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GETTING A.I.D. POPULATION PROGRAMS STARTED

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NOTE: This document, although based in substantive part on reports by A.I.D. field Missions and incorporating some suggestions from other A.I.D. officers, reflects primarily the selection of material and intrepretations of the indicated authors. It is not a "cleared" or "agreed"document.

II GETTING A.I.D. POPULATION PROGRAMS STARTED

Factors in Successful Family Planning

The growing adoption of favorable government policies on family planning and the growing public awareness of the problems of continued population growth is a very recent development. Twenty years ago most governments followed pronatalist policies or had no policies at all. The interest of governments in population matters were primarily devoted to increasing the growth rate and was based on the hypothesis that large and growing populations are indispensable for power, prosperity and prestige.

The people were exhorted to have large families for patrotic reasons, contraceptives and abortions were often declared illegal, and various incentives were tried either in subsidies or tax advantages for large familes. These efforts were usually strongly supported by religious organizations which often attempted to prohibit any but "natural" methods of limiting the size of families.

The people were generally responsive. The instinct for race survival is deeply rooted. People like children and want heirs for their way of life, philosophy and inheirtance. In some societies the number of children is considered as an index of virility and barreness is pitied or scorned. In some countries, such as India and Pakistan, people want large families to insure the survival of at least one son. In many countries sons are prized for religious and cultural reasons. For all of these reasons there has been a lack of effective pressure on the politicians or governments to inaugurate, expand, or operate more efficiently family planning programs.

The pronatalist arguments are still being heard in varying degrees around the world and political leaders seldom wholeheartedly support family planning programs. The beneficial effects are essentially long run and the politicians are necessarily concerned with their careers in the short run. There is also often an uneasy feeling that there may be a domestic political liability in family planning that might be exploited.

Basically, however, the misgiving of many top officials is based upon the residual feeling that national size means national power. In a large number of the country review papers the positive correlation of population size and military growth and the fear of upsetting the military balance was noted as an inhibiting factor to the growth of family planning programs.

Other inhibiting beliefs include doubts on the motives of the developed world in promoting family planning on either racist grounds or a fear this is a new form of colonialism, a belief the pressures and tensions of population growth will promote modernization, the desire for a larger national market and a larger working force, and the fear of losing out in the competition between countries and between ethnic groups.

Private Methods

Nevertheless, methods for preventing conception and aborting unwanted pregnancies have been practiced for centuries. Family size has also been reduced by infanticide, especially of female children. Various methods have been followed whether these methods were legally or morally sanctioned or not. A mountian tribe in Asia has long followed the custom of killing

a mother and child on the birth of her fourth baby. This population control procedure stimulated the development of the art of abortion and the search of effective methods to decrease fertility. Such a method however, might lack acceptability in other cultures.

Contraception and abortion is practiced in all of the countries covered by this review and contraceptive devices are available through the private sector whether or not there is a program and whether or not such devices are legal although at a great variation in price. In all of the countries various voluntary agencies were operating in the family planning area although there was little attempt to evaluate the effectiveness of these agencies or to define their role in those instances where the government has a large and active program. The private sector is an important factor in lowering the birth rate or reducing the abortion rate in many countries such as Chile, Costa Rica, Pakistan, India and Paraguay, but of very minor importance in countries such as Ethiopia where conventional devices are probably only obtainable and used by the wealthy.

None of the country papers in the review provided very good data on the role played by the private sector in distributing contraceptives although many considered it of major importance. USOM Thailand has made a good effort in determining the number of devices purchased commercially through confidential reporting from importers. India has made the greatest use of private sector delivery and quite successfully. If commercial sales are overlooked there is always the danger that many people counted

as new acceptors under a government program are simply switching from commercial sales. Where weaknesses in government administration and health structure are apparent, the use of commercial facilities which can, for example, place coca cola or equivalent in every village in Indonesia, should not be overlooked. Expansion of commercial distribution would probably require subsidies and legal changes in some countries. Additional information is required on cost ratios and effectiveness between commercial and government distribution.

Recent Trends

The post World War II period has experienced a dramatic change in natalist policies. Prior to the war governments interest in population matters stemmed from low rates of growth mortality and migration. Today, in nearly two thirds of the developing world the concern is with high rates of growth and policies have been adopted to limit the growth rate.

This trend has been accelerating with the spread of world awareness of the population problem. From very slow starts, over 20 countries have taken favorable positions on family planning or stepped up existing programs in the last 5-6 years. Additional countries are now at least permissive in the field and allow some activity although they have not taken the step of announcing a national policy and embarking on a national program. Although the change in world attitudes has proceeded with remarkable speed, there remains a great uneveness in performance and commitment to mount an effective program.

The differences are also sharply delinated by region. In Asia, which has the largest populations, highest densities, and oldest civilizations, all major countries except Burma and Vietnam are committed to a reduction in the growth rate. In Asia, the movement is based primarily on economic and social development considerations.

The African countries, with the exception of the northern tier, provide little or no support to family planning programs. The newness of many states has meant that the influences favorable to family planning came in to play later than in other areas. Also the historic struggle for survival in a hostile physical environment made high fertility an essential for tribal existence. Today, in many African countries the rhetoric is that Africa is underpopulated and needs more children. The motivating force behind the few countries that have adopted family planning projects has been the economic planners and developers. Health and family spacing has played a rather minor role.

In Latin America, where there are also large sparsley populated areas, family planning activities have lagged behind Asian efforts. However, active programs have developed in some countries with the emhasis on health rather than development, although development may be an equally important, but less publicized reason. The lag may also be explained, in part, by the influence of the Catholic Church in the area. However, Catholocism has not been insurmountable obstacles in many countries, but in these an open confrontation with the Church has been avoided.

In general, countries have moved from little or no interest in limiting population growth through a phase of growing concern and possible action or permissiveness to a phase of adopting a policy and embarking on an action problem. Given the multitude of forces at work behind the adoption of a policy and a program, the process of moving from one position to another varies greatly from country. The Population Council has identified eight steps that are generally observed in the policy making process.

1. expressed government awareness and interest in population size and growth, usually in connection with development planning;
2. a public statement by a responsible official on the adverse effect of the high population growth rate on the per capita income development;
3. a request for a study of the population situation and recommendations by a respected international organization, a foreign government or a local institution;
4. further development in the form of sample surveys, pilot projects, KAP studies and new courses in demography and reproductive biology in the Universities;
5. expansion of MCH care, increased or new budget appropriations, provisions for family planning service through the government health network in cooperation with or subsidy to private family planning associations;
6. statement of a target - to reduce the birth and/or growth rate and/or to support family planning;

7. establishing a family planning authority within the government which then formulates a program to implement the target; and
8. establishment of subsidary units in the family planning agency to deal with various aspects of the program, i.e., information and education, personnel, recruitment and training, records, research and evaluations, and logistics.

These steps are not always necessary and some countries have skipped a number of them. Nevertheless, the pattern appears fairly consistent and the steps can provide a useful check list of the review countries. Ethiopia has not yet entered the scale. Ghana, Ecuador and the Philippines are near the middle of the scale and moving. Kenya and Nepal are well along. The other countries have completed the basic prerequisites although some Latin American countries have programs with little publicity and no publicly stated goals. In one country (Pakistan) there is not the close cooperation between the health network and the family planning program that usually obtains. Although Paraguay has no official policy and no government sponsored program, the operation of private clinics and commercial sales is permitted. The USAID has developed an interesting strategy to further the establishment of a program.

Attitudes

Moving government and peoples from awareness to effective programs requires changes in attitudes and the change must be from awareness and and permissiveness to dedication and commitment. The target group for

the attitudinal change will vary from country to country dependent upon how far the country is along in the population question and the approach must vary to focus on the appropriate target group, such as:

the national power elite, or decision makers;

the intellectuals which includes the professions and academicians;

the opinion makers which would range from the controllers of the media, to the Church heiracly to village priests and leaders;

the politicians;

the bureaucracy;

and finally the potential acceptors which might be further identified by age group, number of living children, urban or rural.

In one country an attempt was made to identify the opinions of the national power elite on the population question and to draw up a strategy to change the attitudes of those susceptible to change. The opposition to the program melted away before the effort was completed. In all countries USIS has spent a considerable effort on identifying target groups developing techniques on how to get information to these groups. Perhaps their experience can be useful. With the exception of a few countries, such as the Philippines, Paraguay and Costa Rica, the country review papers were silent on methods of identifying and influencing opinion and decision makers.

The following section illustrates the way some of the standard program elements have been used to change attitudes and behavior. The list is illustrative and is not meant to te comprehensive.

International Conferences

In several countries, participation in international conferences, particularly those sponsored by international organizations, made converts of influential doctors and health officials who then became active in promoting family planning programs primarily on the basis of better health. Attendance at conferences proved particularly helpful in Ghana, Chile and Costa Rica. Press reports of these conferences have also proved useful in bringing the population problem into the open and starting discussion.

Research

Any program which is intended to be permanent must involve continuing and acknowledged institutions which can provide prestige, continuity, and community acceptance. Local demographic research by a respected University can be very valuable in focusing high level attention. Social and economic projections at various population growth rates can be useful in enlisting support of leaders of economic and social sectors such as education, health, transport, etc., as well as the development planners who have proved to be the motivating force in many countries. Medical research contracts might be useful to gain support for the program in the medical schools and the medical societies. Perhaps more important than the research itself is the fact that it is performed within the country and probably has more acceptance and relevance than the same findings based on work done in other countries. As the work goes forward it becomes known and talked

about increasing public awareness and helps create vested interests favorable to family planning.

Training

The training of family planning workers tends to keep the program in the public eye and increases the vested interests in favor of the program. Participant training abroad, in addition to the training itself, can be useful in demonstrating programs of other countries in a similar state of development. In this connection we might consider a family planning indoctrination visit for every influential participant.

Tempo

The experience with Tempo type materials has been to brief to draw firm conclusions but so far the reactions have been mixed. Those Missions who are adapting the information to the local situation and particularly those who are drawing in a local institution to assist with the adaptation, say the response has been very favorable. However, two Missions thought the material to be too complex to be useful and three could see little value. Two needed translations, one to Spanish and one to French although this need was not mentioned by other countries. One Mission was still awaiting a reply from AID/W on proposed use of the Tempo materials.

Knowledge, Attitudes, Practices

Nearly all countries had done some type of study and the results were nearly unanimous in indicating broad based support for family spacing and/or limitation. This result can be useful in dissolving opposition and laying to rest the sensitivity issue. They also indicate the inability of the people to exert meaningful upward pressure on the bureaucracy for such programs.

Individual Attitudes

USAID/Pakistan noted that the problem of acceptance or not acception of family planning defies rational expectations and is therefore not subject to change by rational methods. This statement reflects the frustrations in this area and nearly every Mission would like more in country research on behavior patterns and motivations.

In every country there is a backlog of people who want to practice family planning. Before programs are underway some of these people have both the knowledge of the practice and access to traditional methods and devices. Information is primarily spread by word of mouth or physicians. In some countries, particularly in Latin America this can provide coverage to a significant share of the population, while on others particularly in Africa and Asia, such services would reach very few.

After a program has started and information on the availability of family planning services becomes more widely known the numbers of volunteers will usually keep pace, for a time, with the expanding facilities. One Mission noted there is no current need to start a motivation program until

they could take care of the demand. The danger of proceeding too rapidly and before the logistics are firm was well illustrated by the case of one Asian country which was carrying out pilot projects with the pill. A late shipment resulted in nearly 100 percent pregnancies.

In the early stages of program development word of mouth and haphazard information programs are probably sufficient. Most Missions consider a satisfied user to be the best seller of the program. Nevertheless, in more mature programs such as Korea, Taiwan, India, Pakistan, and the small city states of Singapore and Hong Kong, a more focussed and intensified motivation program is required to achieve program goals. In these countries a number of different methods have been tried with a general theme of a small family is a happy family better health and nutrition. All forms of media have been used including puppet shows, audio visual mobile units, minstrel shows, posters, pamplets, as well as radio, TV, the press and movies. Unfortunately there has been little evaluation of the effectiveness of the various methods and little cost benefit analysis. Working through womens' organizations when available, the saturation technique of Singapore, and a tie-in with entertainment in rural areas appear particularly promising.

India and Pakistan have tried cash payments or prizes to finders and for acceptors with rather inconclusive results.

Tying in family planning to mothercraft, mother and child health, and nutrition has been tried in a few cases but it is still too early to evaluate effectiveness. In Chile the basic theme is mothers' health and

reduction of the abortion rate. In some LA countries family planning has been tied to tests for cancer. The value of such a tie-in lies in improving the acceptability of the Family Planning program as it becomes a very expensive and inefficient cancer detection program.

Some starts have been made to get family planning and demography into the education system but it is far too early to test the results and effectiv ness. Efforts to introduce sex education into the secondary schools have generally not been successful.

Follow-up and house-to-house visit appears promising but is expensive and could severely tax the administrative resources of the program. Only very limited information on the effectiveness was available but only one country, Ecuador, reported poor results.

Post partum programs have been undertaken on small scales in several countries and evaluation reports are beginning to become available. There is a wide range of USAID views and experience on these programs. Pakistan down plays the value of getting the mother on contraception immediately after birth as she is infertile for several months anyway and could drop out in this period. Pakistan does see some value of post partum visits for education and sterilization. In Chile, on the other hand, at least one hospital inserts IUD's even though there is a higher drop out rate. One country thought the fact that few children were born under any medical supervision made a post partum program impossible. Other countries with similar lack of medical facilities have started home visiting programs.

The work on motivation is still initiatory and a wide range of methods and techniques are being tried. From the country experience it is very clear that the problem has not yet been solved and further work is required.

DEVELOPMENT OF A COUNTRY FAMILY PLANNING PROGRAM

Commitment

In Chapter I, the status of government commitments to population programs as evidenced by both formal policy statements and by actions was reviewed. The point was made that formal statements make more likely that governments will provide leadership resources and manpower in sufficient strength to achieve a reduced birth rate. On the other hand, commitment may be made through financial authorizations and personnel appointments without a policy statement. Judged either way, the commitment of governments to family planning appears to be considerably less than commitments to the new cereal varieties which was the subject of last years review. In the case of the grains, the programs gave promise of an immediate political impact, and there was little or no formal opposition. Family Planning programs, on the other hand, are opposed by powerful groups in many countries, are politically sensitive, and promise only long range benefit. These factors make the obtaining and continuation of a firm commitment considerably more difficult for family planning than for grains.

In some countries that currently have large scale programs the sense of urgency appears to be eroding away. In some instances this may be due in part to a sense of complacency brought about by recent food successes. Difficulties in meeting goals and unexpectedly high drop out rates has caused some disillusionment and discouragement. Some are also experiencing administrative and organizational difficulties accompanied by various bureaucratic road blocks. In some there appears to be a growing tendency to rely on external assistance rather than increasing the allocation of domestic resources.

For those countries which have new programs or are just getting started the degree of government commitment is quite mixed. In Jamaica the degree of government support is high and increasing. In Costa Rica there is strong executive support and good support is developing in Tunisia. If the experience of the countries which have older programs is valid, there may be problems in maintaining and increasing this support. In some countries, the small poorly financed programs indicates ambivalent attitudes. In others, with new programs, such as the Philippines, support is growing but commitment has not yet been achieved. Finally in countries such as Uruguay and Chile there is no government policy but the population growth is low.

Title X legislation and the President's message on population of July 18, 1969, established the intent of both the legislative and executive branches of the U.S. Government to give population control/family planning high priority. A.I.D. policy statements likewise support a high priority for this activity. Some A.I.D. technicians, however, assert that the strength of the A.I.D. commitment occasionally falters in the day-to-day actions which can make or break a program. Recruiting, contracting and procurement require a considerable commitment if population/family planning projects are to be implemented quickly and successfully.

Establishing the Need for a Population Program in a Host Country

Commitment to population/family planning programs obviously requires a prior conviction of the need for them. In a number of countries, such as Korea, the Philippines and Costa Rica demographic research studies carried on through local universities have proved to be important.

In Turkey, such studies have not yet led to much action. In some other countries demographic surveys have been conducted through various local institutions with the help of the Population Council, Ford Foundation, U.N. organizations and others. In Africa, the U.S. Census Bureau has been helpful in gathering and publicizing demographic facts.

In most countries, the registration of vital events and the timely compilation of statistics from these registrations are both incomplete. In order to supplement this data sample surveys have been or are being conducted in a number of countries. Such surveys usually are needed to establish baseline data against which the progress of population/family planning programs can be evaluated. Only one country doubted the need for baseline data prior to a program. This data can be collected in a number of ways. In several countries, schools of public health or medicine began such research. In Pakistan, however, the Institute for Developing Economics and the Population Growth Survey conducted jointly by the Central Statistics furnished the basic demographic data upon which the family planning program was based.

KAP or Knowledge - Attitude - Practice Surveys have been undertaken or are in process in most of the countries and, with the notable exception of Nepal, these usually demonstrate that people are having about twice as many children as they desire and that more people are interested in family planning than is generally believed by the government administrators. These studies have been helpful in gaining political support. These studies and experimental private clinics sponsored by the International Planned Parenthood Federation (IPPF), Population Council, Pathfinder Fund, SIDA etc.

have been very useful in a number of countries in establishing the acceptability of family planning.

Attendance at international conferences by government officials and opinion leaders in a country, and study tours to other countries have been instrumental in starting several of the programs.

Pilot Demonstration Projects

In a number of countries, in which Costa Rica and the Philippines probably offer the clearest examples, the programs developed along similar lines. Private clinics are started by Pathfinder or Church organizations or the IPPF. These activities are accompanied by a growing interest started and fed by the growing literature and often by attendance at conferences. Usually a Family Planning Organization is formed affiliated with IPPF. Often a private demographic association is started. The growth of the private Family Planning agencies tends to create a strong lobby which pressures the government agencies. Finally a national government sponsored national program is started.

Pilot project or projects in some form have normally preceded the launching of a national program. These projects have helped to develop the information needed to plan a national program. They have tested various techniques of contraception and collected data on their relative acceptability and effectiveness. The projects have also provided pilot data on the staffing and training requirements. In at least one country, Paraguay, a pilot clinic was used to test the adequacy of data collecting and reporting.

Projects have also uncovered such cultural factors as the acceptability of vaginal sponges in some areas and their unacceptability in others. They have also been used to test innovations such as incentive payment to village midwives to win their cooperation and the use of sub-professional rather than professional personnel for delivery of family planning clinical services. Field trials of different motivation messages and media have been used in a number of countries.

Occasionally community development groups take the initiative in introducing family planning. In East Pakistan the Rural Development Academy at Comilla contributed new information on the commercial distribution of conventional contraceptives, motivational techniques, use of incentives, and use of sub-professional personnel for clinical family planning services.

Maternal and Child Health (MCH) programs, either private as in the case of Taiwan or Governmental as in the case of South Vietnam and Latin American countries, have also provided a base for pilot studies.

Many countries have obtained outside assistance in establishing pilot model clinics through public or private sources. Sweden, through its SIDA organization, pioneered such clinics in Pakistan, Ceylon, and other countries. The Pathfinder Fund and IPPF have given support to such clinics. The Ford Foundation and the Population Council, as part of their research and training programs, often assist in establishment of pilot clinics and study centers.

Medical association, medical schools, and public health schools are also often utilized to introduce family planning services into a country. The Medical Association of the Philippines, for example, pioneered in training and indoctrinating medical personnel for family planning. The Colombian Association of Medical Schools operated family planning clinics in Colombia prior to Government involvement.

In brief, pilot projects appear to have been very useful in initiating programs, influencing attitudes, testing techniques and administrative arrangements, and assisting program design to fit the country situation. The fact that many similar tests have been run elsewhere often lacks relevance to local personnel.

Administration

The quality of the leadership, which is probably one of the most important ingredients, was discussed in nearly every country paper. In highly personalized societies the qualities of the individual heading the program appear to be of paramount importance. Qualities required were usually the ability to motivate and control the staff; to extract resources from the host country and external sources; to accept new ideas; to possess administrative talent; and to gain the support and acceptance of the society for the program. Programs which have dynamic leadership, with access to the power structure have clearly progressed faster than those with unstable or hostile leadership, or conflicting lines of authority, or where the leadership of the program is well down the ladder of the bureaucracy.

Most country programs are located in the Ministry of Health, usually as a semi-independent department, as part of Maternal and Child Health

program or as a part of the comprehensive health program. In many countries the required clinical medical services are offered effectively through Maternal and Child Health programs. There are three major reasons for this approach. (1) It is claimed that women participating in MCH programs are of proven fertility and have a maximum interest in birth control when they are pregnant or recently post-partum; (2) the staff of MCH programs have rapport with the potential clients and have a relevant background so that they require little training to participate effectively in family planning programs; (3) family planning services extended by MCH programs are more acceptable to many women than those offered in separate mass programs specifically designed for population control. Family planning services, as a function of health programs designes to protect mothers, decrease infant mortality, improve child nutrition, prevent abortions and cancer, appear to be more acceptable in the religiously sensitive countries of Latin America. In most of Africa, family planning is also more acceptable as a health measure. In addition, in some developing countries the substitution of population for health programs in foreign aid may provide confirmation for propaganda that the U.S. is racist. On the other hand, in many countries the provision of country wide health services for all people add up to implausibe or impossible manpower and fiscal requirements. If target levels of acceptors are only achievable through comprehensive health programs, then urgent further work is required.

In most instances, the Missions making the pro-MCH case summarized above are describing a situation where the program has not yet become widespread enough to have a significant demographic effect. When this phase

is planned, various Missions and analysts point out that the infrastructure of qualified health personnel and physical clinic facilities which would be required to meet both comprehensive health and the family planning goals is clearly beyond the capability of most countries. At this point, the expansion of paramedical staff needed to meet family planning goals may surpass the total MCH staff, so that the latter is the tail of the dog. Another problem with complete reliance on MCH is that this program is usually a sub-agency of a health section which is a sub-agency of the Ministry of Health. Thus the family planning activity is buried under so many hierarchical layers that it receives inadequate top level attention and funding to succeed on the desired scale.

Several countries have separated family planning from health services and one or two has competing family planning programs in different agencies. One within the health complex and one without.

A few countries have established high-level family planning councils consisting of cabinet-level members, distinguished private citizens and sometimes religious leaders. The Ministries of Health, Finance, Information, Education, Agriculture and Community Development are usually represented and in at least one the council is chaired by the Minister of Finance and Planning. Although it is too early to document the value of this approach in obtaining broad based support, these early efforts appear promising.

The role of the Ministry of Education in introducing courses on demography, physiology of reproduction and family planning into the educational system, has been mentioned although few examples of good efforts

in this direction yet exist. Extension services in the Department of Agriculture or of Community Development are sometimes utilized to communicate information on family planning to vast numbers of peoples at the village level with unevaluated results.

Contraceptive Methods

Some programs began with primary emphasis on the IUD but by now most recommend the effective clinical methods -- namely, oral contraceptives or IUDs as first choice for spacing, with sterilization recommended where permanent cessation of fertility is desired.

IUDs started as the favored method in most developing country programs because they are cheap, effective, reversible and require only one decision. In practice, they have proven to have clinical complications which although medically unimportant have been an important factor in their losing favor in nearly every country. It appears that in the rush to meet demand when a program starts, services are often swamped so that efforts to cater to patient satisfaction appears unnecessary. It is precisely during this time the quality and tone of the program can set preconditions for success. The best publicity is word of mouth of the satisfied user. Conversley, a dissatisfied woman negates the experience of many satisfied users. With even minimum follow up care, the gossip network can be reduced or work for family planning. In one country it was found that there were wide variations in drop out rates between the patients of different doctors, with one physician recording a 90% retention rate. Based on limited experience, Ecuador observed results varied sharply with the motivation

of the MD and clinical assistants. Costa Rica also indicated that the skill of the individual doctor to be of paramount importance. Nevertheless, widespread publicity has occurred in many countries on the failure of the IUD, and this will be difficult to counteract.

New IUDs being developed will probably lessen the medical complications. More and better-trained personnel will be needed in the clinical medical services necessary for insertion and follow up work. Most countries are now accepting the principle that sub-professional health workers can be adequately trained for IUD work although Tunisia still requires gynecologists for insertion. The acceptance of this premise and the training of large numbers of para-medical or sub-professional health workers could provide the necessary manpower to make IUDs a more effective contraceptive technique through better service to the patient.

Experience with other types of contraceptives is discussed in Chapter III. Here the only additional comment might be that for beginning programs which lack adequate numbers of trained personnel, conventional contraceptives have not been promoted as much as one might expect.

Training Staffing

The shortage of trained people and training facilities was commented on by most countries. Only Turkey thought program training facilities were adequate for the size of the program. Costa Rica, along with other countries, started with training personnel outside the country. As the needs expanded, training was switched to in country at the University and training will be extended to medical, paramedical, and social workers.

A similar pattern was followed in the Philippines with small scale initial training outside the country. Medical training is now carried on by the University of the Philippines College of Medicine; MCH and other Health personnel by the Department of Health. A number of countries have established or planned Family Planning training centers such as Ecuador, Kenya, Jamaica.

Doctors, medical students, nurses and midwives, social workers and teachers, demographers, economist, administrators and planners often are provided some family planning content in their training courses. This background in family planning tends to improve cooperation and public support.

The indoctrination of all workers in family planning programs appears to be helpful in developing understanding as well as skills. In many countries a pilot or demonstration project provides the initial training. Medical schools, public health schools, nursing schools are another source of training for the bio-medical or the health worker. Social science departments of universities are often resources for training social scientists.

Finding adequate staff for a family planning programs is a common problem particularly when family planning is a part of the health service. Often this raises a problem that can be solved only by accepting a level of medical care for family planning consistent with the level of medical care generally provided in the country. In a country where 95 percent of deliveries are made by untrained, village midwives a policy that only gynecologists can deliver clinical family planning services is not realistic. In a number of countries sub-professional medical people have proved adequate,

after training, in areas where medical services are usually rendered by untrained people.

In Pakistan several hundred Lady Family Planning Visitors have been trained in one year to insert IUDs. They accounted for two-thirds of the IUD insertions and a recent study demonstrated that their results were fully as good as those of qualified physicians.

Research, evaluation, and inspection usually requires another category of workers. Although basic research in bio-medical sciences has been more productive in the developed countries, some fundamental research in developing countries usually gains the cooperation of doctors and scientists. In at least one country the medical society is against the program. Retention of an adequate staff is sometimes troublesome. Family planning programs are often considered temporary, such as in Korea, and the staff are temporary employees rather than permanent government civil servants. This handicap of non-civil service status is sometimes overcome by paying larger salaries. When staff members who are working full time for the Government Health Department are utilized for family planning work, some countries have found it necessary to provide them additional compensation. In Latin America this is accomplished by giving them extra pay on an hourly basis for hours worked beyond their normal duties. In other programs, as in Pakistan, they are given a small retainer fee plus a fee for services for clinical contraception and a percentage of the sale price for conventional contraceptives. The Latin American scheme creates problems within the government structure. The fee-for-service compensation has the disadvantage of encouraging over-reporting but both have the decided advantage of stimulating activity.

Motivation

There is increasing evidence that, by merely offering convenient family planning services, a large number of acceptors will be forthcoming in the first year or two with a minimum of motivational effort. However, the evidence seems to be accumulating that after these highly motivated people accept family planning a greater motivational effort is required to maintain momentum. Increased motivation is generally recognized as a common problem in the mature programs and there are some efforts to include all family planning workers such as doctors, nurses, midwives, etc. to participate in motivating patients.

In addition, a number of countries have cadres of people whose full time effort is motivation. This is being tried at many levels and with many techniques, including mass communications, television, radio, newspapers, billboards, movies, posters, and pamphlets. Unfortunately evaluation efforts and cost benefit analysis are spotty and inconclusive.

Individual communication appears to be effective in persuading a potential client to make a decision to actually practice family planning and is being tried in a number of countries. However, even after acceptance, continual reinforcement is nearly always necessary to obtain continuance. Those clinics which make provision for individual counseling when the client starts family planning and provide continued personal contact to encourage continuance have the best records. One clinic in Latin America has 90 percent continuation rate. At this clinic patients receive individual counseling at their first visit to the clinic. The client is given

a revisit card an is again notified one week before her visit is due. If the client does not return on her due date or within one week of that date, she is visited at home by a social worker to encourage her to return to the clinic. Post partum programs are being tried in a few countries. There is difference of opinion among Missions as to the cost effectiveness of these programs. There is considerable variation in the emphasis given to motivation in different programs. In Costa Rica the Demographic Association, an affiliate of IPPF, has a well organized information unit as have other countries. In others, however, these programs are still in the pilot stage or non existant.

Evaluation

The need for a section for evaluation and research independent of responsibilities for program operations is becoming recognized. Where established, this section is responsible for developing a reporting system to provide information needed for making intelligent decisions concerning the operation of the program. In some cases simple analysis of the data can give information as to the acceptability of different types of contraceptives, efficiency in volume of work of various clinics, continuation rates of patients, and other such necessary operational information.

In Pakistan this feed-back information demonstrated that more than two-thirds of those accepting family planning services were poor people from rural areas and not rich urban educated peopel, that more than two-thirds of the IUD clients were brought to the clinic by village dias, that

the IUDs were inserted by sub-professional lady family planning visitors, and that IUDs inserted by sub-professional workers gave equally good results compared with those inserted by physicians. These findings were in contrast to the opinions held at that time.

Funding

No matter how well the program has been planned, there remains the common problem of obtaining adequate budgetary resources. Lack of adequate resources has been a major inhibiting factor in the development of family planning programs. During the Third Five-Year Plan, Pakistan estimated a need for a 40-crore budget but ended up with a 28.4 crore budget. In Korea, program operations have been curtailed, on occasion, because of the lack of currency to pay incentive payments and salaries.

Legislative and administrative policy decisions of both A.I.D. and host countries have delayed expenditure of funds even when they are available. This is a problem common to most projects as is the necessity for complying with the procurement regulations of two countries.

Assistance to Country Programs

External assistance is available to all of the countries. Practically all programs have accepted financial and commodity assistance either directly from the U.S. or through multi-lateral official agencies such as the U.N.,

international voluntary agencies such as IPPF, or through non-official U.S. organizations such as the Population Council and Pathfinders, and Ford Foundation. Technical assistance is also available and is present in varying degrees and effectiveness. A few of the countries are critical of the quality of the available technical assistance and sometimes resent what they consider excessive interference with their programs by some technical advisors. On the whole, however, technical assistance appears to be well received.