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IMPROVING EXISTING A.I.D. POPULATION PROGRAMS

Under Direction of

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AID/Washington, April, 1970

Note: This document, although based in substantial 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 interpretations of the indicated authors. It is not a "cleared" or "agreed" document.

IMPROVING EXISTING A.I.D. POPULATION PROGRAMS

A. Introduction

To identify and clarify issues that confront A.I.D. in respect to actual progress and potential improvement of A.I.D.-assisted family planning programs, we have undertaken within A.I.D., and solicited from outside A.I.D., analyses of the inherent limitations and potentials of the various methods of contraception in their socio-economic context at different stages of national development. We have also undertaken and solicited cross-cutting analyses of family planning programs in specific countries.

To ensure objectivity and determine whether a consensus really exists, we asked the Bureau of the Census to summarize the thinking of 16 A.I.D. Missions on the two subjects of the cross-cutting analyses, and at the same time we also asked several members of TA/POP to review the progress and potentials of family planning programs in some of the same countries. In addition, we requested the Population Council to write an essay on the inherent limitations and potentials of contraceptive technology in the context of countries at different stages of development.

The authorship of the various sections of this document is as follows:

- B. Summary of Relevant Mission Opinion on Actual and Potential Progress of family planning programs in 16 countries by Bureau of the Census (IDSC).
- C. Summary of Relevant Mission Opinion on the Limitations and Potentials of the Methods of Contraception in context of the socio-economic and demographic circumstances by Bureau of the Census (IDSC).
- D. Actual Progress, Potential Improvements and A.I.D. Role in Family Planning Programs in Five Countries:
- Chile - by Harald Frederiksen, M.D., AID/TA/POP
 - India - by Harald Frederiksen, M.D., AID/TA/POP
 - Korea - by Mr. Robert D. Bush, AID/TA/POP
 - Pakistan - by Willard Boynton, M.D., AID/TA/POP
 - Taiwan - by Mr. Thomas W. Merrick, AID/TA/POP
- E. Limitations and Potentials of Contraceptive Methods in Context of the Different Stages of National Development, by Dr. Nicholas Wright, Population Council.
- F. Summary and Conclusions by Harald Frederiksen, M.D., AID/TA/POP

We recognize that this approach makes rather heavy demands on the reader duplicating, as it does, a good bit of the material. But there is such a serious danger of reaching erroneous conclusions in this difficult field that it has seemed worth having the evidence examined and stated by different people and organizations and from different points of view. It is hoped that this approach will lend validity to the "Conclusions" section of this document and to the amplifications and further conclusions that may be expected from the discussion for which this document was prepared.

**B. Review of Mission Reports on
Family Planning**

Report prepared by:

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SANTIAGO, CHILE--Public attitudes toward family planning, sex education, and even abortion are quite liberal in Chile. The church does not seem to play a role in discussions of fertility control. The communication media are generally favorable as well. Compulsory education of children 7 through 15 may be expected to influence preferences for small families.

The government-sponsored family planning program aims at reducing the rate of abortions in Chile. The Mission is working with the government to introduce programs to reduce birth rates.

Government policy in effect sets a limit to the number of eligible women who may be covered by the program. This policy, which follows from a concern with preventing abortions rather than preventing births, naturally inhibits the activities of many clinics.

Nearly 90% of the program clients in 1968 were residents of Santiago province. There are 500 rural health clinics which also provide family planning services.

One serious problem has been staffing of the program. Leadership is largely untrained and unstable. It has been difficult to recruit doctors to attend training sessions, since they must absent themselves from their private practices to attend. Pay scales are too low to entice many professionals, and there is rarely enough work in any single clinic to occupy the full time of a doctor. The shortage of nurses is even greater than that of doctors; midwives are not permitted to insert IUD's or prescribe pills for the first time. Hence there are a number of strains on clinic staff.

There are two private programs in Chile: one run by Dr. Viel and the other the FPA of Chile. The latter conducts seminars and training courses.

IUD acceptances have out-ranked those of the pill by four to one. Both the IUD and the oral have suffered because of slow delivery of supplies from the United States. The order for 1969 did not arrive until February 1970. This left many clinics without materials to distribute. Conventional, especially the condom, are rarely used in Chile. Sterilization for the expressed purpose of ending fertility is illegal. The heavy incidence of abortions is what precipitated government action to set up the family planning program. Rates have dropped from 14.9% to 6.6% in two years.

Contraceptive supplies have been slow in arriving in Chile, and the inventory system does not permit shifts of supplies from clinics with excesses to those having none. Serious shortages have been the result.

Mission role: The Mission is investigating new sources of financing of construction of additional program facilities. In the past AID/W has objected to this direct payment, and the funds have been used for salaries of current program personnel. However, the Mission points out that when their funds are used to maintain present facilities they can do nothing to expand the program.

AID now supports sex education in the schools, and provides audio-visual equipment for the MCH/FP program. They also pay the salaries of some of the university staff in Public Health.

The Mission encourages baseline studies to fill in the gaps in data not already supplied by the abortion and KAP studies. It is hoped that this data can be used to illustrate the implications of population growth, since government policy makers are not always well informed on this issue.

The Mission staff has been overcommitted in recent months, with international conferences to attend and papers to present. It is felt that these activities hinder the day-to-day performance of program staff. It is suggested that the family planning program could make wider use of academic experts. Since AID cannot supply all of the expertise needed, it is hoped that consultants from local universities may be called in.

Washington is asked to keep the Mission well informed about all AID projects relating to Chile. It is suggested that program grants should include research funds so that research can be sub-contracted to local universities, and the results can be integrated into program policy.

Finally the Mission asks that AID/W and IPPF be more efficient in sending contraceptive supplies, so that unnecessary shortages may be avoided in the future.

SAN JOSE, COSTA RICA--In recent years the government's attitude toward fertility control has evolved from one of inaction to one of quiet but strong support.

It is estimated that 24,000 women are practicing family planning through the use of government or related facilities. However, the supplies sold in Costa Rica imply consumption by about 44,000 couples. By the end of this year all health clinics should include FP services, and by the end of 1971 this should also be true of mobile units. The program handled an estimated 91% of all consultations it would have been able to during the past year.

There are several reasons why family planning has been well received in Costa Rica. Fertility has dropped consistently since 1959, especially among women 20-34. The country is highly literate with a large and growing middle class. Education is strongly emphasized. An increasing proportion of women are in the labor force. Infant mortality has dropped to intermediate levels. With increased urbanization the advantages of a small family are more obvious. The Catholic church has taken a passive position with regard to fertility control. However, many individual clergymen have given their support. The transportation and communications systems are good. Family planning is discussed on radio, T.V., in films at movie houses, and in the newspapers. Contraceptives are sold commercially. And the government has attempted to reach and train professionals in medicine, social work and religious occupations; their interest and enthusiasm has done a great deal to mold public opinion.

A number of private organizations and foundations support family planning programs in Costa Rica. There have been some problems. However, for the most part the private programs have made sizeable contributions. They function as a lobby to encourage government action. And they attract many competent professionals who would not be willing to work for the government program, but will work enthusiastically in the private sector.

Problems faced by the program in Costa Rica include "machismo", or pride in siring children, a pattern of early marriage and frequent common-law relationships, dependence on (outlawed) child labor, and --in certain areas--strong opposition from the Catholic church.

Within the program there are administrative problems. There is a shortage of trained personnel. Because of limited coordination and supervision of the clinics, reports of program accomplishments are sometimes inadequate. The National Planning Office has done an inadequate job of planning.

The medical association opposes IUD insertions by nurses, midwives, or paramedical personnel: this remains a monopoly of doctors, despite the need for more clinic staff.

Nonetheless the program has made remarkable headway. The most popular technique of fertility control in Costa Rica appears to be the pill. Three-quarters of the patients in government clinics use the pill, while less than one-fifth accept the IUD. Orals are popular because they can be purchased in drugstores without going through clinic red tape. After an examination at a clinic, the woman receives coupons which entitle her to subsidized pills in any drugstore. There has been sizable Catholic opposition to the IUD, and some doctors do not insert them because of their own religious convictions. The IUD fell in popularity from 29.4% in 1968 to 19.5% in 1969. One private program is experimenting with contraceptive injections, and reports women are highly receptive to this method. Conventional contraceptives are sold commercially, but are not very popular. Sterilizations are not widely used, nor is abortion.

Mission role: Already the Mission has supported a KAP study, provided salaries for some of the teachers in the local CELADE center, expanded FP in the MCH centers, paid for pap smears and sex education programs, and aided in the private distribution of contraceptives. It has also provided a population research position to advise the Ministry of Health. The Mission is now helping to develop admissions and follow-up forms for clients. A request is made for guidelines for a simple, rugged vehicle with portable audio-visual equipment. The Mission also suggests encouraging the creation of a Demographic Unit within the Ministry of Planning.

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QUITO, ECUADOR -- Until seven years ago the topic of family planning was not discussed in Ecuador. Children were regarded as a blessing from God and an insurance for the future. Beginning in 1965 there has been growing public interest, and up to this point the church has remained neutral in these discussions.

There is as yet no government family planning program. The Ministry of Health is formulating plans, but no specific action has been taken. However, there is a private family planning association, and contraceptives are available in the market.

Very few IUD's have been distributed, and rumors connect them with cancer. Still the Mission feels that - with a good information program - the IUD may become increasingly popular. The pill has been well received, although drop-out rates are high. However, cost may be an inhibiting factor to increased oral sales. Conceptionals are available in drugstores, but people seem self-conscious about purchasing them (especially condoms). Sterilizations aren't very popular. They are quite expensive, and few can afford them. More women than men have responded to this technique: tubal ligations may be performed after a woman has had a cesarian section. Abortions are illegal, but it is estimated that one pregnancy in four ends this way. This indicates that women are ready for information about fertility control.

The private program has been hampered by shortage of supplies (due to slow delivery), lack of personnel, and the low level of motivation of most workers. Administration has also been a problem. The post-partum program has been highly effective, but since only 5% of births take place in hospitals, few women are reached this way.

No maternal and child health program has been established in Ecuador. The Mission suggests that this type of program would give a real boost to family planning activities.

Current tax and loan policies act as incentives to large families. Government policy in this regard should probably be changed.

ADDIS ABABA, ETHIOPIA--The government of Ethiopia takes a negative stance on the subject of family planning. Although there is no legal restriction on the sale of contraceptives, neither is there financial or moral backing for efforts to spread knowledge of fertility control techniques.

A minor program is now underway in parts of Ethiopia, sponsored by the Haile Selassie I Foundation. Approximately 600 clinic visits are handled monthly in 55 hospitals and clinics. Twenty-two of these are in the capital city of Addis Ababa.

Government and church resistance are major problems for fertility control in Ethiopia. But even if officials were anxious to begin a program, the task would be enormous. Nearly 90% of the population is inaccessible during certain parts of the year. The road system, communication media, and the general infrastructure are clearly inadequate to launch a mass program. Health centers of the Public Health program cover only 15% of the rural population. And most important, there is a serious shortage of medical personnel, even to staff present hospitals in spite of extensive medical and paramedical personnel training programs now going on.

Mission role: The Mission feels that its first task will be to make family planning a respectable topic for discussion. Because of the total lack of demographic statistics, a major part of the effort will involve data collection and demonstration of the implications of growth. The Mission is maintaining a low profile. Ethiopian officials are very cautious and have not yet made any official pro-family planning pronouncements.

ACCRA, GHANA--Prior to the 1966 coup, family planning was a little-discussed topic in Ghana, although a few products were available commercially. The first sizable effort began in 1966 with the Planned Parenthood Association of Ghana. During the past year the government has formulated an official population policy which has been published under the title "Popul-Planning for National Progress & Prosperity". Because the desire for large families is the major obstacle to program success, one third of the program budget will be devoted to education and motivation.

Although implementation of the population policy has high priority in the government's plans, the national program has not been extensively developed. However, an excellent groundwork has been laid for sound family planning program development. The University of Ghana Department Sociology and Medical School is undertaking USAID assistance, the necessary demographic and medical-public health studies to establish firm base-lines and sound evaluative techniques.

The Ford Foundation has been active in coordinating programs. Its non-governmental nature and supply of expertise put it in a unique position. The Mission suggests continued support of such programs.

As regards specific contraceptives, availability and acceptance of the IUD still leaves a great deal to be desired. The pill is approximately as popular as the IUD. Less than 4% of clinic patients are relying on the condom. Sterilizations have not been popular, nor are there facilities to provide them to many couples. Abortions appear to be increasing.

Mission role: The Mission is supporting the program already in effect in Ghana. It expresses the need for more teams of experts, short-term consultants, and additional staff members.

NEW DELHI, INDIA -- The Indian family planning program was criticized initially for not attaining overly ambitious goals; only recently have the goals themselves been questioned. Targets were set at the maximum number of women who might possibly be reached with existing facilities, in order that enough supplies would be budgeted for them. The targets were then divided into quotas for specific areas and clinics, and these quotas are unrealistically high. Repeated failure to meet the quotas has been bad for worker morale.

Of a goal of 97 million couples in the reproductive ages, 10.3 million (or 10.6 percent) have spaced or limited pregnancy through GOI-provided services. A system of centers and sub-centers is designed to cover much of the land area, including rural places as well as urban. Not only must contraceptives be supplied, but the women served need motivation to limit family size. Large families are still the cultural norm, and couples rarely accept sterilization unless at least one or two sons are past the age of high childhood mortality.

The program incorporates a "cafeteria approach", in which all forms of contraception are used. However, primary emphasis has been given to IUD's and sterilizations. Over three million IUD insertions and 6.5 million sterilizations have been reported. An additional six million condoms are distributed monthly through free and commercial channels. Because some have passed the age of childbearing or are sterile, only an estimated 7.8 million couples, or 8.0 percent of the 97 million couples in the reproductive ages, currently are protected through government-supplied services.

Administrative and other constraints have tended to inhibit an acceleration of the program greater than that already underway.

Mission role: USAID is encouraging the government to (a) place higher priority on matters of fertility control, (b) improve administration, data collection procedures and evaluation, (c) improve involvement in the non-government sector, and (d) improve motivation. The Mission points out that too great a demand for results may jeopardize USAID's influence in the program. It concludes that the complexities of the Indian situation should be given greater consideration. It recommends that A.I.D. provide contraceptives to the extent that they are needed. It urges that AID/W concentrate on the development of better contraceptive techniques.

KINGSTON, JAMAICA -- The Jamaican national family planning program was instituted in 1964. Prior to that time the private Jamaican Family Planning Association had established favorable public response through a program of education. Initial religious opposition was overcome. Most church groups now give active support to family planning activities.

It has been traditionally held that a large number of children demonstrated the masculinity of their father. Family structure is extremely loose in Jamaica: 72% of births in 1960 were to unmarried women. Among both males and females interest in fertility control is growing.

There are 142 clinics now in operation in Jamaica. Forty-four percent of these recruit less than five acceptors per month, however; more than half of the total workload is handled in fifteen clinics. The educational and training program has been hampered by a lack of funds. A shortage of trained personnel - doctors, nurses, statisticians and economists - seriously limits the activities of the program. (Of 30 medical graduates in 1969, only 3 remain in Jamaica.)

A poor system of roads makes access to rural areas difficult. Other communication media are good, although there is no way of knowing how much they influence the lower economic or illiterate groups.

Acceptances of IUD's fell dramatically due to side effects, rumors of cancer, and the high rate of expulsion experienced. In 1966-1967 60% of the acceptors had IUD's inserted; by 1969 the number had dropped to 10%. On the other hand, orals grew in popularity from 33% of acceptances to nearly 65% during the same period. Pills have a drop-out rate in excess of 50% during the first year, however, indicating serious problems for the program as a whole. Condoms have grown in importance recently. Abortions are illegal.

Mission role: The Mission supplies technical assistance to the program, and would like to be able to provide more short-term consultants.

NAIROBI, KENYA--The Government of Kenya has sponsored a family planning program since 1967, in connection with the maternal and child health program. The program has faced little organized opposition although health and family planning educational efforts are just getting underway.

The Ministry of Health coordinates its activities with those of the local Family Planning Association. There are now 213 medical facilities giving family planning services. The Royal Netherlands Government sponsors training centers for medical personnel. At present the family planning program has no full-time staff. Many of the administrators, advisors, medical personnel and researchers are expatriates of other countries.

Because of lack of trained personnel and funds, use of communication media for publicity is limited. Posters, books and meetings have been somewhat limited in number.

The Kenya program advocates the use of IUD's or pills. Sterilizations have not been promoted because of shortage of medical personnel, and the possible psychological implications. The program has concentrated on female methods rather than distributing condoms. Abortion is illegal.

Mission role: The Mission is supporting census advisors and the maternal child health program. It suggests that the training program would benefit from the technical expertise of an audio-visual specialist and a health educator who have been recruited by AID/W.

The Mission is maintaining a low profile, giving quiet support for the program initiated by Kenya.

SEOUL, KOREA -- The Korean national family planning program has been noted for its relative success in recent years. Yet USAID/K reports that the government of South Korea treats it as a low priority project. The entire job of supervising operations, acting as liaison with other Ministries, and coordinating activities of donor organizations is now in the hands of one professional. Only .12% of the national budget is delegated to fertility control.

This situation is probably the result of overdependence on foreign aid and technical assistance. USAID, Population Council, UNICEF, WHO, and SIDA are all actively involved. Money for program expansion has been available from abroad, and the increase in government spending for fertility control has hardly kept pace with inflation. The program depends on a number of poorly paid government officials and temporary, young, untrained female workers.

The program goal is to reach 33% of eligible couples by 1976. To accomplish this, a staff of 2,800 field workers circulates to organize and conduct educational meetings for married women. Magazines are distributed at these meetings, and advertisements also appear on radio, television, and in films.

The traditional desire for sons still pervades Korean culture. Not only do sons provide security, but they carry on religious customs by paying homage at parents' gravesites. Part of the program's task has been to change this desire for many children.

In general, however, Korea appears ready for fertility control. There are no religious sanctions against contraception. The age at marriage is late, since males must serve in the military, finish their education and have an occupation prior to marriage. Urbanization has exposed increasing numbers of women to the world outside the home. The tremendous amount of international support, both monetary and technical, which the program receives seems to be yielding returns.

Unfortunately the lack of reliable vital statistics hampers analysis of program effects in the population at large. The first women drawn into the program were those most anxious to learn about contraception; the Mission expresses the fear that it will be increasingly difficult to attract other women. Educational programs are designed to do just this.

The only method of contraception used extensively in Korea has been the IUD. Because of present record-keeping, in which a reacceptor is treated as a new client, the program reports discontinuation rates of 40%. Oral pills have recently been introduced, and are distributed primarily to women who cannot tolerate the IUD or have not yet had children. There has been little experience with other methods of fertility control.

Mission role: The Mission suggests that without better coordination of activities between international agencies there is a great danger of overlap and omission. It requests better information about AID/W's support for IPPF, UN, POP Council, etc. The Mission also recommends attitudinal studies which improve understanding of why contraceptives are or are not accepted. It further recommends the establishment of an East Asian regional capability to provide expertise in statistics, research and general demographic conferences and seminars.

RABAT, MOROCCO--Until 1967 it was illegal to buy or sell contraceptives in Morocco. Although the rate of growth is exceptional (3.3%), the Government has been reluctant to publicize fertility control. Conservative Moslems and the opposition Party, which argues "strength in numbers", have created a none-too-receptive atmosphere. Mortality is still sufficiently high that large families are regarded as insurance. However, public interest in family planning is growing.

There is no private family planning program in Morocco. The public program is still small and improvements in administration are just being instituted. There is no specific budget for family planning: rather it is incorporated into the Health Service. There are now 129 Family Planning Centers, and an estimated 1 to 1.5% of women 15-45 have been reached. Needless to say this has had no real demographic impact.

The IUD, the method most advocated by clinics, is poorly received by the public. Rumors circulate about their effects on a woman's health, and that of children conceived while the device is in place. Nearly as many women accept the pill as the IUD. Sterilizations are probably out of the question: not only are there too few trained workers to conduct such a program, but Moslems object to any technique which renders a person permanently sterile.

Mission role: The Mission is supporting activities of the government program, especially in the training of personnel. It emphasizes that maternal and child health facilities must be provided with the family planning service, if women are to believe their living children will survive.

KATHMANDU, NEPAL -- The Nepalese government has a positive but unenthusiastic attitude toward family planning. A number of factors encourage high fertility. Doctors have not backed family planning, because of possible professional consequences. Conservative Hindus have opposed contraception, and especially abortion. Early marriage patterns, low rates of school attendance, dependence on child labor, and the use of children as insurance for old age are important factors. Hence while the goal is to attain a zero rate of growth within thirty years, the effort expended by the program seems unlikely to bring about this goal.

The private family planning program is poorly organized, and lacks leadership. The administrative infrastructure of the government program also is inadequate. Medical staffing is a serious problem. Women refuse to have IUD's inserted by male doctors, but there are only about 40 female doctors in Nepal.

The IUD has had other problems. Husbands tend to suspect the insertion procedure. Rumors about side effects have been circulated. Hence the acceptance rate has fallen considerably during the past year. A growing number of women have switched to the pill. The Mission suggests that more emphasis should be given to orals, since they can be distributed by paramedical personnel if a proper medical history is taken. Vasectomies have been surprisingly successful in Nepal. The technique has been used in traditional medicine and does not seem to be objectionable to many. Further, sterilization is often the only method available in remote areas; mobile helicopter teams perform vasectomies where no other aspect of the program is active. Monetary incentives to doctors are also influential. With regard to conventionals, condoms are available in Kathmandu, and are given as free samples by mobile teams. However commercial sales have not been encouraged sufficiently.

Post-partum contact will reach a significant number of women in Nepal, since less than 10% of births take place in hospitals.

Only one percent of all married couples have practiced contraception with modern methods -- either in the government program or in the private program; and the embryonic status of the operation precludes further analyses at the present time.

Mission role: The Mission feels that it should stress child spacing rather than limitation. Too direct an approach may alienate certain important segments of the population, whereas gradual introduction of contraception may eventually lead to use for limitation purposes. The Mission is promoting the integration of MCH and family planning activities to give greater assurance of survival to children already born.

It is suggested that Washington provide more and better training for program personnel, giving information which is relevant to physicians and nurses working in Nepal. It is also recommended that more paramedical personnel be used for IUD insertions and the prescription of pills, to alleviate pressure on the overworked medical staff.

Finally the Mission suggests that if commercial sales of contraceptives were encouraged more people could help themselves without consulting a doctor.

RAWALPINDI, PAKISTAN -- Present Ayib Khan gave full support to the family planning program in Pakistan during its formative phase. When his government fell in 1969, the program was attacked because of its association with him. The present government supports the program in private discussion and continues to give financial backing; however its public statements remain cautious, mainly stressing the importance of private distribution of supplies. Efforts to decentralize the program will, in the opinion of the Mission, impair cohesiveness and weaken the program.

A schism has developed between the family planning program and the Ministry of Health. The program is semi-autonomous and does not get much support from the Ministry. Its administration has been outstanding. Pay scales have been relatively high, so that a good group of workers have been attracted. Unfortunately, even after five years there is no consistent training program.

A number of social and cultural factors work against the interest of a family planning program. Education and health have been given relatively low priority. Communications are badly organized in the country. Adults aren't educated, and don't appreciate the value of education for their children. Parents tend to depend on the productivity of child labor. And the purdah system prevents women from entering a more modern sector where they might choose between childbearing and other activities. Although important Islamic leaders are not opposed to fertility control, many village religious leaders have labeled it "un-Islamic". Finally, mortality is still high and women have large families to insure the survival of male heirs.

The IUD was the principle method suggested by the program because with it women can be assured of protection over a long period of time, after only one or two visits to the clinic. Unfortunately two thirds of acceptors have some side effects after use, and clinics lack facilities for adequate medical follow-up. Orals were not used in the last Five Year Plan, but are now being introduced. They are available commercially. The major disadvantages of the pill are side effects, need for continuous use, need for follow-up, and cost. Condoms are available, and the quality has been good. However conventionals are not expected to be very successful, since much of the sexual intercourse in rural areas takes place in fields or wooded areas (privacy is impossible in the home). Foam tablets were distributed for four years but have been discontinued because of low efficiency. Foam creams continue to be used successfully.

It was originally anticipated that sterilizations would be rejected by Pakistanis, since in other cultures Islam has opposed such permanent treatment. Yet a surprising number of men have accepted vasectomies, especially in East Pakistan. Possible reasons for this include the fact that incentive payments have been made, the population of East Pakistan is especially dense and the program in that province has more trained workers and better facilities. Disposable scalpels are now being used to minimize earlier problems with local infections. While women are interested in tubal ligations, limited hospital facilities make them impractical.

Abortions are not forbidden by Islamic law, provided they take place during the first three months of pregnancy. Workers suspect that many women ask to have an IUD inserted when they learn that they are pregnant with the hope of an abortion ensuing.

Mission role: Greater coordination with the Health Ministry should be encouraged. At present the Mission feels the family planning program's low profile is preserving it from damaging attack, since 1970 will be an active political period.

The Mission is endeavoring to restructure family planning activities by placing more emphasis on strategic analysis and developing a sound information base on which to make meaningful policy decisions. It suggests more background studies to give researchers a broader cultural orientation. It also recommends more extensive use of university consultants, since they can lend both expertise and prestige.

ASUNCION, PARAGUAY -- The government of Paraguay has no official population policy. The country has a good land/man ratio, and is able to export agricultural produce. Officials maintain that this is evidence that there is no population problem.

There is no government-sponsored family planning program.

Fifteen private clinics have been established, twelve of which are concentrated in Asuncion. Together these clinics service only about 5000 women. All types of contraceptives are sold in pharmacies, including orals which may be purchased without prescription.

The private clinics are mostly in urban areas. Hence the pill has been accepted by nearly a third of the clients, and the IUD has accounted for the other two thirds. Probably IUD's would be more popular relative to orals in rural areas. Condoms are used primarily as a protection against venereal disease in promiscuous relationships, and this connotation makes it unlikely that married couples would use them. Sterilizations are not accepted because of prevailing cultural and religious attitudes.

Mission role: The Mission is promoting and supporting a number of studies of socio-economic, demographic and nutritional topics, as well as an abortion and a KAP study. They hope to use the information collected to demonstrate the probable impact of continuing population growth. It appears that the Mission's role is one of working with policy-makers of Paraguay.

The Mission is also trying to encourage the government to integrate family planning and maternal and child health activities into the health program, to assure women of medical attention for the children they already have.

MANILA, PHILIPPINES -- The Philippine population policy was adopted only in December of 1969. It has not yet been implemented, although some private activities have already begun in the field of family planning. Members of the legislature, church and press agree that the current growth rate should not be maintained. The position of the church has changed considerably in recent years as internal debates brought the question into the open. About 90% of the Philippine population is Catholic. There are still strong preferences for large families because children provide labor on farms, security for older relatives, and because they are appreciated for their own sake. Most of the rural, lower class population continues to resist modern contraception. To avoid religious conflict the program may also educate and motivate women to use the rhythm method.

The educated elite are only now learning about demographic and health repercussions of large families. Medical schools have just recently begun to teach fertility control techniques. There appears to be a sizable pool of native administrators, medical personnel and management experts. Unfortunately the Philippine government has not taken the initiative in coordinating activities; USAID staff members are currently carrying out these responsibilities, although they express the hope that Filipinos replace them shortly in this role.

Mission role: In addition to coordinating activities, the Mission provides technical expertise in a number of fields. It **does not** favor the use of TDY assignments or temporary contracts through universities or foundations. The staff requests more regular staff for these activities.

TUNIS, TUNISIA -- The government of Tunisia has initiated progressive legislation to encourage fertility control. A national family planning program was begun in 1962, and in 1964 marriage laws were changed to increase legal age at marriage. The program suffered a loss of momentum when the President in 1967 stated that population was not a very serious problem. The effects of this statement are still felt, but the program continues to be active.

Certain social and economic factors seem to favor success. Moslem leaders have given their support so that there is little religious opposition. With increasing levels of education (73% of children 6 to 14 were in school last year), reliance on child labor is decreasing. And Tunisia's communication media are relatively well developed.

There are now 280 locations at which family planning services are regularly available, as well as fifteen mobile teams in rural areas. Government regulations prohibit IUD insertions by anyone other than a trained gynecologist, (a policy which will probably continue until all gynecologists are fully employed). In rural areas this has been a constraining factor, since women refuse to be examined by male doctors, and there are very few female gynecologists.

The Mission expressed dissatisfaction with the Ministry of Health's administration and management of the program. There appears to be a serious shortage of trained public health and hospital administrators on which to rely. Distribution of supplies is also inefficient.

Early in the program the IUD began to face resistance because women experiencing side effects were not properly treated. The government has never provided a training program for staff members working with IUD's, which further adds to the problem. The pill was introduced in the program just prior to the outbreak of negative publicity in 1968. Rumored side effects led the government to discontinue distribution. Pills are still sold - without prescription - in commercial markets, although this is illegal. Demand for orals seems to be growing. Condoms are available and free at the clinics, but are not widely sold in the private sector. Male sterilizations are still in the experimental stage, although tubal ligations are readily accepted. Both therapeutic and social (i.e. after 5 children) abortions are legal in Tunisia. Often a tubal ligation is performed after an abortion.

Only 14% of the women contacted through the post-partum program return for family planning services. About as many are drawn in by the house-to-house canvas. These two delivery systems perform an important educational function in the program.

Mission role: Mission officers are interested in extending commercial sales of various techniques, to reach a greater number of couples. AID has provided condoms, but these were not well accepted; reasons are now being studied.

ANKARA, TURKEY -- Family planning is not a high priority program in Turkey.

It is regarded as a health issue, to be handled either by private physicians or the Maternal and Child Health program.

Government officials do not believe Turkey has a significant population problem. Some hold the nationalistic view that the strength of a country is related to the size of its population.

The national family planning program has reached less than 5% of Turkish women. Program administration is not centrally focused: no single government office takes this responsibility. Hence there is no driving force to accelerate activities. The program has reached into rural areas, on the assumption that urban residents can learn about contraception privately if they wish to do so.

The Turkish program has stressed two methods of contraception, the IUD and the pill. Primary consideration has been given to the IUD, although the Mission feels that more attention should be given to the pill. It is suggested that since orals are available for purchase in

the market, government subsidy for commercial sales might greatly increase the number of contraceptors in Turkey.

C. Potentials and Limitations of Various Birth Control Techniques

The primary interest of this report is in evaluation of contraceptive methods. However, since abortion is one major technique of fertility control in the countries reviewed, we will broaden the topic to that of birth control in general.

For convenience we will group birth control techniques into two categories. The first includes the more reliable methods (the IUD, orals, sterilization and abortion); the second includes less reliable techniques (condoms, foam, diaphragms, jellies and creams). The first group are likely to have important demographic influence because of their potential effectiveness. Aside from abortion, they are generally the methods promoted by family planning programs. Less emphasis is usually given to the second group.

The Mission reports from which this summary is drawn include:

Latin America: Chile, Ecuador, Jamaica, and Paraguay

Asia: India, Nepal, Pakistan, Philippines

Africa and the Middle East: Ethiopia, Ghana, Kenya, Morocco, Tunisia, and Turkey

The IUD

The IUD is now the most popular contraceptive device used by family planning programs. While its theoretical effectiveness is less than that of the pill, it has certain clear advantages from the point of view of program administrators. It does not require that the client remember to use it, either in relationship to intercourse or on a daily basis. Nor does it have a continuing cost. Once successfully inserted, the client may be protected for as much as several years. For these reasons, both program administrators and clients have been interested in trying the device.

However, patients' confidence in the IUD has been declining. Program leaders have found that their initial progress is difficult to sustain. Reasons for declining popularity are many:

1. In many traditional cultures, women are unwilling to be examined or treated by male gynecologists. There is a critical shortage of female doctors, which limits the number of insertions which can be handled by the program. Tunisia and Nepal both expressed this problem; in neither country are paramedical personnel doing insertions.

2. Side effects are common. A large proportion of women have some initial bleeding or pain. Often rumors begin to circulate connecting the device with cancer. Women lose confidence in the safety of the IUD.
3. This problem is magnified because of a lack of follow-up programs. After the device is inserted, there should be periodic examinations to catch problems before they are serious. Facilities for examination are not always available, nor are there enough trained personnel. This is especially serious in rural programs conducted by mobile clinics, which return to a village infrequently if at all. The Missions in Nepal, Pakistan, Morocco, Tunisia, Ecuador and Jamaica all mentioned points 2. and 3.
4. Staff-client relationships are often very poor. Training programs for staff members are frequently inadequate. Most of the clients are usually poorly educated. The Tunisian Mission reports that staff members have even been known to refuse treatment when a woman was bleeding or in pain. Such experiences discourage women, and many may leave the program.

Experience has shown that where IUD's are dispensed in private clinics or by private doctors, the continuation rate is significantly higher. Given adequate follow-up, many more of the devices can be kept in place. But private facilities are expensive, and restricted to urban areas. Government programs are attempting to improve their own performance by:

1. Increasing the number of trained personnel working in the IUD program. Special emphasis should be given to female gynecologists and paramedical workers.
2. Increasing the training of other clinic workers. The staff-client relationship needs to be improved considerably.
3. Improving follow-up.
4. Increasing the number of facilities offering IUD's.

The Pill

Oral contraceptives have the highest level of theoretical effectiveness of any method currently available. When used properly, they are close to 100% effective. Support for the pill has gained momentum as more and more women have stopped using the IUD. Although in most programs orals still rank second among techniques used, the Jamaican program now prescribes them for close to 65% of its clients.

The pill's major shortcoming, from the point of view of the program, is its high drop-out rate. In the Jamaican case over 50% of acceptors stop using the pill within a year of acceptance. Morocco, Pakistan and Ecuador also report poor continuation. Common reasons for this difficulty are:

1. The lack of trained personnel means a poor orientation for women about to adopt the pill. Users don't always know what side effects to expect, or whether they are actually serious. Often the women don't even understand the instructions about when to take the pills.
2. As with the IUD, facilities are not available for extensive follow-up. Women having difficulty are likely to drop the pill entirely, rather than returning to the clinic to be treated.
3. Adverse publicity about the medical effects of pills tends to upset the public. In Tunisia the program has stopped distributing them because of medical reports.

Still the pill holds great promise for certain countries, especially in urban areas where women are better informed. The Turkish Mission urges more use of commercial channels. Certainly subsidies would help to make the pill available in wider areas.

Sterilization

Religious and cultural reaction to sterilization is usually stronger than that aimed at other techniques. The countries of Latin America studied here have not accepted the method with any enthusiasm. In Chile sterilizations are only legal for medical reasons. In Ecuador they are performed on women, but the cost is prohibitive and acceptance is low. This Latin American response may be partly due to religious attitudes, and partly because "machismo", or masculinity, is associated with the ability to procreate.

African cultures have not accepted sterilizations very readily either. In Kenya and Ghana they are unpopular because of psychological implications. In Morocco Moslems are heatedly opposed to any method which renders a person permanently sterile. Tubal ligations are performed in Tunisia, but vasectomies are still in an experimental stage. Tunisian women seem to accept them with interest, and Islam has not been an inhibiting factor.

The greatest popularity of sterilizations has been in Asia. In India this method is one of the two most strongly advocated by the program.

It is also surprisingly popular in Nepal and Pakistan. Although Moroccan Moslems totally reject sterilizations on religious grounds, the Pakistani attitude is quite favorable. Possible explanations for this success in Asia are:

1. Sterilization has been done in traditional medicine, and is not completely foreign to the Nepalese.
2. Monetary incentives have been important in promoting vasectomies.
3. Sterilizations may be made available through the use of mobile clinics (traveling where IUD insertions are not done), in railroad stations, or other convenient facilities. Vasectomies are quick and safe. They are also permanent.

Where this technique is acceptable to the public, the major complications are those of cost and personnel. Hospital facilities for tubal ligations are rarely available, and although vasectomies are quick, they also require medical workers.

Abortions

While abortions are not a "desirable" birth control technique, they are probably one of the most commonly used. Abortions are illegal in Paraguay, Ecuador, Chile and Jamaica. Yet the incidence is very high: the family planning program of Chile was founded specifically to decrease abortion rates.

Among the African countries, a similar situation prevails. Abortions are illegal in Kenya, and unacceptable in Morocco. But rates are increasing, especially in Ghana and Tunisia. The Tunisian government has legalized abortions, both for medical and family planning reasons.

Asians are also using this primitive method of birth prevention. It is reported by program workers in Pakistan that women often ask to have IUD's inserted when they learn that they are pregnant: this is a simple method of obtaining an abortion. Islamic law does not object, provided it occurs before the time of quickening, or about four months. It is estimated that two out of every nine pregnancies in India now end in an abortion.

Conventional Methods

As suggested above, conventional methods are likely to have less dramatic effects on fertility rates. They are given less attention than the techniques treated above because few programs stress them at the clinic level.

The condom is the method most often used in the countries examined

here. It has not been widely accepted in Latin America because of social stigma attached to it. It is used primarily for protection against venereal disease, especially in promiscuous relationships. Although condoms are sold in pharmacies in Paraguay and Ecuador, as well as Chile, they do not appear to be used extensively. Only Jamaica reports growing emphasis on this method.

Asians have a more positive attitude toward prophylactics. They are sold in pharmacies in Kathmandu, Nepal, and are distributed free by clinics and mobile teams. Pakistan and India both provide them within their programs, for those couples unwilling or unable to use other methods.

African countries have made them available in urban areas through commercial channels and also through clinic distribution. They are used successfully in Tunisia, Morocco and Kenya.

Most Missions suggest that commercial sales should be encouraged in rural as well as urban places. Since this method can be used without medical advice, availability at local shops should increase the number of couples protected by a substantial number.

Other conventional methods which are mentioned in passing include the diaphragm (distributed in Ecuador), and foam and foam tablets (also distributed in Ecuador; foam tablets were discontinued by the Pakistani government, although applicator-foam seems to be popular).

One other fertility limitation device might be mentioned: control of legal age at marriage. In certain Latin American cultures, especially Jamaica, this factor would have virtually no influence on fertility. Extramarital relations are socially sanctioned, and births outside of wedlock are common. However, where there is little risk of extramarital pregnancy governmental regulation may help slow down population growth. One country attempting to use this device is Tunisia. The age at marriage was increased in 1964. As yet it is impossible to establish the effect on fertility rates, but since fertility is dropping this may contribute in some small way.

**D-1. Actual Progress and Potential Improvement
In the Chilean Family Planning Program**

Chile has entered the final phase of economic and demographic transition. Although infant mortality was relatively high until very recently, Chile is really too advanced in terms of per capita product, organization literacy, health services, etc. still be considered an undeveloped country. (See profile of relative development.)

The birth rate has been quite commensurate with that of a country only entering the final phase of economic and demographic transition. In recent years the birth rate has been declining rapidly, so that now the growth rate has dropped below two per cent. The age-parity grid indicates the distribution of excess births by age and parity. (See age-parity grid showing live births by age of mother and live birth order.)

Surveys of knowledge, attitudes and practices relating to fertility and contraception indicate a generally favorable attitude of the public toward family limitation. However, the epidemic of illegal and botched abortions also indicates the magnitude of the unmet need for education and unmet demand for services.

First, the physicians responded on an individual basis to the epidemic of abortions by providing medical relief rather than legal sanctions. This was followed by the adoption of an official policy to offer family planning as an integral part of maternal child health services to reduce the number of abortions and to promote maternal and child health.

Prior to the incumbent Frei Administration, the Chilean Government did not officially recognize or support family planning programs which were being carried out privately (those private efforts began around 1938). However,

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the organization which has been most active in the family planning effort in Chile, the Committee for the Protection of the Family, was organized (1962) under the auspices of the Servicio Nacional de Salude (SNS, i.e., National Health Service) and has utilized SNS facilities.

After the election of the Frei Administration, the new SNS director stated the government's policy as promotion of birth control in such cases where husband and wife agree. He also stated that doctors in out-patient clinics would begin a birth control information program, counseling mothers and providing services according to personal needs. These statements constituted a radical departure from previous policies on birth control. It must be emphasized, however, that official government policy sanctioned birth control program in response to the alarmingly high rates of induced abortions in the country, and that government policy in this area has consistently reflected that aim.

But the government has no overall policy to reduce the birth rate. To the contrary, the National Health Service has in effect, set a limit on the extension of family planning, which follows from the concern with abortions rather than reducing the birth rate.

Chile has a fairly comprehensive scheme of curative and preventive medicine that reaches most of the population, 70 percent of which reside in cities and towns with health services, adequate in quality as well as quantity, and the National Health Service probably has the ability to extend family planning to all.

Family planning services have been incorporated into the maternal and child health programs of the SNS. Therefore, separate accounts indicating resource inputs into the area of family planning are not available. Furthermore,

the extent of involvement of SNS clinic is not known. Instructions were sent to all SNS offices in September 1966 regarding the basic norms governing birth control activities, but leadership in the implementation of these norms was largely left in the hands of local administrators.

The norms of the birth control programs are to lower the rate of maternal and infant mortality and to promote family welfare. The objective of the SNS program is to assure priority attention to (a) all women receiving treatment for abortion; (b) up to 40 percent of the women attended for child-birth in SNS facilities, preferably multiparous with serious socio-economic problems or with chronic diseases; and (c) up to 10 percent of the women of childbearing age.

Birth control information and contraceptives are now available at all SNS hospitals and clinics. However, as stated above, under SNS instructions each hospital district was to develop its own action program. This leaves local administrators with great latitude in pushing or holding back on a widespread program, depending upon the administrator's own views regarding birth control.

Support for the program over the years has grown along with the extension of the size of the program. Initially, support came principally from the IPPF and the inputted services of the GOC. Over the period of the last five years, however, the Rockefeller and Ford Foundations, and the Population Council, in addition, have contributed varying amounts of support, mainly directed toward the research and evaluation aspects of the Chilean program.

Examination of the results of the program indicated that of the actual techniques employed, principal reliance has been made on the use of IUD's, although some emphasis seems also to have been placed on orals, especially

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in recent years. In addition, there has been a rather limited use of sterilization, and an even more restricted use of rhythm and traditional methods.

So far the organized programs, either public or private, have protected only about 10 percent of the female population in the age groups 15-44 years of age. Thus about 15 per cent of the eligible couples (i.e., excluding those with pregnancies) are practising contraception whereas more than 60 percent of the eligible couples would have to practice perfect contraception to reduce the birth rate to less than 20 per thousand population.

Thus it is obvious that the recent declines in the birth rate have to be ascribed to a combination of factors beyond the scope and influence of the organized family planning programs, both public and private.

The principal role for A.I.D. Mission would seem to be an educational one. AID's role also includes ongoing and proposed projects to facilitate testing and demonstration of alternative approaches for the extension of health and family planning services, singly and in combination, in urban and rural areas. Success for that program will require the development of feedback systems to permit concurrent evaluation and program modification.

PROFILE OF RELATIVE DEVELOPMENT OF HUMAN AND NATURAL RESOURCES
 IN CHILE ^{1/}
 IN COMPARISON WITH TEN LEVELS IN THE GLOBAL GRID OF SECTORAL
 DEVELOPMENT ^{2/}

Indicators of Development	No. of countries	Percentile Rank										
		0	10	20	30	40	50	60	70	80	90	100
Product per capita ^{3/} (U.S. per annum)	120	70	135	226	432	1615	3300					
Agricultural occupation (percent) ^{4/}	110	72	56	42	23	11	5					
Wheat yield (100 kgs per hectare) ^{4/}	87	6	8	13	17	28	42					
Rice yield (100 kgs per hectare) ^{4/}	97	7	13	17	24	41	62					
Maize yield (100 kgs per hectare) ^{4/}	113	5	8	11	18	28	49					
Calories (per capita per day) ^{5/ 6/}	76	2000	2200	2430	2695	3110						
Total proteins (grams per capita per day) ^{4/}	52	1800	2120	2295	2600	2940	3510					
Animal proteins (grams per capita per day) ^{4/}	52	48	59	78	85	94	112					
Electricity generation (kwh per capita) ^{5/ 6/}	120	42	52	72	80	90	112					
Steel consumption (metric tons per 1000 pop.) ^{6/}	67	10	17	25	32	47	57					
Literacy (percent) ^{5/ 6/ 7/}	113	6	14	20	32	53	77					
Newspaper circulation (per 1000 pop. per day) ^{6/}	147	8	25	55	85	99						
Primary school enrollment (percent of age group) ^{8/}	75	3	12	35	75	96	99					
Secondary school enrollment (percent of age group) ^{8/}	75	0	2	8	17	29	57					
Tertiary school enrollment (percent of age group) ^{8/}	75	0.1	0.7	3	5	9	33					
Teachers, primary and secondary (per 10,000 pop.) ^{8/}	68	0.0	0.3	2	4	8	33					
Crude birth rate (per 1000 pop.) ^{9/}	105	12	23	41	60	80	135					
Infant mortality (per 1000 live births) ^{9/ 10/}	112	2	24	35	43	70	135					
Life expectancy (years at birth) ^{5/ 9/}	73	51	47	42	23	13	13					
Inhabitants per physician ^{5/ 9/}	123	59	49	45	35	20	13					

1/ As indicated by Histogram. 2/ As indicated by the scales in the rankings of indicators from the latest year and the maximum number of countries, for which comparable data are available. 3/ Population Reference Bureau, October 1951. 4/ Food and Agriculture Organization, Production Yearbook, 1954. 5/ A.I.D. Economic Data Books, 1954. 6/ United Nations, Statistical Yearbook, 1951. 7/ Ginsburg, M., Atlas of Economic Development, 1951. 8/ Morrison, F., and Myers, C.A., Education, Manpower and Economic Growth, 1951. 9/ United Nations, Demographic Yearbook, 1954. 10/ Countries with virtually complete reporting of estimated rates.

PARITY	AGE IN YEARS								UNKNOWN AGES	ALL AGES		MEDIAN AGE
	Under 20	20-24	25-29	30-34	35-39	40-44	45+	Number		Percent		
1	19,602	23,869	10,470	4,672	2,169	638	132	1,215	42,767	23.0	22.3	
2	7,973	20,783	12,138	5,636	2,369	671	97	299	49,966	18.3	24.1	
3	2,637	14,663	11,465	6,571	2,915	698	89	202	39,240	14.3	26.0	
4	694	8,739	9,953	6,624	3,231	831	105	134	30,311	11.1	27.8	
5	154	4,406	8,344	6,437	3,247	904	141	88	23,721	8.7	29.3	
6	35	1,919	6,115	6,076	3,483	1,042	151	82	18,903	6.9	31.1	
7		664	3,853	5,258	3,351	1,007	151	47	14,331	5.2	32.5	
8		223	1,985	4,226	3,188	1,140	150	33	10,945	4.0	33.8	
9		70	986	2,884	2,761	1,063	151	32	7,947	2.9	35.0	
10+		45	665	3,598	6,383	3,935	646	50	15,322	5.6	37.6	
Unknown parity	71	223	227	156	100	26	8	1,059	1,870		27.5	
All parities	No.	31,166	75,604	66,201	52,138	33,197	11,955	1,821	3,241	275,323	100.0%	27.2
	%	11.5	27.8	24.3	19.2	12.2	4.4	0.7		100.0%		
Median parity		1.3	2.2	3.4	4.9	6.3	7.7	7.8	1.4	3.1		

D-2. Actual Progress And Potential Improvement
In the Indian Family Planning Program

The Indian profile of relative development indicates a relatively low product per capita and also relatively high levels of illiteracy and infant mortality along with a relatively large number of inhabitants per physician. In such circumstances it is not surprising to find a relatively high birth rate as well as considerable difficulties in reducing it. The excess of births over deaths is large not only in terms of rates, but even more so in terms of numbers as a result of the enormous magnitude of population experiencing the high rate of excess fertility. There are 15 million more births than deaths in India every year!

Data from 1963 for selected Indian cities with more than 100,000 population indicates that at the end of reproductive lifetime, the median birth order is 7. The median birth order of 2 is reached before 24 years of age. There is no reason to believe that fertility is any less in the rural areas. It should be emphasized, however, that these figures are for 1963, before the family planning program was really underway.

KAP studies reveal little organized religious or community objection to family planning in India. They also indicate that the urban families want 3 children whereas the rural families desire 4 children, of which 2 should be male.

The government of India was the first government in the world to adopt a national population policy and a national family planning program (1951) as an integral part of its development.

2.

The fourth 5-year plan document sets the objective of reducing the annual birth rate from 39 to 32 per 1,000 by 1974 and to 25 in another 5 to 7 years.

The family planning program in India, the largest in the world, is entirely voluntary. The approach is based on the provision of education, contraceptive means and services. The Indian policy makers have decided that financial incentives are no substitute for education and efficient services including follow-up. However, moderate compensation for expenses and loss of wages is provided.

Although the family planning program is financed 100% by the Central Government, authority for its implementation rests with 28 separate state and union territories. The 16 major states contain 97.7% of the population, ranging from 4 million in the state of Jammu and Kashmir to 89 million in Uttar Pradesh, which has been called the "11th largest country in the world."

The state programs provide sterilization, IUDs and conventional contraceptives. Oral contraceptives are being provided by the government on a pilot basis in limited areas.

The delivery systems involve approximately 70,000 full-time family planning workers who staff 5,000 primary health centers and more than 20,000 rural subcenters.

Aside from state clinics and to a lesser extent mobile clinics, the delivery of services involves post-partum and house-to-house approaches as well as subsidized sales of condoms and commercial sales of oral contraceptive.

3.

The performance statistics are accepted at face value, not knowing the system for independent verification of the data. These statistics indicate that 87% of the government-supplied contraceptive protection has been provided by sterilization. But both the number of sterilizations and the number of new IUD insertions have dropped off -- at least temporarily. (See table).

The program expenditure per eligible couple in India has been about the same as that in Pakistan and Korea, but twice that in Taiwan. The ratio of full-time family planning workers to eligible couples in India is almost 10 times greater than that in Taiwan. But, it appears that the output per family planning worker in Taiwan may be about 10 times greater than that in India. Within India itself, there is a wide range among states in the portion of eligible couples currently protected by sterilizations and IUDs late in 1968: by sterilization, 2.5% to 17.4%; by IUD, 0.6% to 16.7%; by sterilization and IUD 5.2 - 27.7%. This variation in performance cannot be explained in terms of staffing. Only little correlation was found between the percentage of targeted district bureau staff in position and the IUD insertions and sterilization per 1,000 population during the past year. (See tables on performance and correlations of inputs and outputs by state.)* This correlation was hardly improved by holding population density constant. However, about half of the variation in the sum of sterilization and IUD insertions per 1,000 population during the past year can be explained in terms of the expenditures of the program per capita.

* The Regional Bureau Office of Population Programs questions the interpretation of data on output measurements and relationships cited above.

4.

On balance, the evidence suggests that efficiency in the utilization of existing inputs is even of greater importance than further increases in inputs. More effective use of existing resources will require greater flexibility in planning and implementation of operations. Pre-auditing and rigid line-budgeting impede program development. Lack of administrative flexibility also impairs corrective action upon feedback from systems of evaluation to the extent that such a rapid feedback system exists. Thus problems, when detected, are being corrected slowly because of traditional rigidity and inertia.

Ideally, the program would attempt to improve quality, as well as quantity, of staff. At this time only half the targeted positions have been filled. More importantly, a significant number of the current staff have not yet been trained specifically for family planning.

The government of India has associated the family planning program with its health services, particularly with maternal and child care. To the extent that health services are available this is most appropriate. But, the network of health services is still far from adequate to cover the country.

Noting the limited sphere of influence of static health facilities, greater reliance needs to be placed on an auxiliary staff to extend the reach of health centers. However, it will take many years before there will be enough auxiliary nurse mid-wives to take care of the maternity as well as contraceptive needs in the rural areas. Thus, alternative solutions must be sought in the interim on a considerably greater scale than at present.

5.

Since the program has been largely one of sterilization, it is worth examining its implications for a reduced birth rate. At this time the average age of women protected by sterilization is 32 years, when the parity undoubtedly exceeds the norm of the program of 3 children prior to sterilization. But the 1st, 2nd, and 3rd birth orders add up to a birthrate of 22 which is only little less than the target set for the end of this decade. Thus, all births would have to be prevented among all those who have had three children to achieve the target of 25 births per 1,000 population. India cannot reach its target unless the average age and parity at which women are protected by contraception are substantially lowered.

It is evident that child spacing must supplement family limitation. Thus, reversible methods must be extended to younger age groups for purposes of spacing.

At present the IUD remains the reversible method with advantages of cheapness, effectiveness, and the need for only periodic rather than continuous program and client action. It might be "rehabilitative" with better training and supervision of staff so that they could do better education and follow-up of patients. Younger age groups might be reached by training of auxiliary staff on a much larger scale so that they could visit homes to detect births and offer a post-partum IUD insertion in homes. This auxiliary staff would also have to make periodic follow-up visits for reinsertions or for referral to a nearby subcenter.

The utility and feasibility of oral contraception in India remains to be established in suitable pilot projects. These should also include tests of periodic delivery to the home, since the method is not dependent upon clinic facilities.

Although the effectiveness of condoms also remains to be established in pilot projects, improvements in the distribution systems hold promise that increasing demand for condoms could be met.

The chief difficulties faced by the Indian program seem to have been: first, the cumbersome multi-level administrative apparatus required by virtue of India's federal political structure; second, an inadequate flow of program statistics to the center thus making timely evaluation of program performance almost impossible; third, an inadequate and poorly coordinated evaluation and research effort. All of these problems are being faced up to by the program administrators and a large share of the increased foreign aid for family planning in future years is expected to be in the areas of evaluation, communications and education.

Perhaps the greatest and most pervasive drawback is the unpromising socio-economic milieu in which the program operates. The vast majority of the people are still illiterate, peasant farmers living in relatively inaccessible villages with little contact with the modern sector. Health and education services are minimal and resistance to change is endemic. Hopes for dramatic short-run accomplishments in family planning must be evaluated against this background.

HFrederiksen

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PROFILE OF RELATIVE DEVELOPMENT OF HUMAN AND NATURAL RESOURCES
IN INDIA ^{1/}
IN COMPARISON WITH TEN LEVELS IN THE GLOBAL GRID OF SECTORAL
DEVELOPMENT ^{2/}

Indicators of Development	No. of countries	Percentile Rank										
		0	10	20	30	40	50	60	70	80	90	100
Product per capita (U.S. per annum) ^{3/}	120	70	135	226	482	1615						
Agricultural occupation (percent) ^{4/}	110	72	89	185	305	797	3300					
Wheat yield (100 kgs per hectare) ^{4/}	87	3	6	7	8	10	13	15	17	24	28	42
Rice yield (100 kgs per hectare) ^{4/}	97	5	7	10	13	16	17	21	24	34	41	62
Maize yield (100 kgs per hectare) ^{4/}	116	3	5	7	8	10	11	13	18	22	23	49
Calories (per capita per day) ^{5/ 5/}	76	2000	2200	2295	2430	2600	2695	2940	3110			
Total proteins (grams per capita per day) ^{4/}	52	48	52	59	72	76	80	85	90	94	112	
Animal proteins (grams per capita per day) ^{4/}	52	10	14	17	20	25	32	37	47	53	57	77
Electricity generation (kwh per capita) ^{5/ 6/}	120	8	21	51	93	151	600	2637				
Steel consumption (metric tons per 1000 pop.) ^{6/}	67	8	16	20	31	69	120	277	371	545		
Literacy (percent) ^{5/ 6/ 7/}	113	3	8	12	25	35	55	75	85	96	99	99
Newspaper circulation (per 1000 pop. per day) ^{6/}	147	2	6	11	19	38	64	100	291	499		
Primary school enrollment (percent of age group) ^{8/}	75	15	26	36	44	52	62	65	67	77	94	
Secondary school enrollment (percent of age group) ^{8/}	75	2	5	8	12	17	22	27	35	57	95	
Tertiary school enrollment (percent of age group) ^{8/}	75	0.1	0.3	0.7	2	3	4	5	8	9	33	
Teachers, primary and secondary (per 10,000 pop.) ^{8/}	68	12	24	28	35	41	48	60	70	80	135	
Crude birth rate (per 1000 pop.) ^{9/}	106	51	49	47	45	42	35	23	20	18	13	
Infant mortality (per 1000 live births) ^{9/ 10/}	112	172	127	94	65	53	39	21	26	20	14	
Life expectancy (years at birth) ^{5/ 9/}	73	35	37	43	46	50	58	62	67	70	73	
Inhabitants per physician ^{5/ 9/}	126	41400	12400	7100	4300	2600	1610	760				

1/ As indicated by Histogram. 2/ As indicated by the deciles in the rankings of indicators from the latest year and the maximum number of countries for which comparable data are available. 3/ Population Reference Bureau, December 1955. 4/ Food and Agriculture Organization, Production Yearbook, 1954. 5/ A.I.D. Economic Data Book, 1954. 6/ United Nations Statistical Yearbook, 1954. 7/ Grosvenor, N., Atlas of Economic Development, 1951. 8/ Harrison, C., and Myers, C.A., Education, Manpower and Economic Growth, 1954. 9/ United Nations, Demographic Yearbook, 1954. 10/ Countries with virtually complete reporting or estimated rates.

PARITY	AGE IN YEARS								UNKNOWN AGES	ALL AGES		MEDIAN AGE
	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49		Number	Percent	
0												
1		76,046	94,394	36,143	10,147	2,798	934	161	738	221,361	24.6	21.8
2		21,207	82,236	42,451	11,279	3,377	849	155	370	161,924	18.0	23.6
3		4,450	53,542	53,232	19,796	6,295	1,522	246	390	139,473	15.5	26.1
4		1,152	23,543	49,904	24,220	8,412	2,049	528	248	110,056	12.3	28.0
5		295	8,616	36,880	27,733	9,576	2,522	1,316	223	87,161	9.7	29.7
6		120	3,203	20,561	25,353	11,597	2,539	1,012	149	64,534	7.2	31.6
7		88	937	9,622	16,763	10,643	2,967	917	84	42,021	4.7	33.1
8		95	545	4,390	11,339	10,363	2,913	970	85	30,700	3.4	34.5
9		80	275	2,017	6,190	7,657	2,562	759	57	19,597	2.2	25.8
10		184	604	1,222	4,366	7,880	4,877	1,222	162	20,517	2.3	37.4
11												
12+												
Unknown parity		197	445	476	408	164	53	23	4,414	6,180		27.5
All parities	No.	103,914	268,340	256,898	157,594	78,762	23,787	7,309	6,920	903,524	100.0%	26.5
	%	11.6	30.0	28.7	17.6	8.8	2.7	0.8		100.0%		
Median parity		1.2	2.0	3.4	5.0	6.3	7.0	6.7	2.9	3.0		

TABULAR DESCRIPTION OF SELECTED VARIABLES BY 16 MAJOR STATES: GOVERNMENT OF INDIA FAMILY PLANNING PROGRAM
APRIL 1, 1968 - March 31, 1969 (IFY 1968-69)

Major States	Estimated population Oct. 1, 1969		IUD inser- tions per 1,000 popula- tion, 1968-69	Sterili- zations per 1,000 popula- tion, 1968-69	Sum of inser- tions & sterili- zations per 1,000 popula- tion, 1968-69	Percent- age of targeted district bureau staff in position	Esti- mated rupee expendi- tures per capita, 1968-69	Popula- tion density per square mile, 1968-69
	(Nos. in 000's) (1)	(Percent) (2)						
Andhra Pradesh	42,647	8.1	0.4	4.8	5.2	85.8	0.48	385
Assam	15,321	2.9	1.4	1.0	2.4	46.2	0.21	306
Bihar	56,787	10.8	0.4	1.5	1.9	64.7	0.27	805
Gujarat	26,069	4.9	0.5	3.8	4.3	56.0	0.60	341
Haryana	9,871	1.9	3.0	2.0	5.0	60.4	0.66	548
Jammu & Kashmir	4,008	0.8	1.9	3.0	4.9	20.5	0.70	73
Kerala	20,945	4.0	1.7	3.5	5.2	84.6	1.00	1,328
Madhya Pradesh	40,055	7.6	0.9	3.4	4.3	51.3	0.48	223
Tamil Nadu	39,034	7.4	0.6	2.9	3.5	64.5	0.36	749
Maharashtra	49,210	9.3	0.2	5.5	5.7	55.3	0.54	394
Mysore	28,839	5.5	0.7	3.2	3.9	52.6	0.49	370
Orissa	21,283	4.0	1.7	3.3	5.0	71.6	0.65	338
Punjab	14,479	2.7	2.5	2.7	5.2	70.6	0.82	702
Rajasthan	25,771	4.9	0.8	1.5	2.3	47.9	0.57	184
Utter Pradesh	89,425	16.9	1.0	1.7	2.7	51.9	0.38	752
West Bengal	44,074	8.4	0.5	3.8	4.3	65.6	0.41	1,233
Totals: all-India: columns 3-7: major states: columns 1-2, 8	527,818	100.0	0.9	3.0	3.9	56.3	0.56	

Source: Direct tabulations or computations based solely upon Government of India reports.

COEFFICIENTS OF CORRELATION BETWEEN INPUTS AND OUTPUTS OF THE INDIAN FAMILY PLANNING PROGRAMS IN 16 MAJOR STATES, APRIL 1, 1968 - MARCH 31, 1969.

Dependent variables (outputs)	Independent variables (inputs)	
	Percentage of targeted district staff in position	Estimated rupee expenditures per capita
IUD insertions per 1,000 population	$r = 0.05$ $r^2 = 0.00$	$r = 0.56$ $r^2 = 0.32$
Sterilizations per 1,000 population	$r = 0.32$ $r^2 = 0.10$	$r = 0.30$ $r^2 = 0.09$
Sum of IUD insertions and sterilizations per 1,000 population	$r = 0.29$ $r^2 = 0.08$	$r = 0.68$ $r^2 = 0.47$
Percent targeted district staff in position	---	$r = 0.23$ $r^2 = 0.05$
Estimated rupee expenditure per capita	$r = 0.23$ $r^2 = 0.05$	---

Source of basic data: Government of India Reports.

D-3. Actual Progress and Potential Improvement
in the Korean Family Planning Program

The profile of relative development indicates Korea is more advanced than its per capita GNP would indicate. Literacy is quite high, and manufacturing is relatively advanced and diversified. The demographic situation tends to reinforce this impression. The crude birth rate is now estimated to be in the mid-thirties per 1,000. The death rate as well as the infant mortality has also declined in recent years. The average age at time of marriage has risen from 22.3 in 1955 to 24.2 in 1960 and this trend continues. Female participation in the labor force also showed a substantial upward movement between 1960 and 1965. The proportion of the total Korean population living in urban areas increased from 24.5 percent in 1955 and to 32.3 percent in 1965.

The Korean attitudes toward fertility and contraception also tended to be progressive. Surveys taken in Koyang and Kimpo in 1962-1964 indicate that although Koreans did seem to indicate a preference for fairly large families, that there was no widespread negative attitude toward birth control before the beginning of the family planning program. Additionally, the high incidence of induced abortion (which is illegal, but the laws are not enforced, in Korea) indicated a high potential demand for family planning services in Korea. In the Mid-1960's a survey indicated that over 25 percent of the women in urban areas had experienced at least one induced

abortion and of those women over one-half had experienced multiple abortion. The use of abortion in limiting family size, has if anything, increased after the advent of the family planning program.

All these factors point to an environment favorable to the implementation of a family planning program. The Korean experience in many ways has born this out, but the record in this regard is far from uniform.

The ROK (Republic of Korea) Family Planning Program dates functionally from 1962. Vasectomy operations plus a choice of four conventional methods were offered through the existing health center network. In 1963 IUD's were made available and in 1968 orals were provided to selected individuals (initially IUD dropouts). The program expanded smoothly and rapidly through '1966, by this time approximately 27 percent of the eligible couples (non-pregnant married women between the ages 15 and 45) were contracepting through the efforts of the family planning program. Yet from this time on little further progress has been made. The program essentially reached a plateau at 30 percent of the eligible couples, and has not shown any signs of breaking through this barrier. One of the major reasons for the problem arises from the heavy reliance placed on IUD's throughout the history of the Korean program. This, coupled with a high and increasing dropout rate (40 percent per year +) mean that almost all of the IUD's inserted are offset by dropouts. The way in which the pill was introduced into the program may have created this situation, it was initially

available only to IUD dropouts. This would tend to produce IUD acceptors with low motivation for remaining with the method. It also appears that most of the couples who were receptive to family planning have been serviced and the program is now dealing with more resistant individuals.

The record of inputs into the ROK Family Planning Program seem to follow the same pattern as the program outputs. Initially, the domestic financing of the program increased rather rapidly but after 1965 the increases barely kept pace with inflation. Any increase after this period was largely a product of external financing and the assistance (especially A.I.D.) tended to end up in rather a lengthy pipeline and have little impact upon the action program upon receipt. Beyond that in 1968 and 1969 the family planning program did not receive a part of its budgeted funds until late in the year. This produced a shortage of funds to reimburse doctors (private) for IUD insertions and sterilizations. When the funds were made available later, it was too late to make up for lost time. The problems with this arrangement have now been recognized, and funding for 1970 will be on a full year basis. ROKG appropriations were increased from 475 million won to 615 million won in 1969 and to 715 million won in 1970.

The manpower inputs exhibit this tendency to plateau even more strikingly. Although the data for the earlier years is only approximate, there has been no appreciable increase in Family Planning manpower since 1964. It would be unfair to say

that this staff is adequate for the task. A substantial portion of the rural population of Korea resides in townships with no doctors.. In a program that puts such heavy emphasis on clinical methods of contraception (in 1968 approximately 85 percent of the couples contracepting through the program, were doing so by clinical methods), this implies the need for additional staff to service these areas on some special basis. Additionally, the quality of the workers has not improved materially over the course of the program. In a survey of fieldworkers, over one-half of the respondents felt their training was inadequate. The fieldworkers also receive an inadequate salary. They are not part of the civil service and do not receive the usual raises to compensate for the substantial inflation which exists in Korea. These workers find themselves in an increasingly worse position relative to other government and private workers. This is not conducive to keeping the better, more ambitious workers.

There are some problems in the administrative structure of the program. The administrative and evaluative capability of the ROK program is limited by lack of central staff. This limitation has been circumvented to some extent through the utilization of the PPFK, with their larger staff, in the areas of training and research-evaluation. Population Council has also carried out or funded a large part of the evaluation effort within the program, the PPFK, and local universities. While these arrangements do alleviate some of the problems, the lines

of authority have been blurred and maintaining an operationally relevant approach to evaluation is difficult.

The lack of accurate vital statistics makes the job of evaluation even more difficult. This system was restructured and simplified recently, but the creation of a viable system doesn't seem possible in the near future (most births occur in the home without professional medical help).

The ROK family planning program has been successful in the past. They have succeeded in bringing 30 percent of the eligible couples into the family planning, but if they wish to move beyond this point they must be willing to expand the program effort significantly. Up to this time, any external aid has been viewed as an opportunity to cut back on the domestic effort. Yet much of this aid has been limited direct benefit to the action program and often late in arriving. Both the quality and quantity of manpower available to the program must be increased. The internal managerial capability of the program must be increased. Finally, the increasing difficulty of making progress (both because of the less receptive people which remain to be reached and because of the rapid increase which will take place in the magnitude of the fertile age group in the 1970's as a result of the postwar baby boom) must be recognized and increasing efforts in the area of motivation made. While there are areas in the above where external funds may be of assistance, the primary burden rests on the ROK and their commitment to the success of the family planning program.

PROFILE OF RELATIVE DEVELOPMENT OF HUMAN AND NATURAL RESOURCES
IN SOUTH KOREA ^{1/}
IN COMPARISON WITH TEN LEVELS IN THE GLOBAL GRID OF SECTORAL
DEVELOPMENT^{2/}

Indicators of Development	No. of countries	Percentile Rank									
		0	10	20	30	40	50	60	70	80	90
Product per capita ^{3/} (S.U.S. per annum) ^{3/}	120	70	135	226	432	1615					
Agricultural occupation (percent) ^{4/}	110	72	56	42	28	11					
Wheat yield (100 kgs per hectare) ^{4/}	87	6	8	13	17	28					
Rice yield (100 kgs per hectare) ^{4/}	97	7	13	17	24	41					
Maize yield (100 kgs per hectare) ^{4/}	116	5	10	16	21	34					
Calories (per capita per day) ^{5/ 6/}	76	2000	2200	2430	2695	3110					
Total proteins (grams per capita per day) ^{4/}	52	48	59	78	85	94					
Animal proteins (grams per capita per day) ^{4/}	52	10	17	25	47	57					
Electricity generation (kwh per capita) ^{5/ 6/}	120	8	51	151	600	2637					
Steel consumption (metric tons per 1000 pop.) ^{6/}	67	8	20	69	220	371					
Literacy ^{5/ 6/ 7/} (percent)	113	8	25	55	85	99					
Newspaper circulation (per 1000 pop. per day) ^{6/}	147	2	11	38	100	291					
Primary school enrollment (percent of age group) ^{8/}	75	15	36	52	65	77					
Secondary school enrollment (percent of age group) ^{8/}	75	2	8	17	29	57					
Tertiary school enrollment (percent of age group) ^{8/}	75	0.1	0.7	3	5	9					
Teachers, primary and secondary (per 10,000 pop.) ^{8/}	68	12	28	41	60	80					
Crude birth rate (per 1000 pop.) ^{9/}	106	51	47	42	23	18					
Infant mortality (per 1000 live births) ^{9/ 10/}	112	172	94	53	31	20					
Life expectancy (years at birth) ^{9/ 9/}	73	35	43	50	62	70					
Inhabitants per physician ^{5/ 9/}	126	41400	12600	4600	1610	760					
		189300	25000	7100	2600	910					

^{1/} As indicated by brackets. ^{2/} As indicated by the deciles in the rankings of indicators from the latest year and the maximum number of countries, for which comparable data are available. ^{3/} Population Reference Bureau, December 1953. ^{4/} Food and Agriculture Organization, Production Yearbook, 1954. ^{5/} A.I.D. Economic Data Books, 1954. ^{6/} United Nations Statistical Yearbook, 1954. ^{7/} Ginsburg, M., Atlas of Economic Development, 1951. ^{8/} Harbison, F., and Myers, C.A., Education, Manpower and Economic Growth, 1954. ^{9/} United Nations, Demographic Yearbook, 1954. ^{10/} Countries with virtually complete reporting or estimated rates.

PARITY	AGE IN YEARS								UNKNOWN AGES	ALL AGES		MEDIAN AGE
	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49		Number	Percent	
0												
1		4,493	52,576	21,722	3,154	932	457	200	580	84,114	20.1	23.5
2		905	32,116	42,120	7,810	2,085	700	417	609	86,762	20.8	26.2
3		216	10,493	45,316	17,930	4,656	1,501	626	544	81,282	19.4	28.3
4		43	2,067	24,514	24,740	7,846	2,696	965	391	63,262	15.1	31.0
5		13	418	7,640	20,114	10,640	4,091	1,199	248	44,363	10.6	33.5
6			145	1,739	9,925	10,425	4,662	1,210	143	28,249	6.8	36.1
7			74	437	3,377	6,793	4,220	1,123	74	16,098	3.9	38.0
8				137	916	3,125	2,899	797	33	7,907	1.9	39.6
9				48	231	1,004	1,375	425	15	3,098	.7	40.9
10					111	481	868	457	11	1,928	.5	42.1
11												
12+												
Unknown parity		32	222	271	148	94	48	11	142	986	.2	27.9
All parities	No.	5,702	98,111	143,944	88,456	48,081	23,517	7,430	2,790	418,031	100.0%	28.6
	%	1.4	23.5	34.4	21.2	11.5	5.6	1.8	.7	100.0%		
Median parity		1.1	1.4	2.7	4.1	5.3	6.0	5.7	2.7	3.0		

D-4. Actual Progress and Potential Improvement in
PAKISTAN FAMILY PLANNING PROGRAM

Introduction

Family planning was introduced into Pakistan in 1952 by the private Family Planning Association through a few clinics, largely staffed by volunteers. Their supplies of contraceptives were mostly of relatively inefficient conventional types.

During the First Five-Year Plan, 1955-1960, it became apparent that the estimated two percent growth rate in population would prevent economic progress. Therefore an unrealistic 1.4 percent growth rate was utilized in order that the plan might project progress. When President Ayub took office in 1958, he announced a Governmental policy of population control. A plan was developed with the assistance of Population Council advisors, but there was little implementation before the end of the First Five-Year Plan.

Under the Second Five Year Plan, 1960-65, the Health Department was charged with implementing a program of population control through family planning. Valuable KAP studies were initiated. Almost 3,000 clinics were opened and several hundred staff people were trained. By 1963, however, less than ten percent of the program's modest goals had been attained owing to administrative weaknesses of the Department of Health, its inability to overcome administrative restrictions imposed by other Ministries, and a generally inadequate health infrastructure. Both the GOP and A.I.D. deemphasized health during that period in favor of "productive" sectors of the economy. After rejecting two of the Department plans for reorganization of the family planning program, the GOP appointed Enver Adil,

2.

a Senior Civil Servant as Family Planning Commissioner in September 1964. In one month this intelligent and dynamic administrator reshaped the family planning program for the Third Five-Year Plan in great detail, basing his plan on the considerable experience, both positive and negative, developed during a decade of family planning concern in Pakistan.

Third Five Year Plan for Family Planning

Commissioner Adil had the support of the President and enough stature to work directly with the Secretary of Health. He created an organization reaching from the Central Family Planning Council at the national cabinet level, to Provincial Family Planning Board with provincial cabinet level members, to District Family Planning Boards chaired by Deputy District Commissioners, to Union Councils, the lowest political units. This organization and paralled administrative and technical staff at all levels, with some 3,000 full-time officers and 50,000 part-time workers, plus 100,000 commercial distributors. Provision was made for reporting and information feedback from the bottom to the top in order to facilitate administrative decisions consistent with the actualities of the program.

The essential strategy of the program was to bring all types of contraceptive services to all of the people at their door steps. At the same time that services were provided provision was made for public information/education/communication support by all available means in order to motivate the people to accept family planning as a way of life.

On the basis of studies by the National Research Institute of Family Planning, the IUD was thought to be the most suitable contraceptive for

3.

use in Pakistan. Oral contraceptives were considered too expensive, too cumbersome because of the necessity of daily use, and of doubtful medical safety. The IUD was acceptable, cheap, reliable, reversible and required only one decision and action on the part of the patient. Sterilizations were provided for, but considered of little importance because of doubtful acceptability, the need for surgery, and their irreversibility.

Conventional contraceptives which could be used without medical staff and which had been found acceptable in previous programs were provided: condoms, foam tablets, Durafoam, Emko and Delfin, and diaphragms.

During the first three months of the program some 30,000 people were trained from one to three weeks. Since family planning was a special temporary project, the full-time staff was not composed of government civil servants and, therefore, could be hired and fired at will. Though they received approximately double the pay of Health Department civil servants, they were denied pensions and job tenure. Many staff members were lured from the Health Departments by the higher pay and many Health Department staff members work part-time in family planning, with a monthly retainer fee plus a fee for service.

Urban family planning clinics were established in areas not adequately served by existing Health Department facilities and rural clinics were established in existing health facilities and in newly established family planning clinics. Temporary facilities called IUD camps were established at the union council level, usually in a room in the union council headquarters. Mobile teams came to these temporary facilities to provide family planning services when the motivational staff members had created a demand for such services.

4.

Motivation was stressed during the Third Five-Year Plan because many family planning clinic servicers had been under utilized during the Second Five-Year Plan. A thousand family planning officers were planned for each of the two provinces to devote full-time to motivation and supervision. About two-thirds of that number actually were placed. Seminars, meetings, lectures, individual discussions and audio-visual aids including movies, books, manuals, pamphlets, posters, bill-boards, newspapers, magazines, souvenir gifts, wandering minstrels, T.V. programs and many other techniques were freely utilized. Official IE&C programs were augmented by the efforts of voluntary agencies such as the FPA and social and university groups.

Plans for research and evaluation were made at the beginning of the program. The National Research Institute for Family Planning was revitalized and two provincial Research and Evaluation Centers were established. The University of California and Johns Hopkins Research Units were continued. The five training cum research institutes organized with SIDA assistance were continued as training units with minor research duties. Detailed monthly reports of program progress were required and were compiled within a few days of the end of the month. IUD record cards supplied detailed information on IUD acceptors. Special studies such as the impact survey and the IUD retention survey provided information needed for administrative decisions.

Plans for long range institutional development of a population center prepared by the Notestein Committee have not been implemented.

5.

Financial resources available to the program were considerable. The Third Five-Year Plan provided 284 million rupees (28.4 crore) for the overall budget compared to the requested budget of 40 crore. Theoretically this budget included all internal and external costs including donations by other countries or organizations. In practice the Mission was able to provide some extra support through project agreements which provided rupee support for items omitted or underestimated in the Third Five-Year Plan such as, compensation for vasectomies and salaries for lady family planning visitors. In FY 69 A.I.D. provided 36.3 million rupees for such extra-plan budget items. SIDA, Ford Foundation, Population Council, UNICEF, UK, The Netherlands, Universities of California and Johns Hopkins also provided substantial assistance.

Progress to Date

In 1965, Pakistan had about 115 million people. A crude birth rate of 50 per thousand and a crude death rate of 20 per thousand resulted in a 3% growth rate. The planned goal was to reduce the birth rate to 40 and the growth rate to 2.5 percent on the assumption the death rate would decrease from 20 to 15. The reduction in birth rate was to be accomplished by having five million of the 20 million couples practicing family planning by 1970. By January 1, 1969, after three and a half years of program operation it was estimated that 3.4 million couples were practicing family planning. Thus the goal was almost being met in spite of the Indo-Pakistan War which largely prevented activity in the family planning program during the first six months. As of January 1, 1970, nearly three million IUDs have

6.

been inserted, about one million sterilizations have been performed and more than one-half billion conventional contraceptives have been distributed. In the last month for which figures are available to AID/W, October 1969, 66,000 IUDs were inserted, 57,000 sterilizations were done and 16 million contraceptives were distributed. Thus it appears that Pakistan will just about meet its goal of having five million couples practicing family planning by July 1, 1970 provided the estimates on IUD rejections and re-insertions are reasonably accurate. Meeting the goal should result in a drop in the birth-rate from 50 to 40 per thousand and should prevent a million and a half births per year.

Factors in Success

Why has the Pakistan Family Planning Program been able to meet its goals in spite of the Indo-Pakistan War of 1965, the riots of 1969 and numerous program problems? Some of these factors are:

1. Intelligent dynamic leadership with access to the power structure. Secretary Adil was an experienced Civil Servant with access to high officials including the President. The President himself fully believed population control necessary for the survival and development of his country. His successor, Dr. Sardi is an intelligent, tireless and fearless worker with sufficient social and bureaucratic status to effectively tackle program problems.

2. A sufficient full-time, trained supervisory staff. Non-civil service status permitted firing incompetents and high salaries attracted well qualified workers.

7.

3. A highly developed administrative organization provided supervisory and logistic channels and a feedback mechanism with built in evaluation and research programs.
4. Monetary incentives including fees for services, and profits for the private sector.
5. Pakistan made the pioneering decision to utilize subprofessional workers to provide clinical family planning services such as IUD insertions, when there were insufficient medical professionals for that purpose. Since only females may do gynecological examinations in Pakistan, less than ten percent of the physicians in the country were available for IUD insertions.
6. A pragmatic approach to the problem. Built in provision for feedback information enabled modification of the program while it proceeded. Analysis of management problems was carried on simultaneously with program implementation. As part of continuing improvement since April 1969, special emphasis has been given to training, research, evaluation and administrative reorganization.

Program Problems

The requested budget in 1968 was reduced from 40 to 28.4 crores of rupees. Implementation of the project was constantly delayed by the failure of the Finance Ministry to make the allocated funds available to the project managers in a timely fashion. Failure to provide funds on time not only delayed scheduled implementation but also diverted the time and energy of the top administrators from project implementation to bureaucratic discussions.

8.

Lack of adequate well trained staff below the administrative level was the next most important detriment to implementation. Pakistan does not have an adequate infrastructure of health, staffing, facilities, or equipment. The medical staff needed to provide clinical family planning services was not available and improvisations had to be made. The lack of medical staff was further aggravated by the decision to separate family planning from the Department of Health. This was done only after a severe intra-ministry bureaucratic struggle which left scars not yet healed and prevented full cooperation between the family planning program and the health program. Family planning has been brought back within the health structure but headed by a joint secretary for family planning.

A lack of demographic statistics makes an accurate evaluation of the program difficult and, thereby weakens the arguments for the effectiveness of the program.

Administrative policy restrictions by both the GOP and A.I.D. hampered the program somewhat especially in the provision of such commodities as contraceptives and transport. At the beginning of the program A.I.D. could not assist with contraceptives and the development of an adequate supply of contraceptives took considerable time. The transportation problem was never solved. The GOP is trying to solve this by providing transport specialists to recommend an improved system of operation and maintenance of existing and new vehicles. SIDA will release \$400,000 for vehicles upon the establishment of transport improvement.

9.

The Future of the Program

Future progress of the program is presently uncertain because of the political instability in the country and the current development of the Fourth Five-Year Plan which begins in July 1, 1970. With the participation of five million couples regardless of the outcome of political events, it would seem that family planning is firmly enough established as a way of life in Pakistan to ensure its continuation. Thus, it would seem rational to try to expand assistance to the Program despite some uncertainties as to the future.

Information available at this time indicates that Pakistan intends to have a large family planning program in the Fourth Five-Year Plan -- still separate from the Department of Health, but much better coordinated with it. The Family Planning Program staff will provide leadership, motivation, research, evaluation, and program supervision while the Department of Health will provide joint use of staff and clinical facilities and medical services for family planning clients. This approach represents the best utilization of the resources of both Family Planning and Health Departments.

The Family Planning Program needs to be greatly expanded during the Fourth Five-Year Plan. Less than half of the people of Pakistan had good geographic coverage during the Third Five-Year Plan. Health services for handling the complications of clinical family planning are entirely inadequate. The Mission and GOP are trying to improve and expand the family planning program as fast as input can be absorbed.

D-5. Actual Progress and Potential Improvement
In the Taiwan Family Planning Program

Taiwan is a small island about 90 miles off the southeast coast of mainland China. This island, which is about 245 miles long and only 85 miles across at its widest point, has one of the highest population densities in the world -- about 970 persons per square miles in a 14,000 square mile area. Half the island is mountainous with few inhabitants; the other half, the West, is fertile with more than 2,000 people per square mile.

In 1905, when the Japanese conducted the first census, the population of Taiwan was 3.1 million. By 1943 the number had increased to 6.6 million. Emigration of Japanese left the total at about 6 million in 1946. Between 1946 and 1968 the population more than doubled to 13.7 million, reflecting an average annual rate of increase of over 3%.

The crude birth rate had been around 40 per thousand, but decreased slightly to 38 per thousand in 1947 as a result of the war. The rate rose to 50 per thousand in 1951, but gradually came down to 36 per thousand in 1963, a year before the expanded family planning program was begun. The death rate, however, has declined steadily from 18 per thousand in 1947 to a little over 5 per thousand in 1968.

Because of the high fertility rates, the population of Taiwan has been young. Nearly 50 percent are less than fifteen years of age. This means a ratio of 90 dependents per hundred person in the working ages, as compared with 68 per hundred in the United States.

Declining rates of fertility and mortality in Taiwan since 1950 have been associated with rapid socio-economic change. The economic growth of Taiwan in the last two decades has been remarkable. Total national income tripled between 1952 and 1967, although income per person only doubled because of population growth.

Despite high population density and the erosion of many economic gains caused by its rapid population growth, official government support of family planning efforts in Taiwan came only in 1968. Private efforts in family planning began in 1954 but on a limited and sporadic basis. In 1959 the government agreed to allow inclusion of family planning information in a pre-pregnancy health program.

Movement toward family planning on an organized, comprehensive basis came in 1963 with the Taichung experimental program, which was the basis for later expansion of the family planning effort to all of Taiwan.

The target was to reduce the growth rate from 3 percent to 2.5 percent in five years, starting in 1963, and to 2 percent in ten years. The chief method chosen was the IUD; the estimated number required was 600,000 for the first five years.

By the end of June, 1969, 565,000 women of the approximately 1.7 million wives aged 20-44 had tried the IUD (about 33 percent). In addition, almost 80,000 have begun to use the oral pill, which was introduced in January, 1967. On the average, Taiwan has about 10,000 IUD acceptors monthly and about 3,000 women each month trying the pill for the first time.

Most of the success to date has been with women over age 30, although 35 percent of IUDs have been accepted by younger women. Taiwanese women marry on the average at 23, but they bear children rapidly after that. Because the number of women aged 20-24 will increase by 60 percent by 1973, it is important to reach them.

In addition to the need to reach younger women there is the problem of discontinuation of use with both the IUD and the pill. It is estimated that at the end of 1968, of the 462,000 new IUD acceptors (excluding reinsertions) about 220,000 (about 48%) had discontinued. Although the rate of IUD acceptance among wives 20-44 was 27 percent, the rate of current users was only 14 percent.

In order to provide another choice for those discontinuing the IUD, the pill was made available. It also, however, has not proved to be as good a continuer as hoped. Although 63,000 women had accepted by the end of 1968, the number of cycles being used monthly was only around 23,000.

Assessing the overall demographic impact of Taiwan's family planning program is difficult because Taiwan's demographic situation in 1963 was not one of uncontrolled high fertility. The birth rate had declined from 50 to 36 per thousand between 1951 and 1963, and a substantial socio-economic transition was well underway before the initiation of the program. The demographic impact of the program can be viewed as a successful attempt to intervene in a process that was already underway and to speed it up. Prior to the program the decline in the birth rate occurred at an annual rate of 2.3% per year. Between 1963 and 1968 the decline has averaged 5% per year. Perhaps as important, however, are the indirect effects of the program in reinforcing the transition from traditional to modern values concerning family formation. When demographic pressures conflict with traditional norms, the availability of information and services play an important role in moving couples toward the more modern type of action sooner than they would have otherwise.

There is growing concern in Taiwan whether the downward trend in the birth rate will continue. The analysis of Dr. R. Freedman shows that the fertility decline underlying the falling birth rate is concentrated in age groups above 30. The present program has done much to make it possible for women who have nearly reached their desired level of childbearing to maintain that level. There is no corresponding decline in fertility rates at younger ages. With increasing numbers of younger women just entering their reproductive years, and no decline in fertility rates at those ages, the prospect for the birth rate is a

leveling off or even a rise in the years ahead rather than continued decline. In terms of contraceptive methods, this failure of fertility rates below age 30 to show a decline is not consistent with the level of acceptance rate for IUDs in those ages. One explanation may be that large numbers discontinue use fairly soon after acceptance. Clearly, more needs to be known about the timing and spacing of childbearing and the interaction of family planning service delivery with the behavior of younger mothers if the program is to succeed in its effort to speed the decline in the birth rate.

Until 1968, Taiwan had no official family planning policy and therefore the annual budget did not allot money for the family planning program, which began in 1962. To get the program started, other sources of money had to be found. Direct A.I.D. funding was not possible because the Agency was not funding population programs prior to the time Taiwan "graduated" from the program in 1965. Similar procedural obstacles blocked assistance from SIDA and IPPF. Money came primarily from two sources, counterpart funds and the Population Council.

Counterpart funds were the main source, being second generation funds from the earlier A.I.D. lending program and drawing interest at about 10 percent a year which was controlled by the local Embassy and the trustees. About \$1.5 million were set aside to establish a five-year fund to support the program.

From the beginning of the pilot Taichung program in 1962 to 1969, the Population Council supplied more than \$1 million for the Taiwan program. This has supported a wide range of activities from testing new methods to evaluation.

T. Merrick
TA/POP/AE
April 1970

PROFILE OF RELATIVE DEVELOPMENT OF HUMAN AND NATURAL RESOURCES
 IN TAIWAN ^{1/}
 IN COMPARISON WITH TEST LEVELS IN THE GLOBAL GRID OF SECTORAL
 DEVELOPMENT^{2/}

Indicators of Development	No. of countries	Percentile Rank										
		0	10	20	30	40	50	60	70	80	90	100
Product per capita ^{3/} (\$U.S. per annum) ^{3/}	120		70	135		226	482	1615				
Agricultural occupation (percent) ^{4/}	110		72	56		42	28	11				
Wheat yield (100 kgs per hectare) ^{4/}	87		3	6	8	10	13	15	17	24		42
Rice yield (100 kgs per hectare) ^{4/}	97		5	7	10	13	16	17	21	24	34	41
Maize yield (100 kgs per hectare) ^{4/}	116		3	5	7	8	10	11	13	18	22	28
Calories (per capita per day) ^{5/ 6/}	76	2000	2200	2430		2695	3110					
Total proteins (grams per capita per day) ^{4/}	52	1800	2120	2295		2600	2940	3510				
Animal proteins (grams per capita per day) ^{4/}	52		48	59		78	85	94				
Electricity generation (kwh per capita) ^{5/ 6/}	120		42	52		72	80	90	112			
Steel consumption (metric tons per 1000 pop.) ^{6/}	67		10	17		25	47	57				
Literacy (percent) ^{5/ 6/ 7/}	113		6	14		20	32	53	77			
Newspaper circulation (per 1000 pop. per day) ^{6/}	147		8	51		151	600	2637				
Primary school enrollment (percent of age group) ^{8/}	75		2	21	93	373	1240	10761				
Secondary school enrollment (percent of age group) ^{8/}	75		8	20		69	220	371				
Tertiary school enrollment (percent of age group) ^{8/}	75		2	16	31	120	277	545				
Teachers, primary and secondary (per 10,000 pop.) ^{8/}	68		3	8	25	55	85	99				
Crude birth rate (per 1000 pop.) ^{9/}	106		3	12	35	75	96	99				
Infant mortality (per 1000 live births) ^{9/ 10/}	112		0	2	11	38	60	291				
Life expectancy (years at birth) ^{5/ 9/}	73		0	6	19	64	163	487				
Inhabitants per physician ^{5/ 9/}	126		15	36	52	65	77					
			3	26	44	62	69	94				
			0	2	8	17	29	57				
			0.1	0.7	3	5	9	33				
			0.0	0.3	2	4	8	33				
			12	28	41	60	80	135				
			2	24	35	48	70	135				
			51	47	42	23	18					
			59	49	45	35	20	13				
			172	94	53	31	20	14				
			259	127	68	39	26	14				
			35	43	50	62	70					
			26	37	46	58	67	73				
			41400	12600	4600	1610	760					
			189300	25000	7100	2600	910	400				

1/ As indicated by Histogram. 2/ As indicated by the deciles in the rankings of indicators from the latest year and the maximum number of countries for which comparable data are available. 3/ Population Reference Bureau, December 1953. 4/ Food and Agriculture Organization, Production Yearbook, 1954. 5/ A.I.D., Economic Data Books, 1964. 6/ United Nations, Statistical Yearbook, 1954. 7/ Ginsburg, N., Atlas of Economic Development, 1951. 8/ Harbison, F., and Myers, C.A., Education, Manpower and Economic Growth, 1954. 9/ United Nations, Demographic Yearbook, 1954. 10/ Countries with virtually complete reporting of estimates rates.

E. Dr. Nicholas Wright, Population Council

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FAMILY PLANNING: A brief discussion of some of the cultural and developmental limitations in delivering four major methods to a target population.

The technological limitations of sterilization, oral contraceptives, IUDs and the condom have been well-summarized recently by Segal and Tietze.¹ The purpose of the following remarks is to outline some cultural and developmental factors that limit the application or feasibility of the above four methods in national family planning programs.

In the light of specific country reports, global or regional generalizations lose strength. Topography and population density also qualify generalizations. So do cultural factors, particularly those which define the status of women. Many other considerations might be mentioned, but, in line with the original request, these remarks are not intended to be exhaustive. Nor do they necessarily represent Population Council policy.

Sterilization

Male and female sterilization warrant separate consideration since they require rather different delivery systems. Female sterilization is the more difficult and expensive because of the need for specialized medical skills and relatively sophisticated hospital services. These requirements are usually met, however, in urban areas of developing countries. Even in less developed, male-dominated societies, the demand for tubectomy after childbirth from the urban population often strains or exceeds the capacity of available services. Performing the procedure before hospital discharge after childbirth is most expeditious and, at that time, client fears of surgery are less vivid than later. Culdoscopy may be more acceptable to clients than the abdominal approach and will be helpful where anesthesia services are limited. This procedure requires hospital services, however, and cannot be performed in the immediate postpartum period.

Expansion of tubectomy services in urban areas, however, is sometimes limited by the shortage of small amounts of foreign exchange necessary to import specialized equipment. The cost of general expansion of tubectomy services will usually be prohibitive.

Male sterilization, although sometimes limited at first by popular superstition, often proves more acceptable than tubectomy. Vasectomy services are also easier to provide and extend into rural areas. When limited by the unavailability of medical hands, or their unwillingness to travel to rural areas, it appears possible to train reasonably well-educated paramedicals in the necessary skills. Hospital facilities are not required and the equipment is easily movable between standing or improvised clinics. So are the operating skills, but short-term follow-up care should be provided when mobile services are employed. Long-term follow-up is not required and this simplifies the delivery system. Funds spent in reimbursing the recipient of vasectomy services for days of work lost have proved useful in encouraging acceptance and the efficient utilization of mobile and fixed clinic services.

¹ Segal, S.J., and Tietze, C., "Contraceptive Technology: Current and

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The irreversibility of sterilization (for all practical purposes) does not appear to be a cultural limitation. Most potential family planners in the developing world are already under acute demographic family pressure and are eager to accept a permanent method after appropriate reassurance that the method will not cause them harm. Information stressing the finality of the procedure should, of course, be given.

Oral Contraceptives

Orals are highly acceptable and relatively easy to introduce into a national program. In several instances orals have soon become the major initial method where a choice is offered. It appears possible that women who would not use any other method will be recruited to their use. Where a complete initial medical examination is thought to be necessary, however, acceptance will be slowed. The two main reasons are the reluctance of clients to undergo a pelvic examination and of women doctors to station themselves in rural areas to screen clients. Some countries have found it feasible and satisfactory to allow trained, medically-supervised field workers to prescribe and distribute oral contraceptives after taking a pertinent medical history. The medical contact follows later and sometimes includes cervical cancer screening when this is feasible.

Although highly effective in clinical trials and in carefully selected populations in developing countries, the problems associated with continuing use of orals in national family planning programs, particularly outside urban areas, are formidable. Many of the problems are common to all repetitive methods, principally sustaining motivation to continue regular use and providing an adequate supply line to ensure that supplies are available when needed. The former requires considerable input of program support for each new acceptor, particularly, but not exclusively during the first three months or so. Many female field workers, adequately trained and supervised, are required -- and in the right place at the right time -- with reassurance and continuing supplies. Without these supports, difficult to achieve in even the accessible urban areas, continuation will be disappointing. To some extent, a supply line utilizing private commercial outlets may substitute where women can leave the home to collect the next cycle or induce their husband to collect it.

IUDs

In terms of continuation rates, the IUD is superior to repetitive methods in programs where both are available. Its acceptability is compromised, however, by the requirement of a pelvic examination and the nature of its most common side-effect, vaginal bleeding. Its widespread availability and continued use are often limited by the lack of a medical and/or paramedical infrastructure necessary for insertion and adequate follow-up.

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There are several studies indicating that specially trained, confident lady paramedical workers can perform insertions and deal with the vast majority of follow-up problems. The extension of this practice will make the IUD more accessible to rural women and perhaps improve continuation. Mobile clinic services are expensive, but may be the only way to reach remote target populations. They must be accompanied by a system for continuing care. Where private physicians are available outside urban areas, they can be utilized to perform insertions and provide follow-up care.

The necessary inputs are considerable and difficult to organize, but it appears that sympathetic follow-up can encourage continuation and promote acceptance by anticipating and thereby controlling damaging rumors about real and putative side-effects. Where it is culturally permissible, mothers classes, organized around satisfied acceptors, may give vital support to the method and family planning in general. Despite such efforts, however, the bleeding that almost all IUD acceptors experience may be culturally unacceptable and decrease both continuation and continued acceptance.

Condom

Although a repetitive method, the condom, in certain cultural situations, has clear advantages over the other three methods discussed above. Its use and method of action are obvious and probably arouse fewer fears in presentation. It does not require a medical or even paramedical infrastructure.

The method may be less attractive, however, if associated in the public mind with prostitution. There may be a disposal problem. Finally, the supplied must be available when needed and this means a distribution system with widespread outlets. Even in the least developed country, small business may be well-enough organized to serve as outlets for condoms. Such a distribution system may be the only practical way to extend the program into remote areas.

Without considering specific cases, generalizations about the feasibility of the four methods are vulnerable. The less developed and the scarcer the resources -- human and monetary -- in a region, country, or province, the more useful the condom and perhaps male sterilization in a national program. With more development and more available resources, orals, IUDs and female sterilization can be added. Regardless of the stage of development of the region, country or province, all four methods can usually be delivered in urban areas. All should be available there.

In discussing the difficulties of delivering imperfect contraceptive services to developing populations in rural areas, it is possible to be overwhelmed with the difficulties and forget that the problem is urgent. The overriding consideration is that there are people ready to accept in the remotest and least developed areas. Given a little time, these potential acceptors are almost always reachable with some acceptable level of services if the problem is approached pragmatically and with imagination and energy.

F. Summary and Conclusions

The preceding sections analyze experience by contraceptive and by country using both A.I.D. staff and outside experts. Now, we can attempt to generalize on the progress and problems with the different methods of contraception and their modes of delivery in countries at different stages of development. But the more we generalize the more we, perforce, must ignore how the inherent limitations and potentials of the different methods of contraception and their modes of delivery are affected by the different needs and resources at the different stages of development. The countries under review range almost the full scale of the continuum between the traditional and modern stages in economic, social and demographic transition.

The IUD has been the most popular method of contraception, since it does not need continuous attention from patient or program. But increasing difficulties in extending or maintaining gains require increasing use of paramedical staff qualified to overcome rumors, insert IUD's and provide counseling and follow-up. We really need a better IUD with fewer side effects and with higher continuation rates. In the meantime, countries need staff members who will counsel women at the beginning and will follow-up. Both actions may appear to reduce the number of women covered but they insure better long-term results.

Increased use of the pill will also require increased use of paramedical staff to advise patients, follow up dropouts and even deliver pills periodically to the home, if necessary. Here again, side effects have become a problem, which calls for a better pill.

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Sterilizations have gained no acceptance in Latin America or Africa, and in some Muslim cultures (Morocco), but have gained considerable acceptance in Asia, including some with Muslim culture (Pakistan). Lack of physicians has also been a constraint. More importantly, acceptors have tended to have already reached their desired family size and this curtailment of their relatively limited potential of reproduction remaining will not suffice to achieve national targets to lower fertility.

The condom has proved to be the most popular of the conventional non-medical means of contraception; however, its potential use, at least in Latin America, is limited by the stigma from its association with promiscuity and prostitution.

Turning to a review of population policies and programs in 16 A.I.D.-assisted countries, we find negative action at worst and inadequate action at best. Several Missions reported a pro-natalist government policy, several Missions noted the lack of an official family population policy even if they permitted family planning, and the remaining Missions almost invariably lamented that the family planning programs suffered from a lack of priority.

Once governments are really willing to extend family planning on a national scale, some of these might be able to do so with little or no outside assistance. The government of Chile is the notable example of a government which is quite able but not willing to extend family planning on a full scale to significantly reduce population growth.

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On the other hand the government of India is the notable example of a government that is much more willing to extend family planning, but can use external assistance to extend family planning with greater effectiveness and efficiency to significantly reduce population growth through efforts in the private as well as the public sector.

Specifically the following issues have been identified as key issues in the major programs:

In India, rigidities in external assistance and national programming might be alleviated by direct collaboration between international agencies and experimental programs in several states to demonstrate the feasibility and conditions of success in the circumstances of the particular state.

In Pakistan, lack of inputs and lack of infrastructure have limited the success of promising policies and programs although the original goals may be met.

In Korea, the lack of program inputs and remuneration of staff have not been overcome by progressive increase in external aid, some times of doubtful operational relevance. In this instance the merits of requiring matching funding might be considered

In Taiwan, the need to reach the younger age groups suggests a possible role for the pill in low parity women who are not the most successful wearers of IUD's.

In Chile, the principal issue is the lack of will, not the ability to extend family planning on such scale that all excess or unwanted births might be prevented. A.I.D.'s role might concentrate on the elicitation of

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In Turkey, Morocco, and Ethiopia, in varying degrees, policies are still uncertain because of out-moded ideas about the correlation between military power and growing population.

Thus the single most important issue seems to be the need for national policies and priorities to sanction and support appropriate and acceptable, effective and efficient, action programs. Financial, commodity or technical assistance may become increasingly important to remove critical bottlenecks, if and when more countries decide to give sufficient momentum to family planning programs to achieve the demographic objective of a low population growth rate. Such external assistance may be required to correct problems and compensate deficiencies in respect to motivation, training, organization, logistics, management, planning, evaluation, coordination, etc.

These problems and deficiencies, each one noted by one or more Missions, but in different combinations and contexts, will require resident teams with qualifications in multiple disciplines to recognize the magnitude and nature of the salient problems and their appropriate solutions in their proper sequence. The diagnosis of the problems and the prescription of the solutions must be undertaken in their operational context, not from a distance. Thus we will need in the Missions sufficient staff with sufficient competence to be given sufficient authority to act with backstopping but not back-seat driving from Washington.

So as not to engender complacency, we should sound a note of caution. In some of these countries we are facing a boom in the number of young women with maximum reproductive potential. So far age specific

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fertility has not gone down in these age groups which could produce another baby boom in many of the less developed countries.

Individuals in the younger age groups have relatively little motivation to limit their reproduction because they are usually of low parity, and the pressures thus far have been towards limiting family size, not spacing children. Because of this, younger women are harder to recruit into the program and will drop out if any inconvenience results from contracepting (for example, side effects from the pill or IUD's). A greater effort must be made to induce younger groups to adopt spacing if a significant demographic impact is to be produced by the program.

So as not to engender defeatism, we could end on a note of optimism. The official family planning program in one country which, for example, has so far only half tried, has induced 30 percent of the eligible couples to adopt contraception. To this might be added the unknown proportion of the eligible couples that are practicing family planning as a result of their spontaneous efforts. Thus it is not unconceivable that increased and more timely inputs into the official program, including more adequate remuneration of the staff, in combination with the free workings of the private sector might reach the proportion of eligible couples necessary to reduce the birth rate to Western levels in the foreseeable future.

Last but not least it should be reiterated that the organized family planning programs may have indirect as well as direct effects.

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As mortality declines and the economy develops, pressures build a demand for family planning which can be met by the provision of means and information to those without sufficient motivation to limit or space their family formation in the absence of appropriate, acceptable and accessible services.

The provision of services and their growing acceptance may in turn induce other couples with varying degrees of ambivalence to limit or space families independently or with assistance from the program.