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U.S. POPULATION-RELATED ASSISTANCE

Analysis and Recommendations

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U.S. POPULATION-RELATED ASSISTANCE

Analysis and Recommendations

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THE PURPOSE

AID has been asked to evaluate experience with alternative approaches to reducing fertility in LDC's, to identify promising approaches for the future, and to suggest directions for U.S. population-related assistance in the next decade. The Agency gives continual attention to program directions; the analysis presented here builds on substantial earlier efforts.

In reviewing this paper, it is crucial to bear in mind the caveats presented above, particularly noting that this paper focuses on only one aspect of AID's program -- its impact on fertility. AID's overall purpose, like that of many LDCs, is to improve the well-being of the poor; limiting population growth is only one means, albeit an important one, to that end. AID does not seek to impose any course upon an LDC, and provides population assistance, like other assistance, only when asked.

CURRENT POPULATION GROWTH

Rapid population growth in developing countries seriously exacerbates the already difficult task of improving the welfare of millions who already live at or near subsistance. Such growth creates additional demands on already scarce resources and impairs the already precarious health of women and children who share present and future development burdens. Worldwide, population growth generates increasing environmental pressures that may be serious now or eventually.

And it contributes to international political and economic disruption. In developed countries population growth has abated recently, averaging about 0.71 percent annually, with birth rates at about 16.3 per thousand and death rates at about 9.2 per thousand.1/ In developing countries, however, the picture is different. While birth rates have begun to fall in many countries recently, the rates still average about 32.7 per thousand; death rates, which have also declined dramatically over the last two decades, still remain at about 12.8 per thousand.2/ Resulting population growth averages about two percent annually.3/,4/ This growth rate implies a doubling of LDC population every thirty years or so, at least until birth planning or increasing disease and malnutrition intervene. Moreover, the task of containing population growth through birth planning is complicated by the "built-in momentum" of a growing population: with a high proportion of young people who have yet to bear children, growth would inevitably persist for many years even if the two-child family should suddenly become the norm. Thus, though an encouraging start has been made in reducing fertility, much of the task remains ahead. Development programs over the next decadeswill inevitably have to consider population growth; the question is how much, and what the funding implications will be.

1/ North America, Europe, excl. USSR, Oceania, Japan.

2/ Latin America, Africa, Near East, Asia incl. PRC but with Japan among the developed countries.

3/ These rates assume our best estimates on the PRC. Without the PRC, birth rates would be about 39.1, death rates about 15.2, and the resulting rate of natural increase about 2.39.

4/ World-wide, birth rates average 28.1 per thousand, death rates average 11.8 per thousand, and the resulting rate of natural increase is 1.63 percent annually.

THE PROBLEM

Population growth rates reflect the size of individual families.

Couples need not affirmatively decide to have a child, but they must affirmatively decide to practice family planning, whether they just want to postpone pregnancy or whether they want to end their childbearing.[1/] Consciously or unconsciously they weigh the pros and cons, as they see them, of a child against the pros and cons, as they see them, of available means of family planning. Their attitudes toward family planning depend on the type (hopefully reflecting both cultural acceptability and bio-medical concerns), cost, and accessibility of the family planning services available and on the extent to which they accurately understand those services. Their views on the desirability of a child are more complex, and depend largely on their social, cultural, political, economic, and medical milieu.

Thus, the number of children parents actually have includes:[2/]

(1) the minimum desired number of children that parents would want even if the best possible family planning services were available;

1/ Couples who wish to have a child for whatever reason (including sub-fecundity) will plainly not be interested in family planning to prevent pregnancy.

2/ No one pretends, of course, that sharp lines divide these three categories of births. But they do reflect reality and they also help to clarify analysis.

(2) any more "insurance" births they may want to insure survival of the desired minimum;

(3) any extra births they don't consciously seek, but which result from miscalculations, laissez-faire attitudes, casual assessments of long run costs and benefits, etc.

Minimum desired family size depends on all the economic, social, cultural, and personal influences on the family. It does not depend directly on the availability of family planning services, though it is likely that the successful use of services available now may well influence future attitudes and expectations on appropriate and acceptable family size. Attitudes on minimum desired family size can also be directly influenced by information and education programs specifically designed to influence them. And development policies in any number of seemingly unrelated areas can change minimum desired family size by changing the economic, social, cultural, and personal circumstances of the family in such a way as to make smaller families a more attractive option.

Insurance births can be reduced by improving child health -- by providing better health services, better nutrition and even better family planning services (since wider spacing of pregnancies greatly improves child health where mothers and children are ill and poorly fed).

Extra births, which may be numerous, can be greatly reduced or even eliminated by providing acceptable, affordable, and accessible family planning services and appropriate information.

The basic question of this particular paper is how to achieve the most voluntary reduction in family size and fertility with limited resources, bearing in mind that both LDC and AID objectives are of course much broader than this, as discussed above. But many LDC's receiving U.S. aid have low target birth rates; for argument's sake, we take their ultimate demographic objective to be a stable population.[1/]

Providing better family planning services -- effective, safe, affordable, and accessible -- seems the simplest way to tip parental decisions in favor of family planning. In the few countries that have such services on a wide scale, birth rates are falling -- not to stable population levels yet, but far below their recent high levels.[2/] The cost-effectiveness of such services depends on whether they are used efficiently, on how many children the users have, on how many fertile-age couples are users, and so

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1/ A stable population requires essentially a two-child family -- or a "net population rate" of one (meaning each woman has, on average, one daughter).

2/ Examples of countries where birth rates have declined from high levels: Taiwan (23 per thousands population), Costa Rica (28), Korea (29); Colombia (32). Several other countries, including India and Thailand, now have birth rates in the mid-30s. Sri Lanka and the State of Kerala in India also have low birth rates.

on.[1] So far, really good services -- i.e. safe, effective, affordable, and accessible -- do seem to be used extensively and by people who otherwise probably would have had several more children.[2] Thus good services probably represent the cheapest approach to reducing birth rates so far. And a good many more people in LDC's stand ready to use good services. It is only sensible to provide them with such services, which need not be costly, as a start.[3] That much is clear. Thus AID has devoted most Title X assistance, totaling some $750 million over the past decade, largely to improving and extending family planning services (including information), and plans to continue to do so.

But family planning services and information alone will probably not suffice to reduce birth rates to near stable-population levels.[4] Essentially, this would require an average

1/ The demographic impact of services depends on the proportion of fertile-age couples using them ("prevalence"), on the number of children those users have ("parity"), on service effectiveness, etc. Parity data are poor, but available prevalance data suggests birth rates do fall as prevalence rises, especially over 20%. Some people believe, at present levels of acceptance and birth rates, a two percent increase in prevalence leads to about a one-point decline in the birth rate, through this relationship is very tentative. Prevalence in most LDCs, is under 15%; such countries have few good services on the whole.

2/ This is particularly true when both conceptive and post-conceptive services are made available, data seem to suggest.

3/ The question of where acceptance rates may peak is discussed below.

4/ Most family planning experts believe that population stability would require prevalence on the order of 60-70%, based largely on developed-country and Asian experience.

family size of only slightly more than two children. Making family planning as easy as possible can certainly eliminate unwanted pregnancies and help reduce "insurance births" as wider spacing of pregnancies improves child health. And through their influence on social expectations over time, services may encourage people to want fewer children as a minimum. But services alone may not much reduce the minimum number of children parents want. That may be no problem if most parents would be content with two children. But if many parents want three, four, five, or more children even when good services are available, then it will be essential to combine services with development policies and programs that also encourage smaller families.

No one really knows what the situation is in fact. In the few places (including some poor, rural areas primarily in Asia) where good services are really available, indications are that around a third of the couples, mostly with 3-4 children, may use them.1/ This suggests that extending good services further can indeed reduce family size sharply, and certainly good services should be provided as rapidly as possible. But historical evidence also suggests reductions in average family size sufficient for population stability can be achieved faster when family planning services and information are combined with appropriate development policies and programs. For as parents become more determined to have smaller

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1/ In other words, prevalence exceeds 30%. One major example is in parts of Indonesia.

families, they naturally become more willing to use the services available, however imperfect those may still be.

In recent years, AID has devoted both Title X and other AID resources to exploring the links between fertility and development policies and programs so that all AID assistance programs -- or those of other donors or LDCs -- can be designed as appropriate with a view to their possible impact on fertility. We expect to expand such efforts in the future.[1/]

Developing a strategy for population-related assistance thus requires determining what sorts of family planning services and information appeal most (and what they cost), what development policies and programs encourage smaller families most (and what they cost), and how these may best be combin

One major conclusion is that we are woefully short of hard information on which to judge services, information, or policies -- because services and information are not widely enough available to permit measuring their ultimate impact accurately, because measuring anything is difficult in many LDC's, and because sorting out the tangled influences on fertility -- services, information, and all the other changes development brings -- is difficult even with sophisticated statistical analytic techniques.[2/] That sort of analysis certainly cannot get far with the data now available. Major attention needs to go into developing and refining the

1/ The trade-offs among different types of Title X expenditures will be discussed briefly in the conclusions section.

2/ Multi-variate analysis of fertility determinants requires data sufficient to permit reasonable separation of the impact of a given influence -- or "holding constant" for everything els

necessary data and techniques. Only thus can we sort out just which approaches are likely to reduce birth rates fastest and at lowest cost and what the trade-offs and complementarities among such approaches may be. Among other things the Agency should build more such analysis into its annual program review process.

Even at present, however, some reading of the comparative effectiveness of various services, information and education programs, and development policies and programs can be made.

OUTLINE OF THE ANALYSIS

We examine experience in reducing fertility through policies and programs divided into three categories: Development policies and programs; information, education, and communication efforts; and family planning services. We give particular but not exclusive attention to U.S.-assisted efforts, both bilateral and intermediary programs. Given what has worked in the past, what AID's role has been, and what new approaches seem most promising, we suggest future policy and program directions for U.S. population-related assistance for countries requesting such assistance.

We base our analysis on assessments of development policies, IEC, and family planning services in most LDCs of major U.S. interest. These are available as Annex 1 to

to interested readers. In addition, we have made special studies of ten countries of major importance to the U.S. or with particularly interesting family planning programs: Bangaldesh, Indonesia, Korea, the Philippines, and Pakistan in Asia; Ghana and Tanzania in Africa; Colombia and El Salvador in Latin America; and Tunisia in the Near East. The country studies are also available as Annex 2 to interested readers.

FAMILY PLANNING SERVICES

Methods: offering variety

In terms of methods, the most effective approach seems to be to offer variety. Each method has its own adherents. No program focusing on a single method has achieved dramatic success. But several methods -- pills, condoms, sterilization, and abortion -- seem particularly effective and appealing to users.

Pills, which are effective and easy to use, appeal particularly to the young, to those with few or no children, to those with little access to clinics, and to those who want to space births. Many family planning programs began before pills were widely available, and enjoyed sharp increases in acceptor rates when pills were introduced.

Not all pills have the same chemical composition, and some are less likely to produce side-effects like nausea. Choosing one of the pills less likely to cause side effects and maintaining a supply of the same pill can be crucial to continued use.1/

1/ Thus AID is supporting research to explore side effects and thus help provide more suitable pills to clients.

The appeal of condoms is less well documented, but given their low cost, ease of distribution, effectiveness, and absence of side-effects, they deserve further attention.

Sterilization -- both vasectomy and tubal ligation -- has proved surprisingly appealing even among poor, ill-educated people with no more than three children; it is an obviously effective method, can be handled on an outpatient basis fairly inexpensively, and deserves to be encouraged considerably.

IUD's have proved acceptable, but particularly in better-off LDCs like Taiwan and Korea where medical follow-up is good and where side-effects did not cause undue medical problems or cultural backlash.1/

Foam and diaphragms have their adherents but do not appeal to many people and are relatively difficult to use effectively. They should be considered, but probably not encouraged.

Available data indicate that safe, legal abortion finds ready acceptance in many countries, even where good contraceptives are widely available. AID is barred by the Helms Amendment from financing abortion.

In terms of AID's own assistance to family planning service programs, perhaps pills, condoms, and sterilization stand out as deserving priority over the next several years.

1/ In some countries, the extra bleeding sometimes caused by IUD's is regarded as unclean, and the woman is not allowed to cook for her family.

Acceptance rises when methods improve, and the methods we have are imperfect. Ideally family planning should be so easy and inexpensive that no couple would think of doing without it unless they truly want a child. Thus, research is particularly needed to explore possible side effects of pills and other methods to achieve reversible sterilization, and to develop longer-acting contraceptives, including injectibles.

Modes of delivery: village distribution

In terms of delivery systems, village-level distribution[1/] (incorporating village-level leadership) deserves major focus at the moment. The fastest growing and most vigorous programs seem to be moving in the direction of non-clinical and non-commercial distribution of services in villages. Early results are encouraging acceptor rates exceed 30% of fertile-age couples in some areas.[2/]

Most family planning programs have begun in clinics, and most are still clinic-based. For countries able to afford to put clinics within easy reach of all people, extending the clinic system may be the best way to improve family planning services. In some areas (particularly in Latin America) where clinics are already fairly plentiful,

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1/ House-to-house or at least with services accessible within the villages.

2/ Notably in rural Indonesia and Egyptian pilot programs. In Indonesia, strong peer pressure is a key point of the program.

additional family planning services should certainly be integrated into clinics or expanded to assure they are available daily. In some areas we may have no choice but to limit programs to clinics, though there may be a better way than exclusively clinic-based (or clinic-bound) services.

Few developing countries can really afford the clinic route; most now serve only 15-20% of their populations with clinics. To reach the poor majority and keep total program costs manageable, most countries must limit per-user costs by paring services down to bare essentials. This means trying to serve areas beyond easy reach of clinics with paramedics or "health auxiliaries" -- midwives, "promotoras" and other low-level and possibly multi-purpose workers -- instead of physicians.

Pilot level experience indicates that health auxiliaries or even village people with a little training can be used effectively to provide excellent family planning information and services. They can distribute contraceptive pills (though easing prescription requirements is a prerequisite), and auxiliaries can insert IUDs (even in the U.S.!). Some do sterilizations safely if well trained and supervised, though AID so far has preferred physicans in the performance of sterilizations.[1/]

(See page 13a for footnote.)

1/ It bears emphasizing that consumer safety arguments actually militate in favor of a judicious easing of prescription requirements and restricitions on health auxiliaries. Present evidence indicates strongly that the hazards to poor, undernourished women of repeated pregnancy and childbirth in the absence of a physician are far greater than any hazards, which appear to be minimal, from contraception in the absence of a physician particularly when good paramedic supervision can be provided. Maternal mortality rates in many poor LDCs approach 500 per hundred thousand (as compared to about 20 in the U.S.). Mortality from complications of oral contraceptives (mostly thromboembolic) in developed countries is on the order of 3 per hundred thousand per year (bearing in mind that three year's use averts one birth on the average), increasing several-fold for women over forty who of course also suffer higher maternal mortality. But women in LDCs have fewer thromboembolic complications from oral contraceptives because their different diets, work habits, exercise levels, genetic background, etc. leave them far less prone to blood clots. Of course some people may be reluctant to assume the risks of a "new" method however they compare to the long-endured risks of pregnancy, just as people are sometimes hesitant to try new medicines or indeed any innovation, however promising. And to the extent pills substitute for traditional methods like abstention or withdrawal, they entail an added risk; to the extent they substitute for methods like illegal abortion, they probably entail lower risks.

While the ideal may be a doctor in every village, that cannot be achieved easily even in developed countries. Well-trained paramedics are an excellent solution and should be used far more where otherwise many people (rich or poor) will simply do without services.

Indeed, a village worker may be more effective in dealing with her peers on a personal subject like family planning than white-coated health technicians or doctors -- who are too often disdainful of their poor and illiterate clients. Much more needs to be done to expand the use of village laymen and health auxiliaries, particularly women. Private traditional or modern providers of health or family planning services -- midwives, pharmacists, herbalists -- can also be encouraged and equipped to provide a broader range of modern family planning services. Often, indeed, they already enjoy the confidence of clients, which facilitates acceptance of new family planning services.

In terms of program development, where services have begun in clinics, one generally reasonable course of action may be to gradually move pill and condom distribution to the village level and reserve clinics for more complicated services such as sterilization, IUD insertion, etc., or initial introduction to pills. In Indonesia, for example, a woman goes to the clinic for initial supplies and screening (but is served by a paramedic, not a physician) and returns

to village distribution points for re-supply. But for poorer countries, a key question is whether village-based distribution of just the simplest and most basic services can precede major clinic-based distribution, or whether a substantial clinic network must be in place to provide reasonable back-up.[1/] In poorer countries, focusing on village-level distribution before many clinics are in place may make sense, but pilot projects and research should be undertaken before ambitious national programs are launched.

Reaching the poor while keeping costs low may also call for combining delivery systems where possible, so that related health, nutrition, and family planning services can be delivered as a package. Such integration of services permits taking advantage of joint products, program synergisms, and scale economies -- getting more done for the same cost. As with family planning services only, integrated basic health, nutrition, family planning information and services can be provided effectively by health auxiliaries or trained laymen to help keep costs down. Integration at a higher level of planning and implementation for <u>all</u> programs with major impact on health and fertility may also be essential to get the most out of a limited budget.

Consumers may also prefer integrated services. People may more readily accept family planning services as part of

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1/ This question is being explored in Tunisia among other places.

a broader health package because the combined services protect their privacy, because they have learned to trust health workers, because they find it cheaper and easier to get health, nutrition, and family planning services on the same trip (which may be long, expensive, and difficult), or because they want to assure the health of their existing children before foregoing additional births.

As with family planning, most rural health services have been provided through clinics. Indeed, such family planning services as are available are usually provided through those clinics, so that integration at this level has occurred. But often it has occurred imperfectly; clinic staff tend to focus on family planning one day, sick babies the next, etc. necessitating multiple trips that seriously discourage use of services.

AID is, of course, promoting integration of services wherever that makes sense. The Agency urges more complete integration at the planning level so that more programs can be brought to bear on health, nutrition, and fertility in an organized way, at a village level so that consumers have greater access to non-clinical services; and at the clinic level so that services of various sorts can be obtained daily.

In some situations it may be possible or sensible for political, economic, administrative, or other reasons to move ahead on either the health, nutrition, or the family planning front

first. That should be done; the second service can then be grafted onto the first. There is no good reason to hold back on one service until both can be implemented simultaneously. Particulary in Africa, it may be essential to provide both health, nutrition, and family planning services in an integrated way.

Of course, no family planning services will be effective without adequate administrative capacity -- procuring the necessary commodities, distributing them to assure continued re-supply, training and locating personnel, and so on. Because LDCs are often critically short of administrators, relying on local leadership (particularly for village-level distribution) can pay off very well. And intermediaries like IPPF can play a major role in reaching really large numbers of people, sometimes by piggy-backing their family planning services on publicly financed health services, sometimes by providing free-standing family planning services. But whether services are provided by government or private agencies, some central direction is crucial. Among government programs, it seems to matter less which ministry controls the family planning services than that the controlling ministry be able to coordinate effectively with others whose programs also affect services and their appeal. Giving family planning responsibility to a minister rather than a lower level bureaucrat naturally helps assure leadership.

It is worth pointing out that in some cases, where governments may be reluctant to give de jure backing to family planning, de facto backing can go a long way if sustained and practical. Such informal arrangements may affect provision of all contraceptives, pill prescription requirements, etc.

At current program levels, most country analysts seem to consider present bilateral funding and supplies adequate for now, given current program scale and problems, but program planning and administration inadequate. In terms of AID programs, helping train additional family planning personnel, particularly program planners and administrators, may therefore be crucial. While funding may well become a more serious constraint as programs expand, administration is the greater bottleneck now. Interregional program funding is, however, inadequate in AID's view at present. And of course this does not suggest that services are on an optimal scale at current program levels.

The comparative cost of alternative approaches to family planning services is extremely difficult to estimate from present sketchy data. Available sources disagree, sometimes by more than 100%, on total family planning program costs for a given year. AID and other donor inputs can usually be pinpointed, but LDC inputs are more difficult to fix because health, family planning, and other expenditures are often lumped together in government accounts.[1/] Nor are data from small pilot projects or intermediary operations much better.[2/] Far more attention should go to cost data

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1/ The two major sources used here are Population Council and the AID/IGA worksheet; the latter are relied on here, and generally give higher estimates.

2/ It is difficult to draw conclusions from either Danfa or Narangwal, for example; IPPF, the major intermediary, also has relatively little detailed data.

to assure better estimates of comparative cost-effectiveness in the future.

At present our best guess is that annual expenditures on family planning of at least $.10 per capita of total population are necessary, though certainly not sufficient, to have a meaningful program. Good programs seem to run in the $.10-.25 range by and large, though some of these are more efficient than others or are in different program stages.[1/] Only a few have expenditures exceeding $.50 per capita; these include both mature and start-up programs[2/] whose effectiveness varies widely.

Reported costs per new acceptor seem to run around $10-15 in most good programs.[3/] [4/] Of course some new acceptors drop out; continuation rates vary. Taking into account (a) continuation rates and (b) the usual assumption that one birth is averted for every three years protection against pregnancy, the cost per birth averted will naturally be far higher -- perhaps $50-100.[5/] [6/]

1/ These countries include Korea, Taiwan, Thailand, Indonesia, India, Ghana, and Nepal -- a wide variety of programs. Of course, these are only the official financial costs reported; volunteer labor, etc. would have to be included to give real resource costs.

2/ Costa Rica (impressive mature program); Tunisia (disappointing mature program); and Pakistan (ambitious new program).

3/ These are not true marginal costs; they include all program costs for old and new acceptors and may not count new acceptors accurately either. But probably they exceed true marginal cost.

4/ The $.10-.25 per capita expenditure implies a broad range of $2.50-$15 per acceptor, depending on prevalence of 10-20%. But see note 3/.

5/ Sterilization and abortion do not have continuation rate problems, and each abortion prevents one birth.

6/ These rough estimates are based largely on Asian data.

As a program matures, we expect the cost curves associated with each major program approach to look "U-shaped". Per-acceptor costs will be high in the beginning because of high start-up or "fixed" costs; they will drop as the program matures and reaches many acceptors; and they will rise again as ready acceptors become scarcer.[1/] Hence, combining many approaches will help ward off diminishing returns to any one approach.

We believe that normally lower costs can be achieved through village distribution[2/] and through piggybacking family planning services on available distribution systems including public clinics, private clinics, private commercial channels, and cooperative systems. We should try to avoid spending population funds on bricks and mortar or on services other than family planning, though such expenditures might be perfectly justified for non-population programs. Where family planning and other services are integrated, however, we would normally favor cost-sharing according to program shares, as determined from some reasonable if necessarily approximate analy

But per capita program costs are not the only consideration in allocating AID population funds. One of AID's principal purposes has been to help get family planning started in

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1/ There is a constantly changing flow of acceptors as time goes on. Exactly how this affects cost patterns will depend on differences in the characteristics of acceptors.

2/ The cost-data from the previous page is based largely on clinic-based family planning services. But village-based distribution may have resource costs far in excess of official financial costs because so many volunteers may be involved, etc.

countries where such services are very limited. This has required AID to bear a fairly high share of total program costs to get programs off the ground. Such a policy can be cost-effective utlimately if it does inspire good LDC programs. It is not easy to predict success, but we try. And we must undertake some start-up risks to have any chance of eventual broad success. Of course, we take pains to avoid investing in programs that are obviously too capital-intensive -- too many buildings, too much training compared to what is required, and so on. We look to find programs promising real impact from lean services. And we pay particular attention to shifting financial responsibility to LDCs, including the responsibility for funding contraceptive purchases or production. Given the paucity of data on which to judge comparative cost-effectiveness of alternative approaches to family planning services, the Agency is undertaking major experiments to test and evaluate alternatives under different conditions.

INFORMATION, EDUCATION, AND COMMUNICATION

Educating and informing potential acceptors on the benefits and requirements of family planning seems essential; various IEC efforts have apparently helped encourage the use of family planning services.[1/] But considerable debate exists over which approaches work best. Data on IEC are extremely sketchy; we do not yet have a precise sense for the proper role of IEC or for IEC funding requirements particularly vis-a-vis services. More attention must be directed to assessing comparative cost-effectiveness of different IEC approaches,

1/ Whether these are most appropriately funded locally or from foreign exchange provided by aid donors is another question.

and more approaches should be pre-tested.[1/]

Past IEC efforts span a broad range -- interpersonal contact, meetings, TV, radio, posters, pamphlets, puppet shows, traditional theater, etc. Many have been mass media campaigns designed to spread a general awareness of family planning among present and future generations. The limited evidence now available suggests IEC efforts work best when they are country-specific, when they advertise specific family planning services, when they "make a case" for family planning in personal health, economic, or other terms,[2/] when they involve short, self-contained messages, when they reach many people at once, when they use a variety of approaches, and when they use low-cost media requiring little or no reading. For AID, use of radio and "comic book" materials in preference to higher cost TV and films may be indicated, though radio, TV's, and films can all have major outreach into village life. Any opportunities to "piggyback" a family planning message in existing publications, programs, etc. should naturally be seized. The simultaneous use of multiple channels and media may be crucial to encouraging acceptance particularly as time goes on. Of course, peer pressure can be the most persuasive form of communication, and should be considered.

1/ Determining cost-effectivness of alternative IEC approaches is extremely difficult, of course, because of the problems of relating subsequent changes in behaviour to IEC as opposed to other intervening influences like new services.

2/ Arguments in terms of national benefits seem less persuasive generally, though there are cases where they seem to have effect.

If the key to extending family planning services in rural areas is simple and inexpensive information and a few goods supplied through health auxiliaries or laymen, then the role of the IEC message becomes critical. The key to success in such programs will be the ability of the health/family planning worker or volunteer to lead his or her neighbors to do something differently. Much AID attention could usefully be directed to this interface between worker and villager. How can the worker best motivate on family planning? Similar problems exist at clinics, of course,, where much family planning advice is provided by doctors or auxiliaries many of whom expect to be obeyed, not to motivate.

DEVELOPMENT/POPULATION POLICIES AND PROGRAMS

It is a common observation that family size falls as modernization proceeds; in the more advanced countries, family size began to fall even before good family planning services were widely available. As parents become more determined to have smaller families, they will be more willing to use available family planning services despite their imperfections. And when education, health, or other non-family planning budgets can also be brought bear on fertility, the family planning budget will be that much more effective. Thus it is important to ask what about the development process most influences parents to seek smaller families, and how smaller families may be encouraged.

Answering this question requires unraveling a paradox: for a nation as a whole, when population grows significantly faster than supplies of other productive resources, the eventual result must be low labor productivity, hence low living standards, unless technical change continually intervenes to save the day; yet in populous countries many poor parents (particularly in rural areas) still insist it is in their interests to have three or more children. Why? The answers are complex, but some useful insights are emerging.1/

Odd as it may seem, even for the extremely poor -- the landless rural laborer or very small-scale farmer -- the pittance each additional child earns probably exceeds the additional cost of supporting that child, for parents provide little more than minimal extra food.2/ Crucial to this analysis is the parents' belief, probably well-founded, that their children cannot break out of their current poverty to anything qualitatively different -- that substantial education, land acquisition, better health, and other means to a really better life are simply not realistic possibilities. The additional cost of another

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1/ Certainly more research should be done.
2/ Dowries, bride-price, and a few other costs may also concern poor rural parents.

child is kept low in good part because of this ceiling on parental expectations.[1/] For such parents, the only road to whatever modest improvements they can achieve lies in increasing family income through the contribution of several children. Moreover, since such parents must usually rely on their children for old-age support (there being no institutional form of social security), they need an ample supply of children, particularly sons. With high child mortality, they may well "over-insure" to prevent disaster. These high family-size preferences get codified into social customs; most women get their satisfaction and status from having large families. Aspects of this description may be debatable in different countries, but the gist of it emerges again and again from analysis of poor rural areas.

All this suggests parents may opt for <u>far fewer children</u> -- say just two -- only when they have a quantum improvement in living standards that encourages them to prefer fewer children of higher quality (in terms of health, education, earning power, etc.) to many hungry, illiterate ones who can earn but little. The key is to make the fewer-

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1/ If population growth persists, labor producivity may decline until it equals the marginal cost of another child--at subsistence wages or the equivalent. But the basic purpose of development is to raise the marginal product of labor, especially among the poor. This may or may not be consistent with maximizing GNP growth. It is possible that allocating investment capital to both human capital and, say, physical capital agriculture would raise individual living standards of the poor faster than allocating it all to agriculture, if the latter allocation would lead to faster GNP growth but had less impact on fertility.

but-better option be real--and seem real--to poorer parents.

There is ample reason to believe that massive rural development with major production increases directly benefiting the poor, accompanied by education, health, nutrition, and family planning services and supported by active community organizations, encourages declines in fertility, especially as women are encouraged to move beyond their traditional roles. A few LDC's, especially those enjoying sustained and substantial GNP growth, can afford this route and show encouraging progress. But what about the others? They must be far more selective, finding the pressure points of the development process that most encourage lower fertility and focusing on those. Of course, the better-off LDCs working to lower fertility will also find the job that much less costly if they too focus on these pressure points.1/

What are these pressure points? They seem to fall in five major areas. One is public leadership, laws and administrative regulations, which can encourage smaller families at very little cost. High-level statements favoring small families and opinion-leaders' visible support for family planning can help. Other apparently effective measures include raising the minimum legal age of marriage, relaxing restrictions on abortion,2/ easing prescription requirements

1/ This does not suggest that LDC's focus exclusively on programs that encourage lower fertility, of course.

2/ There is no doubt that liberalization of abortion has helped reduce birthrates even in countries with good contraceptive services. The Helms Amendment restricts AID's activities on abortion.

on contraceptive pills, and permitting paramedics to provide a broad range of family planning services. Other possibilities include restricting child labor, passing right-to-work laws for women, providing opportunities for working mothers to breastfeed, and restricting subdivision of agricultural land, though these all entail obvious problems.

Another key pressure point seems to be the status of women.

Female education, even if pursued for only four to six years, seems to encourage significantly lower fertility. The more extended the education, the fewer children the woman is likely to prefer. But exactly how or why female education encourages lower fertility is not entirely clear, and should be explored further. Preferences for smaller families seem to result from work activities outside the home, from middle-class family aspirations shared with an educated husband, and -- apparently particularly important for women with only a few years' education -- from an introduction, however fleeting, to the notion that women need not live today, even in poor countries, quite as they always have.[1/] Where education affects fertility primarily by equipping women to work outside the home, the availability of jobs as well as education becomes important; but aside from employment opportunities, education alone seems to encourage lower fertility in many areas. Where budget limitations prevent attaining even a few years' education, this approach to reducing fertility may be limited.

1/Some changes may be pro-natalist, of course. We need to sort out better the sorts of changes that most encourage lower fertility.

Female employment, particularly in jobs incompatible with continual child-bearing, is also strongly tied to fertility declines. We do not know what the fertility impact would be if poor women were given access to more-than-menial jobs, but sketchy evidence suggests that they might indeed opt for fewer but healthier and better education children as their expectations and opportunities for themselves and their children rise. In countries suffering substantial and chronic male unemployment and underemployment, of course, it may be argued that more good job opportunities for women must be put off for another day. It is particularly important, therefore, that care be taken with employment opportunities for women, that jobs do not simply continue the exploitation of women which is all too common particularly among the poor and that children are cared for, especially among the poor.

Also promising are any measures like women's associations for health, handicrafts, etc. that help replace the fatalism of the traditional woman with a sense that one can improve one's own life at least to a degree.

A third pressure point involves changing the economic cost and benefits of children to encourage smaller families through the deliberate use of rewards (incentives) to parents who limit fertility or penalties (disincentives) on parents

who do not.[1] In considering incentives it should be remembered that social and economic conditions inevitably influence parental views on family size - or on health, savings, employment, etc. Incentives are but one way of deliberately adjusting economic conditions to encourage smaller families; the alternative to deliberate action is, of course, laissez-faire with all that implies for haphazard influences on individuals. Incentives do, of course, leave parents who truly want many children able to choose large families. It bears emphasizing that when population pressure on resources is extreme enough so that labor productivity is very low, then averting a birth can save resources; an incentive can be designed to give part of this saving to those who made it possible--the couple practicing family planning. In other words, when demographic pressure exacerbates resource scarcities so that some rationing of some goods outside the market is virtually inevitable, then one reasonable basis (or practical basis) for that rationing is to favor those who help ease demographic pressure. When parents rely on children for old-age support in the absence of social security, providing extra resources as an incentive or reward for family planning can compensate for what additional children might have provided to their

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1/ Incentives at least preserve freedom of choice, and can be designed to fill real economic needs of parents at little or no social cost.

parents, and so fill a real economic need of parents at little or no real cost to society. (In the shorter run, of course, there may be budgetary problems in managing incentives.)

A fourth pressure point is child health, as discussed above. As more children survive, completed family size will supposedly fall.[1/] To the extent this argument is valid, it militates in favor of integrating health and family planning services or at least seeing that both are provided in a coordinated way.

The fifth and perhaps most important over-arching pressure point is broad rural development. Cross-country studies suggest countries with more egalitarian income distribution have lower fertility, but no one is quite sure why. Studies of poor countries ov time (as income distribution changes) are lacking. In these countries appears that income growth alone need not lead to lower fertility at any time soon, at least if the increases are modest and bring income to no more than low-to-moderate levels; it all depends on how the income growth comes about. As we said at the start of this section, massive rural development involving sustained increases in agricultural production (particularly food), infrastructure, health services, and education, supported by active community-based organizations, can encourage lower fertility if it involves and benefits the majority who are poor and if

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1/ The evidence on this point is sketchy. Considerable additional research is needed to determine whether parents are over-insuring, what it would take to get them to stop, etc.

it encourages new options for women.[1] But because of budget limitations, relatively few LDCs can afford such widespread and massive rural development; most must take a more selective approach to reducing fertility and stimulating development, focusing on those aspects of rural development that promise both increased output and smaller families in order to raise individual living standards as much as possible given available budgets.[2] Generally the aspects of rural development that most encourage lower fertility are the same as in development as a whole--the aspects we have just discussed in points one through four.[3] Thus the wheel comes full circle.

Given its Congressional mandate, which of the fertility-reducing policies and programs should AID encourage particularly through its programs?

AID's Congressional mandate includes among its several objectives the voluntary reduction of fertility through both provision of services and policies to strengthen motivation for family planning; reducing fertility can be crucial to efforts to improve per capita living standards, which is the ultimate objective of our mandate and indeed of most LDCs. Thus the question is whether working to lower fertility through changes in development policies and programs will seriously compromis

(See page 31a for footnotes.)

Footnotes for page 31.

1/ Many people believe the poor must reach a new threshold of well-being (especially in terms of food) before they will seek families of about two children.

2/ Assuming reducing fertility is an objective of the LDC concerned.

3/ One must ask whether this suggests investing in health, education, family planning "instead of" agriculture. Of course the decision must be the LDC's. But the evidence suggests it may be preferable to combine investments in agriculture with modest investments in these other fields to get both growth and lower fertility, hence fastest improvement in per capita living standards. If all productive resources were owned by all people in equal shares and if each factor earned its efficient economic return, the maximum improvement in per capita living standards would occur when output growth was maximized--in whatever factor intensities that resource endowments and technology indicated were optimal. But particularly if poor people have only limited claim on productive resources other than their own labor, raising their living standards requires raising their labor productivity--technically, the marginal product of labor. This in turn depends not only on how fast output grows, but also on how slowly population (hence labor force) grows and how labor quality changes. All things being equal, the more output, the higher the MPL (Marginal Product of Labor); the fewer the people, the higher the MPL. With most LDC economies grounded in agriculture, agricultural output is certainly the cornerstone of poverty-focused development. Investing to augment capital supplies and improve technology in agriculture may maximize the growth of agricultural output, thus raising the marginal product of labor. But it may not in and of itself help dampen fertility. A more composite investment package focusing on human as well as physical capital may help more to stimulate output and dampen fertility. More precisely, investing a little less in agricultural capital and technology and a little more in family planning, other health services, basic education especially for women, etc., may provide almost as much stimulus to agriculture, hence output growth, while also encouraging smaller families--thus possibly working more effectively to improve individual living standards.

other mandate objectives or violate mandate restrictions in the attempt to improve per capita living standards for the poor, particularly in rural areas.

Basically, the policy changes needed to lower fertility are the same ones needed to reach other mandate objectives. While some qualification is necessary, generally the more AID assistance serves to improve the well-being of the poor (especially women) and involve them in development processes--whether through rural development, improved food production and more equitable distribution, widespread and practical education, broad and effective health programs,[1/] programs that combat malnutrition, measures that help foster reasonable trust in political and economic institutions, or programs that generally encourage and equip people better to take charge of their own lives-then the more AID's assistance also serves to contain fertility.

Thus the basic recommendation here is for more coordinated programming, not only to reduce fertility where that is desired but also to take other steps toward the ultimate goal of improving the life of the poor. The principal focus of AID efforts will be on rural areas, both because most poor

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1/ Including child-spacing.

people are in rural areas and because improving conditions in rural areas will make it that much easier to combat urban problems (most of which are exacerbated by migration from rural areas of people who find too little there to persuade them to stay).

In most AID developing program categories, like education, agriculture, etc., of course, not all programs can serve equally well both their own primary purposes and the secondary purpose of reducing fertility. So far AID has stressed maximum fulfillment of primary purposes. But without jeopardizing the primary purpose of a given program, we may be able to gain a secondary but significant impact on fertility through reasonable and feasible changes in program design and implementation.1/ It should be borne in mind, however, that careful assessment of all the benefits and costs of alternative programs should govern AID funding decisions. While fertility benefits may be important, they must be considered alongside other benefits and within the context of resource availabilities, management capacity, etc. Specific suggestions follow; more need to be developed.

1/ As such dual-purpose programs expand, a serious trade-off may develop between the best primary-purpose programs and the dual purpose ones, but that bridge can be crossed when and if we come to it. For now, suffice to emphasize that lowering fertility and meeting the mandate's other objectives through development policies will in many cases involve complementary, not competitive efforts. Recent experience involving agricultural extension workers and volunteers in teaching family planning may be one example.

1. Food and Nutrition; Rural Development

a. Programs to promote growth in and more egalitarian distribution of income and public benefits, goods, and services.

AID's mandate recommends increasesin and more egalitarian distribution of income, goods, and services for non-population reasons.[1/] AID programs should therefore provide ample opportunity for research identifying links between distribution and fertility, and for programs better exploiting those links as they become clearer.

b. Food production and distribution.

AID or PL 480 programs designed to stimulate food production and assure its more equitable distribution can affect fertility in several ways--as an addition to income, as means of lowering food prices to make available income go further, as an improvement to health through better diets, and as food production depends on female or child labor.

AID is taking major steps to enhance the development impact of PL 480 both Title I and Title II, particularly in the areas of food production and population planning consistent with LDC preferences. AID or PL 480 programs designed to stimulate food production and assure its more equitable distribution can affect fertility positively or

(See page 34a for footnote.)

negatively in several ways--as an addition to income and employment (and a curb to urban migration), as a means of lowering food prices to make available income go further, as an improvement to health through better diets, and as a means to lessen the involvement in food production of traditional child labor. Provision of PL 480 Title II may be used through Food-For-Work or other programs to support establishment

1/ This is a broad-based concept including such matters as agricultural credit, provision of inputs, rural electrification, etc. which may in fact have a strong impact on fertility. In the Philippines in one area where rural electrification has been carried out, birth rates are sharply down in comparison with a similar area without electrification. Increased access to desirable consumer goods (irons, stoves) and increased employment opportunities especially for women (who now do housework at night) seem to be part of the story, resulting no doubt not just from electrification but also from other development policies increasing the demand for labor, etc.

of such things as schools, health outposts providing health, nutrition, family planning services, etc. AID plans to give major attention to the linkages between PL 480 and aspects of the development process including population planning.

c. Employment

AID programs focusing on employment creation should consider both men and women, particularly among the poor, not only in order to fulfill the purposes of the mandate as expressed in the Percy Amendment but also for fertility reduction purposes. Attention should go to the need for child-care that inhibits employment in non-traditional occupations for many mothers especially poor ones. Food processing and marketing of agricultural products may offer special opportunities for women.

d. Education within rural development programs

AID's rural development programs should consider increasing emphasis on women as well as in education provided through agricultural extension or other program components. Moreover, opportunities should be seized to integrate population and family planning messages in agricultural or other rural programs in ways meaningful to the poor who are supposed to benefit.1/

e. Nutrition within rural development programs

As noted above, AID programs in health, nutrition, and family planning can be mutually reinforcing. Agricultural

1/ Studies have demonstrated a coorelation between reduction of fertility and some level of primary education. But the required level of primary education varies among countries and will be examined further.

and broader rural development programs reaching the poor can play a major role in improving nutrition, hence health, by increasing the food supplies that will provide both home consumption and income needed to improve diets and by incorporating information on health and nutrition (e.g. better lactation and weaning practices) or feeding programs into other rural development programs.

f. Community Organizations

The encouragement and improvement of administration and organization at the village level have a number of primary and secondary effects on fertility. Village cooperatives can provide an organization for increasing agricultural productivity and marketing capabilities. (They can also become an interest group for land reform, if that is a needed structural change for agricultural development.) Local government organization can foster individual participation in community decisions and increase awareness of individual responsibility to the community. It can serve as a vital link between villagers and higher levels of government. And it can become a mechanism for mobilizing support for community infrastructure projects and for improving social services. Specifically related to family planning, local government

can act as focal point for entry of an integrated health, nutrition, and family planning program or a single-purpose family planning program into a community. Through education interest groups it can improve local education opportunities for the whole community and women in particular. Through "wives'" and "mothers" clubs and other women's organizations local government can develop a peer-pressure group for creating demand for family planning services, and a distribution system for supplying family planning services, and a feedback mechanism for determining family planning success or failure at the family level, as well as a useful local adjunct to the national census system. Moreover community organizations can assist in the training of administrative and managerial talent and can directly tie economic and social development (and family planning in particular) to the village, the level of government closest to and most involved and interested in the individual.

g. Incentives

Some LDCs may be interested in organizing individual incentive programs with AID technical and financial assistance, drawing on past experience with education bonds, savings accounts, and the like. (Certainly savings institutions including cooperatives should generally be encouraged.) Community incentives--rewarding a community's efforts at family planning with additional health, education, or other

services--can also be explored in interested LDCs. Several LDCs, especially in Asia, have expressed interest in or tried such initiatives. (See point b.) Other changes -- increased demand for labor, increased access to consumer goods provided through improved roads, rural electrification, etc. -- can provide more several but powerful incentives for smaller families.

h. Women's status

Many of the measures discussed in a.-f. have the effect of increasing opportunities for women, encouraging a sense of being able to control and change one's own life at least to a degree, and thus seem likely to encourage lower fertility. Any other aspects of rural development with similar impact on women are likely also to encourage lower fertility, and thus merit AID consideration for both fertility and status-of-women purposes. More women's associations dealing jointly with family planning (see above), education, maternal/child health, handicrafts for market, etc., may be particularly effective.

2. Health and Population Programs

As Part 1 of this paper emphasizes, health, nutrition, and family planning programs can be mutually reinforcing; integration of basic, low cost health, nutrition, and family planning services is specifically recommended in AID's legislation. Thus AID is encouraging development of low-cost integrated health, nutrition, and family planning services for the majority where integration makes sense. The design of such delivery systems is an essential principle of the health program. Thus AID is supporting all sensible types of service integration--organizational integration at clinic and household

levels and integrated planning. Perhaps the greatest gains in health and family planning can be made jointly through greater integration at the household level, to emphasize especially to women the interrelationships between health, nutrition, and family planning and to encourage them to put more of their own efforts into health and fertility management, thus making public funds go further.

Integrated planning of all programs affecting health should also be encouraged, of course, to assure maximum impact on health, hence fertility, of those programs acting jointly. This will assure appropriate weighing of the likely health and fertility impact of single-purpose programs like malaria eradication or free-standing family planning services or commercial sales of contraceptives as well as the organizationally integrated services.

3. Education

AID seeks to avoid discrimination against both women and men. But, in many LDCs far more boys receive rudimentary education than girls (the ratio is 4 or 5 to 1 in many areas), to say nothing of higher education. The knowledge that educating girls even a few years may help lower fertility can encourage further action to integrate women into the development process as suggested both in AID's legislation

and in the plan of action deriving from the International Women's Year Conference. In short, lowering fertility and integrating women more fully into educational processes go hand-in-hand, though, of course, other benefits of education must be given their weight. As to content of education programs, it stands to reason that information on family planning and family health, alternative roles and income-earning opportunities for women, and the possibilities for managing one's own life generally help to encourage smaller families. AID can encourage modifying educational content to include more on such subjects.

CONCLUSIONS: DIRECTIONS AND POSSIBLE FUNDING LEVELS FOR U.S. POPULATION-RELATED ASSISTANCE

The analysis presented so far suggests program directions and, though far more tentatively, possible funding levels for U.S. population assistance including (a) Title X population assistance and (b) other AID assistance and PL 480 that may indirectly but significantly affect fertility. Since the primary purpose of Title X assistance is to encourage voluntary reduction in fertility, funding decisions should be based on a careful assessment of the cost-effectiveness of alternative, appropriate approaches to reducing fertility. On the basis of current information, AID intends to use Title X population assistance largely to improve and extend better family planning services, to fund population-based components of integrated programs (e.g. family planning messages in education programs or family planning services in integrated health, nutrition, and family planning services) or to fund other measures with the primary purpose of encouraging small families.

Generally, other monies will be used to fund programs in education, health, nutrition, rural development, etc., whose primary objectives do not include fertility reduction but which may have a major secondary effect on fertility. It is expected

that due weight will be given to any secondary impact on fertility when the benefits and costs of alternative programs in these other areas are considered, though final funding decisions will of course depend on all the benefits and costs. (Program planners in such areas should also consider research on links with fertility.)

To explain how the new program directions suggested here and the funding levels outlined here relate to present Title X population assistance, we outline briefly the organizational structure of that assistance.

Current AID Title X Population Assistance

AID's population program, since its beginning in 1965, has become the world's foremost source of such assistance and a major source of ideas on fertility control. In the past ten years, AID has provided about $750 million in population assistance with annual amounts increasing to the current level of $110 million. At present this assistance is organized into six functional categories:

Category 1:	Demographic data	(to help assess demographic trends)
Category 2:	Population Policy	(to identify the national self-interests that justify population growth limitation policies and to identify development policies/programs that encourage fertility decline.)

Category 3: Research (to help develop better methods of family planning and more efficient delivery systems)*

Category 4: Family Planning Services (to help extend safe, effective, and affordable family planning services especially to the poor)

Category 5: Information, Education, and Communication (to help extend family planning information especially to the poor)

Category 6: Manpower and Institutional Development (to help develop adequate manpower and institutional capacity in family planning)

To countries wishing to reduce fertility AID extends assistance through bilateral programs, through programs funded by donor consortia, through official multilateral institutions like the U.N., and through intermediaries like IPPF and Pathfinder; assistance is implemented in a collaborative style with the LDC's concerned.

TITLE X POPULATION ASSISTANCE: DIRECTIONS AND FUNDING LEVELS

As a next step we outline potential program directions within the six functional categories. We assume somewhat higher annual program levels, perhaps around $200 million for the next few comming years, and indicate a) relative declines in funding levels; b) stable or continuing levels; c) moderate increases (0-50%) and sharp increases (over 50%) all in real terms.

*Subject to any legislative restrictions (e.g. Helms amendment).

Program Directions

Category 1: Demographic Data

-- Since many countries now have some sort of at least superficial national censuses, we expect to have stable or declining funding for national censuses in the near future except where needed to establish censuses or where techniques for developing more detailed data (see below) may be applicable nation-wide.

-- Moderately expand efforts at developing more complete and detailed demographic data nationally or at least for some representative samples among the poor to permit more accurate estimates of the demographic impact of various family planning services, information activities, and development programs.

Category 2: Population Policy

-- Moderately expand LDC-based research on the policy variables that reflect linkages between fertility and various aspects of development, including:

a) female education of various types and levels;

b) female employment;

c) health (especially of children);

d) nutritional status of women and children;

e) incentives/disincentives to encourage smaller families;

f) income growth, distribution, and rural development (focusing specifically on food);

g) laws and policy statement supporting family planning.

-- Moderately expand "population impact" analysis and other measures to encourage broader understanding of the development implications of population growth and the potential for bringing development programs to bear on fertility;

-- Moderately expand pilot experiments in a)-f).

Category 3: Research

a) Bio-medical Research *

-- Moderately expand projects to field-test promising new family planning methods;

-- Moderately expand research to develop new methods (particularly once-monthly methods and better and more reversible methods of male and female sterilization) and research on side effects of available methods, particularly pills.

-- Moderately expand research on the relationship between nutritional status and fertility.

b) Operations Research

-- Sharply expand LDC-based research on the comparative effectiveness of alternative approaches to family planning services and information, focusing particularly on basic, low-cost village-based distribution with short start-up times.

-- Sharply expand LDC-based research on what services health auxiliaries and laymen may be able to provide.

-- Sharply expand research on whether or under what conditions village-distribution schemes using low-level health auxiliaries or lay personnel can be established without much clinic backup.

-- Moderately expand research on prospects for LDC production of contraceptives and other family planning supplies.

Category 4: Family Planning Services

We expect the major focus of Title X population assistance to continue to be on extending better family planning services; within that focus, we shall give priority to providing more low-cost services for the poor, particularly in rural areas where the vast majority still lack any but traditional services. We shall:

-- Encourage provision of a variety of family planning methods, particularly pills, condoms, and sterilization;

-- Sharply increase efforts to help establish and expand village-based distribution of family planning services in rural areas particularly through low cost systems relying on health auxiliaries and laymen and promising short start-up time.

* Subject to any legislative restrictions (e.g. Helms amendment).

-- Encourage integration of health, nutrition, and family plannin services wherever sensible, taking care to encourage movement on either the health or family planning front where simultaneous movement may be very difficult;

-- Seize opportunities to "piggyback" family planning services on existing delivery systems, particularly clinics, where they are available (e.g. some Latin countries);

-- Encourage allocation of health funds to the establishment of low-cost delivery systems reaching into rural areas that could add in family planning where that approach seems most promising (e.g. some African countries).

-- Encourage provision of appropriate contraceptives through commercial outlets like pharmacies or small shops or through private channels (e.g. midwives);

-- Work with intermediaries, public-funded programs, or both depending on potential effectiveness.

In terms of country priorities, we take our primary objective to be getting family planning services started in developing countries; we will, of course, give careful attention to encouraging those countries to assume total responsibility for their own programs, particularly for their major contraceptive requirements.

Category 5: Information, Education, and Communication

-- Where broad-based family-planning awareness campaigns have not been undertaken, we would encourage those; but since many countries have undertaken such campaigns, we expect relatively less emphasis in this area.

-- Where basic awareness exists, fine-tune existing IEC efforts so they are:

a) country and culture specific;

b) informative on each specific methods of family planning;

c) related to personal needs and aspirations;

d) focused considerably on the interface between village family planning worker and village client;

e) reliant on relatively inexpensive media with broad out-reach that require little reading (e.g. radio).

-- Sharply expand operational field testing and collaboration with the research of other agencies such as UNESCO and UNDP to better determine which combinations of the many modern and traditional media and methods are more efficient, effective and suited to the special and evolving needs of differing countries and family planning programs.

Category 6: Manpower and Institutional Development

-- Sharply expand efforts to help train health auxiliaries or laymen for village-based distribution.

-- Continue efforts to provide advanced training for leadership teams and supply technical assistance to in-country training institutions to man combined health delivery systems and focus on filling specific needs, e.g. for personnel equipped to provide surgical contraception.

-- Moderately expand efforts to strengthen planning and management capacity at all program levels.

-- Continue efforts to assist in-country institutional development to meet longer term support needs for training, research, information storage and retrieval, and the like.

Title X Funding Levels

With data presently available, it is possible to make a case only for very rough funding levels. We do believe, however, that Title X population assistance could easily be justified at considerably higher levels, perhaps $200 million annually in program funds for several years, to finance programs along the lines just outlined.[1/]

Ideally one would set a certain target reduction in birth rates and from that deduce funding requirements for various types of family planning services and information and development policies. We cannot do that with any accuracy, however (of course, we face similar problems in other program areas). Both data and methodology are inadequate at the moment to sort out all the tangled influences on birth rates with any precision, though as emphasized above, more efforts should go to improving both data and methodology. Current AID projects along these lines will help considerably.

Using available estimates of population, numbers of fertile age couples, costs of family planning services, and the relationship between prevalence of family planning and birth rates, one can make rough estimates of the annual costs of just the services needed to increase prevalence enough to reduce birth rates another 10 points -- apparently in the

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1/ Excluding UNFPA.

$300-400 million range. But such estimates are so rough as to be of very limited value.

All this says nothing specific on appropriate levels for AID funding of services, let alone other areas of our population assistance. In the past, to get family planning well underway in many LDCs, we have found an AID expenditure for services of around $1.00 per capita total over a decade is often enough; of course this does not bring down birth rates to stable-population levels, but only to more moderate levels where services are well enough established to be taken over and expanded by the LDC concerned.[1/] But this suggests that U.S. expenditure in the neighborhood of $2.5-3.0 billion[2/] over 1965-85 could go a long way toward at least getting family planning services well established though probably not on a scale sufficient to achieve anything close to population stability. Of course additional funds would be needed to support balanced efforts in areas other than provision of services -- demographic data, information, research, manpower, population policies, etc., our recommendation of $200 million annually is based on such a total approach. The Agency, the Executive Branch, and the Congress might focus on just what the Agency's objectives in terms of fertility reduction

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1/ These were people who already wanted services, the extent of unmet demand is subject to serious debate, of course.

2/ In 1975 dollars, roughly.

should be. Funding for population must ultimately reflect other concerns, however -- such as LDCs' interest in such assistance, absorptive capacity and the ability to use funds efficiently, the role of other donors, the role of LDCs in funding, and competing demands on U. S. funds.

OTHER AID PROGRAMS AND PL 480: DIRECTIONS AND FUNDING LEVELS

Other AID programs -- in food and nutrition (and broader rural development), in education, and in health -- can affect fertility indirectly but significantly as discussed above. It bears reiterating that basically the same types of programs in these areas will help to reduce fertility, increase aggregate supplies of key goods and services, insure their more equitable distribution, and otherwise foster wider participation in development -- in pursuit of the mandate's basic objective of improving individual well-being among the poor. Many of the measures helping most to reduce fertility also help particularly to improve the status of women.

It is particularly important to improve our broad understanding of the links between fertility and rural development, education, health/nutrition/family planning programs, etc. to permit planning, implementing, and evaluating the best possible combination of programs and projects that will act in coordination to improve welfare, ease population pressure, etc.

Specific program directions are discussed below. We emphasize, however, that in each area, additional LDC-based research needs to be undertaken, financed not only by Title X but also by the programs concerned.

Food, Nutrition, and Rural Development

-- Give increased attention to projects that will help elucidate and take advantage of the linkages between these program areas and fertility, particularly focusing on the very poor.

-- Give emphasis to especially those programs that help

reduce unequal distribution of income and other goods and services.

-- For rural development as a whole give emphasis to a "package" of policies and supporting programs and projects designed both to foster production and slow fertility growth as consistent with LDC objectives and preferences and within the limitations of management capacity, which has often proved a particularly serious problem in "package" programs.

-- Give increased attention to projects which encourage community-based organizations and local managerial capability.

-- Take account of potential fertility effects of any proposed redistribution of the land.

-- Test the use of community or personal incentives (relevant for either AID or PL 480; major additional study should be devoted to this area).

-- Design ways to encourage profitable employment for women in non-traditional, non-menial occupations.

-- Give increased attention to planning, administering, and evaluating programs outlined in this section.

Particularly on Nutrition:

-- Encourage integration with health and family planning services where appropriate.

-- Encourage programs having direct impact on reduced fertility, such as promotion of breastfeeding.

Education

-- Give major attention to increasing the number of female beneficiaries in all programs (especially where males outnumber females significantly).

-- Give major attention to expanding, opportunities for basic education for girls.

-- Encourage incorporation of messages on the benefits and methods of family planning into formal and non-formal education programs of all types -- in schools, through rural extension work, through clubs, etc.

Health

-- Encourage development of low cost integrated health, nutrition and family planning services for the majority where integration makes sense (either in one organization system to assure efficient coordination of all programs -- organizationally integrated or free-standing -- that may substantially affect health and fertility).

-- Give major attention to maternal and child health with attention to child-spacing and lactation as critical health measures.

Funding Levels

In the area of development policies and programs affecting fertility it is even more difficult to discuss funding levels, except to say that increased attention should go to programs which, while serving their primary purposes, are likely to have a secondary impact on fertility. It should be pointed out specifically that non-Title X population funds may and indeed should be used in addition to population funds to explore links between fertility and other aspects of development, to help plan multi-faceted programs affecting fertility, and to help implement and evaluate such programs.

SUMMARY: AN INTEGRATED APPROACH

Basically this analysis suggests the fastest way to improve individual levels of well-being among the poor may be a package or integrated approach[1/] -- combining the most effective, safe, affordable and accessible family planning services and information with development policies and programs tailored to affect fertility as well as to fulfill their primary purposes. This will enable us to influence fertility -- always in keeping with the LDC's own objectives and preferences -- through our Title X assistance and through other budgets that may impact on fertility too. This course seems most likely to achieve the rapid and massive reductions in birth rates needed to reach birth rate targets of the LDCs and eventual population stability. This strategy is in full harmony with key recommendations of the World Population Plan of Action adopted unanimously in Bucharest in 1974. Specifically, it responds to paragraphs 31 and 32 of the Plan:

1/ It must always be kept in mind that "packaging" is instrumental and that, therefore, (a) no one package is optimum for universal application, and (b) the acceptance of any package in a particular setting requires the participation, in designing and developing the package, of those who lead and influence the potential acceptors.

"31. It is recommended that countries wishing to affect fertility levels give priority to implementing development programs and educational and health strategies which, while contributing to economic growth and higher standards of living, have a decisive impact upon demographic trends, including fertility. International co-operation is called for to give priority to assisting such national efforts in order that these programmes and strategies be carried into effect.

32. While recognizing the diversity of social, cultural, political and economic conditions among countries and regions, it is nevertheless agreed that the following development goals generally have an effect on the socio-economic content of reproductive decisions that tends to moderate fertility levels:

(a) The reduction of infant and child mortality, particularly by means of improved nutrition, sanitation, maternal and child health care, and maternal education:

(b) The full integration of women into the development process, particularly by means of their greater participation in educational, social, economic and political opportunities and especially by means of the removal of obstacles to their employment in the non-agricultural sector wherever possible. In this context, national laws and policies, as well as relevant international recommendations, should be reviewed in order to eliminate discrimination in, and remove obstacles to, the education, training employment and career advancement opportunities for women;

(c) The promotion of social justice, social mobility, and social development particularly by means of a wide participation of the population in development and a more equitable distribution of income, land, social services and amenities;

(d) The promotion of wide educational opportunities for the young of both sexes, and the extension of public forms of pre-school education for the rising generation;

(e) The elimination of child labour and child abuse and the establishment of social security and old age benefits;

(f) The establishment of an appropriate lower limit {i.e. minimum age} for age at marriage."1/

1/ This could be used to raise the minimum age for legal marriage, thus postponing.

Country Priorities

We have assessed experience with fertility-reducing programs and policies in a variety of countries where AID has had significant programs, and have drawn conclusions on program directions accordingly. Obviously the same type of program will not do for all countries; thus, our general policy and program strategy must be adjusted considerably for a given country, and an approach developed that makes sense in that country. The overall shape of all AID programs actually operating will depend on what countries we actually assist. Country allocation decisions naturally reflect both U.S. economic or political interests and prospects for meeting program objectives -- in this case, reducing world fertility.[1/] Here we propose to give only rough guidelines as to the countries in which AID may concentrate its population-related assistance. Special concern exists for thirteen countries, excluding China, which contribute most to current world population growth: Bangladesh, Brazil, Colombia, Ethiopia, Egypt, India, Indonesia, Mexico, Nigeria, Pakistan, Philippines, Thailand and Turkey. But AID does not operate major bilateral population programs in about half of those countries at present; nor can we mount massive

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1/ It bears emphasizing that reducing fertility is only one of AID's objectives under the mandate -- and that it is viewed as a means of facilitating per capita improvements in welfare.

programs through intermediaries of the scope, design, and vigor we would want. Thus the Agency is also determined to pursue opportunities in a limited number of other countries interested in reducing fertility where prospects seem bright or where unusually good opportunities exist for developing prototypes of programs that may also prove helpful in less accessible or otherwise neglected countries. We are continuing our analysis of program prospects, requirements, problems, etc. in order to refine our list of country recipients, assuring adequate program focus, and expect to make considerable further progress in this area in the next several months.