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**SPRING REVIEW  
ON  
POPULATION**

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**MAY 11-13, 1970**

**SUMMARY FINDINGS AND  
IMPLICATIONS FOR A.I.D.**

SPRING REVIEW ON POPULATION

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May 11-13, 1970

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A.I.D./Washington

PPC/Evaluation Staff

August 1970

Note:

This document, which endeavors to summarize the lessons of this evaluation review, is issued for the information and suggestions it contains and the insights which it is hoped it will provide. The document is not to be considered to be instruction or a statement of policy.

SPRING REVIEW ON POPULATION  
SUMMARY FINDINGS AND IMPLICATIONS FOR A.I.D.

May 11-13, 1970

I. INTRODUCTION AND SUMMARY

The Review had two main purposes: to exchange experience on operational questions and to consider lessons learned on some of the broader questions and issues in order to "improve the doctrine" or devise a more effective overall strategy.

The exchange of experience took place both in the preparation of the Mission Reports and the analytical papers, and in the discussions at the Review sessions. Often the country situations were too diverse to permit generalizations. Some specific highlights, however, have been presented in capsule form as an annex to this report. Since these constitute only a partial check list, A.I.D. personnel, who were unable to participate extensively in the Review, are urged to examine those portions of the country and analytical papers most relevant to their particular problems.

For some of the more general questions of overall magnitudes, accomplishments, limitations and possibilities, the Review tended to coalesce experience and previously held views into a somewhat firmer body of doctrine. Findings in five key areas are summarized in Part II of this report.

On the main issues, where differences in view existed, the Review deliberately avoided the sharpening of issues which with present evidence appear unresolvable. The approach was to start with the evidence from past experience and to explore the extent to which it has narrowed the range of views on these issues -- at least with respect to a determination of appropriate next steps if not necessarily with respect to the ultimate

shape of the program. As dealt with in this report, each of these issues could readily be stated sharply -- A versus B. They have not been because the Review revealed quite clearly that the case is not for either A or B, but, rather, for both A and B. The pros and cons and operating conclusions on five major issues are summarized in Part III of this report.

The general findings in five main areas presented in Part III and the conclusions on five major issues covered in Part III are summarized in the following ten paragraphs.

1. Although the magnitude of the population problem was not specifically under review, the Review demonstrated that it is really of overwhelming proportions. Some new projections, presented at the outset by Dr. Hannah, concluded that even if a net reproduction rate of one were to be achieved by the year 2000, the world population would not stabilize until the year 2070 and would be 7.4 billion, more than double the present world population. For the LDC's, the projections are of even greater concern. For them the assumption of achieving a net reproduction rate of one by the year 2000 seems especially optimistic. But even if this were accomplished, the specific projections for nine major LDC's show that when population did level off, it would in most cases be more than three times the present levels.

2. The Review underscored the narrow limits of present knowledge of how to deal adequately with the problem. The word humility was much in evidence.

3. The evaluation produced a definite conclusion that population programs to date, despite their newness, have taken hold. One commentator described the rapid program growth as "phenomenal." While much of the documentation and most of the discussion focussed on means of improvement and areas of inadequacy, there was no suggestion that progress had not already been substantial. The main thrust of the Review was for a broadening and a deepening of the effort, not a change in course, with the main emphasis for the foreseeable future remaining on family planning programs.

4. The evidence is by now convincing that improved delivery services for contraceptive advice and devices cannot solve the population problem alone. This is not to say that family planning programs have reached their limits. Far from it. But even on very optimistic assumptions about improved contraceptive technology and expanded and improved delivery systems, population growth rates in the LDC's would still be excessive -- very likely of the order of 2 percent in many cases. So far family planning services have been essentially limited to helping couples keep their families to the size that they want, but very many LDC couples still want large families. It is increasingly clear that a broader

range of socio-economic forces, albeit working largely through family planning services, must be brought to bear if even a long-range solution is to be found to the population problem.

5. Research should continue to receive a high priority. In the bio-medical field, it was suggested that an international effort among the developed countries might well be considered. A.I.D. might well join, but could scarcely take the lead. On the other hand, in behavioral and other social science research and experimentation on motivation and socio-economic factors in population growth, a major portion of the research must be in the LDC's. A.I.D. is in a particularly good position to encourage and support the very great expansion that is called for in this field.

6. On the issue of quantity as compared with quality in family planning services, the evidence was far from clear as to the proper relative emphasis. The evidence does suggest, however, that there is a potential danger of a "backlash," which in the longer run could be harmful, if the initial emphasis is almost exclusively on meeting targets and other aspects of quantity to the exclusion of quality of services.

7. Consideration of the question of the relative effectiveness of concentration on a single contraceptive technique as against the "cafeteria approach" suggested that a part of the apparent diversity of experience and opinion may be due to different stages. In new programs and/or particularly backward countries (e.g., very high illiteracy), concentration on one or perhaps two methods for the government service program may be most effective for administrative reasons. Setbacks have been related to preference for only one or two methods. With growing sophistication, however, it may be practicable to move toward the preferable approach of offering a wide range of services.

8. On the role of Mother and Child Health (MCH) and other health services in family planning, the importance of stages again helps to explain the wide diversity of experiences and views. In the initial stages of a family planning program, it will often get off to a quicker start if it can build upon an existing MCH system. But since the costs of a family planning system are much lower, it will eventually be held back if the continuing tie to MCH is too close. In the longer run, some argue that a full integration of family planning and MCH, despite the high cost of the latter, is essential to the full effectiveness of family planning. Others argue it would not be worth the cost. It appears that large-scale experimentation will be required to help resolve this question or that the conservatism and administrative weakness of typical LDC health ministries requires separation of family planning services if they are to get anywhere.

9. On the relative roles of physicians and of non-medical personnel, there were some contradictions in the evidence and sharp disagreements in the discussions. Some of these arose from differences in country situations. But much of the disagreement turned out to be not one of principle, but one of tactics in how to enlist the support -- or at least avoid the opposition -- of the

medical profession. There seemed to be a nearly complete consensus on the key operational principle: "Auxiliary workers should be looked upon as a goal, not as an expedient." The conclusions imply major requirements for the development of training methods and programs.

10. The issue of the roles of "population planning" and "family planning" turned out not to be an issue at all -- the roles are complementary. Population planning deals with the totality of the population problem in the total development context. In principle it endeavors simultaneously to increase the effectiveness of family planning programs, to develop supplementary approaches to dealing with the population problem, and to plan for larger societies. In LDC's with an effective Planning Office or Planning Commission, this would normally be the focal point for population planning. And the limited experience to date suggests that A.I.D. Missions may often be in a position to help strengthen the population planning function in the LDC planning offices. The Review suggested that population planning today stands about where family planning stood a few years ago; we are just coming to realize its essentiality and, despite many uncertainties, we need to tackle it with a great sense of urgency.

## II. GENERAL FINDINGS

### II - 1. The Magnitude of the Problem

The Review assumed a general acceptance of the view that the population problem is one of overwhelming seriousness. An added note of urgency was introduced at the outset, however, when Dr. Hannah presented some recent projections of the Population Council and the U. S. Census Bureau. These projections highlighted the momentum toward continuing population increases, even with highly effective family planning, which are inherent in the present high proportion of young people in LDC populations -- a result of the historically unprecedented drop in death rates, as is the population problem itself. The projections indicate that even if a net reproduction rate of one -- i.e., if all the women living to the age of motherhood had, on an average, only one daughter living to the age of motherhood -- were achieved by 1980, the world population would continue to grow for another 65 or 70 years. And when the world population did stabilize at around the year 2050, it would be at a projected level of 5.6 billion people, more than two-thirds greater than the present world population of 3.5 billion.

But nobody seriously expects the achievement of a net reproduction rate of one by 1980. On the more realistic assumption -- which is still a highly optimistic one in the light of present knowledge and present trends -- that the net reproduction rate would fall to one by the year 2000, population would continue to grow until 2070 and would stabilize at 7.4 billion. For most LDC's, the stabilized level would be about 3 times as much as the present level. On a less optimistic assumption, if the net reproduction rate were to continue above unity until 2050, population would continue to grow until 2120 and when it finally stabilized would be at a level of 14.5 billion, more than four times the present world population. The projections assume an even greater magnitude when they are examined in terms of their potential effect on human welfare and on the opportunity for improved living conditions.

This neo-Malthusian spectre can only lead to the hope that we, like Malthus, will be blessed with saving developments which we cannot foresee. But, since the root cause of the population explosion is the extremely rapid decline in death rates -- a vastly sharper decline than in Malthus' day -- we can scarcely hope for natural developments, unaided, to solve the problem.

This new set of projections and the recognized consequent effect on the quality of life set the tone of the Review as one of redoubled urgency and the need for the active pursuit of all possible means of attacking the problem. Countries which now consider that they do not have a population "problem," such as several in Latin America and Africa which have much open land, will have a very serious problem if their numbers triple or quadruple in a few generations.

II-2. "The State of the Art": How Little We Know

Perhaps the clearest conclusion of the Review was how much more we need to know than we in fact do know. The boundaries of firm knowledge are still very narrow, and the need for humility was noted by a number of participants in the Review. While it was scarcely necessary to have a major evaluation to reach this conclusion, it does seem to be worth noting explicitly and considering seriously.

The limits of present knowledge do not suggest inaction; we certainly know enough already to move forward. But they do suggest a flexibility of approach and the building of experimentation and evaluation into our operational programs. At this stage we can at best deal in probabilities, not in certainties. Different approaches should be considered -- and sometimes carried out -- simultaneously. And the total approach should be one that can change direction as our experience, knowledge and understanding grow.

Thus, one obvious conclusion from the lack of present knowledge is the need for better evaluation, better research, better experimentation. While this general exhortation scarcely advances the cause, some guides did emerge, which are considered at appropriate points below.

II - 3. The Growth and Effectiveness of Present Programs

The awesomeness of the population problem and still limited knowledge of how best to cope with it have not impeded the rapid growth of Population-Family Planning Programs. The Review tended to solidify the general view that progress has been great and that the initial efforts have been in the right direction. One commentator described this growth as "phenomenal" and said, with pardonable hyperbole, that we know a thousand times as much as in 1963. Substantial programs are underway by now in most of the more populous LDC's, and A.I.D. has played an important role in most of these.

The most concrete measure of growth in A.I.D. activity in this field is provided by financial data. From an amount of only \$2.1 million in FY 1965, A.I.D. obligations grew to \$34.8 million in FY 1968, and \$45.4 million in FY 1969. A substantial part of A.I.D. financing has been allotted for research, but well over half has gone, directly or indirectly, to country programs. The limited data on coverage in A.I.D.-assisted programs suggest that progress is being made. Perhaps the most hopeful sign is the change in attitudes, both in the LDC's and in the U. S., that these rapid rates of program growth reflect.

When it is realized how new most of the programs are, with few having been initiated in any very serious way more than a few years ago, present levels of coverage are indeed encouraging. The degree of success to date points clearly to continued major emphasis on family planning programs as the most effective instrument in dealing with the population problem.

II - 4. The Potential of, and Apparent Limitations of, Present Family Planning Programs

Much of the documentation and discussion suggested that "plateaus" had been reached in certain family planning activities, at least the number of new acceptors was decreasing, and possibly the total number of contraceptors was leveling off. A rationale for this possible phenomenon is the observation in some programs that contraception tends to be concentrated in the older couples who already have large families. One expert argued from his field experience that probably only 10 percent of potential acceptors are adequately motivated without some special stimulus from outside. Another expert observed, however, that it is premature to talk about plateaus. A third stated that "the plateau effect doesn't exist" and estimated the "easy acceptor" group to be more of the order of 15 to 20 percent. The detailed data developed for the Review for seven countries showed a tendency to level off in the two most advanced programs, Korea and Taiwan, with continued rapid growth in the newer programs.

Part of this disagreement was due to deficiencies in the data. And a part may well have been definitional. For example, the data for India show a plateau, in fact a slight decrease, for the percentage of the target population protected by IUD's, but the rapid increase in protection by sterilization and the growing use of conventional contraceptives add up to continuing increases in the total amount of protection. A plateau effect for one technique does not imply a plateau effect for the total program.

But the major basis for the differing views appears to be differences in interpretation of what the data mean and, especially, what the implications for the future are. Some argued that the India IUD program can be revitalized. And the basic argument was made by many that no present major program is making major use of all the available techniques. Special hope was held out by several that the pill which is relatively little used has -- despite high

reported rates of discontinuation -- a tremendous remaining potential.

What is the evidence as to the limits of existing and improved contraceptive techniques and the improvement and expansion of present delivery systems? The more pessimistic thought these limits might be reached at perhaps 30 percent coverage -- or even less. The more optimistic view was that the limit might be as high as 50 percent -- or more. In either case, it seems clear -- and was generally agreed -- that the limit has not generally been reached and that intensified efforts are called for to achieve the substantial remaining potential.

Another very important conclusion, however, emerges from this analysis. Even if half of the couples of fertile age were to practice contraception, population growth rates would still be high. This is true in part because the acceptors tend to be disproportionately in the higher age groups and to have several children already. For example, in Pakistan 65 percent of the IUD acceptors had already had five or more children. Moreover, with the high proportion of the population in most LDC's in the very young age groups who will soon be of marriageable age, it is necessary to increase the proportion of acceptors just to keep birth rates from rising.

The underlying factor is that most couples in the LDC's appear to want fairly large families, with three or four or five living children being typical. The best possible contraceptive techniques and the most efficient possible delivery systems will not directly alter these attitudes, although couples who practice family planning for spacing of their children may eventually decide to have fewer children than they first considered desirable. The implication of these attitudes for population growth rates depends on a whole host of factors: trends of mortality rates, the age composition of the population, average age at marriage, etc. But the conclusion which was

generally accepted was that present patterns in most developing countries are such that with well managed and widespread family planning services, birth rates would still be near 30 per thousand -- implying population growth rates of over 2 percent.

Whether one is near the pessimistic or the optimistic end of the scale on the potential of present types of family planning this is generally not of overriding importance in terms of present program decisions. It may make some difference in relative emphases -- and may, of course, be of great importance in some specific, individual cases. But it does not greatly affect the broad, general operational conclusions on developing population programs. These are:

The unrealized potential of present types of family planning programs is substantial and should be realized as rapidly as possible.

Present types of family planning programs cannot, by themselves, solve the population problem and the search for broader approaches should be intensified.

## II - 5. Research and Experimentation

The evaluation of research to date and, more particularly, of the gaps in research suggested some new emphases. There was a reaffirmation of the importance of research in contraceptive techniques and of the further basic bio-medical research that is probably a prerequisite to any major breakthrough. The main point of emphasis in this area from the evaluation was the tremendous potential if improved contraceptive techniques could be developed. But there also emerged from the analysis a clear indication that the time has come, or is perhaps overdue, for greater emphasis on additional approaches. The magnitude of the problem and the limits, although by no means reached yet, on what present types of programs can be expected to accomplish, led to an emphasis on greater efforts of three types: 1) More behavioral and social science research, 2) more research within the host countries themselves, and 3) a greater role for outright experimentation.

Relatively little is known of what personal and social factors determine the number of children that parents want or how the size of the "ideal family" may change over time. It is clear that at some level the socio-economic context becomes a binding limitation on further "success" in birth rate reductions. But it is not clear at what level this "cultural bind" becomes controlling nor which of those elements in the development process which influence human fertility are most amenable to change. Greater knowledge in these areas would improve the effectiveness of present programs and will become indispensable as we move closer to the limits of those programs. It will probably require years of intensive research to provide an adequate level of understanding. But this time requirement between intensified research efforts and the payoff is not an argument for a low priority. On the contrary, it adds

to the urgency of moving ahead sooner. Some research of this type has already been launched.

Much of the behavioral and social science research must be carried out in the LDC's themselves. The great differences in the social/cultural contexts and in birth rates between them and the more developed countries make this clear (although the experience of some countries, Japan in particular, which have made both the developmental and the demographic transition with unusual rapidity may have important lessons). Moreover, host countries are more likely to be convinced by, and act upon, research results that apply to their specific situation. Thus it is important that, although such efforts will doubtless need outside financing and professional talent and encouragement, this research be closely integrated into host country institutions and that it develop and draw on host country social science research talent.

Some of the areas in which greater knowledge is urgently needed may be in large part unresearchable, or it may be that standard research techniques would take an inordinate amount of time to yield results. Controlled social science experiments may help fill the gap in some cases. This is suggested in some detail in connection with the role of MCH in item III-3 below. Other areas where it might have applicability are in the role of education (both in the schools and in adult and community education) and in the possibilities of various kinds of financial incentives to fertile couples to limit their families. Although the latter was considered by most participants in the review to be prohibitively expensive, the possibilities of schemes that would limit costs by concentrating on special target groups may well merit further exploration.

Many of the aspects of this broadened approach to research and experimentation that emerged from the Review relate closely to the suggested increased emphasis on Population Planning suggested in III-5 below.

### III. GENERAL ISSUES

#### III - 1. The Relative Importance of Quantity and of Quality in Family Planning Services

There are several reasons why the quality of family planning services should receive serious consideration along with a rapid expansion of the quantity of services made available. Able, better trained, better supervised personnel with strong motivation and adequate facilities are likely to be able, over time, to induce a larger number of potential acceptors to practice contraception. "Satisfied customers" are probably a major element in program expansion. Conversely, "dissatisfied customers" may damage the effort to increase the number of users. The clearest importance of quality is with respect to drop-out rates.

The drop-out rates for IUD's are often more than 50 percent, and the rates for the pill may well be even higher. Many of the drop outs are evidently unavoidable consequences of acceptors changing their basic views on family size or of side-effects being truly intolerable. But there is considerable evidence that the drop-out rate is influenced by the quality of family planning services that women receive, particularly with respect to sympathetic support from family planning workers. Adequate warning of what to expect and assurances that the side effects are not serious can certainly reduce the requests for removal of IUD's. And sympathetic and informed reassurance when the side effects do develop can convert many requests for the removal of IUD's into a willingness to continue. On the other hand, inadequate preparation of women to expect possible side-effects may result in very "dissatisfied customers."

In some cases it has been reported that rumors have been started associating IUD's with cancer. And if there is no support when the side-effects do develop, or if the request for removal of an IUD is immediately complied with,

with no effort at further persuasion, the number of drop-outs will plainly be greater. Preserving "confidentiality" is also an important element of quality of service and preventing drop-outs in many cultures. Although it is difficult to assess the importance of these elements of quality, and the importance of attitudes that are one element of quality, the wide variation in drop-out rates from one clinic to another, often found within a single country program, suggest that they are substantial.

The IUD program in India, although debatable as to both its results and future, illustrates some of the considerations. The available evidence shows India having the highest drop-out rate among major programs (although not by a wide margin) with drop-outs actually greater than new insertions in 1968, the latest available year. Many observers attribute this record, at least in part, to the system which set targets or quotas for family planning workers with no adequate means of adjusting the quantity by quality. Although many observers hold that it is premature to judge the Indian IUD program a failure -- some argue that it can be rehabilitated and others that IUD's are being supplanted by more effective techniques -- it does illustrate some dangers.

There are, as the above discussion illustrates, no clear guides to be drawn from experience to date: the evidence is too unclear and the country situations too diverse, although quantitative goals are useful in focussing effort systematically, in providing action incentives and in evaluating progress. But one principle does emerge clearly. Since the longer-range effects of a family planning program are obviously more important than the immediate effects, program development should try to carefully assess the dangers of what some have called a "backlash" from overzealous concern with meeting numerical targets at the expense of quality. Although experience provides

little generalized guidance of the proper mix between the emphasis on quantity and quality, it does demonstrate that it should be a mix; exclusive preoccupation with quantity is nearly certain to be self-defeating.

III-2. Concentration as against the "Cafeteria Approach" as Alternative Strategies on Contraceptive Techniques

Most family planning programs are built around one or a combination of the following four techniques: IUD's, the pill, sterilization, and the "conventionals" (condoms, foam, etc.). The rhythm method is included in a few cases. Also of great, but often undetermined, importance are coitus interruptus and induced abortion, but these are not generally included in family planning programs as such.

Theoretically, there should be one "best" contraceptive technique, if one had to choose a single one, for any given country situation. Also, with a single technique it should be easier to devise and administer the optimum delivery system. On the other hand, a range of choice in techniques, the so-called "cafeteria approach," may appeal to a wider range of potential contraceptors and may keep many drop-outs in the program by offering an alternative. There is some evidence, for example, to suggest that IUD's have a greater appeal to older women and the pill to younger women and some drop-outs from IUD programs are using the pill. The point is to get women or men started in the habit of contraception by whatever means, and to give maximum encouragement to their sustaining this habit by offering the greatest feasible range of alternatives to fit their varying preferences.

The "cafeteria approach," however, may pose special difficulties in backward countries where illiteracy predominates, especially if women have a low status and very limited range of experience. If confronted by a choice among several techniques and the advantages and disadvantages of each, they might be totally confused and discouraged. Skillful "sounding out" by the family planning worker to ascertain which technique is likely to be the most effective, and then a careful explanation of that technique, might mitigate this

difficulty. Additional knowledge about what works best for various ages, parities and educational levels might help the clinic worker provide guidance. But in very poor countries with limited training and general illiteracy, the family planning worker is likely to be at a relatively low educational level, which may make it difficult to impart the necessary skills to her, and the superior organization necessary for effective use of the cafeteria approach will be harder to develop.

Taking all of these considerations together, it becomes clear that the relative effectiveness of a concentrated as compared to a cafeteria approach will depend very substantially on (1) the stage of development of the country and (2) the stage of development of the program. A new program in a backward country may well need to concentrate mainly on one or at most two techniques. And as either or both develop, a movement toward a more complex program may well be appropriate. Ultimately, the widest possible range of choice would appear to be the system to move toward.

The Review heard a strong plea from a representative of the Population Council for consideration of the role of officially sanctioned abortion in supplementing contraception. It was pointed out that abortion has been significant in Japan and some East European countries and that several legislatures in the United States have recently enacted laws liberalizing the conditions under which abortion is permitted. Some of these leave the decision up to the woman and her doctor. The Review did not discuss this issue, partly because safe use of abortion requires more medical facilities than are available in many countries.

III-3. The Optimum Relation Between Family Planning Services and Maternal and Child Health (MCH) and Other Health Services

This issue was discussed largely in terms of MCH, although similar considerations apply in part to a broader range of health services. (One aspect of this question is the role of the physician, which is treated separately in III-4 below.)

The views ranged all the way from "you must start with what you have" to "you can't make do with what you ain't got."

In addition to this basic question of facilities, there are other questions of relationships. Ministries of Health are generally not very powerful in the government hierarchy, and MCH is often not very high up within Ministries of Health. The addition of family planning services to other MCH and/or general health services may mean that de facto, whatever the understanding in principle, it gets only secondary or tertiary attention. Moreover, a tying of family planning services to MCH and other health services, where these are not already extensive -- and they are often limited primarily to urban areas -- places serious limits on expansion because the health services are, relatively, so costly.

On the other hand, there are some clear advantages to associating family planning and MCH services. It provides in at least most cases some initial base of personnel and organization, and a place in the government. It places family planning in a public context where the plainly humanitarian goal of improved health for mothers and children is being considered along with the more abstract and negative sounding goal of reduced birth rates. And, from the personal view, it contacts women in circumstances where they are likely to be most receptive to family planning guidance and advice. Some argue that, from their experience, family planning can be "sold" only to a very few unless combined with some more immediately attractive product.

Given these opposing considerations, are there any lessons to be learned from our experience? Here again, and subject of course to major individual country variations, the most likely generalizations appear to be linked to the different stages of family planning programs.

An interpretation of the experience to date is that most family planning programs will get off to a quicker start if they are, initially at least, linked to MCH or similar health services. The chance to use an existing institutional arrangement, however inadequate, and in some cases to draw in part on existing trained personnel is an important one. Moreover, this connection may make a family planning program more acceptable, both to political leaders and the public at large, where such acceptance is shaky.

But as a family planning program expands, it may well go beyond the need for initial support and may rapidly outstrip the facilities of the MCH that are available. The outreach of family planning services, particularly to rural areas, can be achieved at a very much lower cost than expanding the extension of a full array of MCH services. Some separation from, or expansion beyond, the MCH organization appears to merit serious consideration at this stage. (And, by inference, in countries where such a preference is likely to develop, it will be wise to plan for it from the outset.)

Finally, the Review established a reasonably broad consensus that at some point short of solving the population problem, further improvements in family planning programs will have largely used up their capacity for expansion. At that point, wherever it may be, a closer integration between family planning and broader elements of the development process will be essential to rapid further progress. (See IV-5 below.)

There is a prima facie case, on the basis of experience to date, that one of the most immediately effective points of integration would be with an expanded and improved MCH program. There is a strong presumption that this would materially increase the number of acceptors. But there is also a clear indication that it would have a relatively high cost, especially recurrent costs. (One estimate is that such a system for all LDC's, excluding mainland China, would have a capital cost of \$2 billion and annual operating costs of some \$750,000,000, but there is some opinion that this grossly underestimates the likely cost.) While even these high costs would probably be within the realm of the possible, if there were assurances that they would solve the population problem, there of course are no such assurances. Although the benefits seem clear, the benefit-cost ratio, as compared to alternative approaches, remains uncertain. The judgments of participants on this subject showed a wide range and the observation that "we're using the same evidence to reach opposite conclusions" strongly suggested the need for more evidence, and probably for comparative analysis of some alternative types of local delivery systems.

Better understanding of the MCH role seems to call for more than the usual retreat to the need for more research. It also, however, appears to be ripe for a relatively new approach -- outright experimentation. Large-scale A.I.D. assistance to meet local costs would probably be needed. But this would not encounter the usual dilemma of greater outside assistance discouraging greater local self-help in a frankly experimental program. Some such experimental work is already being undertaken, notably in the Punjab and in Ghana. But as a number of the papers and the participants suggested, a considerably wider range of experimentation seems necessary. With careful

design, such experiments should add greatly to our knowledge of the extent to which a widespread integration of family planning and MCH programs could increase the number of acceptors and reduce the number of drop-outs. To a lesser degree, it should improve our understanding of its longer-run potential by indicating the degree of increased appeal to the younger, lower-parity women. As the urgency of increased family planning becomes increasingly apparent, and as the limits of lower cost methods are more closely approached, funding for this prime contender for the next major step may well be in the hundreds of millions. A few tens of millions for experimentation to improve our knowledge might well -- wholly aside from the immediate gains from the program -- prove to be a very high-yielding investment.

III-4. The Relative Roles of Physicians and of Non-Medical Personnel

There was sharply divided opinion on this subject. One doctor cited numerous illustrations of how little rapport doctors have with the masses in less developed countries. Another doctor coined a new word -- "dephysicianize" -- to describe a proper operating principle for family planning programs. Another participant, not a doctor, argued that programs needed to be built on a strong medical base. The Country Reports indicated a variety of experience.

Moreover, there appeared a clear dilemma in the evidence. On the one hand, ~~many~~ physicians do not find family planning work particularly attractive; it is generally not profitable and it is not very professionally interesting or challenging. On the other hand, no program is likely to succeed without the support, or at least the acquiescence, of the medical profession.

Some of the diversity in view reflected the widely varying country situations -- the role of the doctor in Chile will obviously be much greater than in Pakistan since Chile has nearly five times as many physicians relative to its population. But much of it represented real differences in viewpoints.

Yet out of this welter of divided opinion emerged some operating conclusions that are supported by the documentary evidence, received the general support of the participants in the Review, and appear to be generally applicable in widely diverse situations.

1) The manager of the program should be a ~~manager~~, with stature in the government. If he happens to be a physician as well, this may be an added advantage. But the important requirements are managerial talent and entre to the government's and the society's decision-making process.

2) Very heavy reliance on para-medical personnel is essential for a successful program of adequate scope. (In a few countries that have enough doctors -- which, by definition are at most barely classifiable as LDC's -- this may not be true. And in a few countries where the medical profession has already taken a strong stand against extensive use of para-medical personnel, it may not be immediately possible -- thereby virtually precluding a program of "adequate scope"). In most countries, it is evident that the number of doctors is insufficient and their own interests are not likely to be strong enough to build a program around them. For the time-consuming work of convincing potential acceptors, of preparing them for undesirable side-effects, and for following up to help acceptors from becoming drop-outs, para-medical workers can be adequate. Even for some more technical aspects such as inserting IUD's, experience shows that para-medical workers can be satisfactory. For some of these functions, other types of workers have been reported to do a better job than doctors. Thus, the real problem becomes one of how to select, recruit, train, motivate and supervise para-medical workers. The use of auxiliaries should be considered a goal, not an expedient.

3) The role assigned to the physician, accordingly, is less a question of basic approach than one of tactics. Their active opposition must of course be avoided, and their active support is of course most important. Convincing them that the program does not jeopardize their interests is plainly necessary. Convincing them that the program does not jeopardize professional standards, which has reportedly happened in some cases, is a desirable further step. Involving physicians in the training process may be a good way of doing this. But the extent of reliance on physicians is essentially a question of temporary tactics when one starts from the clear premise that in most country situations the main reliance must be on para-medical workers.

4) The foregoing conclusions imply major requirements for organizing appropriate divisions of labor, job analysis, developing suitable training methods and building training programs.

III-5. The Complementary Roles of "Population Planning" and "Family Planning"\*

Population planning -- which seems a much more appropriate term than population control -- starts from the assumption that present types of family planning programs cannot be a total solution to the population problem. It recognizes that declines in family norms are largely dependent on economic and social development, and seeks to identify and accelerate those elements in the development process which influence human fertility and are amenable to change, to create an atmosphere in which most couples will feel it is right to plan and produce smaller families. It may also be concerned with the need to plan for dealing with larger populations, for migration aspects, and for the implications of rapid urbanization or of how to hold people in the rural areas. In a sense, population planning is concerned with both the magnitude of the problem and the magnitude of the solution.

Another way of describing the role of population planning is in connection with the stages of evolution of population programs. One Review document suggests four stages: (1) services to the "ready acceptors,"; (2) a high quality delivery system with general coverage; (3) integration of family planning services with other elements of development, of which the most important may include general health services (especially MCH), information services and education programs, and economic incentives and disincentives operating throughout the society; and (4) the demographic effects of the general, and imperfectly understood, process of "modernization". These stages may, of course, exist simultaneously. A role of population planning is to consider these stages in order

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\* The standard dichotomy between "family planning" and "beyond family planning" is a somewhat confusing one since many activities that go beyond present family planning programs, e.g., education programs in the schools, have their ultimate effect in widening the acceptance and practice of family planning. Two other sets of terms were used in the Review. One was to divide the range of possible activities into present family planning, additional activities within family planning, and activities beyond family planning. The other was to draw a distinction between "family planning" and "population planning." It is this latter terminology that will be employed here.

to assure adequate lead time in getting aspects of the later stages, particularly stage 3, into operation.

The basic essential for population planning is to get the power structure in a country to understand the need for such a concern and to undertake a program. Population becomes a concern of Finance, Education, Labor and Housing Ministries as well as of the Health Ministry.

The experience brought out in the Review strongly suggested that one of the most effective ways of encouraging population planning, in addition to family planning, is for A.I.D. Missions to work with country Planning Offices in this area. Where this is practicable, it appears to provide the best assurance that population problems will be considered in an appropriately broad context. It can also have the further advantage, if the necessary staffing is practicable, of initiating and continuing the necessary exploration of the most effective ways of integrating family planning into the development process. Work with the Planning Offices may also have a more immediate advantage. Since such offices often have a concentration of analytical skills within the government, they will often understand more quickly than other elements of the government, and be more responsive to, the adverse economic effects of an excessive rate of population growth. They may also have more access to, or be able to specify collection of, better census and demographic data. This could well lead to broader governmental support for family planning as well as population planning. One participant suggested that such analysts might start by considering what a desirable level of population or a desirable rate of growth -- in relation to the environment as well as the economy -- would be, rather than the "negative" approach of population limitation.

The practicability of dealing with the Planning Office will, of course, vary from country to country. The suggestion is made more as an indication of

the nature of the activity than as a specific proposal. Other elements of government organizations will also often be appropriate. In any case, Missions with reasonable prospects for population programs will probably find it useful to organize themselves to deal with population planning approaches as well as family planning.

With respect to the relative roles of family planning and population planning, they appear to be almost wholly complementary rather than competitive. In terms of financial resources, the amounts that can be effectively used for population planning in the near future are likely to be relatively small. With the growing concern about population problems, meeting these financial requirements should pose no major difficulties at least so far as A.I.D. funding is concerned. In terms of personnel, again, there should be no major conflict. The types of skills needed for population planning will generally be different from those needed for family planning, so diversion would not normally occur. At top managerial levels, such as A.I.D. Mission Director, attention to population planning might divert attention that would otherwise go to family planning. But the converse seems equally likely. By putting family planning more immediately in his broader range of concerns, the Mission Director might take an enhanced interest in family planning along with population planning. And finally, the fact that discernible results from population planning may be slow in coming does not argue for giving it a low priority. On the contrary, the need is clear and the fact that it is a long-lead-time kind of activity adds to the urgency of intensified efforts now.

On the whole, the evaluation suggests that population planning stands today about where family planning stood a few years ago. We are just coming to realize its essentiality, we are not sure just how to tackle it, but we need to get started anyhow -- and with a great sense of urgency.

ANNEX

Selected Highlights of Specific Findings

INTRODUCTION

As noted in the introduction to the main report, the diversity of experience due to differing country situations precludes generalization on many of the topics considered by the Review. But this does not preclude one Mission's learning from other Missions' experience. For those unable to participate in the Review, this will necessarily depend on going to the basic Review documentation. Even so, it has appeared useful to select a few highlights of problems and approaches that, although not readily generalizeable, may serve as a sort of a check list for elements to consider or points to investigate further. These "highlights" are not comprehensive. Nor are many of them novel. Most of them are known to most of the population program managers. They are presented on the assumption that not all of them are known to all of the program managers and that they may in some cases help to guide further investigation.

1. Influencing country leaders. Private leaders as well as government leaders are often important. Within government, Planning Office personnel as well as Ministry of Health personnel and political leaders may be important. The GE-Tempo material emphasizing the economic costs of rapid population growth may help. Demographic and census statistics are often persuasive. A more "positive" approach relating an optimum population to preventing a crowded environment, particularly in the cities, may also help. Emphasis on the growing concern and action about population in the U. S., for the U. S. itself, may help convince leaders of LDC's of our sincere concern.

2) Motivation of couples to practice family planning. Relatively little seems to be known, beyond the obvious burden of very large families, about what motivates couples. This may be a fruitful field for local research. The use of advertising, billboards, slogans, etc. is being undertaken in some countries. "Satisfied customers" and advertisement by word of mouth appear to be important. Emphasis on the welfare of the children may help to persuade couples to have smaller families. Acceptors in present programs tend to concentrate in the older age groups and to have several children already.

3) Use of pilot or demonstration projects. Most programs have found them useful; experience from elsewhere is evidently not an adequate substitute for local experience. Voluntary agencies are frequently very helpful. In some cases it has been found useful to have competing pilot projects and, possibly, to go on to a larger program before all of the pilot work has been finished. Pilot projects must strike a balance between being simple enough to replicate manyfold and being sufficiently complex to provide the needed information on alternative approaches.

4) Alternative contraceptive techniques. There are strong indications that the pill is more attractive to younger women than is the IUD. Sterilization is of course generally limited to older couples. Our experience suggests that more attention might usefully be given to the choice of techniques to be emphasized in order to make them less a matter of chance and somewhat more determined by an analysis of their probable effectiveness. Abortion is evidently of considerable importance in some countries in reducing fertility. The apparent current change in attitudes toward abortion in the U. S. may eventually make this a topic for further consideration.

5) Alternative delivery systems. Clinics, home visits and post partum programs are all useful systems but, in most circumstances, no one of them is adequate for a complete system. Any system should provide for adequate orientation and follow-up. Some experience suggested that post-partum programs, even in rural areas, may have more promise than has as yet been exploited because of the special receptivity of women at this time. One major delivery system that has received relatively little attention is the private sector. The limited experience recorded suggests that further attention and inducements to the private sector may in some circumstances yield very handsome returns. There are other possibilities for government supported, multi-purpose local delivery systems (including but not limited to family planning services) tailored to provide outputs and inputs that best fit the local circumstances. The evidence of the Review suggested that additional attention in some cases is needed to coordinate the type of delivery system employed more closely with the particular contraceptive technique(s) being employed.

6) Emphasis on child spacing in family planning. A preponderance of the acceptors so far under family planning programs have been in the older age groups that already have several children. A greater emphasis on child spacing holds some promise of increasing the appeal of family planning to younger parents. This should have a psychological appeal in changing the image of family planning from one of terminating family growth to one of family planning in its broader sense. The effect on birth rates and population growth is not clear, but it is certainly plausible to expect that families will end up with fewer children if they start practicing contraception early and that population will grow more slowly if the average time between generations is longer.

7) Selection, training and motivation of para-medical personnel.

Improved effectiveness in each of these areas is of great importance for

family planning. The training and use of auxiliary workers should be considered a goal, not an expedient. With proper supervision, auxiliary workers can do much of the required work just as well as more generally trained personnel. The auxiliary workers need not necessarily be even at the mid-wife level, and certainly need not be trained to U. S. standards. For most purposes, women are better as auxiliary workers. Motivation is obviously of very great importance.

8) Evaluation. Evaluation in most programs needs greater attention than it is currently receiving. This includes establishing better baseline data and better vital statistics. The evidence is impressive that more attention to evaluation is likely to have high yields in improving total results, since so little is known yet in this new field of what really works. Evaluation may also be a way of supplying helpful technical assistance in the critical management area that would be less sensitive and therefore more readily accepted than direct intervention in administration. Evaluation of actual program performance and results should be clearly separated from research to develop needed new knowledge, with only the most essential elements included in the former in order to avoid an excessive and unrealistic burden of paper work on the family planning workers.