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PROGRESS TO DATE:  
A SELECTIVE BACKGROUND SUMMARY

by

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PROGRESS TO DATE;  
A SELECTIVE BACKGROUND SUMMARY

I. Population Policy and Programs: An Overview

A. Population Policy: Discussed and Defined

It has been said: "The time has already come when each country needs a considered national policy about what size of population, whether larger or smaller than at present, or the same, is most expedient. And having settled this policy, we must take steps to carry it into operation."

This warning, contemporary in tone and intent, was actually uttered 50 years ago in 1920 by John Maynard Keynes. Twenty-five years later, Frank Lorimer wrote in The Annals, "...the need for formulating and implementing realistic policies directed toward population control is general and urgent." (January, 1945, p. 199.)

In all the years since Plato, the first to discuss optimum population size and population policy, there has emerged a relatively small body of literature on the aspects (better the parameters) of population policy, and serious discussion on the subject has been limited to the most recent past.

The question of what is, in Keynes words, "a considered national policy" is a difficult one with which to introduce this overview. A general discussion of governmental population policies may serve to illustrate this difficulty.

Obviously what a government says and what it does need not coincide, and quite as obviously what a country says and does may vary in tone and intent in as many directions and for as many reasons as there are countries, problems, religions,

cultures, and social mixtures. A given country may believe it has too many people, but make no effort, or little effort, to affect that growth. Another country may say it has no problem of excess people, but may in actuality support public birth control clinics. Another country may believe it is underpopulated, but offer family planning assistance based on a philosophical rather than a demographic ideal. A country may believe that in terms of steadily rising economic growth its population is too small, but in terms of an economic take-off, it presently has too many people. When then does a government acquire a population policy? It may be unreasonable to say a government has a population policy only when it acts, for in fact the inaction of another government may also strongly imply a deliberate policy.

Since the early 1960's when the connection between family planning and public policy began to be de-sensitized, there has been a number of articles, monographs, conferences, papers, and the like that have discussed in great detail the subject of national population policy, but there have been few working definitions of such policies postulated. Usually, it is assumed everyone agrees on what population policy means, and/or policy is equated with the existence of a defined program. In preparing this paper a general review of the literature was made to find a commonly accepted definition of population policy. The search included, but was not limited to, proceedings, papers, monographs, textbooks, international symposiums, encyclopedias, congressional hearings and speeches. It was

concluded that "population policy" in everyday usage, lacks agreement on what constitutes policy. In the vast majority of the literature, moreover, "policy" and "programs" are consistently used synonymously.

The author of this paper offers the following definitions for discussion purposes. Population growth limitation policy is "A settled, determined, or definite course, method, or plan, adopted and followed by the legitimate organs of governments designed to reach and maintain a certain population growth and/or size." Or, population growth limitation policy could be defined "as a set of officially approved government activities and attitudes designed to promote the development of family planning services and the availability of contraception. Ideally its aims should be stated in the form of quantitative targets and qualitative services, both to be achieved by an announced prescribed time."

These definitions have at least one serious drawback; namely, they are so tightly constructed that perhaps with the exception of just a few countries, no country could be considered to have a population policy. Perhaps it would be more realistic, albeit not as accurate, to state that a population growth limitation policy is "the government's implicit or explicit support of family planning activities by public or private organizations." This more loosely constructed definition says nothing about the policy being pursued on a level designed to achieve some demographic, social, economic, political, or philosophical ideal.

Further, it leaves out of consideration "officially approved and administered programs."

The issues of population growth limitation policy have been raised. In the real world, a number of governments have decided to limit or decrease their population growth through the concept of voluntary fertility regulation. They do not all, in the end, and at this point in time, have an all-encompassing, inclusive, integrated policy. They support programs with varying degrees of enthusiasm and commitment; some have set goals while others have not. Most believe that family planning is a basic human right; others believe also it is an instrument for achieving a demographic/health/social goal(s). The diversity of policy in the real world is immense.

In the absence of a generally acceptable definition, the following criteria are used in the following section, as a common denominator for countries with a population growth limitation policy: (1) there must be an official announcement of a population growth limitation policy; (2) some step(s) must have been taken to implement that policy.

B. Population Policy: A Review of the Real World

The recent emergence of governmental policy designed to bring about decreases in fertility or the population growth rate is a factor whose importance cannot be assessed from a large body of empirical data. It is quite clear that population growth limitation policies are of relatively recent origin, and may accurately be said to be presently emerging and developing.

It is generally believed that India was the first government to establish a population policy designed to reduce the rate of growth (1952), followed by Pakistan (1955), Korea (1961), Jamaica (1963), Malaysia, Ceylon, Singapore, Turkey and Tunisia (all in 1965), Kenya, Mauritius and Morocco (all in 1966). (See: "World Population Situation," op. cit., pp. 182-184.) "Thus, by the end of 1966, family planning had become official, national policy in only fourteen developing countries of which one-half were in Asia." (Ibid., p. 186. The U.N. report included Mainland China.) By mid-1969, according to the U.N. report, 25 countries had official national population policies. (See Table 2.)

In preparation for the Spring Review, a listing of government positions was made. The table entitled "Family Planning Policy and Programs for Selected Countries" appears at the end of Section I, Population Policy and Programs: An Overview. A word about the compilation is in order.

With respect to policy and programs, the table includes information relative to the official position of 61 countries.

Most of those included in the listing were chosen because they fell into at least one of the following categories:

(1) Countries participating in the Spring Review; (2) Countries known to have official policy and programs; (3) Countries in the less developed world which are independent, national states and have IPPF affiliation; (4) LDC states which signed the U.N. world leaders declaration. Other countries for which information was available or were considered important were added.

Of these 61 countries, 20 are classified as having "both policy and program." Of these, five are in Africa, five in East Asia, three in Latin America, and seven in Near East/South Asia. Additionally, all but three of those with policy and programs (Morocco, Taiwan and Iran) have a national affiliation with the IPPF, and five (Mauritius, Taiwan, Jamaica, Ceylon and Turkey) did not sign the U.N. Leaders' Declaration on Population. Conversely, four countries (Philippines, Thailand, Colombia, and Dominican Republic) which signed the U.N. declaration, did not in this compilation fit into the category of "both policy and programs." Of the 15 countries covered by the Spring Review, nine are classified under "both policy and programs." This review uncovered a most interesting footnote: family planning activity of some

scale is taking place in almost every country of the world, although in Africa according to the IPPF, there are 22 countries that have no organized family planning activity, and according to the United Nations, at least five countries on that continent have stated a policy of increased population.

A few additional observations about the table are appropriate.

First, almost all countries which have opted for a population growth limitation policy, have established (1) policy goals (generally stated and which usually appear either in an official position paper or in a development plan), (2) program goals (explicitly stated in terms of population to be reached, or contraceptives to be used over a period of time), and (3) demographic goals (stated in terms of an ultimate or intermediate **demographic response** to be achieved over a specified period of time as a result of the policy and program goals.) To the extent possible, all such goals are listed. Indeed, the setting of goals appears to be fundamental to those countries which have decided on a population policy. In a few countries, goals appear to have been set in the absence of a clearly defined policy. (It should be recalled here that this compilation lists a country as having a policy if there is evidence of an official announcement that such a policy exists.)

Secondly, the designation Public and Private refers to the sponsorship of existing family planning/contraceptive delivery services. No effort was made to specify or assess

either the quantity or quality of such services, since these (1) do not lend themselves to such an analysis in this type of table, and (2) such analysis is being accomplished elsewhere in the Spring Review papers. Thus there is no distinction between a country that sponsors several hundred clinics as opposed to one that supports only a few. The same holds true for private sponsorship. This efforts shows only that such clinics exist.

Third, there is a growing number of countries that have no official policy, but permit programs (both public and private) to operate openly, often with some government support and/or encouragement. These programs may be equally successful with those supported by government policy, although judgement awaits further analysis. Within each of the official position stages, some programs are more advanced, more serious, more efficient, more purposeful, more intent, more target-minded, than are others.

It should further be noted that within each official government position classification, attitudes differ widely, raising the observation that in no case can regions be considered homogeneous entities. Some governments are strongly in favor of a growth limitation policy (albeit reasons vary), some are nominally in favor, and generally it can be said that policy attitudes, except in a few countries, are not cemented at this point in time, but are in a state of flux, even ambivalence.

(This may be due to the fact that countries which pursue a voluntary fertility regulation policy anticipate a demographic response that would more likely flow/a total, integrated, cross-sectoral population policy. As it is shown that voluntary family planning will achieve a specified demographic response, these policies will earn the credibility they presently seek. It may also be due to the short time such policies have been in existence.)

Fourth, an attempt was made to list to the extent known, the legal situation bearing on policy and programs. It is part of the general theory of social behavior that a legal system and laws are to one degree or another influential on individual and social behavior, at least in so far as the system and the laws create the conditions for such behavior. As such, laws and their application can contribute to the success of a policy or a demographic response. There is a high degree of suspicion that the act of legitimizing contraception and family planning by the duly constituted organs of government and the social/political institutions may be as important to a decreasing population growth rate as the policy stated, the program established and the methods offered.

Also, knowing even in a basic way, the legal status of contraceptives/family planning in a given country can be a decisive element in policy and program planning, since it seems most expedient to allocate available resources and personnel toward those countries where legal provisions invite success.

Areas of the law that bear on family size and population growth include: health, marriage/divorce, family and child benefits, tax, commerce, social security, abortion, sterilization, pharmaceutical, maternity, inheritance, advertising, manufacturing, transportation, publication, among others.

It is obvious a great deal needs to be known not only about existing laws, but the inter-relationships between law, and policy and programs.

Finally, "It is useful to note, further, that the official adoption of family planning as a policy seldom, if ever, represents a revolutionary change in Government policy. Such decisions more often are the culmination of a long process during which family planning evolved from a small to a large private programme with steady gains in Government support." ("World Population Situation" op. cit., p. 184.)

This last observation leads into an obvious discussion of how governments move toward a population policy.

In the policy area as elsewhere, governments usually move from position A to position B in an orderly, rational, measured, intentional way, although the reasons for, and the speed whereby, change is made vary according to administrative peculiarities, and political, social, economic, cultural dissimilarities. A uniform, predictable pattern for all countries has not emerged.

The Population Council, however, identified eight steps that are generally observed in the population policy-making process. These steps discussed elsewhere in the Spring Review papers include recognizing the relationship of population growth to development, the articulation of this

concern by top government officials, an in-depth study of the situation with government sanction, an effort to identify knowledge, attitudes and practices of the people, the **allocation** of monies for family planning, the setting of targets, the identification of authority for the program, and finally an involved and integrated policy and program. (Nortman, op. cit., pp. 12-13.)

This apparent passage from one policy position to another, however, does not take into account two additional areas; (1) the reasons why governments opt for a population growth limitation policy, and (2) the endemic factors that influence acceptance of a national population policy. These areas are discussed below.

One. Why countries move toward a population policy is not uniform, but generally some combination of the following are usually visible.

1. An awareness and concern of the role population size and population growth play in economic development, with special emphasis seemingly centered in employment, housing, education and resources. Increasing awareness is usually speeded along by better demographic data and studies on the impact of population pressures and urbanization.

2. Increasing concern for the health of mothers and children and of the adverse medical effects of large-scale, high-risk, illegal abortions.

3. Concern for family health, family structure and family stability.

4. The belief that family planning is a basic human right. In fact, the humanitarian principle (including human right, family stability and maternal health) was implicitly or explicitly enunciated in almost all statements on population policy.

5. A change in the attitudes and willingness of developed nations since 1962, to assist developing countries in the pursuit of their population policies. It may be recalled that in 1962 only one developed country was giving family planning/population assistance (Sweden), and "one developed country which in 1962 had voted against assistance by the United Nations to action programmes in population and another that abstained from voting have since established channels for both bilateral and unilateral aid in this field." ("World Population Situation," op. cit., p. 182. The U.N. report identifies The Netherlands as casting the negative vote, and the United States as abstaining on a proposal "that the United Nations give technical assistance, as requested by Governments, for national projects and programmes dealing with problems of population.")

6. Awareness of a change in international opinion toward government sponsorship of population programs.

7. The availability of improved contraceptive technology and increasing sophistication of delivery services.

8. The existence of KAP surveys showing latent indigenous support, backed by the successful efforts of private international and local groups in delivering family planning services.

9. Increasing belief that family planning programs could hasten the completion of the demographic transition.

Of the possible combination of factors listed above, the first four may be found in almost all statements reviewed in the process of preparing this paper.

Two. While the next section will address itself to identifying political and quasi-political impediments to the policy making process there are some immediate factors that influence government acceptance of family planning as national policy. These include:

1. The knowledge that social/political mechanisms and the legitimization of new norms must be brought to bear on the decision to effect a certain policy, taking into account the chief policy-approving groups in the country which include: the medical community, the communications media, the university community, the "upper classes," the military and civic action groups, organized labor and trade unions, various professional societies, political parties, organized women's groups, religious groups, well-identified community leaders.

2. The belief that intelligent, knowledgeable, dynamic leadership in the top civil service, including the various ministers, must clearly agree to the policy decision and verbalize

enthusiastically the commitment to pursue a certain policy.

While this does not guarantee the pursuit of successful policy and programs, in its absence no policy will be formulated and no goals will be established.

3. A high degree of popular concern and government commitment for health matters, and the existence of maternal and child care services within the total health infrastructure.

4. The existence of local expertise or imported expertise capable of working successfully through and with most of the groups mentioned in one above.

5. The belief that nationals can be trained to administer programs with a minimum of foreign intervention and advice.

6. The existence of an acceptable, working private family planning association.

### C. Population Policy: Political and Quasi-Political Impediments

In light of the over-whelming evidence that (1) rapid population growth in many less developed countries carries with it the potential to disrupt the economic, political and social order, and (2) the fact that a number of developing countries are pursuing policies designed to limit or halt their population growth, and (3) despite the fact that a number of more developed countries are willing to financially and technologically assist population programs, some are concerned that more developing countries have not undertaken a population growth limitation policy. This section seeks to identify, not explain, political and quasi-political impediments and considerations, some of which are forces at work and beliefs held in some countries in varying degrees and in varying relationships to other considerations in the national policymaking process.

#### 1. National Pride

- a. In spite of contrary evidence, population size and military strength are positively correlated. The subliminal defense mechanism against national extinction is a strong force.
- b. Former colonial powers are associated with advocacy of birth limitation.
- c. Elitist theories postulate the "lower classes" would refuse family planning.

#### 2. Fear of Change

- a. Poverty, illiteracy, isolation create fatalism and inertia resulting in governmental helplessness and endorsement with status quo. Such conditions are resistant to change and feed the fear of cultural shock.
- b. Fear that traditional values will disappear or unnecessary conflict will emerge.

- c. Some political leaders may be unsure of their administrative machinery, especially in situations requiring that machinery to take the lead in changing attitudes and mores.
- d. Given their understanding of social dynamics, some leaders believe their people will tolerate only a low level of innovation, imagination and experimentation.
- e. Hesitation in starting national programs of untested quality.
- f. Knowledge that in one country where birth limitation was openly and intelligently pursued in a political environment of no apparent restraints, government support of the program was an issue during a period of civil unrest.
- g. Fear that family planning is a sensitive issue with both the people and formal and informal policy-approving groups.

### 3. Political

- a. Reluctance to allocate or mobilize a national program that has no apparent wide spread public demand.
- b. Politicians and political leaders are more likely to lend support to policy and programs that show measurable results -- especially during their term in office. Results of population programs may not be visible for many years.
- c. Family planning may be seen as being inconsistent with cultural ideas of child labor, role of women or dominance of males.
- d. Family planning and birth limitation is inconsistent with the personal behavior of important political and village leaders.
- e. The belief may be held that no developed country has achieved a low rate of population growth based on a policy determination.

- f. The urban areas that would attract the most successful family planning are also the seats of large non-nationalist minorities who aspire to more political and economic participation in their adopted society. Further, these urban areas are power bases of the governments.

4. Economic Policy

- a. Some leaders have a blind faith that present economic policies are correct and are loath to admit need of birth limitation as a corrective measure.
- b. Tension and pressure created by fast growth are believed necessary to force modernization, as demonstrated by historical linkage of intellectual and economic advance with such social tensions.
- c. Slower population growth may have a negative effect on economic growth, at least in the long run after a take-off point has been reached.
- d. Family planning is a misplaced emphasis by donor countries who are unwilling to make a total commitment to development. Some leaders are mindful that in the years the U.S. foreign aid program is cut to its lowest totals in its history, increasing funds are made available for family planning in foreign lands.

5. Ideological

- a. Intellectuals of both right and left, especially in Latin America, have lived a long time with the concept of underpopulation. Orthodox Marxists believe that economic problems would be solved by socialism, and nationalists believe there is a continent to populate and develop.

#### D. Population Policy: Some Conclusions

The foregoing parts of this section have sought to: (1) discuss some of the problems involved in identifying population policy; (2) review and discuss the existence of policies and programs in the real world; (3) identify and recognize some of the possible political attitudes and impressions that sometimes obstruct the establishment of population policies in the less developed world.

For purposes of this paper, population policy refers to a policy of population growth limitation. Assuming a government has such a policy only if it officially and publically announces its policy and has taken steps to carryout that policy, 20 governments in the less developed world may be said to be executing a policy of population growth limitation. Approximately 28 percent of the world's people live in those 20 countries. (If Mainland China were considered to have a population policy and included in the tabulation, the figure would rise to about 49 percent.)

The rise in the number of governments involved in seeking a lower or slower population growth is a relatively recent phenomenon and is of increasing world interest. Government involvement with two aspects of population dynamics-- mortality and migration--has existed for centuries, but until recently governmental preoccupation with decreasing births has been rather remote and removed from politics and policy. (It might

be recalled here that government efforts to intentionally manipulate fertility upward has occurred several times in this century: Italy-1927; Germany-1933; France-1939; U.S.S.R.-1944; and outside of Europe, Japan in the 1930's.) All of the countries which pursue a population policy do so through the delivery of voluntary family planning services, and all seem to have made the decision based upon (1) the interplay of population growth and development, and (2) some assessment of humanitarian principles involving health, families and human rights.

The question of why have a government policy at all, when it is realized that reduced fertility will come through successful programs and not policy statements, deserves some comment. Generally, a population policy: (1) allows for government resources to be planned for, and budgeted toward, the achievement of certain goals which usually follow from instituting a policy; (2) tends to encourage cooperation between and among many branches and agencies of government, which is necessary for successful programs; (3) legitimizes the program activity for the doubtful and solidifies support of the committed; (4) promotes more open relationships concerning the problem with other governments and international organizations and groups thereby allowing a freer exchange between official actors; (5) presents symbolic if not real evidence of a national plan to achieve a pre-determined, well-thought out goal(s); (6) removes doubt where doubt of government position may bring

irregular and even contradictory approaches in national planning; (7) tends to give equal status with other areas of high priority.

The above, however, should not appear to overstate the case. Even with a well-enunciated, clear statement of policy, some of the following kinds of problems may exist: (1) a reluctance to advertise and publicize policy, programs and targets; (2) lack of endorsement from certain key government officials; (3) a weak program and/or managerial ineffectiveness; (4) continuing ambivalence within ministries to relate population problems to other sector problems; (5) the inability to transfer high caliber civil servants (or recruit outside personnel) into the program; (6) an over emphasis on targets which may result in rumors and false reporting. In a word, policy does not ensure program effectiveness in the absence of other factors, but program effectiveness would seem to be dependent on policy positions.

The following may be important points of interest for review and consideration.

1. Continuing recognition that in some cases it would be an act of indiscretion to urge a government into a premature policy position is desirable. Governments in the less developed world are in varying degrees of readiness and ability to pursue policy and programs of population limitation. That 20 governments in the past 18 years have decided to reduce their population

growth rates is remarkable when it is considered that 15 of these countries did not exist as independent states 25 years ago. Indeed, of the 136 independent states in the world in 1970, 66 have become independent since World War II, almost all of which are in the less developed world. It should also be remembered that just eight years ago, only one developed country was assisting LDC's in family planning and fertility reduction efforts.

2. On the other hand, governments that appear ready to state and pursue a population policy should continue to be encouraged and assisted in stating clear and well-defined policy goals. In the nascent stages of policy development, non-U.S. government organizations can have a most salubrious effect on the speed and direction of policy formulation.

3. Sensitivity and appreciation of host government positions is essential. The policy position of the host country, no matter where it falls in the spectrum, is a key factor in USAID and AID/W decisions, programs, approaches and general population effort. Accurate assessment is critical and important.

4. There should be aggressive but quiet pursuit of political inhibitions as they are identified in the host country setting. Part C. of this section recognizes some of those impediments. There are undoubtedly others. As these views and attitudes are detected they should be intelligently and sensibly resolved. There are logical reasonable,

accurate and persuasive counter-argument to most of the impediments mentioned in Part C.

5. There should be continual recognition and awareness that the legal situation is not a thing apart from the social/political environment. If legal reform, a low priority item in many countries, is to come about in the setting of the less developed countries, a degree of awareness must eventually (perhaps immediately) be created, for more so than in other areas of development, only the countries themselves can in the end effect the necessary legal change.

Population policy is both important and difficult for the same reason: namely, it gives official recognition and sanction to both the problem and possible solutions.

In the years to come desire on the part of governments to decrease fertility will continue to confront the desire to reproduce, which is a driving force in the history of civilization, is basic to human nature and is part of the laws governing life itself. Population policy must reconcile the conflicting desire for reproduction with the absolute and sometimes immediate necessity for reduced fertility. Policy determinations will determine if, when and how this will be done.

Region and country	Official government position				Goals	Legislation
	Opposed to family planning	Neutral or position unknown	No policy but approval of programs	Full policy and programs		
<u>AFRICA</u>						
Algeria			Private			Anti-contraceptive law repealed.
Botswana		X				Contraceptives shipped through government duty free.
Cameroon	X					Anti-contraceptive publicity law.
Congo (Kinshasa)		X				Art. 178 prohibits sale, distribution, display, advertising, transportation of contraceptives.
<u>Ethiopia</u>	Private					No legal prohibitions exist to deliver of services.
<u>Ghana</u> **				Public Private	Two Year Development Plan, 1968-1970: Designates MCH services deliver family planning  March 1969 <u>Ghana Population Policy</u> promises action program "to provide information, advice and assistance." "... present rates of population growth are detrimental to individual and family welfare and constitute major hindrances to the attainment of development objectives."	Legal structure and policies are to be studied according to policy paper.

Country	Family planning government position				Goals	Legislation
	Official policy	Actual policy	No policy but approval of programs	Both policy and programs		
Ghana (Cont'd)					<p>Program: 200,000 contraceptors or 10% of females by end of 1974.</p> <p>Ancillary goals in policy paper relate to migration, maternity benefits, status of women, study of law, children allowances, etc.</p>	
Kenya**				Public Private	<p>Development Plan, 1966-1970: Reduce fertility through voluntary control, through health education and programs; upgrade quality of life; bring about development.</p> <p>Program: Integrate family planning into health services; subsidize private clinics. Emphasis on family planning education.</p> <p>Demographic: To reduce population growth of 3.3 percent.</p>	
Liberia*			Private			
Libya		X				
Lesotho		Private				
Madagascar		Private				French anti- contraceptive law in force.

Region and country	Official government position				Goals	Legislation
	Opposed to family planning	Neutral or position unknown	No policy but approval of programs	Both policy and programs		
Malawi	X					
Mali	X					
Mauritius*				Public Private	Demographic: Reduce growth rate, but no target established.	
Morocco <sup>+</sup>				Public	1968-1972 Five-Year Development Plan.  Program: Plan to reach 600,000 fertile couples in five years.  Demographic: Reduce crude birth rate to 45/1,000 by 1972 and to 35/1,000 by 1985.	1939 law repealed by Royal Decree in 1967. Sale and advertising of contraceptives permitted. Abortion legal for some medical indications. Change in marriage age and family allowances proposed.
Nigeria*				Private (Public: state governments)		No anti-contraceptive legislation.
Sierra Leone*				Private		Contraceptives may enter duty-free.
Swaziland		X				
Tanzania*				Public Private		

Region and country	Official government position				Goals	Legislation
	Opposed to family planning	Neutral or position unknown	No policy but approval of programs	Both policy and programs		
<u>Tunisia</u> **				Public Private	<p>Quadrennial Plan, 1965-1968: "...it is necessary to undertake action on the national scale to educate people in this field and to encourage them to adapt voluntary birth control."</p> <p>Policy: To develop sense of responsibility in regard to procreation on part of people.</p> <p>Program: Develop institutions and personnel.</p> <p>Demographic: Reduce birth rate from 45 to 34 per 1,000 by 1975; to drop growth from 2.8 to 2.3 percent.</p>	No inhibiting legislation exists. Passed laws to legalize sales; abolish polygamy.
Uganda*		Private				
Zambia		Private				

Region and country	Official government position				Goals	Legislation
	Opposed to family planning	Neutral or position unknown	No policy but approval of programs	Both policy and programs		
<u>EAST ASIA</u> Indonesia				Public Private	<p>1968 Presidential Instruction: Government will help people themselves implement family planning.</p> <p>Program: Improve maternal health, training, develop interest, start clinics. 3 million acceptors over 5 year period; 100,000 by 1970. 800 clinics by 1970.</p> <p>Demographic: Decrease birth rate.</p>	<p>High customs duty on imports.</p> <p>Imports through Ministry of Health only.</p> <p>(Art. 534-Dutch anti-contraceptive law--may still be in books, but not enforced.)</p>
<u>Korea</u> **				Public Private	<p>Program: 45% married women 15-44 practicing by 1971.</p> <p>Demographic: Reduce growth rate to 2% or less by 1971, and 1.5% by 1976. Reduce rate of natural increase from 29.5 (1962) to 20.0 in 1971.</p>	
Loas		Private				1920 French law.

Region and country	Official government position				Goals	Legislation
	Opposed to family planning	Neutral or position unknown	No policy but approval of programs	Both policy and programs		
Malaysia**				Public Private	<p>First Malaysia Plan, 1966-1970: Implement a positive program of family planning in conjunction with extending health/medical facilities. "Family Planning services will be made available to those who desire it."</p> <p>Program: 400,000 acceptors by 1971 (36% of women 15-44).</p> <p>Demographic: Reduce growth rate to 2% by 1985.</p>	Family Planning Act, 1966.
Philippines*				Public Private	<p>December 1969 policy statement expresses need to limit population growth, and to set goals. Will seek to formulate policy.</p> <p>Program action goals presently being formulated.</p>	<p>According to policy statement legal situation should be studied.</p> <p>Restrictions on imports of contraceptives was lifted in 1969.</p>
Singapore**				Public Private	<p>Second Five-Year Development Plan, 1968-1970: Intention is "to bring the message to every married woman (within the fertility range)... that family planning brings her immeasurable benefits. And, at her request, to advise her on the best available methods of family planning..."</p>	<p>No anti-contraception legislation.</p> <p>Maternity privileges restricted after third child.</p> <p>Housing laws assist childless couples.</p>

Region and country	Official government position				Goals	Legislation
	Opposed to family planning	Neutral or position unknown	No policy but approval of programs	Both policy and programs		
Singapore (Cont'd)					Demographic: Reduce birth rate to 20/1,000 by 1971.	
Taiwan				Public Private	Demographic: Reduce birth rate to 25/1,000 by 1975, and natural increase to 1.9%	No anti-contraceptive legislation.
Thailand**			Public Private		Expanded family health program.	Advertising prohibited.
Vietnam		Private				1920 French law.

Region and country	Official government position				Goals	Legislation
	Opposed to family planning	Neutral or position unknown	No policy but approval of programs	Both policy and programs		
<u>NEAR EAST/ SOUTH ASIA</u>						
Afghanistan			Public Private			Family Guidance Law promotes family planning.
Ceylon*			Public Private	Program: 1 million acceptors by 1975.  Demographic: Reduce birth rate to 25/1,000 and natural increase to 1.7% by 1975.		No anti-contraceptive legislation.
<u>India**</u>			Public Private	Fourth Five-Year Plan, 1966-1971: Through a concerted drive, control population growth through family planning.  Program: Stress sterilization; increase production of contraceptives; intensify delivery of services.  Demographic: Reduce birth rate to 25/1,000 by 1976.		No inhibiting legislation.
Iran <sup>+</sup>			Public Private	Policy: Increase health and welfare of peoples. Popularize family planning.  Demographic: Decrease growth rate to 2%.		No inhibiting legislation.
Jordan**		Private				No inhibiting legislation.

Region and country	Official government position				Goals	Legislation
	Opposed to family planning	Neutral or position unknown	No policy but approval of programs	Both policy and programs		
<u>Nepal</u> <sup>**</sup>				Public Private	<p>Policy goal: To improve quality of human life, coupled with economic development.</p> <p>Fourth Five-Year Plan, 1970-1974: Soon to be released, will contain program goals. (Likely: 350,000 contraceptors, or 15% married couples, by 1975.)</p> <p>Demographic goal: To prevent total population from exceeding 22 million, or preferably 16 million. Accepted idea of ultimate ZPG.</p>	
<u>Pakistan</u> <sup>**</sup>				Public Private	<p>Program: 5 million contraceptors by end 1970, or 25% women 15-44 married. 3 million of these to be IUD wearers.</p> <p>Demographic: Reduce crude birth rate to 40/1,000 by 1970, and reduce growth rate to 2.5%. Reduce birth rate to 25/1,000 in 25 years (1965-1990).</p>	No inhibiting legislation.
<u>Turkey</u> <sup>*</sup>				Public	<p>1965 legislation stated couples may have "as many children as they wish," and that family planning is a public health service.</p>	<p>No specific legislation inhibits family planning.</p> <p>Legislation does not stress social/economic implications.</p>

Region and country	Official government position				Goals	Legislation
	Opposed to family planning	Neutral or position unknown	No policy but approval of programs	Both policy and programs		
Turkey (Cont'd)					Second Five-Year Development Plan, 1968-1972: To make family planning available to 5% more women each year until 1972 when 2 million women protected.	
U.A.R. **				Public Private	Demographic: Reduce Growth rate to 1.7% by 1975.	No inhibiting legislation.

Region and country	Official government position				Goals	Legislation
	Opposed to family planning	Neutral or position unknown	No policy but approval of programs	Both policy and programs		
<u>LATIN AMERICA</u>						
Argentina*	Private					
Bahamas**				Private	Development Plan, 1965-1968: "Indeed population control measures must be implemented if living conditions are to be improved and per capita real income is to rise."  Program: to cover 60,000 women in three years.	
Bolivia		X				
Brazil	Private					
<u>Chile</u>			Public Private		Policy is not to reduce birth rate, but to reduce incidence of illegal abortion and promote family welfare and responsible parenthood.	Reform of legislation pending.  Family allowances and maternity benefits considered to be generous, and are popular.

Region and country	Official government position				Goals	Legislation
	Opposed to family planning	Neutral or position unknown	No policy but approval of programs	Both policy and programs		
Colombia <sup>*+</sup>			Public Private			
<u>Costa Rica</u> <sup>*</sup>			Public Private			Importation and sales of contraceptives apparently legal, but imports restricted.
Dominican Republic <sup>*+</sup>			Public- Private		Demographic: Reduce crude birth rate to 28/1,000 in 10 years. Reduce growth rate to 2.7% in 4 years, and to 1.5% in 10 years.	
<u>Ecuador</u> <sup>*</sup>			Public Private		Policy: Provide increased family health services and raise general health family.	Tax, social security and other laws seem to favor large families. Legal situation to be studied. High import duty.
El Salvador <sup>*</sup>			Public Private		Program: 200 health facilities providing family planning services by 1972.	
Guatemala		Private				
Honduras <sup>*</sup>			Public Private			

Region and country	Official government position				Goals	Legislation
	Opposed to family planning	Neutral or position unknown	No policy but approval of programs	Both policy and programs		
<u>Jamaica*</u>				Public Private	<p>First Five-Year Plan: To bring about awareness of population pressures and to assist in limiting and spacing children.</p> <p>Program: Institute IUD post-partum in 22 hospitals. To reach 20,000 new acceptors each year to ultimately reach and hold 35 - 40% of eligible population. To increase clinics to 160 by 1971.</p> <p>Demographic: Reduce birth rate to 25/1,000 by 1976.</p>	
Mexico*		Private				Advertising for family planning illegal.
Nicaragua			Public Private		Expanded MCH program offering family planning services	Restrictions on import and sales.
Panama			Private			
<u>Paraguay*</u>			Private			
Peru		Private				Sales are legal.

Region and country	Official government position				Goals	Legislation
	Opposed to family planning	Neutral or position unknown	No policy but approval of programs	Both policy and programs		
Trinidad & Tobago**				Public Private	Demographic: Reduce growth rate to 2.3% in 5 years, and to 1.9% in 10 years. Reduce crude birth rate to 19/1,000 in 10 years.	High import duty on contraceptives.  Restrictive legislation.
Uruguay	Private					
Venezuela		Private				

Notes:

Underlining indicates countries participating in Spring Review.

\* Indicates IPPF affiliate membership.

+ Indicates signatory of "World Leaders Declaration on Population."

x Indicates judgement of position, but no knowledge of programs.

Sources:

1. Country Profiles, (various) New York, The Population Council.
2. Family Planning in Five Continents, IPPF, London, England, August, 1969.
3. "Governmental Policy Statements on Population: An Inventory," Reports on Population/Family Planning, New York, The Population Council, February, 1970.
4. Howell, Catherine. IPPF World Survey, "Factors Affecting The Work of Family Planning Associations," London, England, February, 1969.
5. International Planned Parenthood News, (various) London, IPPF.
6. Nortman, Dorothy. "Population and Family Planning Programs: A Factbook," Reports on Population/Family Planning, New York, The Population Council, December 1969.
7. Situation Reports, (various), London, IPPF.
8. TA/POP files.
9. "World Population Situation, Note by the Secretary General, United Nations Population Commission, Geneva, November 3-14, 1969. E/CN.9/231, 23 September 1969.

Table 2

Countries With National Population Policies<sup>1/</sup>

	United Nations	Population Council	IPPF	A.I.D.
<u>AFRICA</u>				
	Botswana	----	----	----
	Ghana	Ghana	Ghana	Ghana
	Kenya	Kenya	Kenya	Kenya
	----	Mauritius	Mauritius	Mauritius
	Morocco	Morocco	----	Morocco
	Tunisia	Tunisia	Tunisia	Tunisia
	UAR	UAR	UAR	UAR
<u>ASIA</u>				
	Ceylon	Ceylon	Ceylon	Ceylon
	India	India	India	India
	Indonesia	Indonesia	Indonesia	Indonesia
	Iran	Iran	----	Iran
	Korea	Korea	Korea	Korea
	Malaysia	Malaysia	Malaysia	Malaysia
	Nepal	Nepal	Nepal	Nepal
	Pakistan	Pakistan	Pakistan	Pakistan
	Singapore	Singapore	Singapore	Singapore
	Taiwan	Taiwan	Taiwan	Taiwan
	----	----	Thailand	----
	Turkey	Turkey	----	Turkey
<u>LATIN AMERICA</u>				
	Barbados	----	----	Barbados
	Chile	----	Chile	----
	----	----	Columbia	----
	Costa Rica	----	Costa Rica	----
	Dom. Repub.	----	Dom. Repub.	----
	Honduras	----	Honduras	----
	Jamaica	Jamaica	Jamaica	Jamaica
	Nicaragua	----	Nicaragua	----
	Trinidad & Tobago	Trinidad & Tobago	Trinidad & Tobago	Trinidad & Tobago
TOTAL	25	19	23	20

<sup>1/</sup> As listed by four organizations, covering the less developed world, excluding Mainland China.

## PROGRESS TO DATE

II. Family Planning Through the Private Sector:  
An Alternative Approach

This Chapter reviewing and summarizing progress to date in the area of population policy and programs would not be complete without some mention of the role of private channels, or the commercial sector, as a delivery mechanism around the world. Although many, if not most, analytical and evaluative surveys and studies concentrate on the delivery of contraceptives through national programs, there is a high degree of suspicion in some sectors that a greater impact will be made on reduced fertility in the LDC's by a more intelligent, imaginative, dynamic use of the commercial markets than through country program efforts.

This virtually untested but important hypothesis has marginal utility at this time due to (1) the fact that so little data has been generated about the private sector as an alternative or complementary delivery mechanism, and (2) the fact that few countries have made a concerted effort to introduce or involve the private sector in getting contraceptives into the hands of potential eligible couples. Some efforts have been made to collect and analyse commercial market data, most notably and almost singularly, The Population Council, but little is known of market behavior, and market trends and potential.

Contraceptives are made in, sold in, shipped into and shipped out of, many countries of the world including less developed countries. Within a rough order of reliability, it is known, for example, what brand name, by contraceptive, is available in the private sales sector of many countries, but total sales, sales trends, points of embarkation, market vitality, private store distribution outlets, prices, etc., is not generally known.

Some initial forays into this area have been made -- e.g., The Population Council in Thailand -- but by and large knowledge in this area is sparse. The Population Council is currently preparing for publication in May 1970, a report entitled, "Contraceptives: Production, Commercial Distribution, Marketing" but the publication is by the Council's admission, a beginning effort into understanding a much larger, complex, interrelated area of contraceptive delivery.

Thus, it has become increasingly clear to those working in the family planning field, that there does not presently exist reliable documentation of the global patterns of contraceptive manufacturing, importation, exportation, distribution, sales and use (commodity flow) taking place through the private sales sector. While there have been

some estimates of an increasing commercial activity in contraceptives around the world, there is still an immense gap in the knowledge of who is manufacturing contraceptives, where these products are being shipped, and in what form, and eventually how many couples are purchasing contraceptives regularly in the private sales sector. In a word then, it is becoming more apparent that evaluative and analytical studies cannot ignore this area of family planning practice in determining fertility reduction, births averted, family planning acceptance, etc.

A review of cable traffic from the missions around the world, including the Spring Review emphasis countries, sheds little light on this important and potentially dynamic area of contraceptive activity. Several countries were able to make some rough estimates of the private sector sales. Paucity of data was usually related to the lack of required and systematic reporting procedures. Where data was available it usually related to importation, and sales data from unspecified sources. Table 1 attempts to piece together information available from The Population Council efforts in this area, and field submissions in various forms over the past year.

TABLE 1  
ESTIMATES OF COMMERCIAL SALES OF CONTRACEPTIVES FOR SELECTED COUNTRIES

Country	Year	Orals: Avg. Monthly Cycles Sold	Condoms: Avg. Monthly Sales (Single Units)	Comments
Chile	1969	120,000	--	Condoms currently not imported
Costa Rica	1968	17,000	--	Commercial sales equal public & private program
Ecuador	--	--	--	Believed 10% of women buy orals on commercial market
Hong Kong	1968	45,000	45,000	Sales exceed public program
Indonesia	1968	55,000	45,000	Sales exceed public program
Korea	1968	110,000	50,000	Sales exceed public program
Mexico	1968	500,000	70,000	Sales exceed public program
Paraguay	1969	4,000	--	Sales exceed public program
Singapore	1968	80,000	20,000	Sales exceed public program
Thailand	1968	160,000	60,000	Sales exceed public program
Turkey	1969	100,000	--	

The tentative findings of an AID study in 1968 indicates that oral contraceptives are manufactured in 11 less developed countries, condoms in five countries and IUD's in none.<sup>1/</sup> However, a more complete effort in the same year shows that perhaps a total of 25 LDC's manufacture IUD's, orals, condoms and conventionals.<sup>2/</sup> Both studies indicate that most all types of contraceptives are imported into almost all less developed countries, but the level of importation is not known. Contraceptives are manufactured, distributed, used and exported from most developed countries, but little is known of the specific nature of this commercial activity, especially in the area of exportation. For example, The Population Council estimates that nine countries produce about 15 million gross of condoms per year, but that approximately 13 million gross are manufactured in three countries: United States, Japan and United Kingdom. Information from the missions, most notably the East Asia region in February and March 1970, indicates that orals and condoms are generally and easily available in the private sector. A 1966 estimate indicates that "western" manufactures are distributing orals in 40 countries abroad.<sup>3/</sup>

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1/ "Legislation, Regulation, Availability of Contraception, Sterilization, Abortion in Selected Countries," A.I.D., WOH/PS, June, 1968.

2/ Levin, Harry L. and Peers, Rotha, Directory of Contraceptives, The Population Council and IPPF, 1968.

3/ U.S. News and World Report, May 9, 1966.

The December 1967 Studies in Family Planning produced by The Population Council, has given some indication over time of the use of orals in selected countries and regions. That information is contained in Table 2.

TABLE 2

*Estimated Number of Women Using Oral Tablets, by Area\**

	January 1965	July 1966	July 1967
<b>DEVELOPED COUNTRIES</b>			
United States	5,205,000	7,235,000	9,960,000
Canada	4,000,000	5,000,000	6,500,000
United Kingdom	250,000	450,000	750,000
Australia, New Zealand	275,000	415,000	700,000
Europe, including U.S.S.R. (excluding SIDA purchases)**	380,000	590,000	670,000
Japan	250,000	690,000	1,200,000
Other	50,000	90,000	140,000
<b>DEVELOPING COUNTRIES</b>	795,000	2,380,000	2,883,000
Latin America	500,000	1,600,000	1,934,000
Mexico	55,000	170,000	270,000
Brazil	n.a.	646,000	750,000
Argentina	n.a.	260,000	340,000
Colombia	37,000	64,000	75,000
Other	n.a.	460,000	499,000
Far East	100,000	307,000	507,000
Singapore	25,000	60,000	73,000
Malaysia	15,000	37,000	46,000
Hong Kong***	20,000	30,000	30,000
South Korea	6,000	32,000	30,000
Thailand	n.a.	10,000	20,000
India	n.a.	10,000	20,000
Other, Far Eastern	34,000	10,000	10,000
Near East & UAR	145,000	100,000	120,000
UAR	n.a.	100,000	220,000
Turkey	n.a.	15,000	60,000
Iran	n.a.	10,000	18,000
Iraq	n.a.	13,000	22,000
Other	10,000	10,000	10,000
<b>THE WORLD</b>	6,000,000	9,515,000	12,843,000

Figures were consolidated from reports of actual sales and production by the individual manufacturers of oral tablets throughout the world, cross-checked against marketing research surveys and government import records. The number of users was calculated by dividing the total number of pills used in an area over a 12-month period by 12.

\*\* SIDA is the Swedish International Development Authority, which gives substantial numbers of oral tablets to developing countries.

\*\*\* Some of these pills were apparently destined for export.

Table 3 gives further evidence of the use and non-use of commercial markets as a means of providing contraceptives.

TABLE 3

World-wide PERCENTAGE of Contraceptive Distribution: 1968

	Commercial Markets	Public Programs	Private Programs
Developed Countries (Excluding U.S.)	98	--	2
United States	95	3	2
Developing Countries	40	55	5
Developing Countries excluding IUDs	64	34	2
World (41-48 million users)	80	19	1

Tentative findings of a study conducted by The Population Council New York, to be published later in 1970. (The author appreciates the Council's permission to use these tentative findings.)

Another recent study reports: "The potential market worldwide is huge. There are 735 million women age 15-44 in the world, 43 million of them in the U.S. Thus, only 2.3% of the women in this age group took the pills, while overseas the rate was a mere 1.15%. If worldwide use were to come up to the level now prevailing in the U.S., there would be 154 million users."<sup>1/</sup>

<sup>1/</sup> Applezweig, Forman, "Steroids," Chemical Week, May 17, 1969.

It seems clear from this brief review that little is presently known about the manufacturing, exportation, importation, distribution, marketing and use of contraceptives through the commercial sector, but perhaps more importantly, little effort, attention or funding has been made to exploit this potentially dynamic area for moving contraceptives into the hands of couples in the less developed countries. The Spring Review submissions did indicate interest in the market potential for contraceptive distribution.

It would appear the following is called for: (1) a systematic, world-wide profile and marketing analysis of contraceptive marketing characteristics; (2) the institution and maintenance of a contraceptive marketing reporting system or network; (3) testing ways the commercial markets can substitute for and supplement national program efforts and delivery systems; (4) an investigation of the numerous possibilities for the improvement of the distribution of contraceptives through the private sector.

Governments impressed with the necessity for reducing their population growth through the voluntary use of contraceptive techniques, will also be impressed with the immense number of eligible couples who would be self-supporting contraceptive users if methods were easily and cheaply available through innovative and imaginative use of commercial markets.

Thomas C. Lyons, Jr.  
TA/POP

April 1970

## PROGRESS TO DATE

III. Family Planning Programs: A Summary of Possible Demographic Effects and Problems 1/A. Introduction

Countries that have officially decided on a policy of population growth limitation have instituted voluntary fertility limitation programs designed to bring about a demographic response usually stated in terms of a reduction in either the growth rate, the rate of natural increase, or the birth rate. Further, in many cases this anticipated response is to be achieved by a specified point in time.

The question arises: Will voluntary family planning achieve the demographic response desired? Will it in the end succeed?

The relationship between the use of family planning and changes in the rate of population growth is extremely complex. There are a large number of other factors which come into play in this situation which can make it extremely difficult to measure the success or failure of a family planning program; at least in terms of its direct effects on general demographic change in a country.

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1/ This summary section was based on a background paper prepared by Peter Gardiner, I.D.S.C., Bureau of the Census.

This is an important point to remember. In the short run, conflicting factors may prevent a family planning effort from registering more than minimal reductions in the birth rate or rate of population growth. This does not mean that the program should tacitly be judged a failure; in fact it should serve as a warning that short run evaluations may fail to reach accurate conclusions about the potential benefits of family planning to a particular society. Success of family planning in many areas, particularly those still undergoing rapid mortality decline or where cultural resistance to family planning is high, at least for the first several years of the program, may be viewed in terms of the prevention of further increases, rather than actual decreases, in the rate of population growth.

On the other hand, where noticeable reductions in the birth rate or the rate of population growth do occur, it would often be wrong to ascribe the results solely to inroads made by a family planning program. It appears more often that family planning may play a largely supportive role, albeit, a very important one, to wider trends of modernization in the social and economic climate of a country that may, in fact, be the prime factors in motivating families to produce fewer children.

B. Family Planning and the Demographic Transition.

The transition from a situation of high fertility and high mortality to one of low fertility and low mortality (the demographic transition) is now essentially completed in areas such as Europe and North America. However, it is far from resolved in most of the less developed areas of the world. The nature of this transition, as it is progressing in the less developed countries, is important for a full appreciation of the role national family planning programs can play.

In many countries of the less developed world mortality has been falling rapidly in the last few decades. Only moderate improvements in sanitation, nutrition, or in the control of infectious or parasitic diseases have been sufficient to accomplish a falling mortality. Death rates in much of Latin America are presently comparable with those of the more developed nations. In parts of Asia and Africa mortality is still relatively high, but it is considerably lower than it was only a few years before. Comparable declines in the birth rate in many of these areas have not, or are now just beginning, to take place.

This transition is both a product of and a barrier to economic and social development. Historically, it is the transition from the predevelopment state of high birth rates and death rates to the low birth rate and death rate situation which now exists in the more advanced countries of the world. There is no inherent problem in this phenomenon, in fact, it is an integral part of economic development. Yet one finds that the shift in the birth rates and death rates has not and is not occurring simultaneously. Specifically, the fall in the death rates has preceded the fall in the birth rates. When this occurs the society affected undergoes a period of extremely rapid population expansion, which makes economic development difficult. There is a paradox inherent in this situation. Development produces the fall in the death rate, which produces the birth rate-death rate gap, which makes further development necessary to bring down the birth rate difficult. This means that once this gap exists it becomes increasingly difficult and time consuming to close it.

This is the problem to which most of the family planning programs of the world are addressing themselves. They seek not to stop or eliminate the demographic transition but to bring it about more rapidly and minimize the gap which is certain to exist.

Given this setting, family planning programs can operate on several levels to accomplish the above goals. These levels are based on certain assumptions about the factors which delay the fall in the birth rates in developing countries. The first postulates that the people have neither the knowledge nor the means to limit their reproduction. This implies that the provision of these lacking elements will have a substantial impact on fertility. Inherent in this viewpoint is the assumption that people desire to limit their families. The second level admits that the motivation to limit fertility is marginal and that the provision of "painless" methods of family planning is needed. The final level postulates that the people do not desire smaller families. Cultural inertia preserves the old high birth rate-death rate behavior patterns, even though this is inappropriate to the evolving social setting. In this setting efforts must be made to establish new reproductive norms both in the absolute number and timing of children.

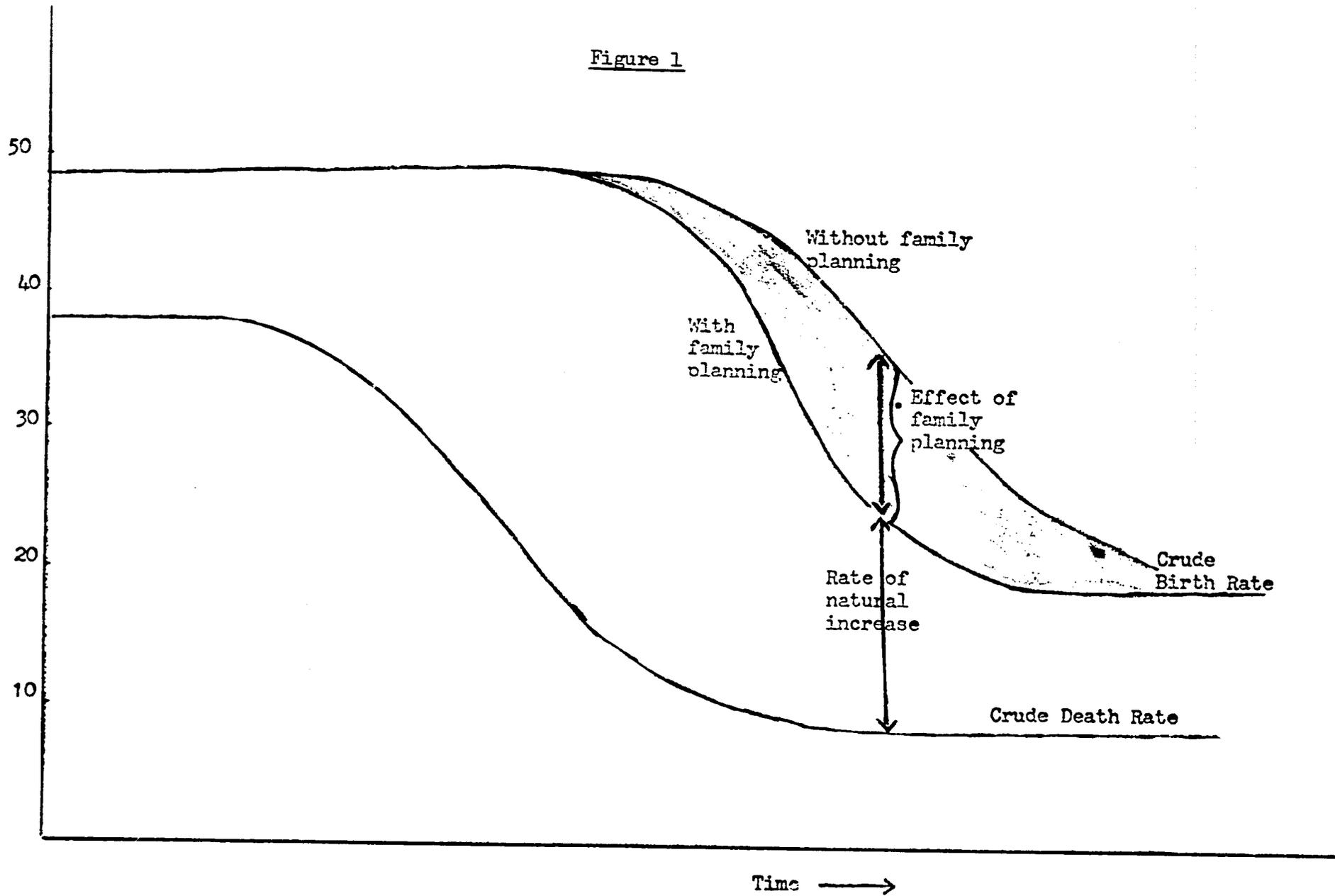
It can be readily seen that each of these views hold quite different implications for the structure and operations of family planning programs. Yet choosing any one view would oversimplify the

real world. In actuality countries have elements of all three views and any one approach will reach only a fraction of the population. The real problem is to identify some optimal path. This implies that as a family planning program progresses it is trying to reach a changing target population.

Many countries are faulted because they reach only the older and higher parity women. These are primarily women whose fertility would have been relatively low, even in the absence of a program. Some say this is not effective demographically, and if one is too concerned with the immediate product this may be true. Yet as certainly as these high parity acceptors have a lower demographic impact, they also are easier to recruit due to high motivation. As the methods of contraception become more and more "painless" those of marginal motivation and lower age and parities will accept. The early groups, by their very behavior, then form a powerful force to break the cultural inertia with respect to family size.

The potential supportive effect of family planning on the demographic transition is conceptualized in Figure 1. The upper lines represent the crude birth rate, the lower line the crude death rate, and the vertical distance between them the rate of natural increase, or  $r$ , in lieu of migration, the rate

Figure 1



of population growth. While both birth rate lines eventually seek the same lower level, it can be seen that without family planning the slower rate of fertility decline results in a markedly higher rate of growth over the period.

C. Hong Kong: A Case In Point

Hong Kong's population structure is so unusual as to render crude birth rates virtually useless as measures of fertility levels and trends. Moreover, because age of mother is not recorded on birth certificates, age-specific data are not available through the registration system.

To obtain data capable of tracing the trend in fertility, the University of Michigan and the Hong Kong family planning program have collected data for 1965, 1966, and 1967 from a probability sample of birth records in hospitals and nursing homes. These data were related to estimates of the age-sex-marital status of the population to provide the following analysis:<sup>1/</sup>

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<sup>1/</sup> Material in this section is based largely on Studies in Family Planning, number 44, August 1969.

Previous work by Freedman and Adlakha indicated that the rapid decline in the crude birth rate between 1961 and 1965 (35.5 to 28.8) was largely a result of changes in age structure and partly due to changes in marital status. Only 10 percent of the 1961-1965 change was attributed to declines in marital fertility.

On the otherhand, the 10 percent decline in the birth rate between 1965 and 1966 was due largely to changes in marital fertility. The decline in marital fertility continued between 1966 and 1967 and again accounted for virtually all of the decline in the birth rate.

During the period 1961-1965 such declines as were recorded in marital fertility occurred at the older ages. During the later period 1965-1967 declines were recorded for the younger ages. A major part, although not all, of the decline can be attributed to activities of the family planning program.

#### D. Taiwan: A Case in Point

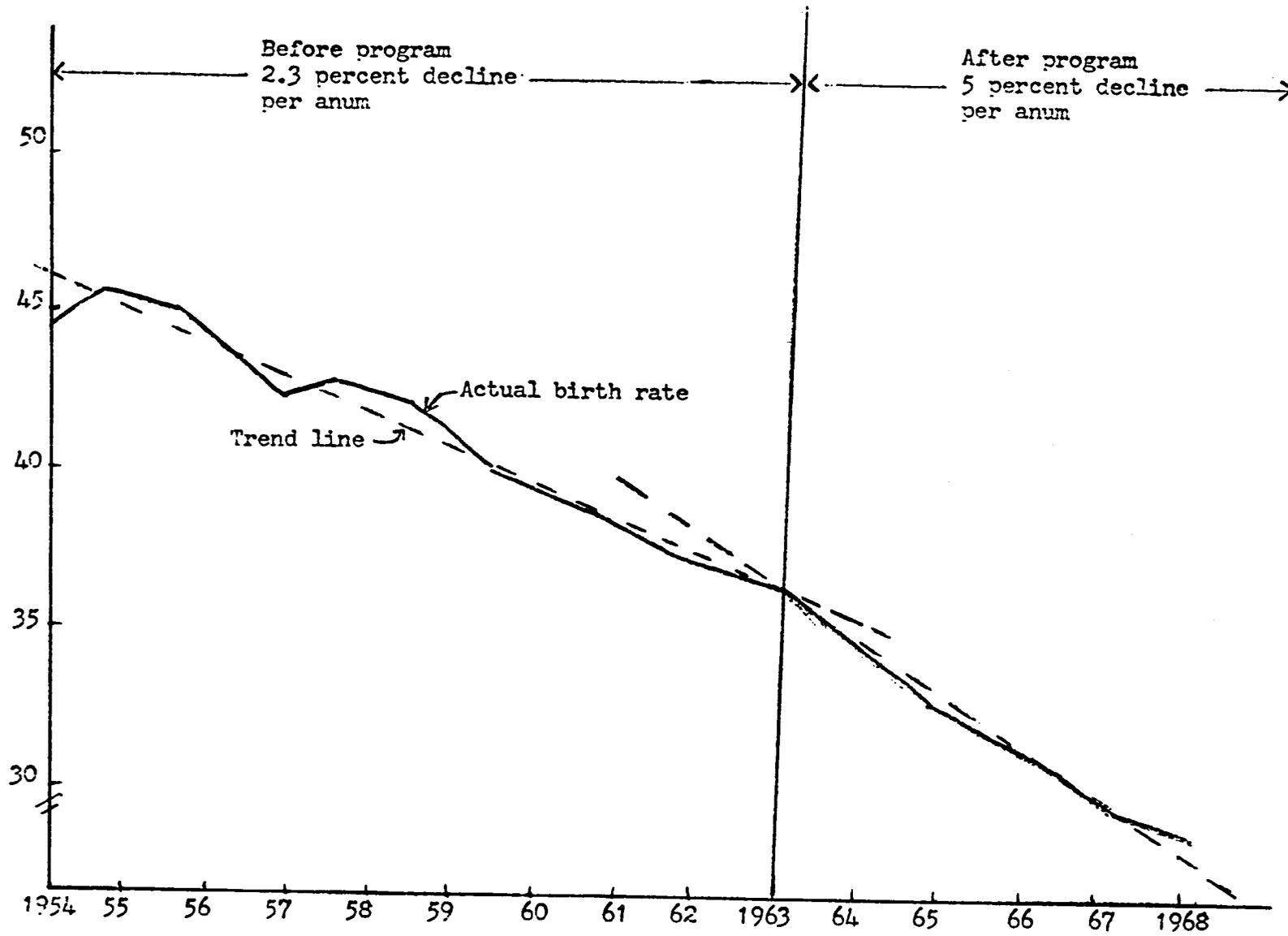
Although Taiwan has been covered elsewhere in-depth in these papers, several relevant points bear repetition in this summary

The reinforcement effect of a national family planning program is evidenced in the case of Taiwan. The crude birth rate in Taiwan declined from about 45/1,000 to close to 38/1,000 between 1955 and 1963 for a rate of decline of about 2.3 percent per year. With the establishment of the family planning program in 1963 the rate of fertility decline noticeably increased and has averaged close to 5 percent per year between 1963 and 1968. (See Figure 2.)

It is interesting to note that during the latter period the basic values regarding ideal family size hardly changed at all. A series of KAP surveys shows that between 1965 and 1967 ideal family size remained relatively constant at about 4.0 children. However, during the same period the percentage of wives who had ever practiced contraception rose from 27 to 42 percent; and those currently practicing from 23 to 34 percent. Thus it appears that the main effect of the family planning program was not in changing values or goals, but in conveniently providing family planning to those who had already decided that limiting their fertility would be a good idea.

It is true that there are other factors, such as an increased age at marriage, that account for a part of the decline and that partially obscure the direct effect of the family planning

Figure 2  
Taiwan



effort on the birth rate. However, as demonstrated in the previous paragraph, the benefits of having inexpensive, convenient, and effective means of contraception available in a population where the desire to limit family size is gaining precedence cannot be denied.

E. Some Further Considerations

Unfortunately, it is often extremely difficult to demonstrate with certainty the effects of family planning programs on the demographic transition of a country. Among the reasons why this is true are the following:

1. Inaccurate Data. The data collected may be too insensitive to reflect actual change and improvements in vital registration (of births for example) but more complete recording of data may give the appearance of increasing fertility when it actually is falling.

2. Other Factors Affecting Fertility. Changes in the number of women of childbearing age, the proportion of married women, the age at marriage, migration, death rates and other factors can strongly influence crude birth rate and growth rate figures. Rate measures adjusted for age and sex composition can partially alleviate this problem but require accurate data. For example, in Taiwan large decrease in age specific fertility will be necessary to keep crude birth rates from rising because of the large number of women born in the post-war baby boom now attaining the ages 20-30 years.

3. Short Time Span and Low Proportion of Population using Family Planning. In countries such as India and Pakistan where 5-10 percent of the eligible couples have been reached with family planning programs or where programs have been operational only a few years, it may not be possible to show much change attributable to the program. In spite of these difficulties in some countries, notably Taiwan, Singapore, Hong Kong, and South Korea, a measurable impact of family planning programs in decreasing fertility can be demonstrated.

Between 1961 and 1968 Hong Kong discussed previously, showed a decline in crude birth rates from 35.5 to 21.3 and Taiwan previously discussed, a decline from 37.7 to 28.8. Age specific measures showed a decline for all ages except a minor increase in the 20-24 year age group in Taiwan.

In South Korea a decline in crude birth rates of 21 percent (42 to 33) between 1961 and 1968 occurred during a time of rapid social change and modernization but this decline was noticeably hastened by the introduction of IUD into the national program in 1964.

Since initiation of the Korean IUD program in 1964 a total of 1.5 million IUD's have been inserted reaching 35 percent of all currently married women age 20-44. However, less than 600,000 of these IUD's remain in situ, the majority having been removed. It appears that IUD's have contributed to about half

of the Korean fertility decline. Other means of family planning are also important including a growing usage of oral contraceptives (about 250,000 users), 160,000 vasectomies and the abortion of 19 percent of all pregnancies (in 1967-1968).

F. Some Conclusions.

In writing on the "Impact of Family Planning Programs on the Birth Rate," (A Ford Foundation Reprint), Oscar Harkavy warns of "some of the hazards involved in using a nation's birth rate as a measure of success in family planning. It is indeed too early to claim at this time in history that national family planning programs are sure to bring world population growth under control. But it is entirely too early to make gloomy predictions as to the ultimate impact of these programs which, after all, are still in their infancy." (p. 11.)

In his excellent "National Family Planning Programs: Where We Stand," Bernard Berelson writes: "A few national programs under favorable conditions have kept up with ambitious targets and have probably lowered the birth rate in the process. But over the short run (say, five to ten years), there is a natural limit on how much can be done, and only in the advantaged situations is the take-off point likely to be approached." (Reprinted in Studies in Family Planning, March, 1969, from Fertility and Family Planning: A World View, Behrman, Corsa and Freedman (eds.), The University of Michigan, 1969).

Some excerpts from Berelson's article follow:

"The key question on the impact of a national program is clear: has it brought down the birth rate and, if so, by how much? That question cannot be answered unequivocally at the present time. Among other things, it must be qualified by programmatic, technical, and temporal considerations."

"In any case, the question of impact on birth rates, with one exception, is now incapable of a direct answer because of technical difficulties, and that will probably be true for the next five years as well. Outside of Taiwan in the developing world, the system of vital statistics will not provide the necessary data; and even there a definitive answer is hard to come by because of analytical technicalities (particularly, how to determine what would have happened to fertility in the absence of the program). Accordingly, impact for the next period will rest mainly on acceptance figures and what flows from them: e.g., Pakistan's measure of "couple years of protection against pregnancy" or efforts to infer births prevented from use. In the absence of the direct measure, difficult at best, the indirect will have to do."

"All of which raises a central question about a program's impact: what is "success"? Is a program "successful" if it reduces the birth rate by 10 points in three to five years? If it meets a predetermined target? If it secures 10 percent of the married women of reproductive age as initial acceptors in its first year of operation? If it secures 10 percent of the married women of reproductive age as continuing acceptors in its first year of operation? If it institutionalizes family planning within a society in the sense that it is now institutionalized in Western Europe or the United States? These and other definitions of "success" can be given, and such a list is useful if only in demonstrating how arbitrary the term can be. So long as the specifics are known, the term itself adds little but propaganda value, one way or the other."

"What is important, however, is to have some notion about natural limitations on a program's achievement. In any period of a few years -- and the history of this field in the past five years shows how rapidly events have moved -- there are some crucial "given's" in the situation, notably the level of popular interest, the contraceptive technology, and, to a lesser degree, the capacity of the family planning organization. These factors impose limits on what any program can do in the short run."

"Program impact in that period, then, can thus be seen as a race toward two points: which will be reached first? One is the saturation point: the proportion of family planners beyond which a program can reach only with special difficulties and extra efforts. The other is the take-off point: the proportion of family planners within a society that is large enough to disseminate the practice without major input from a governmental program. The United States today can illustrate both points: family planning reached the take-off point decades ago and produced an essentially controlled fertility for about 85-90 percent of the society, the other segment being outside the mainstream of the society in other respects as well, as members of the ethnic poor. For them, special governmental programs need to be devised and are in the process at this time."

"In the developing countries, what is the take-off point? South Korea and Taiwan have already, in only a few years, brought family planning to well over 20 percent of the married women of reproductive age, and the programs are still in full swing. We do not know what the take-off point is for any reasonably large interacting population, though in my judgment it is not likely to be lower than 50 percent. Whatever it is, will it be reached before the program loses momentum? We do not know that either, though one can guess that the answer is favorable in the advantaged sites and doubtful in the others."

### III. Family Planning Programs: Inputs and Outputs to Date and Their Relationships

Attached Tables 1 and 2 give a summary view of A.I.D.'s activity in the population field. The most striking fact, of course, is the rapidity of the growth of the program as shown in Table 1. Table 2 gives somewhat greater detail for the actual funding obligations in Fiscal Year 1969 and the current (March 31, 1970) best estimates for Fiscal Year 1970.

The remaining tables 3-9 are summary reports of more detailed studies of the progress of selected family planning programs around the world. Utilizing service statistics, estimated demographic measures, and data on program expenditures and manpower, measures of program performance are derived. The data are of very uneven quality and any results must therefore be used with great care. Only contraceptives distributed by organized country programs are included. In countries where a considerable number of couples are contracepting outside of organized programs, this is admittedly a severe handicap but not a crippling one. It is after all the organized programs that we are evaluating and increases in private efforts at birth control can be viewed as indirect benefits which, at this time, are largely unquantifiable

Although the concepts used in Tables 3-9 are widely known, it is useful to define some of the terms employed to eliminate possible misinterpretations.

1. "Full-time equivalent family planning workers" represents the sum of full-time workers plus part-time workers (multiplied by some fraction representing the time they work for the program). In lieu of hard data, one-half was used as the adjustment factor for all part-time workers.
2. "Eligible couples" is the number of married (both consensually and legally) women between the ages of 15 to 45.
3. "\$ Exp" represents dollar expenditure data largely derived from Professor Warren Robinson's study on Cost-Effectiveness. An attempt was made to quantify actual expenditures rather than budgeted expenditures although, in many instances, this was impossible.
4. The concept of "births averted" has been considerably simplified in this report. It does not take into account differences between the total population and acceptors with respect to prior contraception, time since last birth, and differential fertility and sterility. Our version of "births averted" attempts to standardize for such factors as differing contraceptive efficiency, differing ages of acceptors and differing acceptor fertility

rates. The tables display this concept in two forms and the above limitations apply to both.

- a. "Total births averted", like CYP, is the product of the program efforts within a single year and is the sum of the births averted in that year and all subsequent years.
  - b. "Current births averted", like prevalence, refers to births averted within a single year and is a product of program efforts in all prior years.
5. "CYP" or Couple Year Protection is the number of contraceptives distributed within a program year, by type, multiplied by the average length of time that they are effective. For orals and conventionals, time spans of  $1/13$  and  $1/100$  of a year, respectively, are used. For sterilizations and IUD's the average time varies with the age distribution of acceptors and a decay rate (which in the case of IUD's represents the dropout rate and, for sterilizations, the death rate).
6. "Expected births" is the sum of "current births averted" in a specific year plus the actual births during that year.

The summary results in Tables 3-9 are not presented as exact measurements of the phenomena they describe. In some instances, the quality of the available data was dubious and, as noted above, many simplifying assumptions were incorporated in the methodology employed. These limitations necessarily qualify some conclusions but do not limit the usefulness of the study in providing a statistical framework and in testing a methodology. The detailed country statistics from which the summary tables were derived together with an explanation of the methodology used will be distributed separately. These may also be obtained by writing to: Mr. Robert D. Bush, AID/TA/POP, or Mr. Carl J. Hemmer, AID/PPC/ES.

TA/POP

May 5, 1970

Table 1  
**Summary of A.I.D. Dollar Obligations**  
**For Population and Family Planning Projects**  
(Fiscal year obligations in \$ thousands)

5

<u>NONREGIONAL</u>	<u>1965</u>	<u>1966</u>	<u>1967</u>	<u>1968</u>	<u>1969</u>
Office of Population	808	746	525	10,513	17,340
Office of Program and Policy Coordination				110	24
Office of International Training	26	65	41	38	40
A.I.D./W Other	58	61	405	435	1,426
U.N. Fund for Population Activities				500	2,500
Nonregional Total	<u>892</u>	<u>872</u>	<u>971</u>	<u>11,596</u>	<u>21,330</u>
<u>LATIN AMERICA</u>					
Country Missions	92	269	1,178	5,457	3,072
Regional Projects	1,105	565	1,191	2,468	7,255
Latin America Total	<u>1,197</u>	<u>834</u>	<u>2,369</u>	<u>7,925</u>	<u>10,327</u>
<u>NEAR EAST—SOUTH ASIA</u>					
Country Missions		2,100*	337	9,061**	3,336
Regional Projects				655	1,011
Near East—South Asia Total		<u>2,100*</u>	<u>337</u>	<u>9,716**</u>	<u>4,347</u>
<u>AFRICA</u>					
Country Missions	10	9	4	404	983
Regional Projects			30	259	457
Africa Total	<u>10</u>	<u>9</u>	<u>34</u>	<u>663</u>	<u>1,440</u>
<u>EAST ASIA</u>					
Country Missions	35	77	334	3,475	6,388
Regional Projects			350	1,325	1,608
East Asia Total	<u>35</u>	<u>77</u>	<u>684</u>	<u>4,800</u>	<u>7,996</u>
<u>VIETNAM</u>					
			50	50	
Country and Regional Total	<u>1,242</u>	<u>3,020</u>	<u>3,474</u>	<u>23,154</u>	<u>24,110</u>
GRAND TOTAL	<u><u>2,134</u></u>	<u><u>3,892</u></u>	<u><u>4,445</u></u>	<u><u>34,750</u></u>	<u><u>45,440</u></u>

\*A development loan to Turkey, originally for \$3.6 million, signed October 1966.

\*\*Includes \$2.7-million loan to India for program vehicle parts.

Summary of A.I.D. Dollar Obligations  
For Population and Family Planning Projects  
(Fiscal year obligations in \$ thousands)

	<u>FY 1970 Estimate as of March 31, 1970</u>
<u>NONREGIONAL</u>	
Office of Population	21,174
Office of Program and Policy Coordination	-
Office of International Training	307
AID/W Other	1,958
U.N. Fund for Population Activities	4,000
	<hr/>
Nonregional Total	27,439
<u>LATIN AMERICA</u>	
Country Missions	4,670
Regional Projects	6,701
	<hr/>
Latin America Total	11,371
<u>NEAR EAST - SOUTH ASIA</u>	
Country Missions	3,421
Regional Projects	695
	<hr/>
Near East - South Asia Total	4,116
<u>AFRICA</u>	
Country Missions	1,895
Regional Projects	320
	<hr/>
Africa Total	2,215
<u>EAST ASIA</u>	
Country Missions	7,289
Regional Projects	641
	<hr/>
East Asia Total	7,930
<u>VIETNAM</u>	
	180
Country & Regional Total	53,251
Undistributed*	21,749
Grand Total	<hr/> 75,000

\*To be allocated to country, regional, or non-regional programs as additional projects or activities are developed.



Table 4  
FAMILY PLANNING PROGRAM OF INDIA

		1960	1961	1962	1963	1964	1965	1966	1967	1968	1969
COVERAGE	Full-time equivalent family planning workers per 1000 eligible couples	--	--	--	--	--	--	--	--	.5	--
	\$ exp. per eligible couples	--	--	.10	.10	.10	.20	.20	.40	.50	--
ACCEPTANCE	% of eligible couples IUDS: Start:	.0	.0	.0	.0	.0	.8	1.3	1.4	1.3	--
	end:	.2	.4	.5	.8	1.1	1.7	2.6	4.4	5.9	--
	Orals:	--	--	--	--	--	--	--	--	--	--
	Conv.:	.0	.0	.0	.4	.5	.6	.5	.5	.9	--
	TOTAL	.2	.4	.5	1.1	1.6	3.0	4.4	3.6	8.1	--
	Current births averted as % of expected births	.0	.2	.4	.5	1.0	1.5	2.7	3.9	5.6	--
EFFECTIVENESS	Full-time equivalent family planning workers per 1000 c y p	--	--	--	--	.1	--	--	--	2.1	--
	Full-time equivalent family planning workers per 1000 total births averted	--	--	--	--	--	--	--	--	9.1	--
	\$ exp per c y p	.0	2.00	2.80	1.90	2.10	2.00	1.40	1.50	1.80	--
	\$ exp per total births averted	.0	5.30	13.00	7.70	8.90	9.90	7.00	7.30	8.10	--

Table 5  
FAMILY PLANNING PROGRAM OF KOREA

	1960	1961	1962	1963	1964	1965	1966	1967	1968	1969	
-COVERAGE	Full-time equivalent family planning workers per 1000 eligible couples	--	--	.1	.1	.6	.6	.6	.6	--	
	\$ exp. per eligible couples	--	--	.10	.20	.50	.40	.70	.70	1.00	--
ACCEPTANCE	% of eligible couples IUDS:	--	--	.0	.0	2.5	6.5	12.3	14.0	13.8	
	contracepting at yrs' end:	--	--	.1	.6	1.3	1.6	2.0	2.4	2.9	
	Ster:	--	--	.0	.0	.0	.0	.0	.4	2.6	
	Orals:	--	--	.0	.0	4.3	5.1	4.5	4.0	3.6	
	Conv.:	--	--	.0	.0	4.3	5.1	4.5	4.0	3.6	
	TOTAL	--	--	.1	.7	8.1	13.2	18.8	20.4	23.0	
	Current births averted as % of expected births	--	--	--	.1	.7	6.6	10.5	14.6	15.0	
EFFECTIVENESS	Full-time equivalent family planning workers per 1000 c y p	--	--	5.2	1.8	3.2	2.6	1.8	2.2	2.8	--
	Full-time equivalent family planning workers per 1000 total births averted	--	--	23.5	8.1	13.4	10.8	7.3	8.9	11.4	--
	\$ exp per c y p	--	--	9.70	2.90	1.80	1.80	2.20	2.80	4.60	--
	\$ exp per total births averted	--	--	44.50	13.00	7.50	7.40	9.00	11.30	18.90	--



Table 7  
FAMILY PLANNING PROGRAM OF TAIWAN

		1960	1961	1962	1963	1964	1965	1966	1967	1968	1969
COVERAGE	Full-time equivalent family planning workers per 1000 eligible couples	-	-	-	-	.1	.2	.2	.2	.2	.2
	\$ exp. per eligible couples	-	-	-	-	.10	.30	.30	.30	.40	.40
ACCEPTANCE	% of eligible couples IUDS:	-	-	-	-	2.3	6.2	8.8	10.8	12.1	13.0
	contracepting at yrs' Ster:	-	-	-	-	.0	.0	.0	.1	.1	.1
	end: Orals:	-	-	-	-	.0	.0	.0	.5	.9	1.0
	Conv.:	-	-	-	-	.0	.0	.0	.0	.0	.0
	TOTAL	-	-	-	-	2.3	6.2	8.9	11.4	13.1	14.0
	Current births averted as % of expected births	-	-	-	-	-	2.0	5.1	6.8	8.3	9.1
EFFECTIVENESS	Full-time equivalent family planning workers per 1000 c y p	-	-	-	-	2.2	1.3	1.1	1.4	1.3	1.4
	Full-time equivalent family planning workers per 1000 total births averted	-	-	-	-	13.9	8.5	7.1	8.8	8.4	9.1
	\$ exp per c y p	-	-	-	-	1.50	2.60	2.00	2.10	2.60	2.70
	\$ exp per total births averted	-	-	-	-	9.60	16.60	13.20	13.50	16.60	17.20

Table 8  
FAMILY PLANNING PROGRAM OF TUNISIA

		1960	1961	1962	1963	1964	1965	1966	1967	1968	1969
COVERAGE	Full-time equivalent family planning workers per 1000 eligible couples	--	--	--	--	--	--	--	--	.2	.3
	\$ exp. per eligible couples	--	--	--	--	--	--	--	--	1.10	--
ACCEPTANCE	% of eligible couples IUDS:	--	--	--	--	.2	1.6	2.8	3.0	3.2	3.4
	contracepting at yrs' end:	--	--	--	--	.0	.1	.2	.3	.5	.8
	Ster:	--	--	--	--	.0	.0	.0	.0	.2	.6
	Orals:	--	--	--	--	.2	.1	.1	.0	.1	.2
	Conv.:	--	--	--	--	.3	1.8	3.1	3.4	3.9	5.0
TOTAL		--	--	--	--	.3	1.8	3.1	3.4	3.9	5.0
	Current births averted as % of expected births	--	--	--	--	--	.3	1.0	3.1	3.4	3.9
EFFECTIVENESS	Full-time equivalent family planning workers per 1000 c y p	--	--	--	--	--	--	--	--	3.6	3.4
	Full-time equivalent family planning workers per 1000 total births averted	--	--	--	--	--	--	--	--	12.5	11.8
	\$ exp per c y p	--	--	--	--	--	--	--	--	16.40	--
	\$ exp per total births averted	--	--	--	--	--	--	--	--	56.80	--

