OXFORD

human reproduction update

Human Reproduction Update, 2024, **30(2)**, 131–132
https://doi.org/10.1093/humupd/dmad036
Advance Access Publication Date: January 10, 2024
Editorial Commentary

The complicated ART of finding consensus on family-building health policy: a comment on the IFFS consensus document

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The world has witnessed a substantial decline in fertility rates for the last five decades: from 4.8 children per woman in 1970 to 3.3 in 1990 and to 2.3 in 2022. These declines have been the focus of much research. In high-income countries (HICs), where fertility rates currently average 1.6 children per woman, the reductions below the magical 2.1 replacement level have been ascribed to a range of ideational factors, described in the rich literature on the 'Second Demographic Transition' (Lesthaeghe, 2010; Zaidi and Morgan, 2017). In low-income countries (LICs), the reduction is largely the product of longstanding population programs anchored in a neo-Malthusian paradigm: it associates high fertility rates with negative outcomes in terms of neonatal-maternal health, educational attainment, economic growth, and the natural environment. Other factors, such as sperm count decline, could also play a role (Levine *et al.*, 2023). In either case, despite some variation across countries, population policies across most high- and low-income settings have promoted low fertility through a combination of maternal and child health, including family planning, and increased investment in human capital, with an emphasis on gender equity. This dual focus has been the dominant approach since the UN International Conference on Population and Development in Cairo in 1994.

Most researchers and practitioners have welcomed the resulting fertility declines. Yet even as a combination of high fertility (mostly in West Africa) and population momentum (mostly in Asia) will continue to drive the global population above 10 billion by the mid-2050s—having crossed the thresholds of 2, 4, and 8 billion people in the last century—new concerns about fertility have been emerging and taking hold.

The consensus document by the International Federation of Fertility Societies (IFFS) recently published in *Human Reproduction Update* grows out of these new concerns (Fauser *et al.*, 2024). The document raises essential questions about rapidly declining global fertility rates and their implications for planning and building of families and communities. It successfully describes most of the major disparities in access to fertility care and raises the critical issue of affordability. The document also encourages us to develop a new global perspective on the desirability of raising fertility levels in low fertility countries, in large part by helping individual women achieve their 'family building' goals. These are important contributions. Some may see them as too willfully ignoring older neo-Malthusian approaches dedicated to reducing fertility. However, given the overarching goals of medical sciences in HICs, which is to help individuals realize their health-related aspirations, and the specific goals of this document, it is a reasonable position.

Despite these achievements, we think there are two notable deficiencies in the consensus document. We point to them in the hope of helping to broaden the scope of the consensus, or its direct application in medical systems and clinical settings.

The first appears toward the beginning of the section on '*Access to fertility care*'. The authors enumerate how disparities in infertility are affected by '*barriers to access aligned with race, class, socioeconomic status, gender, sexual orientation, and other forms of difference*'. This is a reasonable list of within-country barriers. However, in global terms, these are second-order sources of inequality. What is missing is reference to a much larger source of inequality, which the authors' global focus appears designed to also inform, which is cross-national differences in access to fertility care. For example, the otherwise excellent section on '*Context*' acknowledges that '*Fertility care is not affordable for many people around the world, especially in low-resource settings*'. However, there is no direct reference to how the global flow of health personnel from LICs to HICs exacerbates those inequalities. This is a widely-critiqued attribute of the global medical political economy. Applied to the focus of the consensus document, it suggests that broad access to high-quality fertility care in general, and to ARTs in particular, will remain effectively zero in LIC countries, since those countries will continue to lose their scarce fertility specialists to HIC medical systems. Or, at the very least, access to such services within LICs will remain the prerogative of the wealthy, since those same fertility specialists will be in such short supply. In either case, to the extent that one of these hypotheses is correct, differences across countries in ART utilization will not—and cannot—be narrowed until this issue of migrating medical staff and health disparities is addressed. A similar note could be attributed to public health efforts and disparities that impact fertility beyond 'prevention' such as air quality, water quality, food insecurity, exposure to hazardous substances, etc.

A second set of deficiencies can be linked to the document's relative neglect of demography as a discipline. The lengthy bibliography does not include a single reference to publications in

Received: November 17, 2023. **Revised:** December 26, 2023. **Editorial decision:** December 29, 2023.

specialist *fertility* journals within demography (e.g. *Studies in Family Planning*; *Family Planning Perspectives*), to the leading generalist journals within demography with long traditions of publishing on fertility (*Population Studies*, *Demography*), to their counterparts in French (*Population*), Italian (*Genus*), or to various region-specific demographic journals. This absence means that the document is missing important areas of research that could help sharpen the message.

A notable example can be seen where the authors point to '*an urgent need for more and better data on all aspects of global fertility and associated demographics*', and in their subsequent declaration that among '*key knowledge gaps*' is the fact that '*Reliable data on fertility patterns, trends and causes of fertility or infertility are missing in developing countries, especially for male fertility*'.

Demographers will fiercely disagree with most of these claims. Much is known about fertility trends and determinants in both HIC and LIC settings. Regarding LIC settings, the main data source is 40 years of Demographic and Health Surveys (DHS) and their various add-ons (https://dhsprogram.com). The core modules in these surveys include questions on all births, ante- and postnatal care, contraceptive use, female genital cutting, fistulas, and are answered by women of reproductive age in large nationally representative samples: e.g. more than 40 000 women in Nigeria (2018), 26 000 in Ghana (2017), 30 000 in the Philippines (2022). These data have been fielded repeatedly across more than 90 LICs, beginning in the 1980s. The data are freely available as stand-alone files. They increasingly also include biomarker data on sexually transmitted infections and are geocoded to allow for spatial mapping. In addition to these standard household modules, the DHS also fields more focused Service Provision Assessment (SPA) surveys, whose goal is to collect information on service availability and quality of care within a country's health system, again, with a particular focus on antenatal care, family planning, maternity care, and sick child services. In summary, there is no lack of fertility data in general.

It is important for us to emphasize that these two problems do not significantly diminish the value of the consensus document. But they arguably could undermine its authority outside the disciplinary circle within which it was created. That would be unfortunate, given the document's overall set of contributions.

We conclude with the issue of perspectives. The IFFS consensus document reflects the voices of a highly skilled constituency of healthcare professionals who offer fertility treatment within existing healthcare systems. That is the correct core constituency for composing a consensus document on how to increase investments in fertility care and family building in general, and ART in particular, how to make those investments more effective, how to reduce inequalities in access to these services within given health systems, and more than anything, how to help women and couples achieve their individual fertility goals. Those are all important policy goals that we share.

Yet, as is widely known, it is much easier to create consensus across a group of experts and professionals in a given field than across a diverse group of experts representing very different fields. This difference in level of ease follows from a core axiom in the sociology of science. Academic areas and subfields socialize their members into shared modes of thinking, with shared vocabulary, sources of data, interests, and increasingly self-referential scholarly literature. In this case, in particular, by omitting the concerns of ecologists and their allies, who have long pointed toward the global environmental impact of Increasing Population multiplied by Increasing Per Capita Consumption, the document has inadvertently stepped into an old conflict between ecologists and economists, with demographers somewhere in the middle.

In that respect, to the extent that the IFFS is interested in a global mandate, we would encourage the participation of demographers and epidemiologists, especially those who work in or on LICs. They are often the most active scholars of fertility and health-related inequality in these settings, and they often collect clinically useful data. In addition, in future iterations of its work, we would encourage the IFFS to confront some of the underlying assumptions in the document, some of which—especially questions about balancing the rights of individuals over collectives like states, or balancing global commons over national ones—are sidestepped in this version. Including those two things would make the consensus document even stronger. We hope that our comment will help extend the discussion to additional disciplines, leading to a wider consensus and broader scope on this important issue.

Authors' roles

All authors contributed equally to the commentary and approve it's final version.

Funding

No specific funding was used.

Conflict of interest

None.

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