judged on the basis of these isolated instances.

39. Whether or not a particular programme of incentives and disincentives is justified or justifiable in terms of "free and informed choice" will usually depend on a cluster of factors and can ultimately be decided only by the community and persons affected. What is politically, legally and administratively feasible in one country may not be so in another. At the 1984 International Conference on Population, national delegations reaffirmed "the basic human right of all couples and individuals to decide freely and responsibly the number and spacing of their children" (para. 25) but added that "Any recognition of rights also implies responsibilities; in this case, it implies that couples and individuals should exercise this right, taking into consideration their own situation, as well as the implications of their decisions for the balanced development of their children and of the community and society in which they live" (para. 26). There does not appear to be any universally approved criterion or criteria that can be readily applied to specific circumstances or events.

40. Governments have the responsibility to protect the interests of both individuals and society as a whole. This responsibility may lead sometimes to difficult choices, and in such situations Governments have to assess carefully the seriousness of the problem involved and the relative merits of supporting either individual or community interest. In reaching a decision in regard to incentives and disincentives certain criteria could be used. These might include the following: incentives and disincentives should not be unjust or harmful to any particular group of people; they should not interfere with any basic right nor exploit any weakness in an individual's position, and they should operate in an atmosphere of complete openness and fully informed consent. In addition, it might be suggested that, as a prerequisite, information and services for all methods of fertility regulation should be widely available; that less restrictive measures be used before more restrictive measures; and that incentives and disincentives in family planning should be a part of a set of social and economic measures aimed at promoting individual, community and national development.

VI. SUMMARY AND CONCLUSIONS

41. The preceding sections have attempted to raise and discuss many of the important issues surrounding the use of incentives and disincentives in family planning programmes. Such incentives and disincentives have been born out of the realization that the provision of family planning information and services may not always be sufficient in itself to reduce fertility, and that fertility behaviour is influenced by many other factors which promote the desire for a particular family size.

42. Individual acceptor incentives are usually designed either as reimbursement of costs incurred in accepting a family planning method, or as compensation for having a different number of children than traditional logic would otherwise dictate. Such incentives may be in cash or in the form of other rewards and may be given immediately upon acceptance of a method, or be made dependent upon achieving a specified family size. Over the course of time, such payments can usually be phased out.

43. Provider incentives to those who dispense family planning are little different from payments made for other types of medical and surgical services. They do require, however, particular attention to the establishment and monitoring of informed consent procedures, and, unlike acceptor incentives, they can become a continuing component of recurrent expenditure.

44. Motivator incentives can also be seen as similar to a wage agreement, and provided that monitoring of methods of recruitment, eligibility of acceptors and adequacy of counselling is carefully maintained, such payments may best be judged on a cost-effectiveness basis.

45. Community incentives, linking fertility behaviour to locally perceived economic development goals and to local programme participation attempt to avoid some of the problems encountered with individual incentives. They can

be made responsive to community development priorities, sensitive to local autonomy, and oriented towards improving the quality of life of the community. In addition, they tend to improve the status of women through their active participation; involve capital grants for loan funds rather than recurrent expenditure; and can be structured to avoid peer pressure and emphasize voluntary participation by demonstrating to non-participants the advantages of joining with their neighbours. While community incentives require considerable assistance for strengthening local administrative, technical and managerial skills, they do appear to be particularly promising for the largely rural areas of developing countries.

46. Disincentives are largely oriented to those who may prefer to disregard established norms of reproductive behaviour. They are associated with a strong political commitment to fertility reduction, and attempt to reinforce the concept of the small family by emphasizing cost-benefit factors, while still allowing couples to have additional children if they wish to pay the costs entailed. In such situations much importance is attached to enhancing public perception of both the need for fertility reduction and the equitable application of restrictions on child-bearing within an overall programme for improving the quality of life.

47. Although the terms are widely used, it is nevertheless difficult to formulate universally acceptable and applicable definitions of incentives and disincentives. Definitions may vary according to the intentions of the designers of such measures and according to the perception of the recipients. It is often argued that such provisions as free contraceptives, reimbursement of expenses for acceptors, and family and tax allowances linked to family size are not incentives per se, but simply part of a broader social welfare programme. Payments to providers and motivators are also often viewed not as incentives but simply a form of wage agreement.

48. As of September 1984, there were no reports of large-scale, scientifically conducted, longer-term empirical studies of the effects on fertility of varied incentives or disincentives implemented under diverse conditions of cultural or political acceptability, financial feasibility, or administrative and operational controls. Despite the large amount of money expended on incentives, there are virtually no controlled studies of specific types of incentives or disincentives, used in clearly delineated socio-cultural contexts, in single or package form, directed towards individuals, couples or communities for specified policy objectives.

49. While there is wide agreement that incentive programmes should be voluntary, and also take into account such factors as the local cultural context, past experience of the family planning programme, and the expressed needs of the participating communities, the operational aspects of such programmes still require further refinement. Pilot studies should include determination of which rewards and constraints are effective in raising contraceptive prevalence and lowering fertility, at what cost and with what impact on the quality of services and the quality of life. Such studies

should be designed and monitored so that, if successful, elements can be identified for eventual replicability nationally and internationally. Consultation with appropriate government officials and influential leaders is essential from the very beginning if eventual recommendations are to be implemented and a supportive administrative structure developed.

50. The ethical and human rights issues raised by incentives and disincentives are extremely complex. In assessing them it is vital to take into account the socio-cultural context within which they operate. This would include a consideration of value systems, community consensus, individual and national perceptions, and the overall programme for socio-economic development. Such issues may best be settled by continuing dialogue between policy-makers and the community aimed at reaching and maintaining a consensus.

51. Incentives and disincentives alone are not enough. They require as a base a commitment to both social and economic development and to the wide provision of family planning information, service and motivational programmes oriented towards the perceived desire of the people for a better quality of life. This integration of population and socio-economic development policies was urged in the World Population Plan of Action (para. 2), and reaffirmed (para. 18) at the International Conference on Population, 1984, which also restated that "the Plan also recognizes the sovereignty of nations in the formulation, adoption and implementation of their population policies, consistent with basic human rights and responsibilities of individuals, couples and families".

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