



Demographic aging and biopower

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ABSTRACT

The aging of the world's population is an unprecedented recent phenomenon in human history, as for millennia - at least from the Neolithic to the mid-18th century - the age structures of human populations have changed little. The question posed by this anthropological perspective seems at first sight quite simple: how did this aging come to be? We will see that from a demographic point of view, the answer seems trivial: a basic shift in population structure is at the origin. However, we will go further by exploring the historical and political conditions of this transition by mobilizing the Foucauldian notion of biopower. We argue that this notion has the heuristic advantage of linking several core processes at work in the demographic transition. Although our analysis focuses on France to illustrate the notion of biopower in Foucault's work, we also discuss several non-western societies to explain why demographic aging is inevitable across the globe due to biopower strategies and "dispositifs". This article also constitutes a reflexive analysis on our practices as gerontologists and on the widespread "successful aging" concept.

Introduction

The aging of populations we know today has taken humanity by surprise. From the Neolithic to the mid-18th century, the age structure of human populations has changed little. It was only in the second half of the 20th century that aging grew so widespread that it became a recognized social issue and attracted scientific attention. With a few exceptions (e.g. Forth, 2018; Katz, 1992), broader social science research is situated in a latent presentism, dictated largely by political and societal concerns. Thus, the central questions of social gerontology often remain concrete: How to finance pensions? How to improve the quality of life and well-being of older people? How to limit their feeling of loneliness? How to transform the negative images? Even the French social theorist Simone de Beauvoir (1970), in her profound work on old age, explicitly stated that she wanted above all to "shed light on what is the fate of old people in our society today"¹ (p. 16). The same can be said for anthropologists in China, Peru, Italy, the United States, as well as the small islands of Polynesia or rural Africa, where aging is most often studied to capture the fate of elderly populations in specific

contexts, and the social movements that drive and transform these contexts² (Sokolovsky, 2009).

The question that guides this article is upstream of these more dominant questions in gerontology and can be formulated very simply: how did we arrive at an unprecedented increase in life expectancy on a global scale? To answer this question we will focus on the level of populations and not individuals. What interests us is what unites populations and allows us to better understand the generalized aging of humanity. Demographic aging and transition will be at the heart of this analysis, which will engage the notion of biopower (Foucault, 1976a). The case of France, where biopower has been described by Foucault, will first be used as a paradigmatic example of these transformations, but Chinese and Senegalese societies are also analyzed to demonstrate that biopower can explain demographic aging and transition in all societies, taking into account their distinctive cultural features and temporality in the development and spread of biopower.

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¹ However, it is also possible to consider this book as a critique of capitalist society and the social inequalities that, if they do not structure it, are associated with it.

² Modernization (Featherstone & Hepworth, 2009) and globalization (Sokolovsky, 2009), in particular, are at the heart of anthropological questions on aging.

Aging and demographic transition

Demography and aging

In some societies, it may be exceptional to live to 90 years of age - as in rural areas in the Sahel³ - while it may be common in others, such as on the island of Okinawa in Japan (Kinsella, 2009). Likewise, being 70 years old in France in 2018 and the 17th century does not refer to the same experiences of aging (Bourdelaïs, 1993). Moreover, at the beginning of the 21st century, being 70 years old does not refer to a common experience (Ennuyer, 2011). Individual idiosyncrasies are particularly apparent with advancing age. There is no precise age of entry into old age, neither between societies nor within a given society at a given time. Sociologist Bourdieu (1992, p.145) argued that “age is biological data that is socially manipulated and manipulable.” Nevertheless, it is commonly accepted in anthropology that “old age” and “older adults” are universally shared notions⁴ (Barker, 2009). Similarly, linguists believe that these terms exist in all languages (Montandon, 2004). At the center of these notions shared on a human scale are the links between the advanced age and the materiality of the body: it is through the aging, living, experienced, and perceived body that the feeling and the perception of aging are socially and individually shaped (Hurd Clarke & Korotchenko, 2011; Macia, 2013). Phenomenological and anthropological approaches meet on this essential point (Macia, Dial, Montepare, Hane, & Duboz, 2019) and support the use of chronological age as an *indicator* of aging, as is practiced in demography.

By keeping in mind the limits of chronological age to understand aging, it is possible to compare the differential aging of populations. If aging has become a major subject of study at the global level in recent decades, we must recognize that it is because the number of aging people has increased exceptionally in many societies. For example, in the middle of the 18th century, France had only about 7% of people aged 60 and over (Bois, 1989). According to data from the (French) National Institute of Statistics and Economic Studies, this proportion was around 12% in 1900, 16% in the 1950s and 20% in 2000.⁵ According to all the forecast assumptions, it will be higher than 33% in 2050 (Brutel, 2002). Similar patterns can be seen in all the developed countries.

Aging populations now touch almost the entire world. Although, there are still populations where the proportion of older adults is changing less dramatically due to the combined effect of low progress in reducing mortality and stable high birth rates. This is the case in many developing countries, particularly in their rural populations (Sajoux, Golaz, & Lefèvre, 2015). However, current population projections also indicate that developing countries are aging much more rapidly than has been observed in Western countries (Pison, 2009).

The demographic transition and its theories

In demography, population aging is explained by the demographic transition process, which affects all world populations and is complete in some countries such as France or the United States (e.g. Kinsella, 2009). This transition corresponds to the change from a demographic regime with high birth and death rates to a regime characterized by low birth and death rates. In both the initial and final stages, population growth is low, when there is growth.

Classically, the demographic transition is considered to be made up

of two phases between the two states of demographic balance. The first phase corresponds to a decrease in mortality, especially infant and child mortality. For example, in France, the first country to evidence the demographic transition, mortality began to decline in the 17th century (Chesnais, 1986). Agricultural and food advances are believed to have played a key role, but biomedical and hygiene progresses have also contributed (Bley & Boëtsch, 1999). This decline in mortality continued in the 19th and 20th centuries, with three major events in particular: Pasteur's discoveries in the 1870s and 1880s, the generalization of health education after the First World War, and, the discovery and use of antibiotics after World War II (Bley & Boëtsch, 1999). In France, it is traditionally accepted that the birth rate remained unchanged at the beginning of the decline in mortality, and the population became younger and larger. This population growth was particularly significant until the second phase of the demographic transition, characterized by declining fertility, towards the end of the 18th century, well before what was observed elsewhere in Europe (Bourdelaïs, 1993).

The reasons for the decline in the birth rate are much more complex than those associated with the decline in mortality and remain controversial. Various theoretical models of transition have been developed: structural-functionalist, culturalist, Marxist, and feminist (e.g. Piché & Poirier, 1990). A common point across these theories is that modernity is at the heart of the process (Johnson-Hanks, 2008). It is no coincidence that the initial and final demographic stages are referred to as “traditional” and “modern” respectively. The second common point across these theories is that they are primarily focused on fertility reduction. The structural-functionalist approach, historically the first to emerge, considers that industrialization, or modernization, is at the root of the decline in mortality. Concurrently, urbanization, the social division of labor, an increase in schooling, a change in status among women, etc., were the phenomena that generated new ways of thinking about kinship and the number of descendants (e.g. Goldscheider, 1971; Notestein, 1945).

The culturalist, or diffusionist, approach is based on empirical critiques of the structural-functionalist model, starting with the work of Ansley Coale and his team on the demographic transition in Europe (e.g. Coale, 1973; Coale & Watkins, 1986). As Johnson-Hanks (2008) summarizes, these critiques argue that “mortality decline did not always precede fertility decline and that the speakers of the same language generally experienced fertility transition at the same time, regardless of economic development” (p. 305). Within this theoretical model, the diffusion of representations, values and norms of modernity would be at the root of the decline in fertility.

At the intersection of the structural-functionalist and diffusionist approaches, Caldwell (1976, 1980) developed the theory of the direction of wealth flows. According to this approach, the “traditional” and “modern” balances are distinguished by the fact that net wealth flows favour parents in the first case and children in the second. These micro-economic transformations would be rooted in modern family values, including a reduced focus on ancestors and older adults along with greater concern for children. Here, the media and the school system play a major role in spreading modern norms and values promulgating the nuclear family.⁶ Rationality, particularly economic rationality, is at the heart of John Caldwell's model, which of course reflects the modernity and spirit of capitalism (Weber, 1964). However, these rational choices have been challenged by several studies indicating that the total number of children is not so much the result of a rationalized form of family planning as it is of other factors, including the culturally and physically appropriate intergenerational interval (Bledsoe, 2002) or the social value associated with descent (Johnson-Hanks, 2002).

Finally, it is necessary to say a few words about Marxist and feminist

³ Where some of the present authors work.

⁴ Arcand's (1982) famous article entitled “La construction sociale de la vieillesse” is a counter-reference to the universalism of the notion of old age. Among the Cuiva, a hunter-gatherer population in Colombia's eastern plains, older men and women are not considered to be a particular social category. However, this case remains isolated in the literature.

⁵ See: <https://www.insee.fr/fr/statistiques/1906664?sommaire=1906743>.

⁶ This approach meets the central ideas of the theory of modernization applied to aging and postulating the devaluation of aging people as a consequence of modernity (Cowgill & Holmes, 1972).

approaches to the demographic transition because they complement the theories described above. The Marxist approach emphasizes the transition to capitalism and subsequent inequalities, both between countries and social classes (Piché & Poirier, 1990). It postulates that the different social classes have their own reproductive logics, inherent to their living and working conditions. At the population level, the same can be observed by comparing the least developed and most developed countries. For example, among West African herders and farmers, the high productive value of young people is associated with high fertility. For some feminist demographers, these diverse family strategies must be linked to male domination in most societies. Not only are men often the main beneficiaries of large descendants in high-birth societies, but the cost of this fertility is primarily borne by women. The transition to capitalism would transform this balance by placing the cost of this descent equally on men (Folbre, 1983).

Demographic transition and biopower

The notion of biopower, as developed by Foucault (1976a), makes it possible to link together the structural-functionalist, culturalist, Marxist, and feminist interpretations of the demographic transition since power relations intersect with social structures, social norms, social class and gender. For the moment, this notion has only very rarely been used in the context of demographic aging and transition (Johnson-Hanks, 2008), although it makes it possible to explain them in a new light. The subsequent discussion is first focused on France in line with the notion of biopower in Foucault's work, and then applied in two very different contexts – China and Senegal – to demonstrate why demographic aging and transition seem inevitable everywhere despite some temporal and cultural variability.

Biopower: definition and uses

Through an analysis focusing on sexuality, Foucault (1976a) shows that a fundamental paradigm shift in the exercise of power took place in Europe between the 17th and 18th centuries. In previous centuries, “sovereign power” was characterized by the right to life and death over its subjects. Thus, *Surveiller et Punir* (Foucault, 1975) opened with the torture of Robert-François Damiens on 28 March 1757 on the main door of the church in Paris, found guilty of attempting to kill Louis XV with a knife. For Foucault, this right of life and death is in reality only the right to make people die. At that time, power was exercised mainly through levy mechanisms, whether it was wealth, goods, services, work or - therefore - life.

Through his analysis of discourses on sexuality from the Ancien Régime, the French philosopher shows that, towards the middle of the 17th century, power ceased to be exercised only in and through death - *to make people die or let them live* - to be exercised over life - *to make people live or reject them into death* (Foucault, 1976a, p. 181). This power over life has developed in two complementary forms. The first, observable since the 17th century, focuses on the disciplines imposed on the machine body: the anatomo-politics of the human body. Schools, barracks, workshops are the main institutions for disciplining bodies. The second form of development of biopower, visible in the mid-18th century, focuses on the biological control mechanisms of the species body: the biopolitics of the population. It is then that reflections on birth rates, longevity, public health, hygiene, housing or migration emerge. During his 1978's lessons in the Collège de France – *Sécurité, Territoire, Population* (Foucault, 2004a⁷) – Foucault explained precisely how this notion of “population” emerged in Europe, and why it precedes thought on biopower.

For Foucault (1976a, p. 187), “Western man is gradually learning

what it meant to be a living species in a living world, to have a body, conditions of existence, probabilities of life, an individual and collective welfare.” As early as the mid-18th century, medicine ceased to be essentially clinical and began to be social, focusing on aspects other than the diseases themselves. Doctors began to teach people the basic rules of hygiene, food and housing - encouraging them to seek treatment for illness and to respect their health and that of others. The population began to be governed by a set of prescriptions concerning diverse social fields, ranging from ways of eating to sexual behavior. Foucault makes a very clear link between the development of biopower and that of capitalism, a link that will notably take up the 1979's lessons at the Collège de France (Foucault, 2004b). Through these mechanisms, it is above all a question of preserving the labor force of the population (Foucault, 1976b).

Although Foucauldian concepts have been taken up by critical gerontologists (Powell & Biggs, 2003), from care of the self (Frank, 1998) to governmentality (Powell, 2006; Powell & Cook, 2001) or heterotopias (Sayers & Brunton, 2019), the relevance of biopower as an operational concept for analyzing aging has, to our knowledge, rarely been explored (e.g. Katz, 1992). As Rabinow and Rose (2006, p. 197) note about the concept of biopower in social sciences: “Yet surprisingly little work has been done to develop Foucault's own sketchy suggestions into a set of operational tools for critical inquiry”.

Biopower as a driver of demographic transition

While it may seem surprising to link biopower to demographic transition and aging, this link is visible in a number of ways between the lines of Foucault's work (Paltrinieri, 2014; Rabinow & Rose, 2006). In our view, the notion even has the heuristic advantage of linking the processes at work in the demographic transition. To understand how, it is necessary to describe the “dispositifs”⁸ by which biopower - understood as power relations that exist between individuals (or between groups) and related behaviors (Foucault, 1982) - may be carried out. To illustrate these dynamics, we first turn to France with examples relevant to the demographic transition. In order to globalize these arguments and to analyze them in other contexts, we next turn to two non-Western societies: the Chinese society, where dispositifs of biopower may seem obvious (e.g. Rabinow & Rose, 2006, p. 209), and the Senegalese society, which is among the less advanced countries for demographic transition.

Dispositifs for reducing mortality

France

During the 17th and 18th centuries in France, progress in the field of food and hygiene was the main factor in reducing mortality. How did this happen? The three volumes of the “*Traité de la Police*”⁹ written by Nicolas de La Mare at the dawn of the 18th century offer useful explanations, dictating the rules of hygiene and health that must be put in place and enforced to ensure that the population's health and productivity is maintained.¹⁰ In Volume 1, health (“From Health - Book 4”) appears at the heart of political issues with eloquent titles such as: “From clean air to health”; “From water policing to health”; “From remedies”; “From doctors”; and finally “From the discipline that must be observed, when the contagion is in a city, a town or a village”.

⁸ The French notion of “dispositifs” is difficult to translate (e.g. Legg, 2011), so we choose to hold the French term in this article. For Foucault, the “dispositifs” (probably most often translated as “apparatus”) are material operators of power including discourses, behaviors and institutions (Revel, 2002).

⁹ Access here: <http://data.bnf.fr/fr/documents-by-rdt/12450313/a/page1>.

¹⁰ The “*Traité de la Police*” of Nicolas de La Mare is considered as the major publication of the French public law of the 18th century (Epron, 2004).

⁷ The lessons of 1978 and 1979 in the Collège de France were only published in 2004.

Volume 2 is devoted to food (“Food”), ranging from considerations on the quality of wheat grains to poultry, to highly bio-political considerations such as “What butchers should observe in their purchases, & where they can do it”. Finally, Volume 3 continues these considerations, addressing issues related to fishing and market gardening.

To these biopower dispositifs of nutrition and hygiene will gradually be added those more directly linked to the disease. In 1776, the French government decided to create the Royal Society of Medicine. Its objective was to monitor epidemics and inform doctors of the most appropriate treatments. As Foucault (1963, p. 27) points out: “Thus a double control is established: political authorities over the practice of medicine; and a privileged medical profession over all practitioners.” The 18th century medicine became a dispositif of biopower. This was an effective dispositif since medical progress will gradually increase and spread to the population. The history of smallpox vaccination, discovered in the late 18th century by the English physician Edward Jenner and disseminated throughout Europe in the early 19th century (Biraben, 1979), is a paradigmatic example of this phenomenon since smallpox has been eradicated globally since 1977.

While these dispositifs of biopower make it possible to better understand the decline in mortality in 18th century France, it may be argued that they have now been amplified in the field of medicine (Foucault, 1976c). It should also be stressed that the ways in which contemporary biopower is carried out in the modern medical field do not only involve comprehensive disease eradication campaigns, such as the famous example of malaria in Sri Lanka.¹¹ Biopower is also exercised through its internalization. It is a force for self-discipline. Preserving one's health is now a personal responsibility, a categorical imperative in the Kantian sense,¹² and public health services dictate people's individual behaviors. In this perspective, obvious differences in longevity among social classes (e.g. Scambler, 2012) could – partly – be explained by differential levels of biopower internalization.

China and Senegal

In China, mortality – especially of children – began to decline in the early 1950s, before rising again during the 1959–1961 Great Leap Famine, and then falling steadily until the 1980s (Banister, 1987; Banister & Hill, 2004). This decrease in mortality was concomitant with Mao Zedong's rise to power in 1949 and corresponds to the first phase of the demographic transition (e.g. Attané, 2016). Several explanatory hypotheses have been suggested to account for this rapid decline in mortality. The most consistently shared view concerns the development of primary health care (Dong & Phillips, 2008), of which the “barefoot doctors” are a famous and convincing example of the impact of biopolitics on the health of the rural population. However, other explanations – not mutually exclusive – have been offered, sometimes emphasizing mass vaccination campaigns, sometimes focusing on progress in hygiene and nutrition (Banister, 1987; Campbell, 1997; Hipgrave, 2011; Zhao & Kinfu, 2005).

The first Patriotic health campaign, conducted in the early 1950s, was a public health plan that moved forward on all fronts, in both urban and rural areas. First of all, it was a matter of improving the hygiene conditions of the population by promoting the removal of waste, the construction of latrines and the composting of excreta. It was also a matter of fighting the country's “four pests” of mosquitoes, rats, flies, and bed bugs. Public health campaigns targeted at specific diseases

¹¹ Between 1946 and 1948, under the leadership of the WHO, malaria was almost eradicated in Sri Lanka, increasing life expectancy in that country by 12 years in just two years (Meslé & Vallin, 2003). However, Sri Lanka was certified as Malaria free in 2018.

¹² It is not merely a question of advice, but of a moral duty, especially since it involves the whole community in a universal dimension, following the example of the Kantian maxim (Kant, 1985 [1785]).

were also conducted against schistosomiasis, polio, diphtheria, etc. (Banister, 1987). The impact of these public actions has been demonstrated by a recent analysis showing that these campaigns, combined with progress in education, accounted for between 50% and 70% of the decline in child mortality in China during the 1950–1980s (Babiarz, Eggleston, Millera, & Zhang, 2015). Education and public health, anatomy-politics and biopolitics: the two components of bio-power undeniably explain how the first phase of the demographic transition was implemented on Chinese territory.

In Senegal, the situation appears very different. If child mortality was close, as in China, to 400‰ in the early 1950s (Pison, 2010) – demonstrating in passing that France's colonial policy was not a biopolitics of indigenous populations – this figure has since dropped significantly but still remains very high: around 50‰ (HDR, 2018), five times higher than in China and 12 times higher than in France. According to Pison (2010), this decrease in child mortality is primarily the result of public health vaccination campaigns against early childhood diseases (such as measles or pertussis) implemented during the 1970s and 1980s. This increase would have slowed in the 1990s with the decline in “vaccination effort” and the increase in malaria-related mortality (Pison, 2010, p. 4). In the 2000s, the decline would have accelerated again with the resumption of vaccination campaigns across the country. This historical and health analysis naturally puts biopower dispositifs at the heart of the reflection.

Medical anthropology in West Africa makes it possible to more finely understand the slowness of the decline in mortality in Senegal by highlighting the shortcomings of these systems, which are not widely available to rural populations, and their dysfunctions, even in urban areas. As such, the article by Fassin and Fassin (1989), entitled “La santé publique sans l'Etat? Participation communautaire et comités de santé au Sénégal”, appears to be a paradigmatic approach to the situation. In this text, the authors show how, in Pikine, a suburb of Dakar, the Senegalese State, without a strong public health policy (and without sufficient financial resources), delegates the health of the population to the neighborhood notables, through the concept of “participation”, nowadays called “community health” by international organizations. Thus, the slow – and apparently fragile – decline in mortality in Senegal can be explained by the weakness of biopower dispositifs. In the area of hygiene, for example, which is a priority topic in terms of public health, it should be noted that, in Senegal, 13% of households do not yet have a sanitation facility, 23% share their latrines with other households and less than half have “unshared improved latrines” (including flushing and access to a pit). At the same time, the gaps and wanderings of Senegal's disorganized, inefficient and inaccessible health system for a large part of the country's population are highlighted by many researchers (e.g. Bonnet & Jaffré, 2003; Bossyns, Ladrière, & Ridde, 2018), explaining the difficulties encountered in reducing mortality rates. In addition to these biopolitics dispositifs per se, the limitations of the educational system (e.g. Niang, 2014) – more than one in three men and almost one in two women had still not attended school in 2016 (ANSD, 2018) – demonstrate that all dimensions of biopower remain poorly developed in Senegal.

These non-Western examples show that biopower dispositifs are necessary for the first phase of demographic transition: the reduction of mortality. Let us now turn to the second phase of the transition: the decline in the birth rate.

Dispositifs for reducing the birth rate

France

Biopower also makes it possible to explain the decline in the birth rate, an important factor in demographic aging, by reducing the younger age groups. However, a difficulty appears in this analysis, as Johnson-Hanks (2008, p. 310) points out: “demographic transition should be a paradigmatic example of biopower, but at least in France

and in the United States, new kinds of individual self-regulation, visible in birth rates, preceded the relevant forms of knowledge/power by decades." Indeed, when fertility began to decline in France towards the end of the 18th century, the government was holding a pro-natalist discourse aimed at promoting childbearing and parenthood as desirable for social reasons and to ensure the continuance of the population. However, this disconnection between public policies in terms of reproductive behavior and the behavior actually observed in the French population in the 18th century is not enough to sweep away the heuristic contribution of biopower to understand the decline in the birth rate.

In Foucauldian thought, the term power refers to the multiplicity of power relations that are exercised in different fields. In this perspective, *La volonté de savoir* (Foucault, 1976a) can be read as an analysis of how birth control spread in 18th century France. Sex was, and remains, at the heart of a contrasting set of state, religious, economic and medical prescriptions. However, while political discourses were pro-natalist at this time, medical speeches often highlighted the risks associated with uncontrolled sexuality (e.g. bringing births closer together, increasing the number of births). Within the same field, discourses could seem contradictory. For example, despite the eminently pro-natalist position of the Church, the staunch Jansenist movement, which developed from 1680 onwards in France, is said to have contributed to a significant sexual austerity and the spread of the practice of *coitus interruptus* (Chaunu, 1988). At the same time, the Church is placing greater emphasis on the risks of closely-spaced pregnancies and the need to care for children, further blurring its pro-natalist policy (Paltrinieri, 2014).

In line with the work of Ariès (1948), Foucault notes that it was indeed the bourgeoisie that began to reduce the number of their descendants. The bourgeoisie's objective was to develop an economically useful sexuality. This awareness of the political value of his body by the bourgeoisie will precisely build his social class body. These new sexual behaviors of the bourgeoisie will then spread to the working classes through the administrative dispositifs in the fields of medicine, education, etc. The aim was to adjust demographic processes to economic processes as part of the development of capitalism.

China and Senegal

In China, the decline in birth rate did not happen "automatically" with the decline in mortality, it began in the 1970s with the third national birth control program, launched in 1971 (Attané, 2016). The slogan *wan* (late), *xi* (spaced), *shao* (few) was first implemented by measures delaying the age of marriage. The total fertility rate fell from 5.4 children per woman of reproductive age in 1971 to 2.8 children in 1979. However, these measures were nevertheless considered insufficiently effective by the government, which did not hesitate to implement the famous one-child law in 1979, in both urban and rural areas (Croll, Davin, & Kane, 1985). This policy has been explicitly justified by the State as necessary for the country's modernization process (Greenhalg & Winkler, 2005).

Despite population resistance and government adjustments (Attané, 2016), fertility control became a constitutional duty in 1982: "The State promotes family planning so that population growth may fit the plans for economic and social development" (article 25); "Both husband and wife have the duty to practice family planning" (article 49). The effects of this biopolitics were as drastic as the constitution: in 2000, the total fertility rate was of 1.2 children per woman. Of course, this can be read as an extreme biopolitics – or at least not observed elsewhere in the world – that has enabled China to achieve its demographic transition in an exceptionally short time (Attané, 2016).

In Senegal, once again, the situation appears very different. The total fertility rate is still very high compared to societies that have completed their demographic transition: around five children per woman currently (ANS, 2018; HDR, 2018). Yet Senegal is one of the first countries in West Africa to have adopted a Population Policy

Statement in 1988. It should be noted, however, that this declaration did not specify any quantified targets at the time. In 1994, the International Conference on Population and Development – the famous Cairo conference – led to the reorientation of population policies in Senegal. A National Reproductive Health Programme was developed in 1996 (Adjambo & Antoine, 2002). However, there was a huge gap between the written policies and the concrete measures. Economic conditions (Adjambo & Antoine, 2002) and the contingency of life in West Africa (Johnson-Hanks, 2002) partly explain the failure of these programs. However, a biopower analysis can explain the repeated failures of policies aimed at reducing the birth rate. As Adjambo and Antoine (2002, p. 534) point out: "In response to the disengagement of the State, population programs have relied essentially on initiatives taken by international donors (UNFPA, World Bank, USAID, Unicef, WHO) and NGOs". This disengagement of the Senegalese State is of course reminiscent of the work of Fassin and Fassin (1989) on the healthcare system in Senegal and his delegation to the notables of the districts. Above all, it highlights the absence of an effective population biopolitics in Senegal that can be transposed to other countries in the sub-region. These policies are based on a proactive strategy to reduce births. These non-coercive biopolitics, which are poorly implemented, coexist with other powers that value important descendants, such as religious power. In a country where 95% of the population is Muslim and very religious, and where Islam is organized in brotherhoods, the two major Mouride and Tidjiane brotherhoods exert an obviously significant pro-natalist influence (Petit & O'Deye, 2001). At the same time, relations between men and women, particularly in rural Senegal, favour plentiful descendants who are needed to help Senegalese pastoralists and farmers. All these power relations, marked by a disengagement of the State and the weakness of measures aimed at reducing the birth rate, make it possible to explain why Senegal is still far from having completed its demographic transition, unlike France or China. But demographers assure that it will happen, and that with increasing school enrollment, birth reduction campaigns, and economic development, Senegal will follow the path of demographic modernity.

Conclusion

The notion of biopower makes it possible to explain how demographic aging and transition have been implemented on a global scale. The temporal and cultural variability of these processes, finished in most developed countries and beginning in some developing societies, can be explained by its modes of implementation in specific contexts. Through its empirical approach, anthropology must make it possible to grasp the mechanisms at work in societies that are beginning their demographic transition, as in West Africa for example. It is also a question of linking these dispositifs with modes of subjectivation¹³ and resistance to biopower. In the years to come, this program may constitute a research avenue for anthropology and gerontology in order to better associate the micro and macro levels, the social actors and institutional mechanisms, the controls of individual and collective bodies.

This article also constitutes a reflexive analysis on our practices as gerontologists. Since the fate of older adults in our societies is often at the heart of our research, we usually become dispositifs of biopower. That is obviously what we do when we work on health topics, trying to understand what may maximize longevity and help one to age in the best possible state. Our recommendations for public policies – an unavoidable part of socio-medical gerontology articles – are illustrations of our inclusion in these dispositifs. This is especially true when we work in developing countries, where the fate of older adults could sometimes appear particularly difficult.

The "successful aging" concept – now widespread in most societies,

¹³ Subjectivation is, for Foucault, the way people constitutes themselves as subjects (even if, in the same time, they are subjects of power).

from the North America (e.g. Rowe & Kahn, 1997) to Europe (e.g. Balard, 2013) or Asia (e.g. Cheng, Chi, Fung, Li, & Woo, 2015) – may also be seen as a construction of biopolitics which encourages social and physical activities among older adults so that they remain useful and are not a burden for society. Of course, this biopolitics rationalization of existence may be internalized and older people themselves come to see successful aging as active aging. Moreover, in developing countries, Jaffré remarks in his work on west-African hospitals that people who do not benefit of efficient biopolitics dispositifs “dream about it” (Jaffré, 2003, p. 346). While it is not the point of this article to debate the “good” or the “bad” of these biopostifs, we have demonstrated some of the ways through which biopower shapes the demography of the human species.

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