

CONFERENCE ON POPULATION DYNAMICS  
FOR STAFF OF AGENCY FOR INTERNATIONAL DEVELOPMENT

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615 North Wolfe Street  
Baltimore, Maryland

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DR. BAUMGARTNER: Since some people dropped out yesterday afternoon, they asked me in one sentence, to tell what happened yesterday afternoon and what people said.

Don Bogue said two things. I think he said, without presenting all the evidence, and if he was around I would still say that, it is a lot easier than we think. In other words, that most of our rural people, uneducated, illiterate, world people are more ready for family planning than most experts think they are and it is not necessary to do some of the elaborate things that were done before. There was some indication, though I did not get to ask him whether he believed this or not, that this was a situation that was different than it was 5 or 10 years ago. In other words, word has gotten around, and some of the conclusions drawn some years ago from good studies, do not hold up anymore.

I don't know what the people on the India panel will say this morning, but I think conditions in india are different than they were 10 years ago. Then we had a coffee break. Then Sheldon Segal talked at some length about the various methods and described their physiology, their method of working, et cetera. I would say probably he put greatest emphasis on the loop, indicating also great hope that it might be thought of, certainly not of an abortive measure, but if it turns out that it is able to speed the ova down the canal, this may mean Catholic acceptance. He talked also of the new development, possibly in terms of immunization and different steroids. He pointed out that not a single underdeveloped

country had picked up the pill and used it.

Harry Levin gave us an amusing demonstration and told us about the cost and how everything was processed, in detail, so we all can become manufacturing experts. We received some mimeographed sheets he made out that show the price and where materials can be purchased in this country, not in Japan and Taiwan and Hong Kong where they are sometimes picked up cheaper than they are in the United States.

We announced that we would have an end of the day question session and pick up some of the kinds of questions that came from the field as to how we do some of the things. We have talked this over at the breakfast session--because some of us get together at 7:15 every morning and we decided, in view of the rich fare that we have on for Tuesday, Wednesday and Thursday that there would be a good discussion on Friday of your questions, your desires, and what you think you need to make programs work in the field.

Another question has come up, that is, what are those groups supposed to do in their group discussions meetings which are going to be held on Wednesday afternoon and Thursday. You ought to know, by the time your group meets, from the experts that you hear in the meeting today and tomorrow--you should know what is going on, what is the status right now in these countries. The group discussions are for the purpose of talking about how you can accelerate something, what needs to be done next, how you can get it done, and also to outline the sources, the best sources of information, who knows the most about the situation in Country X,

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Y, Z, and so forth. The next thing I am going to do is, I don't want people to be unpleasant about either Dr. Stebbins or me, so I want to say that it was only one moment ago I was asked to chair this meeting, so I am not doing very well. So, we are giving you advance notice. We told Bob Smith yesterday afternoon he was going to chair the meeting before the coffee break.

Any of you that want to have any facts about people will find there are some typed things up here that tell you all about the cast of characters more or less. After the coffee break, Mr. Hanson is here and you will please chair after the coffee break.

The meeting is now open for any other questions that you have.

DR. JESSUP: We have one of the AID people that will be at the Friday morning meeting. We have the papers that we hope you will be working on this week, and also an agenda on any mechanical arrangements. As Secretary in TCR we'll be glad to help you.

DR. BAUMCARTNER: A question has been raised as to the costs of family-planning programs and we are tempted to figure out how much you get out of a dollar put into population versus how much you get out of putting money into economic development. It comes out about \$9 in economic development equals \$1 in population. Even if these figures are off 50 per cent or 75 per cent, that is what the economists call a whale of a return on a dollar, and it is an argument and a point of view that I think is going to be most interesting, to see what the planning commissions of various

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countries think of when they take a look at the returns that we put in. Many of them thought family planning was so expensive they could not do it.

We are starting into today and this will carry through all of today and the first part of tomorrow morning, on this series of discussions of policies and programs in particular countries or groups of countries and I don't really need to go very far to introduce Dr. Carl Taylor, who will in effect be chairman of this panel, and he will introduce the members of this panel who are present. Then we will go on from there.

Dr. Taylor of Johns-Hopkins.

DR. TAYLOR: Let me introduce them, the people who are going to be responsible for the more formal part of this discussion. Although, we want to keep this as informal as possible, and I was told from the beginning that one of my tasks was to set a pattern of discussion rather than presentation.

To Bob Smith's left is John Cobb, who is a member of our faculty here at Hopkins for another couple of weeks, then he goes to Colorado as Professor of Preventive Medicine, Community Medicine.

The next person we have scheduled is Dr. Irma Adelman. She has not arrived yet. I think she may be caught up in the Hopkins graduation ceremony and may arrive later. She is an economist on the faculty in our Department of Economics at Hopkins and has been particularly interested in prevention as it relates to economic development, and she has data on Pakistan in particular. Then,

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second from the left is Harry Raulot, also on our faculty here at Hopkins, who has been with John Cobb in the field, working on the project that Dr. Harper's department has been running with the Ford Foundation support.

Then we have in the program AID mission representatives and the two that are going to be making short presentations are Dr. Boynton who is the AID health representative for Pakistan. To my right, Dr. Dorryberry, who is from the mission in India. With that brief introduction, let me go on to say that we have agreed that we are going to hold ourselves to less than 10 minutes each, and I would like to ask Bob Smith, in order to keep him from feeling too relaxed if he would bang the gavel on us after 10 minutes, so we do really stop when we are supposed to stop, so we can have time for discussion. I am not including Dr. Hanson in this 10-minute listing, because we are going to ask him to sort of be our wise discussor and particularly I am going to call on him toward the end of the discussion to help with the summary comments.

Now, if I may turn to a very quick presentation of the status in India and John Cobb will talk about the status in Pakistan. Harry Raulot will take up the social aspect of work in these two countries. Irma Adelman will take up the economic aspects and the two AID representatives will take up the status as seen from the AID mission point of view.

In Washington, I am told that you hear a lot of talk or

c6 do a lot of talking about the hawks and the doves. In family-planning also we have our hawks and doves. The hawks call themselves the optimists and they refer to the others as the pessimists. The doves call themselves the realists and they refer to the others as the unrealists. This reminds me of a riddle my son asks me. "What is the difference between a turtle and a duck?". When I gave up he said, "They can both fly except for the turtle."

I think our problem here is we are all trying to fly, but I think the difference is we are probably aiming to fly at different speeds. The speed does not determine when you will start. As a matter of fact, the turtle is notorious for getting up early, starting early, and plodding along faithfully. I think that the main question that relates to this issue of whether we are going to be a turtle or a duck is the issue of, how easy does it seem. I think that this basic issue of the ease of the programs that we are so much committed to is very important in terms of the India and Pakistan situation. I say this particularly because I think that India and Pakistan are different, just as every developing country is different.

We ought to recognize very quickly and very clearly some of the differences that relate to India and Pakistan. The first difference I see is just this matter of the problem of scale, the magnitude of the problem immediately when you get into the India-Pakistan situation. A magnitude which makes all of the normal thinking about time tables hazardous. For instance, the

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simple fact that one year's population increase--that is, after you subtract the deaths from the births--the population increase for one year is now running at over 12 million, which is the size of a population of a good many other countries.

The magnitude of the problem is also indicated by thinking about the manpower problem. Now, at the door we have a whole stack of mimeographed documents which relate particularly to the situation in India, and one of the reasons why we mimeograph this material was to save ourselves the trouble of making a speech, but we will refer to it occasionally.

On the second page, you see a projection of what is needed in terms of manpower and particularly when you look at the auxiliary work carefully and see the magnitude of increase that is going to be/required in such things as midwives, auxiliary forces. And when you try to relate this to what is in anyway feasible and practical in terms of setting up training programs, immediately you begin to think in terms which seem fantastic by any normal comparison.

The auxiliary workers are obviously the basis for any thinking about rural work, as you will see in the next set of tables which relates the findings as they now stand in terms of the availability of doctors and the various types of indigenous practitioners to the rural population.

Now, another major difference in India and Pakistan is this cultural and social situation. They are totally different

c8 from the Chinese influenced areas, as Irene Taeuber pointed out. I think that assumption extrapolated from the experience in Taiwan and Korea is hazardous when applied to the India situation.

A third major difference is the administrative framework. I think those of us who have worked in India and Pakistan are particularly conscious of the complexity and bureaucracy in the problems that relate to the simple matter of efficiency in setting up programs, and the bureaucratic and administrative block to any effective programming in India are ones that need to be taken very seriously into account in planning.

We are just beginning to learn what the problems and possibilities are. I don't think that the solutions are going to be as easy as Don Bogue said yesterday. My concern is that in spite of the hope which Shelly Segal mentioned, as prevailing in these countries at the present time and there is a crack of a smile when you talk to people--there still remains a general feeling of hopelessness among the people in these two countries.

Recently, I was talking to one of the upper level Pakistani medical leaders in family-planning, and he said that from the professional point of view family-planning work is a bottomless pit. The professional goes into it and he sinks out of sight and that is the last you hear from him. This feeling of hopelessness in the situation in India and Pakistan still prevails in spite of the enthusiasm which has developed with the coming of the IUDs.

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Now Don Bogue is the optimist who may help to counteract this hopelessness temporarily. That is good. But it is going to be terribly easy to overdo this optimism and if we really create the impression that this whole problem is going to be easily solved, I am afraid the whole thing is going to backfire on us and lead to even greater hopelessness and greater disillusion of the people in the countries we are trying to help. So I think we better be very sure of our prognostications before we oversell our programs, but I think that, to go back to what I first said, we all agree, and especially the turtles that we must get started and get started early.

With half of my 10 minutes gone, let me turn to my real assignment and discuss the status in India. Could we have the first four slides, and we will run them through very quickly.

(There was a film shown at this point.)

This is a familiar graph to most of you, I am sure, showing the population increase in India and you can see where we are heading.

(Next film)

This is Chart A-3. These are the projections taken from Ansley Coale, showing what we can look forward to. These were made in 1956. One comment at this point. Any projection that I know about, in terms of India, has been wrong, but it has always been wrong in one direction. It has always been an underestimate. This was certainly true in these graphs, but you can see the im-

c10 portance of getting started early which is the reason I want to show this. If we can get started and--he projected two different sets of circumstances; on the basis of fertility unchanged and fertility reduced 50 per cent during the period from '56 to '81, and then carries on the projection there--you can see how much difference it is going to make in terms of total population, the difference between 600 million and 800 million people.

(Next film)

The next one, just a slide which is a little out of date, but things have gotten a lot worse. This shows the relationship between population and food. The two graphs show essentially the same thing. This is "exports" and in black "imports". This is the line of self-sufficiency in food, and you can see, back at the turn of the century, India was an exporting country for food, and you can see the direction in which the line is going.

(Next film)

This brings out to me the importance and critical thing that I hope we will be able to get into in the discussion which relates to the difference in the countries that you see here; the U. S. as compared with India in terms of the total proportion of births in population. First births, second births, and third births. As you can see, India is much lower than the other countries whereas essentially half of all the births in India come forth, in higher orders.

(Next slide)

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This slide to me gives more of the story of population increase in India than any set of tables. When we were working in the Lybian district, the Chinese members came to me with this map and said, "We want to show you what our problem is in this village." This map had been made 100 years previously and was the map of the fields of that village for taxation purposes. At that time they pointed to these heavy black lines as indicating the size of the field. You can see they ran about five acres per family. Within that period of 100 years, maybe three generations you can see what has happened to the plots of land. First, they divided it in big chunks. Then they began to really split them down, and at the point that this was taken—which was just before land consolidation in the Punjab, you can see the point to which they had arrived, with each family having a little space of land scattered around various parts of the villages, making an almost impossible situation from the point of agriculture.

Now, I am going to stop at this point, because all I am trying to do is to introduce the whole topic of the status of the situation in India. I hope we are going to have time to really get into a discussion of what is involved in trying to induce this change that we are all interested in. I call then on John Cobb to take up Pakistan.

DR. COBB: Much of what Dr. Taylor has said applies also to Pakistan. Therefore, I won't repeat. You have in your folders to sets of tables on India and Pakistan and I have a few extra

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copies here if somebody needs them. This shows, on the first page, the continuing trends. First of all the growth of population for these countries from 1920 to 1960, and then the projection from 1960 to the year 2000. Briefly, both India and Pakistan had a 27 per cent--26 to 27 per cent increase--from 1920 to 1940, a 36 per cent increase from '40 to '60, a projected 60 per cent to 74 per cent from '60 to '80 and then the two projections diverge, the one with continuing trends being the death rate, declining to a level of about expected life of 63 years at the end of the century and the birth rate remaining constant.

These are United Nations statistics data, at the bottom. The median assumption gives the death rate declining in the same way, and the birth rate declining by 60 per cent in 30 years. That is by 1995. This, it seems to me, is a maximum reasonable family planning goal, based on what happened actually in Japan.

I don't think it is likely that we do any better than that, and this should be compared with the projection that was used in the discussion of Dr. Perlman yesterday, in which it was postulated that the fertility would decline by 30 per cent in the next five years, that is, from 1965 to 1970, for Pakistan. So possibly this goal of 30 per cent reduction in fertility would be achievable, I should think, in 20 years. I doubt very much if anything like that can happen in five years.

Now, I would like to indulge in a little simple-minded demography and trust that the experts here will catch me up if I am making wild statements. On the average, our surveys and others

c13 in Pakistan have shown that couples desire about 3 or 4 children who will survive through the period of fertility of the parents, and we find 85 per cent, in the village where we were working, 85 per cent of women are married by the age of 25. That I think is generally true.

Now, the median completed family size runs around 7. That means that people were in general overshooting this goal of 3 to 4, so this is a differential which the family-planning program can work on.

Why do the families overshoot? Again, I think there is a simple-minded answer. The birth rate is declining rather rapidly, and people do not appreciate this, and so they get more children than they expected. Vice-versa, I think would be true. If the birth rate should start to increase, people would have fewer children than they want, and then they would be trying to get more. They would be undershooting.

FROM THE FLOOR: You mean the death rate?

DR. COBB: I am sorry. I mean the death rate. Now, you can make another simple-minded calculation. If you wanted to be 99 per cent sure of having four children, you would need to have 27 children at the present fertility rate. This is not a sure method. It should be, in order to get an accurate figure, but let us think of what actually happens. Let us assume that no matter what happens to the death rate--and perhaps this is justified--no matter what happens to the death rate, the parents

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continue to try to have these 3 or 4 children surviving at the end of their fertility period.

Now, we give them a wonderful contraceptive which makes it possible for them to achieve what they want. I should also say this might be accomplished by other methods, such as abortion, even without that wonderful contraceptive it might be possible to achieve this goal of exactly four in every family. Now, in fact, in Lybia, in anywhere where we were working, in Pakistan, almost all of the fertile, married women who were menstruating, and had more than four living children, came to our clinic for contraception and of those who had less than three children, only 2 to 3 per cent. I will just put that on the board.

You have got less than three children, 2 to 3 per cent. And more than 4 children, 80 to 90 per cent, that came in for family planning. This is the women who are menstruating, that are not pregnant, not lactating, and married and fertile, living with their husbands.

So no matter how good the contraceptive program is, under these conditions it seems to me that the result will be, in approximately one generation, two people will produce four. This of course, roughly again and in simple demography, means the population will double in approximately 30 years, or that would be a 2.3 increase which is what has been the case. Now, a 2.3 per cent increase might mean a birth rate of 50 and a death rate of 27, or maybe by reason of reduction in death rate and activity

015 in family planning you might get the birth rate down to 30 and the death rate down to 7. Which comes first. I suppose the death rate goes down first, and as it goes down, the birth rate comes down to meet it. But you still have your 2.3 per cent annual increase.

Now that may be simple-minded and pessimistic and all, but I don't mean to stop there. The question is what can we do and what are the possibilities. I think the first thing we must all do is be rational. Use the available data. Use it in high powered ways, rather than the simple minded ways, and get the actual facts in set goals which will be reasonable and which will be obtainable. The second thing I think we can do is to start right now on more research to find ways of inspiring the illiterate, rural, population to seek education, to seek something positive for the women especially, to do. Something which their husbands and they would feel was creative and more worthwhile than having children.

I don't think that we will change this picture unless, especially the women, have something that they can do in the village after they have had their few children, and thereby make an adjustment in the situation.

I would like to finish by saying that I think in Comilla and perhaps in the Quaker Urban Community Development Program, there has been a beginning on this, and I think this is very exciting and I hope we can do more of it.

Thank you.

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DR. TAYLOR: The next presentation will be Harry Raullet, talking about the social aspects.

DR. PAULET: I think I am also going to emphasize problems, and I also may sound pessimistic. If I do, it is partially my background of having worked in Pakistan. The setting has already been covered by Dr. Taylor and Dr. Cobb, specifically with regard to the project which we are working. The point is, as far as our point is concerned, that there is something to do. There are people that are available to become contraceptive clients and, as he pointed out, we got into the program almost all of the women with more than five living children, if you discount those who would not be available because they would be pregnant, lactating, past menopause, widows and so forth. Practically all of the women with 5 or more children that would be available, below 45, were taken into our program. About half of these were the effect of IUDs. On the other hand, it was very difficult to get people in the program, in the community where we worked, where we did most of our work, if they had less than five children, and it was extremely difficult if they had fewer than three. And in two and one-half years, persuasion did not seem terribly effective.

What I will do is just outline some of the factors that are generally associated with fertility that are now undergoing rapid modernization, increases in educational level and chances for social mobility. This certainly is the situation in the villages in Pakistan and in North India generally. Be reminded

c17 that you are still largely involved in a subsistence economy. The economic structure is traditional.

Most of what is produced is consumed in the village. Exchange conditions in the village are on a basis which largely, I believe, mostly are still of the traditional kind. In other words, the exchange relationship involves a certain kind of ritual relationship. In the area where we worked something like 40 per cent of the boys between 5 and 9 would be in school. Most of the boys who started school would drop out at the age of 10 or 12. Of course, there is a program to expand education rapidly, but this would probably be--this is going to be more difficult to accomplish than is sometimes thought in terms of the backlog need and in terms of the very rapid expansion of the school-age group, with the high birth rates.

Of course, we are also concerned with the problem of education for girls. The backlog for boys is not well taken care of.

Well, what are the social factors and cultural factors that are normally spoken of as being involved in repeating the fertility decline in such a situation? One is the importance of kinship ties and it is still the case in this area that even politics are largely organized around kinship ties. To some extent this may be increasing with the importance of elections, but political activity is very largely centered around kinship. This goes along with the feeling that an increase in the size of one's

c18 family group and one's kinship group is something that will increase power of the group, increase the political importance. It is a general factor, but it is of importance in attitudes about family situations.

Then there is a well-known importance of children to individual parents, in terms of their social security function. I am sure everybody is aware of this. Sons are dependent upon to support parents later and the goal is two surviving sons, which usually means four children if this goal is achieved. Then there is a point that the fertility--well, having children is not perceived of as being entirely a concern of the immediate parents. It is a concern to some extent of larger kinship groups. As you know, marriage is an affair that is arranged and bargained for by a fairly-large kinship group. It simplifies the lesser role of the parents themselves, of the couple themselves in the whole matter as compared with the situation in the West. So that is of some significance in terms of attitudes about taking responsibility for reduction of number of children.

The question of lowered mortality is of some importance. This is something that is in a sense rather hopeful. It is hoped that the rapidly-decreasing mortality will have an impact, will be perceived by couples and they will realize it is possible to reduce family size, but the sort of pessimistic side is that there may be a lag factor here. There may be a considerable lag factor. It is hard to know what position to take on this, but it is some-

c19        thing that perhaps could be used constructively by a family-planning program, the fact that family mortality is decreasing. In one community one-third of the respondents polled, did state they felt that a very large number of children was necessary in order to be sure 3 or 4 would survive to maturity. I am never sure what this kind of response means. I might add, in the same community, more than 20 per cent of the household had 1 or more members working outside of the community, usually in the cities, in Curachi, and other places, and sending cash back to their families in the village.

I don't know what the distribution of this would be in North India and Pakistan, but it is a fairly frequent phenomenon. This would tend to hide the local population pressure. It would tend to disguise it. Although the people that work in the cities do not make high wages, they still have an income that is comparable to that which can be earned in the village, or superior to that which can be earned in the village. Furthermore, the income is in cash.

The fact that social mobility is not upward economic mobility, is not characteristic, and education has not yet become a characteristic, and it is an expensive proposition. It is something that is likely to be a slow development. We can discuss the tempo of this. It means that parents will not perceive of their children as properly having a career usually. Not in most cases, and it is not likely to be very salient to them that they

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should invest in the quality of the child rather than quantity. This is something that won't come across in a salient way when the process of career is not involved, the idea of the possibility of moving up in an occupation category, in moving from one occupation category to another.

I think I may be running short of time. I want to point out, turning to a later point, the effect of short-term movements toward modernization. Again, I don't want to sound pessimistic, but I think we should be aware it is quite possible that many short-term movements toward modernization may have effect again toward increasing fertility slightly. They are not all in this direction, but many of them may have this effect.

For example, small increases in educational level of women, at the primary level, may have slight effect toward increasing their fertility because they become more respectable. They are less likely to work in the fields, and so forth, and this may increase their fertility slightly.

The small increases in income without changing traditional social structure may also, in the short run, have effect toward, as a matter of fact, increasing fertility. In the long run, modernization, economic development should be more consistently in the positive direction.

Perhaps I had better stop now. I am getting notes about my 10 minutes being up. We can take up these points at the discussion.

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DR. TAYLOR: The next presentation will be by Dr. Boynton about Pakistan.

DR. BOYNTON: I would like to tell about what has been done in Pakistan and what they plan to do. I think I will read you a statement by the President, because I think the Government wants to do something very important. The President says:

"If nothing is done to check the growth rate, I shudder to think what will happen after a few decades. My consolation is I will not be there to face the situation but my country and my people will be faced with it. The coming generation will not forgive us for landing them in such a bad mess."

That is the attitude of the President who pretty much represents the Government.

The reason they are so interested in family-planning in Pakistan is because of the economic effect. They have had a lot of foreign aid and have made a lot of progress, but during the first five-year plan for '55 to '60, the per capita income went from 297 to 298. During the second five-year plan, which is just ending, they think they have been successful. They added 42 rupees a year, which is about eight dollars, during this five-year period, to the annual income. So in spite of their millions of dollars or billions of dollars that have gone into Pakistan, they are not satisfied with the progress they have made. The military government took over in 1958 and that was really the beginning

c22 of an organized interest in family planning. During this first five-year plan, they did put some money into family-planning, but not very much. Something like five lacs were put in during the first five-year plan. In 1959, Dr. Balfour and Dr. Notestein went to Pakistan and stirred up interest, and Dr. Balfour and Dr. Harper worked out a plan. So, in 1959, they got more interest in family planning and they put in eight lacs of rupees for the rest of the five-year plan. This all led up to having an organized family-planning scheme during the second five-year plan. Three crore of rupees, which is about 30 million rupees, were put into the plan and they were going to do great things, use conventional methods largely and have a national distribution of them. They were going to train 1200 people a year and have a lot of publicity and research and demonstrations. They did get 12 million rupees outside of Government funds, from private organizations. As a matter of fact, in FY 64, U. S. AID allocated 791,000 rupees to establish family planning clinics. I am keeping that project agreement in my desk, because I think it is a historical document. The first time we earmarked money for family planning. So there was a fairly large scheme during the second five-year plan to do something about family planning. What did they accomplish?

Well, it did no good. It did not accomplish what they had hoped to do. By the end of the plan they had had 1 million 200 thousand new and old cases---about a million new and old cases, but the five-year period, whereas the original projection was that in one year they would have about 1 million 200 thousand new cases.

c23 So they went anywhere from 4 per cent to 30-something percent of accomplishment of the goals in the distribution of condoms as the number of clinics and people trained. But they did not accomplish anywhere near what they set out to do.

This led people to be pessimistic and say it did not amount to much, and you cannot do much in family-planning, but it did accomplish some things. It was not wasted. We learned some of the reasons why it did not work, such as the fact that it was part of the Health Department. The man in charge of it was not high up in the administrative scale, as they wished, but he was a lower administrative person. They had a lot of part-time instead of full-time people. The people were not well-supervised. They ran out of supplies. There were just too many bottlenecks to getting the work done. They did focus attention on the problem. They got everybody in Pakistan thinking and talking about family-planning. They came to the realization that there was no simple quick, easy way of solving the problem. They found out it was a pretty complicated matter. The IUD was introduced, and it proved to be much more effective than other means, so a new technique was seen to be more effective, was developed and approved by the people in charge. It established the need for a full-time trained family-planning worker, with proper supervision. It established the need for direct administrative channels. It established the need to work out a system of incentive payments which seems to be important there, and it demonstrated that the Pakistani people did want something

c24 done in family-planning. It trained a backlog of people who are now available. As a result of this second five-year plan work, the third five-year plan has an expanded family-planning scheme in it which is very large and very important and I think is going to accomplish a lot more.

This started out in 1964. They started out a plan which was first worked out by Dr. Safir, to use IUDs primarily in 6,000 villages with a full-time motivator, but he went off to WHO and that fell into discard. Then, Dr. Kaahn (?) worked out another plan in which he was going to reduce the birth rate 50,000 to 40,000. He was going to reduce the growth rate from 30 to 25, within another five-year period. It is estimated there are 20 million fertile couples in Pakistan, and he was going to have IUDs used--from 20,000 the first year to 1.6 million in 1970.

But he was replaced last September. The Government got around to appointing a family-planning commissioner, who is a highly-respected administrative person, who has the position of General Secretary, equal to the Director-General of Health in the Administration of Health and Social Welfare, so he worked out a plan which is now embodied in this book here which is the third five-year plan. If you can take a peak at it, it is in great detail and it has great plans.

Essentially they were going to appropriate originally 38 crores of rupees for this five-year period. That never got approved. It got down to 30 crores of rupees by November of 64 and now the

c25 present plan is that they will have 23 crores of rupees for the third five-year plan. The goal of this plan is again to reduce the birth rate from 50 to 40 per thousand, to give service to all the 20 million fertile couples by 1970, and it is felt that 25 per cent of them could be induced to practice family-planning, and this is 25 per cent effective in this case--they could accomplish this goal.

They planned to use all methods, cafeteria style. They plan to bring items to the doorsteps of everybody, instead of having family planning services just for the health clinics. They will have the conventional methods distributed through shopkeepers and probably a couple hundred thousand people at the village level will distribute them, so all methods will be available. The clinical method probably through the health services or special clinics. Sterilization will be included, but the main hope is placed on the IUD.

We think during the second period we proved they are practical and workable in Pakistan. Something like 7,000 people now have the IUDs, as it is felt they will be the backbone of the plan, although all will be offered, and it is thought by the Family-Planning Commissioner that the conventional methods will pave the way. They will not prove effective and then they will shift to the IUDs and they will really do the job.

There will be 2,100 family-planning doctors who will be available for the clinical method. These doctors will probably

c26           be largely women physicians, but it is also planned to have mid-wives working under family-planning doctors.

          If I told you the cost, crores for the five-year period. A crore is 10 million and a rupee is about 21 cents. The administration of this program will be by the Family-Planning Commissioner at the national level, two provincial Family-Planning Boards; 52 zones in the country, and each one of those will have a full-time family-planning board, the chairman of whom will be the Deputy Commissioner who is the deputy officer of the country. There will be 1,000 family-planning supervisors, full-time in the West. That means 1 for every 3. In the East they will have one family-planning officer for each town, of which there are 400 and at the village level we have 50,000 guys who will be the village organizers and there will be several other people in the village who will handle the conventional contraceptives. The training of this personnel is a problem which is going to be gigantic. It is felt it can be done in 27 weeks, but no one thinks that schedule will be kept. One of the important features of the program is they have built-in incentives. This time they will have full-time people who will get paid. Everybody who works will get something for it, to stimulate the IUDs. Particularly the doctor who introduces them will get 8 rupees. The midwife who brings the people to the clinic will get 2-1/2 rupees. I think this will have a lot to do with getting the people to come to the clinic.

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DR. FERRYBERRY: It is true there is government support for family-planning in India, but you cannot get the Prime Minister to say anything about it. He said, "I have six children. Why should I say anything about it." That also permeates through the entire political structure of India in that the congressional party has not taken a definite stand, and we do think this would have some impact, if they would.

I think it is necessary to say, even in a group of AID people, that India has 16 States and that these are--the one place where they are similar--they are all divided into districts, blocks, and villages, and this is the way the structure is built. You cannot talk about India without talking about districts, blocks, villages; and so I had this difficulty when I was there. So I am bringing to you what my problem was.

Secondly, health is a state subject in family-planning, in the health field. It is a state subject, therefore, the State can behave as they please with reference to family planning and they do. There is a certain amount of uniformity produced by virtue of the fact that the central government produces plans which they call schemes, a word which, to us, means a little different from theirs. It merely means money will be forthcoming if you do things a certain way. And in this way the central government is able to produce programs that are national programs, such as malaria and family planning and others that I do not need to mention. These schemes are centrally administered. The central

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government does the whole business and pays 100 per cent. They are centrally sponsored, in which the central government pays 75 to 100 per cent for non-recurring costs and 50 to 75 per cent for recurring costs. Now, I think you have to know this because this is the way in which any similarity of a program is produced in India.

Now, let me give a little bit about the program, because I cannot possibly give a total picture. Right at the moment it seems to me that the program is welded into two parts. One is due to the fact that the ICMR, Medical Research Council, accepted the IUD. They call it IUCD. They put in this plan in January and the Government accepted it on the 26th of April. There was a conference then of all states in state family-planning offices in May and all states attended but two. One Nagaland, that seldom comes to these things because it is a new state and just getting going, and the other is Madras, that will have nothing to do with the kind of program that at the present moment is an accelerated extension program, as they call it.

One of the problems of the IUCD in India is, at the moment, it is considered that it must be inserted by women physicians only. There are a few private clinics in which the male doctors can insert them, but at the moment they are figuring only female physicians of which there are 15,000 in India, and 10 to 12,000 of these are in practice, and they are all in the cities practically.

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Nevertheless, the point is to train these as rapidly as possible and begin with the insertion of the IUCD in centers of population, and then to move into the rural areas with moving mobile vans, with the female physicians on those vans so that the people will be brought to the Centers where the vans are established or where they move. Their targets are a million IUCDs this year. I have yet to find out whether that million is December 31 of this year, or April 1, which is the end of the fiscal year. I think we will be lucky if we get 1 million by the first of the next fiscal year. Vasectomy is still placed at a target of 6 per cent of the population per year, although it is admitted they won't make it. The other methods of contraception which they expect to give emphasis to are the condoms with provision of the other traditional contraceptive methods.

Now, the long-range extension program, which was instituted in 1963, after they had had a long experience with clinical programs in which the people did not come to the clinic very much, and only those who got to the clinic got any family-planning. After that, they developed a very elaborate, and I think, one of the soundest programs of extension education I have seen anyplace. This extension education called for the placement of an ANM for every 10,000 population and a basic health worker for every 20,000 population.

Then, at the District--I should say, primarily, health center--which serves the block, there will be placed 20 family-

c30 planning workers to assist the primary health center in carrying on family-planning. I will go into that more later at the District level. There will also be a family-planning staff, editors, doctors, supply people, et cetera.

The big problem ahead is training. As Dr. Boynton has said, it is figured there will be 35,000 workers if this plan is laid out. There are 35,000 workers that have to be trained. 44 regional training centers were sanctioned. By sanctioned, that means money was made available so the States can use it. There are 16 already operating and 24--28 more to be built. These will be fairly elaborately staffed if they can find the personnel. A method of training in India is one of a filtered-down processes. The Center trains the State personnel; the State trains the District personnel; the District personnel trains the Block, and the Block trains the Sub Centers ANM. In this filtering down there is a good deal of opportunity for dilution and I sometimes think pollution, too, as I see what happens as you get down to the sub-center level.

Also, there is a reduction in the amount of time that successive workers are trained. Those from the center to the State are trained less and less. It reminds me of Thorndike's statement about dictionaries that we used to have. He says, "You know for the elementary child we have a little dictionary like that. You have one word and it gives you the synonym. You look up the synonym and it gives you the same word." The child does not

631 know either word so he is no better off. "When you are older you have a bigger dictionary and the same problem." In India I sometimes think we have the same problem.

The second problem is evaluation. There is need for evaluation there. The third problem--and I don't think it is the third in importance--is administration. We sometimes here that the Malaria program was a success. So if only we could get family planning out of the health ministry the way we did Malaria, but we did not get Malaria out. The two are alike, except Malaria has a real good administrator pushing the program and we have some problems in family-planning which I would rather not go into too much, but I think Mr. Hanson will.

Another problem is transport. But one problem we do not have is lack of finances. There is plenty of money for the family planning program, regardless of the ceiling that has been placed on the amount that will be given to each state to promote the family planning budget. I have heard this said on two occasions now by members of the Finance Ministry. "Spend as much as you can on sound, effective, programs, according to the scheme and we will reimburse you for the amount that you have spent." So that there is no limitation on finance, and there is very little limitation on any of the other things that they lack except Transport and audio-visual aids. I was going to give you some thumbnails of programs, but instead I told a story.

DR. TAYLOR: Dr. Adelman has now arrived.

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DR. ADELMAN: The topic I want to talk on is somewhat more general than the other talks that have preceded me. I would like to talk in broad terms about the general relationship between economic development and population problems. The relationship on one side of the interaction, namely, the adverse effects of population growth on economic developments are right clear. I will not dwell upon the reduction in per capita income which results as a by-product of increases in population growth. What has not been nearly as well understood or generally investigated is the relationship on the other side of the coin. Namely, the impact that the economic development generally tends to have on population growth. Historically, certain broad generalizations emerge. It would appear that at least the historical experience is that mortality tends to react fairly strongly and unreasonably systematically in changes to per capita income. As per capita incomes rises, mortality tends to drop.

On the other hand, fertility responds either very little or with a long lag. It is this part of the interaction which has been responsible for the population explosion which we have witnessed in the post-war era. A cross-section study of relationship between fertility and various variables which accompany economic development suggests the following pattern. There is a small but significant tendency for birth rates--by this I mean age specific fertility--to increase with rises in per capita income. There is also an accompanying tendency for fertility, again age specific,

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to decrease with urbanization and industrialization. Similarly, there is a systematic association between age specific fertility and the general level of education. Again, in the negative direction in general.

In fact, this relationship seems to be the strongest of all. The way in which this whole picture is put together depends upon the rate at which these various variables move as development progresses. We know that in general development is a complex phenomenon which has as one part of it, rises in per capita income, and, as another part, industrialization, urbanization, as another part, rises in education, mobility, changes in social structures, et cetera. The vigor of the various interaction with fertility determines whether in a given historical period, the birth rate will rise as a result of economic development, or whether it will fall because of those various forces which move in opposite directions. In any case, the effect upon fertility per se historically would appear to be fairly small. On the other hand, the effect is reasonably strong.

Age specific mortality tends to react in the following way: It tends to decline with rises in per capita income; it tends to decline with increases in urbanization. It tends to decline with increases in education, and it tends to decline with public health measures as measured either by expenditures of public bodies on health or by physicians per capita, or hospital beds per capita, et cetera.

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What this tends to summarize into is that we can be fairly confident that in any given country were to make any economic progress in the direction of development, its mortality would tend to decline. Fertility, will, at best, stay constant. Therefore the dimensions of the dimensions of the problem which one has tonight if one is in the process of actively injecting economic development, are clear. The historical and the general relationship which would result if one would not to adopt any policy measures would lead to a large percentage of the fruits of economic development being eaten up in terms of population growth. I don't therefore need to draw the obvious conclusion, namely that positive measures are necessary in order to combat this tendency.

I will dwell a little bit upon the difficulty of achieving any tangible results within a short period of time. The most hopeful approach to tackling the fertility problem would appear to be education. The responsiveness of fertility in terms of declining fertility with educational levels is fairly strong. However, education is a slow and expensive process. In addition, what is necessary is a particular kind of education, namely, the classical type of education is not particularly conducive to decline in fertility. What is necessary is a type of education which tends to inject the attitude that individual members of society do have a certain amount of rational control over both their physical and social environments. In other words the type of education that is necessary is a more Western, more

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logically-oriented education. In many areas of the world this type of education would be a graphic change from the educational pattern which had been perceived previously and that too would militate against expecting any rapid results from attempts to influence drops in fertility.

DR. TAYLOR: Thank you very much.

We have used up a lot of the time allotted to us and I think with what we have left in way of discussion time, we will entertain some questions from the floor.

FROM THE FLOOR: Are the 85,000 workers going to function exclusively in family-planning?

DR. DERRYBERRY: In the family-planning program as family-planning workers, they will be placed in the primary health centers with the expectation that they will also do some of the work there. But it does not include those people who are in the primary health centers, because that is 65,000 more. But those are called exclusively family-planning workers.

DR. TAYLOR: When you say ANM, that is Auxiliary Nurse-Midwife?

DR. DERRYBERRY: That is right.

MR. MONZANO (Colombia): Most of the comment here directly dealt with family-planning through the use of contraceptive devices. I wonder, in the program in India, to what extent you have introduced devices that effect populations in the field? For instance, there is a mention of education, and employment of women would be one. Use of private enterprise to foster distribution networks

c36 which are not being done by the Government. This area?

DR. DERRYBERRY: A plan was submitted to the President of the Chamber of Commerce on what industry could do with its labor for family planning. There is a scheme, so-called, for the distribution of contraceptives through commercial channels subsidized by the Government. This has not yet been thoroughly accepted, but probably will be. The director, the medical director of the railroads, the entire railroad system of India was a member of the group that visited Korea and spent two weeks there, just last week and the week before and plans to introduce a program of family planning in the medical care program that they have in the railroads.

DR. TAYLOR: And the community developing program in India is theoretically tied in with the whole health service in the community development blocks although the actuality has been quite difficult to achieve. On paper at least, there is a close relationship.

DR. HALL (Hopkins): I wonder to what extent the employment of women and the effect of fertility has really been studied in a systematic way. Dr. Staggars is not here, but his work in Lima tends to show that some fecundity in marriage comes first, and employment of the women second. The women who have fewer children in marriage are the ones who tend to work, and are able to hold a job, because of the fewer children. Their attitude toward the number of children is the same as the women who do not work. We always assume that employment of women will cause the

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declining fertility. How much of this is really true?

DR. ADELMAN: It tends to indicate it is not the employment itself which is responsible, but rather the change in status of women which accompanies the employment which is responsible for declining fertility.

DR. DERRYBERRY: In your tea plantations of India, it does not have any effect because the law provides them with a certain amount of income during the time they are off for maternity. This is one of the things that is being considered in the legal problems in India as to whether or not to cut out the subsidy after the third child.

DR. COBB: It may be obvious, but if a good family-planning program is available it might make it possible for the women to work. I think the point is that you have to have a job for the women to work in, otherwise she is going to go back and have another baby.

FROM THE FLOOR: Most of the areas which I have worked in, you don't need to worry about the women working. They do as much or more work than the men do.

DR. BALFOUR: In the light that Dr. Perlman talked yesterday, what can be said about the age of marriage in India and Pakistan? Is there evidence that it is slowly rising, both urban and rural? That is one question. The second question I have is, and/Dr. Baumgartner definitely assures us about this talk after lunch, this second question might be withheld. But the

c38 second question is, what are the prospects on all these beautiful plans regarding improvement in India that are up for fulfillment?

DR. BAUMGARTNER: I will answer it completely and fully at lunch.

DR. TAYLOR: Let me comment on what I know is happening in terms of the age of marriage. The data from the Ludhiana District study indicates there is a shift in the age of marriage related to education primarily, and secondarily, to some of the other things related to socio-economic differentials. Historically, I think that the question of the shift in age of marriage is much more difficult to determine precisely at this point. I don't know of any good studies that show a marriage shift on the time basis. There is a shift within the socio-economic strata level.

DR. RAULET: I just recently looked into our own data and it is an extremely hard thing to measure. You got different kinds of answers depending on the questions you ask. If you ask women who are married and over 20 when they were married--we got pretty good distribution showing that many got married below 15, some even below 10--if you ask a different kind of question and you go up to a married girl and ask them how old they are. They will never say they are below 15 or 16. And apparently, if they are over 20 and not married they will say they are below 20. So it is this kind of difficulty and we have no way of determining their age. It is not an easy thing to get data on.

DR. TAYLOR: Then there is the usual problem of the

c39 difference between age of marriage and age of consummation of marriage.

DR. JESSUP: I would like to ask, is there optimism relative to the planning in West Pakistan as opposed to East Pakistan?

DR. RAULET: That is not the easiest question in the world to answer. Other than the national plan, this is a plan of private or voluntary organizations in East Pakistan that has been going on for some years, run by--actually he is a director-general of the police force. He has not used any coercion insofar as running this program is concerned. It is entirely voluntary. Their primary activities have been in the counselling and family-planning field, and also they recently added these intra-uterine devices to their program. Their funds from private subscription and also some funds from government.

In addition to those the Red Cross runs small programs. In general, I think there is a great deal of optimism particularly based upon the results which are being obtained in the Comilla experiment. This is getting to the people in a very rural area where it seems to me this problem really is.

So, the Comilla experiment as you mentioned before, has set a very active distribution system of conventional devices at a very reasonable price. One peso for a condom and one peso for a foam tablet. The goal is now set at around 2,000 dozen per month, and they estimate that the usage of 40 per cent among those who procure. But the success of the program so far has been

c40 based upon a very elaborate group of people who supervised, not only the people who had the devices ready for distribution and purchase, but also who are in rather frequent contact, at least on a weekly basis, with those in the various villages and the so-called family-planning advisers which are in the small Indian Council groups. Now, just how is it being considered? I think if you get 40 per cent usage it is pretty good usage. How far they will be able to extend this to the other districts throughout East Pakistan remains to be seen.

DR. TAYLOR: Is that 40 per cent of the women in the area?

DR. RAULET: Forty per cent are using, whether it is male or female, there is 40 per cent usage of the devices which are procured in the distribution or sales center.

DR. TAYLOR: 40 per cent of the devices are actually used, or 40 per cent of the women in the area use them?

DR. RAULET: I think it is 40 per cent usage of those which are actually procured on the list.

DR. BOGUE: I wanted to put in another good word for optimism, because I was a little strong in my comments yesterday because I knew the professional crepehanging that would come this morning. I have not been in Asia for a year now, so what I say is a year out of date also, and it takes a little courage to stand up and argue with people who just got off the plane from there. But I think a lot of the difficulties that have arisen in India

c41 and Pakistan in these family-planning program is, from a sociological point of view, failure to use mass communication methods and to involve the people. All of these programs have laid heavy emphasis on organization from the center down. Tremendous amounts of effort have gone into organization in building up family-planning programs. At this point there has been some little effort to involve the masses and to inform them. When I was there a year ago, to the best of my knowledge there had not been produced one single booklet or leaflet that gave specific information on methods of contraception that a private person could read. Despite this fact there was a professional journal for family-planning workers that was circulated every month. There was a family-planning newsletter which I get in Chicago and thousands of people around the world get giving news of the family-planning program in India.

Since that time there has been one booklet published as an experiment because I raised hell over this mass communication business and they decided to try it on an experimental basis. I think 10,000 copies of it were printed in a country of 400 million people. This booklet clearly is labelled on the back, "Limited Edition for Research Purposes only". I talked with the Director of Air India Radio that conducts something like 28,000 discussion forums a year. At that time there had not been one discussion forum on family planning on Air India Radio. A similar type of situation exists in Pakistan, I think. So much emphasis has been laid on organizing and bringing missionaries into the

e42 village, but the idea of getting at promoting discussions and controversy in the village, getting the people involved, has not been very much tried. Every time it is tried it succeeds. This is the secret of this Comilla program. This is the success of the Ghandigram(?) in India and several other experiments like this, because when you involve the people you do get this response, so that I am optimistic and it is more a matter of the professional learning what these experiments signify and changing the game.

DR. TAYLOR: I think I will call on Dr. Derryberry, and then I want to make a couple of comments on this too.

DR. DERRYBERRY: In the Ghandigram experiment, there was no mass media used, but it was successful nevertheless. I think it would have been better if something was combined with it.

No. 2, the experiment you mentioned yesterday was deficient with respect to the fact there was no service provided, and although this was extensive in getting to two of the villages out of the five experimented on, no services were provided, so nothing happened. I think the real problem in India is not in the lack of use or the lack of understanding, of the mass media, the difficulty is getting coordination of services with the mass media. If you start out on the mass media without services, you are sunk, because you will extend your energies in this sort of thing and get nothing.

All administrators or sales agencies know this. Now,

c43 the difficulty of India is the mass media radio and so forth are under the Ministry of Information and Broadcasting, and when you try to put those two together you have a problem. I agree with you that there needs to be more mass media, but it needs to be coordinated.

DR. TAYLOR: I would like to say some more on this, too. I think we need perspective on this. Back in the 1950s there was a good bit of mass media approach on this. I know this because I helped to write a booklet in the Punjab that received wide circulation, and then it went out of existence. I was not able to then find any copies. I personally saw a good many different sort of things being published back during the 50s. There were radio programs at that time that I know about, that were getting out into the rural radio areas, so this may not be going on now because there have been these ups and downs which are so typical of programs in a country such as India.

The thing that worries me about this optimism is, as far as I am concerned. It depends on when you visit a project, as to what you think the success of that project is. If you had visited us in the Milana(?) area 2 to 3 years after we started, you would have gotten the same feeling, that we were getting somewhere. We felt this, though other people did not, because they did not agree with our methods, but we felt we were getting somewhere, and we did have up to 30 per cent of the people of those villages participating in the program. But when you waited and took the results

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after six years, and then did a careful analysis as to what happened, and who those 30 per cent were, it turned out they were the people who had already had their big families. They had already been using some contraceptives and we found out there was a lot of deliberate contraception going on in the villages. After all, 12 is the biological family-size. If they reduce it to 6, to 8, this is a pretty effective utilization already. We are trying to get them down to 2 to 3, and when you go in with a new program, obviously you get a big response because you are substituting a better method for things that have already been used in the past.

The actual effect on birth rate is not touched in the slightest by that sort of response. It seems to me the important thing is to go ahead and do the next thing, which is to bring it down below the acceptance and utilization level which we had in the past. That response in itself can be the basis of a major educational process if it can be tied into an effective and well-organized program for supplying whatever needs to be supplied in the area. Then you begin to get the sort of confidence in the method which I think is the basic requirement in this.

I think that we really need to get across the idea that we have something at work, and if this confidence is established, then you begin to get the spontaneous spread of information which is, after all, the best that we can count on.

Now, I am afraid we are cutting into the time. Do you want to wind this up?

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DR. HANSON: If there are representatives in the room from countries that do not have a family-planning program and have been trying to figure out whether they should have, and if so, what kind, I tremble to think what they are thinking about after this discussion of India and Pakistan.

This group on the panel represents the pioneers in the two largest programs, government-sponsored programs in the world, and probably the two of the biggest, most cumbersome government administrations in the world, and everyone of these men has had his head bloodied at some time in the last couple of years in the process of what he was doing. So they are speaking at a very personal experience in what they are saying. I think I can make a couple of remarks that will put some of their experiences in perspective.

I think first of all, the governments of India and Pakistan are so big in territory and so cumbersome in administration that any preventative health program that meshes itself into their Ministry of Health is in for trouble. The only way that any program has succeeded in the preventative field in India or Pakistan, in making progress, has been to create a semi-autonomous arrangement for itself in which it could be largely independent of the public administration there. I see Dr. Derryberry is shaking his head. I can say it for Pakistan. I will let him comment later on that if he wants to.

The second point is that both of these governments initial-

c46 ly decided to assign their family-planning program to the Ministry of Health, which is administered by Doctors. They choose to--and I say doctors that don't have the overlay of public administration training that is characteristic of our public health service. They have chosen to do it largely through clinics initially, clinics in which probably 95 per cent of the population, in their whole lifetime, never go into, a government clinic. They chose to use these clinics to distribute their contraceptives to do their promotional work. It has taken years in both countries to learn the difficulties of what they started out to do and to start rethinking of what they were going to do next. At the same time that these difficulties were being encountered, there were a considerable series of pilot projects started in both countries. There are about a half a dozen in Pakistan. I am not sure of the number in India, but it is 2 or 3 times that number.

These pilot projects have the advantage of working in small areas with hand-picked local professional people. Some of them were sent to the United States for training, with a few foreign advisors and it is out of those controlled small situations that we learned what we do know about the success of method and about how to proceed with the next five-year plan. I think the optimism that Professor Bogue showed he would agree has come largely out of the few small pilot areas which have yet to be translated into national programs.

However, we are fairly confident that we have incorporated

c47 in both India and Pakistan in the next five-year plan that we have learned in the last five years. I don't think it is going to be easy to translate what was a little project for 5,000 people or for 25,000 people into the hundreds of millions, but nevertheless there is some basis of proceeding now with the thought that we have learned a good deal. As Bill Boynton was talking, I thought of just one contrast that I thought was worth repeating. In 1959, the family-planning association of Pakistan had been conducting work for about 10 years and had been appealing to the government to form a national policy and to give some money to this voluntary organization. They had for 10 years succeeded in getting neither. Today, six years later we have, not only a national policy, we have a program for employing 5,000 full-time people on family-planning and a budget approved within the last 30 days that will give them \$12 million a year to spend on it. I think that it shows real progress and despite the true problems and the bloody heads that these men represent, I think these pioneers have a great deal more accomplishment behind them in the last five years than some of the remarks that have been made would give them credit for. These men in particular are among those that are responsible for these results.

DR. BAUMGARTNER: I would second that.

I go out every 5 or 10 minutes and spend a little time and come back and know all the answers. I in some ways have had my head bloodied a little bit. I think one of these days I am

c48 going to take the recommendations I made in 1955 and compare them to the ones I made in 1965 and I am sure there is a high percentage of duplication. But I think the people that are there all the time fail, Mr. Hanson, to see one other thing. That is the continuing progress that is made even out of the things that are called failures.

In India, for example, the famous Bern(?) experiment which WHO undertook with Abraham Stein, undoubtedly was given up soon after Dr. Stein got there, and it is universally hailed as one of the great failures. As a matter of fact, it was one of the first successes because it gave credence to what was acceptable and what was not acceptable. It took the method that fit in best with the India culture, tried it out, and found out it was not acceptable, and opened the door for a great experiment.

Carl, I think you failed to realize that the Ludhiana Experiment was something that needed to be done. It brought in the prestige of the Rockefeller Foundation and Harvard University to India to give a very careful scientific plan in the field of family-planning. Also, it got this accepted as a modus operandi in India. These are the by-products that I think are not always seen that come out of so-called failures.

DR. TAYLOR: I think we should, with those words, bring this session to a close. There is a whole area of unasked and unanswered questions in my mind as to what is the specific role of outsiders in this program.

Now, I think we should get to our coffee break.

(Whereupon, a short recess was taken.)

DR. HANSON: Our avid representatives from India and Pakistan have foreshortened the latter part of the morning by 30 minutes, and so we will have to have even greater restraint on the part of the speakers who are going to discuss Taiwan, Korea, and I am not sure whether Thailand will come up for discussion or not.

Since most people who are here had an opportunity to get acquainted with each other yesterday, I would like to note that there is a newcomer this morning, Dr. Peter Bing of the President's office of the Science Advisory Group, who has joined us this morning. He might stand up for a moment so those who have not met him will get a chance to in the next day or two.

The first item on this session's discussion is a presentation on Taiwan by Professor Ronald Freedman of the University of Michigan. Dr. Freedman is a professor of sociology, Director of the Population Study Center and for the last three years has been assisting with activities in Taiwan on a commuting basis, financed by the Population Council. You are down, Dr. Freedman, for 30 minutes and if you would use your own judgement as to how long a presentation to give, I will just have to call the question period at the end a little shorter than 30 minutes.

DR. FREEDMAN: I should place myself by saying I am a turtle with wings as I regard myself as being someplace in the

c50 middle of these positions, but I think from what I heard this morning, that I am closer to Don Bogue's position than I am to the realist position. I think perhaps instead of giving into the temptation of getting involved in that discussion, that I will talk about Taiwan in specific terms, because I think that the experience in Taiwan is one of the bases for the optimism.

I think maybe you ought to have something concrete on the basis of which to react to, whether it is useful or not.

Let me say generally that the problem in using the Taiwan experience elsewhere is that Taiwan, like Korea, is a place in which conditions are quite favorable and the encouraging early results can be attributed to those favorable conditions. I think some people say that Taiwan and Korea may be on the verge of a success, it is not transferable because the conditions are different. They are favorable in a different way than India and Pakistan. My position on that is that we do not know that yet. That may be true, but from my observations, I do not think that the kind of programs that have been tried in Taiwan and Korea have really been tried in places like India and Pakistan. And I don't think we know whether they would work or would not.

I would not assert they would work, but I don't think the evidence is all in.

Let me allay your fears and tell you I am not going to talk about all these numbers I have given you on this dittoed release that you have, but we can perhaps use that as a resource

c51 tomorrow and the next day.

Just in general let me say that the problem that you have been talking about generally is especially acute in Taiwan because the death rate has now been low for quite some time, and the birth rate has begun to fall. But still it is high enough for the rate of increase to be about 2.8 per cent per annum. Life expectancy is somewhere around 63 years.

As of 1962, the date that we have on the first page here, you see that the density of population is extremely high in Taiwan. As a matter of fact, Taiwan is the second most-densely populated country in the world. The country that beats it now is the Netherlands, and that of course, is a different kind of situation.

Taiwan is more densely settled by far than most of the other countries that we might want to talk about.

One of the results of the situation is that a very high percentage of the population is under the age of 15. This is what you get when you have very low death rates and high birth rates in combination, so that the percentages in that area are very real and are considerably greater than in India and Pakistan for example.

Now, the birth rate has been declining in Taiwan since 1958. If you look down at Panel D on this first page you will see that the birth rate was about 42 in 1958 and for 1964 it was 34. In other words, the birth rate has declined about 19 per cent. Most of that decline is not attributable to any organized program, because the program is relatively new and most of this has occurred

c52 as a result of other kinds of influences. Which brings me to the fact that in Taiwan we have considerable evidence that under these pressures that most of the children surviving and a beginning of social and economic development, and considerable literacy in raising aspirations, that people tend to do something on their own about the problems of limiting their family size.

If you will turn to page 2, I have there some data from a survey that we did in Taichung. I think the data we have for the Island as a whole has similar results. This is before the program that I am going to tell you about and it indicates something of the fact that most people in the survey have indicated that they want a limited number of children. As has been the case in most of the surveys in other countries, the answers you get are that they want 3 or 4 children, providing at least one is a son.

The situation as shown on Panel A on page 2, is that if you take the women in the child-bearing years in general, 20 to 39, married women, that about 45 per cent of them either already have the number they want or they have more than they want. That is, they would like to have less than they have now, and if you take the woman in their thirties that gets up to about two-thirds. In other words, there is definitely a desire to do something about it.

A very large number have the desired number by the time they are in their thirties. If you look at the next panel you will see, for example, that among women with three children, three

c53 living children, there are actually 5 per cent that wanted fewer, 49 per cent have as many as they want, 46 per cent prefer some more so you have a little over a half of them that either have all they want or would rather have less, and it gets up to the time you get to four children.

Then it goes to 76 per cent. In Panel C, you see what has happened. There were significant beginnings there, some form of family-limitation was practiced whether abortion, sterilization or contraception, but it had been practiced by 35 per cent of the women in the child-bearing years; almost 50 per cent of the women in their thirties and you can see the rest of the figures there.

On the whole, however, they were dissatisfied with what they were doing. The methods of contraception were ineffective. They practiced abortion; they did not like it. They would rather have done something else. That was essentially the position at the beginning of this program.

Now, if you will turn over with me to page 4, I would like to say something about the program in Taiwan. The program that I want to tell you about was one that the Provincial Health Department, with the assistance of the Population Council, undertook, beginning in 1963, in the city of Taichung, which has a population now close to 400,000. It is a capital city. I won't go into the details of the program except to make two points about it, which I think may be relevant for other places. It is what I would call a space saturation program. This was a program cover-

c54 ing the entire population, not little bits of it, but the attempt was made to reach the whole population. However, it was planned in such a way that the effort was not to reach each individual but to saturate spaced areas. In other words, the idea was that if you reached, for example, every third neighborhood you can rely on diffusion to get into other areas.

Now, I stress both aspects of this. One that you understand this kind of program is one in which you do not try to reach everyone, but on the other hand, it is a big enough program and a big enough social framework that you get the natural relationship among people working for you in this setup. You do not depend simply on your health workers. That is just one element in the situation. You are continuing on, getting enough stimulation, going on a massive basis, so everybody knows what is going on, and then you begin to get all kinds of messages in the informal social network of the community.

Another point about it which is relevant is that the government was neutral in this situation. The government still in fact, does not have an explicit pro policy and although this was done by the Provincial Health Department, the government itself said it had no position on this matter. And the success of the program, and I think it is a success, is there without statements by the Prime Minister, the Mayor, and so forth.

Now, some results. There are approximately 36,000 women in the child-bearing years in this city. If you look at Panel B

e55 you have the acceptances in the formal program. This is apart from any indirect effect on other ways. You have the acceptances through March of 1965. One thing I am rather proud of here, by the way, is you will find a lot of these data are very recent, and I think one of the things that the people in Taiwan have done very successfully is to get the data out quickly to feed into the program in order to change the programs in terms of what is going on which is another thing I think is important.

I think too much of the report in this area involves reports three years later when the situation has changed completely. About 9500 women, as you see there, just under 10,000 women, have come into this program. One of the significant items there, however, is that 2800 of those women are from outside of the city. I think the significant thing about that is that the formal program itself was entirely inside the city. These 2800 women came into the city entirely as a result of diffusion, word of mouth, diffusion, without any organized method to bring them in.

The effort in the city was big enough to go outside of the city in that way, and you will see there that 29 per cent was from outside of the city.

Another aspect of it which you can see down at the bottom is that 80 per cent of all these acceptances are inter-uterine acceptances, although the program was initially a cafeterial program, offering everything including contraceptive pills.

Overall, by March of 1965, approximately 19 per cent of

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all married women, 20 to 39, in the city, had been acceptors. About 40 per cent is the figure. If you take those women at the start of the action program who then wanted no more children and were not already sterilized or using satisfactory methods.

I will skip over D, and if you will go down to E with me, there is some material there that is relevant to some of the points that were made about the experience in Pakistan. The experience here is very much similar in that those people who have tried something before are by far the best bets for acceptances. And as you will see there, 7 per cent of the people who are using something when the program began were acceptors but 30 per cent were acceptors among those people who had at some time practiced contraception but were not practicing it then. They were the people who tried something and were not satisfied with it or had a bad experience. Those people are highly eligible. Among those who had never used it before there was a 10 per cent acceptance rate.

If you turn over, one of the other interesting things here that I think is being confirmed in Korea is that people who are especially eligible are people who have used abortion and have been dissatisfied with that and want something else. You will see our acceptance rate there is 29 per cent for people who had only tried abortion, 18 per cent for those who had tried contraception and abortion. That 0.0 for sterilization is not correct. There were two women who were sterilized and wanted to be sure and

c57 came for inter-uterine devices.

The next item here, I think, is not only an item of scientific interest but of practical interest. Obviously those people who do not want any more children are the ones you can reach best. If you will look there you will see where the wife wants fewer children than she already has. You have the highest acceptance rate, 15 per cent. But when you get where the wife has the number of children she wants, the acceptance rate was 10 per cent. Where she wanted one more child--this is when the program first began--the acceptance rate there was also 10 per cent.

Now, some of those women had that additional child in the meantime but even among those, where they wanted two more children, 4 per cent were acceptors. The point I would like to make is, I don't think we should go on the basis of a survey of how many children they want, and when they say 3 or 4, we don't assume that is going to be the crucial point as far as acceptances are concerned.

I think one of the things that is important there is that if they are having 7, 8, 9, and 10, they may have to come down by step, so to speak. If you ask them this question, yes, they want more, but in the meantime this big program got going and they saw that people were taking effective steps were doing things to have fewer children and they began to change their mind. I think the acceptance rate of 4 per cent for those who want two more children is not inconsiderable. I don't want to spend too much time on this, so I will skip over some of this. But I think Item

c58 5 is a rather interesting one here. It is one of the best indicators we have found in a rather complex statistical analysis that we have done of these materials. One of the best ways of predicting whether a woman will be an acceptor in the program is to find out how long it is since she had her last child. The shorter that time period is the greater the acceptance rate, and this goes along with evidence, that women who have had a baby recently and are breast-feeding the child at that time, and women in the post-pardum period are particularly eligible. There are some obvious reasons why that should be so, and this is particularly so, you will see here, for those people who have recently had a baby and have tried to do something. You see these are likely to be failures. They tried to do something. They used contraception or abortion and yet they had a baby, and they are highly-eligible for this program.

FROM THE FLOOR: I don't understand these two columns. You have 14.2 and 29 acceptors at the top. What does that mean?

DR. FREEDMAN: This means the base here, the 14.2, is that among women who had a baby less than 9 months ago and never used any form of family-planning, 14.2 per cent were acceptors. You don't add these percentages. The base is the sub-group involved here. It says that 29 per cent of the women who had a baby less than 9 months ago and had previously done something, 2 per cent of those women were acceptors and so forth. One of the things I think that has been most important in this program, the

c59 things that are coming out of it, is this matter of diffusion. Apart from these women outside of the city and inside the city, the program was also organized so that about 50 per cent of the neighborhoods had no direct programs in them. In other words, we were relying there on word-of-mouth. The situation there--well, it ends up with the fact that more than 60 per cent of all the acceptances in this program came from women who did not have any direct contact with an agent of the program. The results in terms of diffusion are particularly important with respect to the IUD. I think that we have someplace a table on that. If you will turn to page 3 and if you will look under B, the panel that says "IUDs Only", those are the acceptance rates. IUD acceptance rates per 100 women, married women, 20 to 39, and if you will look at the left-hand column there, 9.8, 9.7, 6.7, 6.6, and so forth, the thing I think that is perhaps most impressive there is that nothing figure. Those are groups in which nothing was done. There was no effort, and 7 per cent of those women, 6.6 per cent of those women, came for inter-uterine devices. Every husband and wife is part of a very expensive, intensive program in which each husband and wife gets a personal visit. You have to have a program someplace in order to have the diffusion take place, but I think this does give you some indication of the fact that you do not have to reach everybody in the program.

I would like to turn finally on this Taichung program. On the question of who accepts. One of the interesting things that

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has come out of this is that the acceptance rate among the illiterate, among those living on farms, 100,000 of these people in Taichung are actually farmers and people who are low on all scales of modernization. The acceptance rate in those groups was quite good, and just as good in many instances as the more advanced groups.

Now, there are two reasons for this. One is, they are more eligible women there. The more and better educated women have already done something. But even when you take that into account, there is still a high acceptance rate in the other groups. We are interpreting that in this way. The evidence seems to be that the illiterate groups, the low status groups, want to limit family size just about as much as the higher status groups, but they will not do it on their own. They do not have either the intellectual resources or the personal organization to go out and get it on their own, as some of these higher status people have done. But given a large supporting program, which makes the whole thing legitimate, they come forward in this program, in this place, in just about the same numbers as the people who are better off.

There has been a noticeable effect on the birth rate in Taichung. We can go into that later. It is not a big effect because the program is still too young, but there is a measurable difference between the birth rate in Taichung one year later and that in the four other cities of Taiwan. The program itself was

c61 sufficiently successful so that it has been extended in a greatly modified form to the Island as a whole, with the assistance of the Population Council, first of all, and secondly, with a large injection of second-generation AID funds. The new program relies entirely on the IUDs. The other program was entirely a government doctor program, done through the Government Health Service. The new one is done entirely through private doctors, of whom about 350 have been trained all over the Island through a subsidy program. It relies to a considerable extent to some of the ideas developed in this program.

For example, this idea of space saturation so that they are in many areas, going into a township and dividing the area up and going into every third neighborhood. I have just gotten some results of an interesting experiment, in which they tried this--going into every other neighborhood--and the results indicate that if you go into every other neighborhood instead of every neighborhood, you get 80 per cent as many acceptances at 50 per cent of the cost. That is half of the cost and 80 per cent of the take.

If you will look at page 7 you will see what I think is an unusual curve of acceptances. They began this new program in 1963 with a very small staff. They are not yet fully staffed. There were 542 acceptances in January. They fell back in February because of the Chinese New year and then you will see that the numbers go steadily up and in March of this year they had 10,500 acceptances, which is remarkable in view of the fact the goal they

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set for the year was 100,000. So they are above the monthly goal at present. If you look at page 8, I will stop with that. You have here, for 1964, some of the characteristics of the acceptors, and as you might expect, for example, with respect to ages--this is in the Islandwide program--you see there that your notile group is the 30 to 34-year group. But 31 per cent of all these acceptances are under 30, and 6 per cent are under 25.

As far as education is concerned, you will notice that they have 40 per cent of their acceptances on women who had no education whatsoever, and by number of living children you have the high acceptance rate in the high parities and negligible number at zero; a little beginning at one; not insignificant at two; and it is going up fairly rapidly after that.

I think I will sit down on this.

What I wanted to do was give you some concrete data about a program that I think is successful in that it has a good start, I think the birth rate is going to fall significantly in Taiwan, and that it is going to speed up now, that this program is going to speed it up. The question of how transferrable this is to other places is a very complex one. I think it is important that we do have, in at least a few places, successful experiments, even if the conditions are not favorable, because I can remember conferences like this 3 or 4 years ago when there was some doubt as to whether any program anyplace was successful until there was much more social and economic development than is evident in Korea now.

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DR. HANSON: I think Dr. Freedman's presentation bears out--and the dittoed documents bears out the fact that this is probably one of the best recorded and measured family-planning programs in the world, and it is going to continue to receive the attention it does partly because of the excellent analysis it is receiving from people like Dr. Freedman.

FROM THE FLOOR: (partially inaudible) --then what effect does the rate of expulsion have on acceptances, if any?

DR. FREEDMAN: Something in the neighborhood of 75 per cent after a year and 60 per cent after two years. The evidence is not all in because they began with--we are now getting the data on the people who got the first insertions at the end of two years, and they began with devices which were considered less-appropriate and I just got a record yesterday of the first cohort of women using the more-appropriate devices, and the retention rate is significantly higher. I am glad you asked that question, because that is an extremely-important one and many of the calculations on the effect of the IUDs, I think, fail to consider the fact that not all of the women are going to be continuing with the IUDs, although even if you take 60 per cent after two years, giving the high-protection rate, that is not a bad situation. 50 per cent of those who have given it up are using something else.

And in Taiwan the situation is such that when you get pregnant after giving it up, about half of those are aborted, so the effect on the birth rate is not great in any case.

c64 FROM THE FLOOR: On page 5, panel 2, and I guess panel 5, abortion only 29.1 per cent. Can you compare that with contraception only? Is there a difference in the parity of the population involved?

DR. FREEDMAN: These are uncontrolled. This is just a cross-section of the population. The tendency is to use abortion earlier and contraception later. The women that use abortion only tend to be of somewhat lower parity in much lower social status. That is, the conversion from abortion to the IUDs is heavily concentrated in the lowest social group and lower parity.

Nobody does anything before. There is not much significant action of any kind before second parity and usually third.

DR. JESSUP: I would like to ask Dr. Freedman to comment on two things. That is, in the cafeteria stage, how much freedom was there? Was there an obvious interest in promoting one method? Secondly, would you comment briefly on the role AID has had or should have had and may have in the future that would be most constructive in your opinion?

DR. FREEDMAN: As to whether this was a fair test of the popularity of the AID, I think it was as good as could be made. I think every effort was made. The literature that was put out, I think was fair. An attempt was made in the group meetings and in the presentations to make this a fair presentation. There was a lot of difficulty in that, for I attended a number of group meetings in which they would tell them about various things and the

c65 people would laugh and say, "We don't want to hear about that condom. Tell us about the IUD." On that score, let me say, this is another interesting piece of evidence on diffusion. In these neighborhoods where there was supposed to be a home visit to everybody, 27 per cent of the people who accepted the IUD had already accepted it by the time the home visitor had got to them. In other words, the diffusion was so rapid that by the time they got to them they had already heard about it from another neighborhood and had already gone there to the clinic. I think one of the best pieces of evidence that it was not loaded for the IUD, is that the IUD acceptance rate relative to the total rate, is lowest in those neighborhoods in which you had these home visits. The home visits sold the traditional methods.

One of these tables here will show you, and that is a very interesting item, about the IUD with reference to other things. If you will look at page 3, the bottom panel, this showed you what per cent of the acceptances were IUD acceptances, and in the place where you had that intensive home visit and where the bias would enter, you see--if your health workers were going to put a bias in--you had 60 per cent taking the IUD, 88 per cent where we had a mailing, and where there was nothing at all, it was 90 per cent IUD. In other words, it took the health program to sell the traditional methods.

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 FROM THE FLOOR: Did the people/made the home visit, pass out the contraceptives at the time of the visit?

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DR. FREEDMAN: They would give them to them if they wanted them.

FROM THE FLOOR: This would tend to increase the proportion?

DR. FREELMAN: That is correct. But if they were strongly biased, it would not necessarily do that. But they passed them out if they wanted them. A lot of them came to the clinic after being told about them.

As far as the role of AID is concerned, first of all I think that AID had an important indirect role with respect to the relationship to the Joint Commission on Rural Reconstruction, which, in cooperation with the Population Council fostered a lot of the initial activity. However, this Taichung program initially was financed by the Population Council, and I would say that this began in the early period. It began with rather faint interest on the part of AID, but, there has been an increasing interest, and this new Islandwide program is being financed through the second generation funds.

You can probably report better than I can on the fact, but my impression is that AID is going to remember the research efforts in Taiwan immediately with a grant and is considering a long-term grant for the research effort there.

DR. BAUMGARTNER: I think it is fair to say that foreign aid funds went into the program and put in the basic structure of health centers and the training of a lot of health workers. It

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has been done with full knowledge, and cooperation, but nobody said anything about it for a period of five, six, seven, eight, or nine years. Again, winding up the financing of it, there is a definite demand on the extent to which family-planning would be financed, and I have been told by the people in the JCRR and the Administrative Health of Taiwan, that without this functioning there would be no continuing program. AID has underwritten this. I am not particularly defending AID, but I think it is raising some kind of a question as to what they did. In the days when they were not supposed to do anything, they were doing quite a lot, and I think they were doing quite a lot and should be given credit for it, even though it was called a pre-pregnancy program at the time.

DR. FREEDMAN: All this has been done through the basic health program work which was supported by AID. This pre-pregnancy health program was a small but important program which was the basis for this later development, and as these things go, some of the money that was used for contraceptives was obtained from a revolving fund. The Chinese are very good at revolving funds, and this worked out with money that was initially AID money.

MR. MONSANO (Colombia): After the IUD, what is the most popular form of contraceptives in your program?

DR. FREEDMAN: I identify myself with the Chinese. There are only 2 or 3 types involved at various times. The program is a Chinese program. I think that the condom is the second most

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popular method. Even before this program, by the way, the most popular method in Taiwan in the pre-program days, was the ring. That was one thing that was the basis for the IUD. It was largely responsible for the quick success of the IUD.

FROM THE FLOOR: In the Islandwide program, didn't the shift from clinic to private doctor effect the program? If you were looking back with hindsight and starting over, even in your tribal area, would you not go through the health clinic route now?

DR. FREEDMAN: Both of these were political decisions which in my opinion, were not rational decisions. The original planning for Taichung was to have both these government-trained and private doctors. In fact, they were trained. And a political decision was made to drop them out. Then when it was decided to extend it on an Island-wide basis, for political reasons, again it was decided to do it with private doctors only.

If I were being asked how to do it, I would suggest doing it both ways.

FROM THE FLOOR: But in terms of relative importance to the two approaches, do you have any comment?

DR. FREEDMAN: For the Islandwide program, I think they are better off with the private doctors in Taiwan, because in many of the areas in which they are going to, the doctors in the Government health station are very poorly paid and therefore of low quality. So I mean it is a hard thing to judge. I think for Taichung that was the right way to begin. One of the important

c69 aspects of this Taichung program is a demonstration program. To demonstrate it would be success, and there would be no political problems. There were not any, and I think that would have been much more difficult and much more difficult to provide the data which were then used as a basis for selling the program with the private doctors.

DR. HANSON: If there are no more questions, I think we had better move on. I would like to note, one comment that Dr. Freedman just made, did not come up in the India-Pakistan discussion, when he said there had been no political repercussions to the program, I believe this can be said also of India and Pakistan, although political repercussions were expected in Pakistan. There has been nothing of major proportion that has come up.

The next item on our program was listed as Korea and Thailand. We do not have with us today AID Mission representatives from either Korea or Thailand. We are going to call upon Marshall Balfour and Robert Hamer of Turkey, who has just stopped by Korea and attended a conference there, and will add something to the discussion on Korea. Dr. Balfour is the elder statesman of both Health and Public Medicine and Public Health programs in Asia and is with the Population Council, and he will make the first presentation on the program in Korea.

DR. BALFOUR: My assignment is to discuss policies and programs dealing with population growth and control in Korea and Thailand. Although I wrote a few rough notes about my remarks,

and they are available, I think I had better discard the script and talk more from a few notes.

Some of you have visited Korea and more of you have heard about the program and the accomplishments there, so I am going to be rather brief in describing the developments in Korea, but I will also make some additional report about Thailand. But after the preliminary details concerning these two countries I want to lead up soon to a question which I shall try to answer. This question is, "What are the elements for success in developing a family-planning program, especially a national family-planning program, in the less-developed countries?".

This question, I trust, concerns all of the representatives from AID and would be, I hope, of some interest. In this respect I of course will be stating my opinions and judgements with reference to the question and the answer.

But first, some brief remarks about developments in Korea. Beginning at 1961, only a matter of 3 or 4 years ago, the Government which came into power at that time, a military revolutionary government, adopted a definite and positive policy in favor of population control. This resulted, I believe, from the perception and the understanding and conviction of the members of the Supreme National Council, which was the governing body in that period. And also from the knowledge and understanding of the Economic Planning Board, which had much to do with development of plans for economic development. They saw that a popula-

071 tion growth rate of 3 per cent, or a little higher, which exists in Korea, was too much to be supported by this national economy so that under these favorable conditions, the Government took steps to appropriate new funds. Even before any surveys or assistance came from abroad, they engaged and trained personnel for the specific job of family-planning. Supplies were obtained. Some locally and some from abroad. Funds which amount to the equivalent of \$325,000 or approximately 1 cent per capita, were available at the beginning in 1962.

A group of full-time family-planning workers who were basically nurses and midwives were trained intensively and were placed in the 189 health centers which covered the country. More recently, that is the last year, it was decided to augment the staff and a group of auxiliaries numbering some 1400 were also selected, mostly women from the villages who had at least a high school education. They were given intensive training and there is now at least one of these auxiliaries or full-time workers active in the program at the township level. That is, there is one worker for each ten-or 12,000 inhabitants. These are supervised by the nurse-midwives who are part of the staff of the Health Center.

I am not going into detail, but the program in Korea has been assisted, I believe, by some serious research studies which are comparable to the studies which Dr. Freedman has described for Taiwan. It has been a rural study being carried on in the

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last three or four years, and an urban study has been going on for a year or a year and one-half. I might add that the University of Michigan, through Ron Freedman and his colleagues, has been most helpful in serving as a consultant for the two studies. A word or two as to methods used in Korea. The traditional methods, mainly condoms and foam tablets, were used at the beginning. Foam tablets have gone down in popularity or acceptance and the condoms have increased. A government program to encourage and subsidize vasectomies or male sterilization, was a part of the program, and I think the figure has now reached 50,000 vasectomies that have been carried out in the country.

Beginning a year and a half ago, the IUDs were introduced after experimenting in field research and satisfying themselves and learning that IUDs were acceptable and effective under Korea conditions. They are a major part of the family-planning methodology at present. In fact, last year the total of IUDs inserted in Korea was a little over 100,000.

As of April of this year, there have been more than 170,000 IUDs inserted. At present IUDs and condoms are manufactured in Korea in adequate numbers to meet the need. I would be less than frank if I did not add here that induced abortions are playing some role in population control in Korea. Although illegal, there certainly are a large number of abortions being done, more in the cities and towns, but perhaps to some extent in the smaller communities. One survey has been done recently which shows that 25 per cent of all married women in the sample of Seoul's population,

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have had 1 or more abortions. I think this figure is perhaps quite on the low side, but although illegal, there is no prosecution with respect to abortions and there is no doubt that it is playing some part in fertility control. The targets for the next five years include expected insertions of one million IUDs. This is beginning in 1965, and I think the target for this existing current year is about 200,000. They have scheduled or hoped to accomplish some 200,000 vasectomies and are counting on having some 300,000 women using, being regular users of other methods.

In view of what has happened, it does not take undue optimism to say that it seems to be a reasonably good chance that these targets may be achieved within five years. That is, the Government's plan and hope that the birth rate may be reduced from 3 to 2 per cent by 1971 is not unrealistic.

Just a word or two about Thailand. The situation is quite different there. Although the two countries, Korea and Thailand, have about the same population, 30 million and approximately the same rate of population growth, 3 per cent or a little more, there is a marked difference in the two countries. Thailand, as you probably are well aware, is more arable land, more fertile land, and their rice production is not only enough to feed their own population, but they export quite a few million tons of rice to other countries. It forms an important part of their national economy.

Thus, it has been true, and is still true, that popula-

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tion pressure has not been felt in Thailand by officials or by the people in general. However, some far-seeing people, especially those in the National Research Council of Thailand, decided to hold a conference on population in March of 1963. This was arranged, and with two invited representatives of the Population Council, it came off quite successfully, we feel.

Representatives from most of the Ministries of government and from all of the universities were present, and the foreign or outside influences were minimal. This conference therefore was about Thailand by the Thai and for the Thai people. At the conference where I was present, there seemed to be two camps, those for, in favor of action in population control as well as research, and there was a camp in serious opposition. However, it seemed to me that the majority were in favor of it, but because the minority and several important ministers of Government were opposed the Government's position was one of neutrality. First, they decided that Thailand should have more population research and more trained personnel, both for demographic studies and for family planning activities when undertaken, and finally they approved the conference recommended. Since then the National Research Council and the cabinet approved of a pilot project. Last year two advisors were invited and the rural field study has been carried out. This is in a rural area west of Bangkok. The results are impressive. A 1 to 4 sample from this rural district, which has something like 17,000 inhabitants, showed

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that although very few of these rural families had ever attempted family limitation, there was a strong sentiment in favor of it, once they knew that family-limitation was possible. Some 70 per cent indicated interest, willingness to accept, and a good number have since accepted.

In fact, there has been more than a thousand IUDs inserted in this rural population in the last few months. Lastly, in reference to Thailand, there has been publicity regarding the availability of IUDs which has led to their being tested and offered in three Bangkok hospitals. In one hospital they are inserting about 300 per week or 1200 per month, and long lines of women are waiting for this new method. So much for a very brief sketch about developments in Korea and Thailand.

I have only said enough, I hope, to convince you of my feeling in the matter, and that within the last 3 to 4 years, it is my opinion that Korea has made more progress and is on the way toward successful implementation of its program than any country among the developing nations. That certainly is true in Asia, and it may be true on a world-wide basis. I should make an exception with Taiwan, because there now is a race between Korea and Taiwan to see which shows the most marked decrease in fertility.

Now, coming to the point of what are the essentials for success in family-planning work in the developing countries, why is there the difference in the rate of progress in certain

c76 countries in comparison with others where progress has been slower?

I have thought about this and tried to explain, at least to my own satisfaction, the whys. I grant you what I have to say and the points I will mention of course, are personal opinions and personal judgments.

The first point I would make is, to develop and carry out a successful program. I think there needs to be a definition of the problem. In this case the population problem. In any administrative undertaking, to define the problem is usually the first step. This refers in the case of the population problem to knowing what population growth is in relation to economic development. Information and records come from several sources. This considerable interest in the family-planning field seems to me can be attributable to two factors over recent years. First, the planning commission. The plans that have been developed in many of the Asian countries have brought about a collection of records and analyses by the statisticians and economists that point out the fact that something must be done about population growth.

Secondly, the census results, most of which became available in 1960 and 1961, demonstrated to the Government officials and leaders in these countries that the numbers of people had far exceeded their expectations. The census data has led to greater understanding and definition of the problem. So that the country, the officials in the individual countries, recognize a problem, and we are willing and anxious to do something about it.

Parenthetically I might add, it is my opinion, and I

c77 dare say I share it with all of you, that the national government in the individual countries should establish, decide about their own policies, if they want population control or they don't and AID or any foreign agency must be cautious in attempting to initiate a program until the Government has made their own major policy decisions. So much for my first point.

The second one I wish to stress is the importance of leadership, in the national family-planning program, or any effort to promote family-planning. If I and some of my colleagues travel around and attempt to appraise or evaluate what is going on in the under-developed areas, especially in Asia, we have been impressed by the fact that success, be it Taiwan or Korea, appears to be definitely related to having one or more key persons to assist and direct and guide the activities and the general interest.

To cite individuals as examples, in Korea, they have been fortunate in having a man, Dr. J. Moyan (?), who some of you know, who is a professor in the Medical College, and, at the same time, chairman of the Family-Planning Association; he has played a great role in the developments in Korea.

The Ministry of Health which has the responsibility for the National Family-Planning Program, has a young doctor, T. I. Kim, who is another key person in Taiwan. Dr. Freedman and many others recognize that the one person, Dr. S. C. Shue, who is the Health Chief for the Joint Commission for Rural Reconstruction, has been a vital factor in developing interest and moving toward

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a national program for the islands. There are others in Taiwan, and while I should not make insidious comparisons, I thought of Pakistan and India, as we heard the discussion this morning. It is by no means the only reason, but I think part of the explanation of the slow development in those two countries can be attributed to this lack of adequate leadership. In the case of Pakistan the government did not take the advice they got in finding a key top-level person to carry out the program, and they staggered along with limited confidence, but in this last year, we have a new man, as was described this morning, Mr. B. Deal, the new Commissioner of Family Planning, whom we hope will produce the goods.

I dare not comment on the direction of family-planning in India, but will only say that the Director has been greatly impeded by the bureaucracy that was remarked about this morning. There is an overwhelming degree of bureaucracy, I have found from past experience in India and it is awfully hard to get around it.

My third point is the need and the desirability of a firm government policy to support the family-planning and population control movement. If there is such a policy, as there is in Korea, it is extremely helpful. On the other hand, India and Pakistan have a firm policy but it merely proves that no one factor is the determinant one. On the other hand, we have heard and know from experience in Taiwan that even in the absence of a positive policy, that the national policy in Taiwan is perhaps

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best described as one of toleration and that you can succeed in the absence of a policy. There is still no policy in Thailand. Whether there is going to be a positive favorable policy still remains to be seen.

My fourth point among the essentials for success refers to what I call operational staff. There must be or should be doctors, nurses, midwives or other auxiliaries, to carry out such a program. One reason Formosa or Taiwan and Korea has succeeded is they have an adequate number, quantitatively speaking. Some 12,000 doctors in Korea, 7 or 8 thousand nurses, and an equal number of midwives has made possible the rapid development of a service.

India and Pakistan are less fortunate, but there have been some implications in their previous reports that a great deal can be done with existing personnel if properly used.

Fifth and last of my points, it should not be necessary to remark that funds or money are necessary to carry out family-planning work on a national scale. However, a good deal can be accomplished in my judgment with limited funds. The expense for family-planning is by no means comparable to that of malaria eradication, for example. Korea, as I mentioned, started out with a per capita expenditure of about 12 cents per person annually. That figure has now gone up five cents. Korea has been increasing its appropriation for family-planning, and the money available is about five cents per capita. There is a good prospect that

next year this figure will increase still further.

My point about money, funds, is that in my opinion it is not restrictive or the lack of money is not a restrictive factor in developing programs. These programs are not enormously expensive. In fact, I have said on some occasions that a family can practice birth control at a cost of something between 50 cents and \$1 per year. What Mr. Levin had to say yesterday, I think, bears this out.

Of course, in the case of IUDs, the initial cost of the material is almost negligible, but it does take funds and staff to put a program across.

It has been mentioned, I don't know whether it has been reported, that in Taiwan, a cost of a large-scale program amounts to something like 2-1/2 per insertion. This includes the subsidies to the private doctors, the educational work, and staff. But the major impression I wish to leave with you is that family-planning seems to me to be economically feasible in the underdeveloped countries.

Well, having made these five points for the essentials of success which cover, a definition of the problem, importance of leadership, government policy, operational staff, and the need for funds, I will come finally following Bruce Jessups suggestion, to give from personal opinion, as to what can AID do about these matters. I hope in the course of the next few days, in the group discussions, that these matters will be elaborated further.

c81 As I see it, it seems to me that the AID program can support family-planning movements in different countries. First, in the matter of training personnel. This refers to training of leaders by travel and study outside of the country. That is abroad. There is a need for funds to provide for the training of the nurse-midwives and the auxiliary personnel, I might add, in the country itself.

I might say that regarding Korea, I have felt that AID, and to some extent, WHO and the Rockefeller Foundation, have made a contribution by their past scholarship contributions. They have helped train leaders in the medical field and we now have a nucleus of such individuals to provide the leadership. Of course, everything AID has done starting health education has been all to the good and has contributed to the present situation.

I referred to training. Then, educational materials for health, education personnel. Both training of the local persons or importing advisors is something that they no doubt already consider. The last point is that of the matter of transportation. Family-planning work needs mobility. The supervisors, the field workers, have to move around. I am thinking in terms of such vehicles as jeeps or Volkswagens. Both of them are used in Korea. I am not thinking in terms of mobile vans. Although there may be exceptions, I am skeptical as to what can be accomplished with mobile vans, which operate as clinics or

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as educational facilities, the carriers and educational material on tours around the country, so that I am a little skeptical. Now, there can be programs providing vehicles to move people around. You have to get people moved around, but to try to have mobile clinics does not appeal to me.

Well, as some of you are aware, AID has recently taken a decision in Korea to donate 12 reconditioned ambulances to the Ministry of Health for family-planning work, and that is one instance I know of where they have already taken a step in this direction.

Finally, I hope I have not exceeded my time or left too little for Mr. Hamer, but I would conclude by reading my final paragraph, which is:

"The basic problem in the developing countries is one of organization and administration. Census data, special surveys, the improvement of vital statistics, pilot projects and training of personnel, all play a part in evolving policies and programs."

I have a strong feeling that in the final analysis, the problem is a challenge primarily for organizers and administrators. Top-level personnel are necessary for planning and carrying out programs.

"In certain countries the impedimenta of bureaucracy are a hindrance. Planning and the writing of plans may be good, but implementation of a program is another matter."

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DR. HANSON: We will now have some remarks from Mr. Hamer. He has just been at a conference in Korea.

MR. HAMER: The program in Turkey is just getting underway and we were searching for a country that had a program where there was reasonable similarity in the basic operation of the government, in the basic plan. It was quite interesting to realize that Korea meets this definition very closely. We started our program in 1960 under a revolutionary military government. They are the ones that decided that Turkey would have a family-planning program. This is true in Korea. In both countries they are government-sponsored programs. Population is almost exactly the same size. Almost comparable numbers of medical personnel, doctors, nurses and midwives. A very similar local administrative setup. A population increase that is the same. The same goal, namely to reduce from three to two per cent in both countries, and on the U. S. AID side, a program about the same size or same size staff where supporting assistance is going outside and development, loan funding, is coming inside. So I went to Korea in advance of the IPPF conference, to spend some time finding out what the U. S. AID had done there since 1961 in support of this program.

I was quite pleased to hear Balfour make the statement that in his opinion, Korea had made more progress than any of the developing nations. I took with me a very senior economist and a senior demographer, both the same man, from the University of

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Istanbul, and a man very influential in that in addition to his professional duties he is the Director of the Institute of Journalism at the university and considered one of the key men in molding public opinion. He had the same impression I had when we were finished there. A good deal of similarity between the two countries and a highly-successful program.

I spent quite some time with U. S. AID asking them what they had done, what was their part in this deal, because I could see where we might pattern our activities after what they had done in Korea. This is why they decided I could comment on this. I came away with the feeling that the main contribution that U. S. AID is providing there is moral support of the program. They only have a senior health official within the Public Service, Public Safety Division, and a senior local aid, Mr. Min, yet I found them deeply involved with Dr. Kim the chief of the Maternal and Child Health Section, in his activities and with the Population Council people, giving the full strength of all the support they could dig up to this program. They have done a splendid job, from everything I could gather, in the previous training of MCH personnel.

There was over the past several years, a major budgetary support program to the total health program of the Ministry. Not in the sense directly to family-planning, but part of total budgetary support, and as Balfour mentioned, they have made arrangements to supply certain vehicles to the program. Looking

at it from an U. S. AID viewpoint, I came away with a lot of don'ts, and I think anyone starting a program could profit by a trip to Korea to come up with the same don'ts I came up with.

In Turkey, somebody said we should mount a tremendous program with 1100 vehicles, 220 which would be audio-visual clinics, training clinics. I found, in my wanderings over Korea, that this probably

won't work, so I think I came away with a key "don't do it". I also came away with a key "don't" in Turkey. As I am sure you are all aware, most things in Turkey are done by the government. Given a choice the Government will do it. I was very impressed with the fact that in Korea, where you have, to a certain extent, a similar philosophy, the program of insertions of IUDs was done by private doctors. As you went to any one of the Centers, you found a list of private doctors who were qualified to do the IUD insertions. I worried in Turkey that this could be a stumbling block. There are some 12,000 doctors. They are a very volatile group. They thought they were being kept out of this. We would have some opposition if they felt that.

The doctor who was with me starting to write a series of articles to impress the Government on how important it is to work through the private doctor. I would urge all of you starting a program to consider definitely, not only going yourselves to Korea, but sending some of your own nationals there. "Berry" was the chief guide, protector, and other things for a group from India there. They were there for almost a week. I was extremely im-

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pressed by the program that was mounted three ways, by the Population Council, by the U. S. AID, and by the Korean Government in interlocking a program. All of them had parts in it. U. S. AID provided logistics support for Derry's participants, and despite many of the problems he had with him, I had a feeling that all of them came away with a better understanding of how that program worked.

DR. HANSON: Officially our time that was scheduled on the program is up, but let us take a few minutes for any questions directed at either of these people.

DR. ADELMAN: I find myself in agreement with the organization recommendations made by Dr. Balfour. However, I also find one very basic point that she has omitted, namely, I believe, the importance of the existence of socio-cultural pre-conditioning for the acceptance of a given program. I think it is not an accidental matter that for instance Korea and Taiwan have been able to produce able and vital leadership in the population program, whereas India and Pakistan have not. It is, in fact, a syndrome of the socio-political-economic atmosphere of the two countries or of the two groups of countries, I should say, which is responsible for success in one case and failure in the other.

DR. BAUMGARTNER: May we ask that some of that be repeated.

DR. BALFOUR: I am glad Miss Adelman reminded me of what I omitted. It was in my notes, but I did not cover it. She

c87 is pointing out that in addition to the point I have made there were other factors in the social-economic conditions which have made the position in Korea more favorable and no doubt the same applies to Taiwan.

I did not refer to the standards of education or the levels of literacy. In Korea there is a literacy rate of about 70 per cent. 80 per cent for males, 60 per cent for female. So that you have a relatively literate population and it must be granted that family planning goes more easily and rapidly under those conditions.

And in comparison you note the situation in India where not more than 25 per cent are recorded as being literate. The other point which I thought of mentioning was to point out that in the case of Korea there is much more organization. In fact, 30 per cent of the population of Korea live in communities of 50,000 or larger. If you go down to the level of 20,000 population units, 40 per cent live in such. This is a degree of urbanization which makes a big difference in my judgment and we might as well admit it's been very helpful and facilitated greatly the program in Korea and I dare say the same is true of Taiwan.

On the other hand, my thinking--and I am no economist--but I think you have to distinguish between urbanization and industrialization. I am speaking, in the urbanization factor, of people getting into larger communities. India, for example, is probably more industrialized than Korea. Korea is struggling

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along with a poor economy and not enough industrialization in spite of foreign aid. But industrialization without comparable urbanization gives you a condition which exists in India. I am glad that Miss Adelman pointed out my omission in that the socio-economic conditions certainly bear an important relationship to what can be accomplished and in what period of time.

FROM THE FLOOR: As a part of that, how is the distribution of doctors scattered geographically?

DR. BALFOUR: One-fourth of the 12,000 doctors are in the capital city of Seoul. Two or three thousand are in the armed forces. So that the distribution is not unlike many other countries where there is not as good or poor, relatively poor distribution, in the rural areas. However, the coverage for health services is much better distributed.

FROM THE FLOOR: What about transport in terms of the people? You talk about transport of the doctors, but can people get around in the rural areas?

DR. BALFOUR: There's a moderate amount of bicycling in principal cities throughout the country. Dr. Robinson who has lived there for many years might answer this point about transportation. It is my impression there is more transportation available throughout the country in better road conditions than, for example, mainland China, and not far behind, Japan or the Philippines, but when you get away out in the villages you either-- the field workers go by bicycle or use buses. There is a fair

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bus service and walking also is pretty good.

**FROM THE FLOOR:** Concerning the military structure of Taiwan, what part has the military played in the program, the Turkish program? I am seeking a personal thing here.

**DR. FREEDMAN:** Until recently very little except that the military has not been opposed to it. They were not opposed to the original program. They did not support it. There is now an active program, a special program for what are called military dependent villages. There are a large number of areas in which dependent people in the Army are concentrated and they have a new program for that, which has the support of the military, but initially it was benevolent neutrality as far as the main program is concerned. Now they are very active.

**FROM THE FLOOR:** How important do you think the fee for service aspect of the Taiwan program is, and the lack of this in India?

**DR. FREEDMAN:** As far as Taiwan is concerned, I think it has been quite important. I don't know what the difference would be, in India. My commonsense judgment on it is that there should be a fee for service, of a reasonable kind, if it can be administered. As far as Taiwan is concerned, I don't think the islandwide program could work at all if they did not have the fee. I can't speak for India, but as I said, on a common sense basis, I would be skeptical about a program that did not have such a fee.

**FROM THE FLOOR:** Mr. Hamer mentioned, and you actually

c90 recommended Korea as a place for training, for bringing third country trainees in. Quite obvious in relation to the action program. Is it equally a useful place for exposing people to economic analysis and related labor population effects and so forth?

MR. HAMER: There is a body of work being done, although not as much as you might want on it. I think U. S. Aid has played a major part in that.

FROM THE FLOOR: In other words, it would be a good place to send people who are not necessarily at the action state of any more preliminary state?

MR. HAMER: Yes.

DR. ROBINSON: (Korea) I would like to add one further reason why I think Korea is a good place to send people for training, and this is why. When you talk to the average Korean about colonialism and imperialism the Koreans think of the yellow man, the Chinese and Japanese, as his ruler. He thinks of the white man as his friend, and I think that is a significant factor in Korean growth and development. It probably is true of Korea also. The white man is their friend. They do not associate the visitor that comes with past bitter experiences, and I think by sending people from other countries to Korea you would perhaps find them much more favorable in presenting the Western way than almost any other country.

I think the reason that the Army has been successful

c91 in their government in Korea, is because there was some traditional Korean military that they, for 10 years, from 1950 to 1960, were under American influence, doing things the American way, and they were able to step back into their government and introduce these things much more effectively.

MR. SINGER: (Ed Singer, US AID, Washington) It was stated that one of the factors for the success of the Taiwan and Korean programs compared to other parts of the world was the educational attainment, the literacy rate. Yet on our report from Taiwan you point out that of the 40 per cent of the acceptors in 1964 only 40 were without any education at all. 40 per cent had no education.

DR. FRIEDMAN: I think it would still be important, however, that there is a high rate of literacy and that the earlier efforts in this direction privately were concentrated in the educated sectors, so you have, in the whole islands, already beginning in this direction, which would provide a framework of support for the illiterate population as well. So I think there is something more than that one figure would indicate.

DR. HANSON: Let us make this the last question.

MR. EDMUNDS: (Viet-Nam) I am wondering--in any of the presentations, because this problem cuts across many other ministries within the country, I wonder if there has been any other thought given to setting up a board consisting of representatives from Economic Development, education, and labor and other significant

c92 governmental structures, because it seems to me this problem must cut across all of these various disciplines?

DR. BALFOUR: In the survey and recommendations that were made for Korea in 1962, and I am glad to see one of the surveyors is here, we did make that recommendation, for a high-level population policy committee or advisory board, which would cover other ministries and other parts of governments than the Ministry of Health. However, that recommendation was not fulfilled. The Ministry of Health had its own Advisory Committee under its control and they prefer to do things their way. However, that purpose was accomplished to some degree by a directive from the Prime Minister's office in Korea. The Prime Minister's office was firmly convinced of the need of cooperation from all departments of government. The directive went out to all the ministries. This is the problem. This is what is being done. The Ministry of Health has the major responsibility, but every ministry must cooperate and develop its own program, be it agriculture, or education, or some other part of government, and there has been reasonably good cooperation from other branches of government in addition to those of health.

DR. JANSON: We will now take our luncheon break and return at 1:10 p. m.

(Whereupon, at 12:30 o'clock p. m., the conference adjourned, to reconvene at 1:10 o'clock p. m., the same day.)

GOLDSTEIN

## AFTERNOON SESSION

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DR. STEBBINS: Our plan for the midday session is to have a discussion of activities of international agencies. As you all know, the United Nations have been concerned with population for a long time, and have been active in demographic studies, and more recently in a direct interest in specific problems in countries. I don't need to introduce Dr. Baumgartner, but Dr. Baumgartner was a commissioner to India, and we have asked her to tell us something of the activities of that Commission.

DR. BAUMGARTNER: I thought it would be interesting to point out that the UN mission to India, although it was the first mission that the United Nations had ever sent out, did not just happen. In December of 1963, the Asian countries, under the original UN agency, called what they called the Asian Population Conference. This met for two weeks in Delhi. There were government representatives of all of the Asian countries, of many of the foundations and some observers were invited guest countries.

The United States, USSR, Uruguay, et cetera. At that conference it was interesting that in the first place there was a tremendous breadth and depth of discussion. Without a doubt, it had the broadest agenda of any population conference, I have attended. They went into the perimeters of population growth, what it did to employment and unemployment, rural and urban migration, education, industrialization, status of women. You name it, and they had it on the agenda.

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In the second place, the Asian countries were able to present their own demographic data, so you had a lot of information to go on. They talked somewhat of their own programs also. There was an overtone throughout the conference, however despite the very great amount of factual information that came out, for each country had presented its own program, its own problems and what it was going to do about it.

There was, nevertheless, an insistent voice that said we want action in this field. That persistent voice finally led to the passing of some recommendations, for this was all that this conference could do, but it had a mandate to make recommendations. It was not just a discussion conference. It was called for the purpose of making recommendations, and they recommended that their governing body--that they wished their governing body to have a series of regional conferences on family planning, on all aspects of population problems. Then they invited, which was all they could do, that is, they could not request and they could not do anything but invite the United Nations to help them with technical assistance with all aspects of population problems, including family planning. That recommendation went on up to the Council of \_\_\_\_\_ (?) which met in Taiwan in March of 1964. They developed the recommendations, strengthened the wording slightly and sent it over to New York where it landed in the United Nations.

When a recommendation gets there they have to do something about it. I don't know the whole story of what happened,

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but it found its way to the United Nations and the Director General and the Deputy Director General, who happens to be from India, discussed it, and then there was a request from the government of India for a mission to come and help them in family-planning, the technical aspect of family-planning.

It was decided that the UN constitution gave the Director General the right to send out such a mission and so such a mission was put together. It was put together in record speed for any UN agency. It was composed of five people, Sir. Bevrill (?) was chairman from Great Britain, who turned out to be a tremendous asset. His administrative colonial experience in Africa and Asia as an ex-British colonial stayed him in good stead on the administrative aspect of the recommendations that were being made for the Indian government.

We have Dr. Yang of Korea who gave us of his personal experience in Korea. We had Dr. Momo from Chile. I was here from the United States and we had Howard Gilly who is on the UN Social Council based in Geneva. The task that was given us was to decide how to have India accelerate their family-planning program. Several things happened to make it fortunate for this mission to be in India. I think the chief one was India had two famines. I am serious about these famines. I think the shortage of food made top government officials more interested in family-planning than they had been before. That also led to inflation, and the inflationary aspect of the economy in India was leading

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to the great unrest among the people, so they were much more concerned about the numbers of people that they had and were going to have. I think also the rather good prosperity planning and the good economic front made them realize much more the population dynamics, so to speak, of their economic planning as they looked ahead for more than five years.

At the same time, there had been public criticism of the family-planning program. I think it was also fortunate that the World Bank had of its own volition decided it could send a mission to India to look at family-planning before we got there. They were just about completing their program, their report, by the time we got there and we overlapped.

As a matter of fact, Mr. Sam Keeney, who was on that mission, stayed and worked with the UN mission most of the time that we were in India, and had dovetailed on off-the-record reports since then. We were also fortunate that the planning evaluation organization, which is a part of the Planning Commission, had, in December, of the year before we got there, had about--I have forgotten how many--a stack of reports of evaluations of all aspects of the India Family-Planning Program. They had looked at every State program with a group from India who were not members of that State program, that had gone around and looked at this State and this State and this State. They had looked at research, at demographic training, at everything they could think of about the problem, and we had those evaluation reports to look at.

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The invitation, though it came from the Ministry of Health, was apparently initiated and supported more accurately by the Planning Commission than it was the Ministry of Health. We therefore saw a great many people and had day-by-day access to the head of the Planning Commission. It was delightful to have a Minister of Agriculture who asked to see us immediately and say this is the most important problem in India. "It is as important as increasing food production."

When you have a Finance Minister that says "I sometimes think I will resign from the Ministry of Finance and become head of family-planning and get this thing going", you know you have real support.

We saw therefore top people, not only in the Ministry of Health but in the various parts of Government, including--somebody talked about radio. I think there is a totally different situation in the radio field since Derigrandi/<sup>(?)</sup> is head of this mission. This has made a difference. We had access to other ministries. We also saw a good many business people. We saw university people and we went into the field, either as a total team or part of the team, and we saw and visited programs in 10 of the 16 States in India. We saw places where things were happening and saw a lot of places where things were not happening. As we began to make recommendations we came back and discussed them with the Planning Commission itself, so that by the time we got through, the main recommendations had already been accepted by the Planning Commission,

c6 and we sent the report. It has not yet reached India although they have had a good chance to put many of these into action, I would hope, before the report gets there.

So they can say, as the Minister of Health has written me, "A lot of these things that are going to be in the record, we have done them anyway."

This will show, I take it, that this has been a rather proper way for a group of advisors to act. The report is eventually going to get there, about the 15th of June, I hope. We were supposed to comment on immediate steps and long-term steps. The urgency of this was such that the head of the Planning Commission turned one day to me and asked me if I would write something that should be done and make a practice program for him for another year. This led to my doing this and checked it out with the other members of the mission, in presenting what we called a reinforced program.

"Derry" told you about their extended program, and this we called a reinforcing program for more or less immediate action, and they have already had copies of this since about the end of March. The long report I say will reach them before the first of July. Now, the recommendations are--there are a lot of them--but I don't think there was any question whatsoever in the mind of anyone on the mission that had to do with the administration of administrative planning work<sup>at</sup> the central and state level. I think we all went far enough to say that if the government of India was not ready to organize and do something administratively, then

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they may as well not worry about the rest of the program.

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This is partially the Indian disease. There is not a program you can talk about in India that people who have looked at it do not tell you that it is the bureaucratic structure that is the single obstacle. In addition to this you have this great truism within the Ministry for the program itself. You have some major administrative problems. We also came out with an idea that the program needed much more flexibility in the states than it had. There is another disease in India which demands that you look at all of those 550,000 villages simultaneously. This is the pressure of size in India, and that in some way or other everybody has to talk about all of India at once.

Therefore, family-planning extended the program which is a very good program in many ways, and it has grown from the critic approach in terms of going out to the people. They have taken the principal step already to go out to the people. That program nevertheless inevitably just bogged down because of this kind of feeling that you have to do everything for everybody at the same time. So we certainly put great emphasis on not focusing on that.

In terms of flexibility, I pointed out the differences among the states which are really quite marked. We were able to put the flat emphasis on the loop. The India Medical Research Council accepted it, but it had not been accepted formally by the government before, and I think we were able to convince them to move a little faster on it. We did point out that because they liked sterilization and because it does work in some parts of the

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country they better keep on doing that and we urged them greatly to get condoms going and move them in commercial channels more effectively than they had before. We took into account the training, the lack of training, the manpower shortages, and the gaps are just frightening when you look at them. Their training programs were much too elaborate. We recommended that they simplify them, take care of the manpower shortages, and if possible plan to concentrate on training for the IUDs, because they still had a training program and paid no attention to the IUDs, obviously because they had not considered it when they made up their training programs.

We also took cognizance of the fact because most of the doctors are located in towns, that it will be necessary to train doctors out of towns and therefore they will have a real need for vehicles. I say this is my greatest problem in India, because before I went I think I had almost said, "Over my dead body are we going to have any more of those unused vehicles floating around in India."

Since I have looked again in Pakistan, India, and Africa, I realize this was a stupid view to have taken. Since vehicles are easier to get than human beings, we better put wheels on nurses and midwives and doctors, the ones that can do anything about family-planning at all.

I think India one day will be using midwives to insert IUDs. I think they need more experience in it, but I have already

c9 talked to midwives that had done it and had no problems whatsoever.

I think the other thing we emphasize is to begin where you are more likely to have success. In other words, begin with those mistakes that are ready to go. Put emphasis there and try to get an area in each state in which something or other is happening, so this can be a focus of infection for the rest of the state, but begin in the urban maternity clinics, because here you have the most susceptible women you can find, women coming in after their delivery, and insertion 4 to 6 weeks after delivery is certainly the best time to insert a loop.

Start there. I think we convinced them of this, because they have already had meetings of the heads of their maternity clinics. We also said, "Start in the Health Center distribution, but do start out with the pregnant women." This has a kind of significance which I think I would like to talk about now, because I may forget it.

I think this begins to make the task possible. The other methods that we have had--you have had usually the women after they have had their fourth child, get interested. If you can take the woman who has had her first child and put a loop in her and say, "When you want to have another baby, take the loop out", then you make it easier for people in society who want another child to at least space children for a little bit. Maybe we over-emphasize this, but this is what we thought.

The other thing we did was a great deal of talk and recommending to involve more of the community, the total Indian

c10 community in family planning that had envisaged before.

"Darry" and me did our best to see if we could get Mr. Shastri to make a statement about having six children of his own. We certainly emphasized the need for all Ministers at cabinet level to discuss this regardless of their ministry, the necessity for a cabinet-level committee that would keep their eye on family-planning right along, as well as a committee within the Planning Commission.

The Chamber of Commerce had already started doing something, either because or inspite of us, but we did suggest the business of getting into the railroad and the social security and using as many of the so-called calls in society as we could use to help family-planning along.

The significance of this mission it would seem to me is that perhaps first of all the UN got into the family-planning field. I think the other thing I would like to say is that there is a very real acceptability of what you have to say if you wear a UN hat. That I think I had not realized before, and I think everyone of the people on the mission realized this somewhat. After all, India is a member of the United Nations, so we were their people as well as outside people. There is a subtle difference, I had a feeling, and I think all of us felt that somewhat.

Of course, the bureaucracies of the UN make it difficult. I think the report is probably going to be the dullest report to read you can imagine, because you have to have those little numbered

c11 paragraphs, and it takes the UN a long time to get started about a lot of things. It is certainly a difficult bureaucracy in which to work. Maybe all of our bureaucracies are difficult. But there is something about acceptability in the family-planning field, working on a multilateral basis, that I thought was significant.

I think the other thing is this question of the pregnant woman approach and the relation to spacing. I don't believe that has been perhaps as fully exploited in India and if it were, it may give us a new thrust in the family-planning field.

There was one thing that came out of our working experience. That is, it is easy for a multi-lateral group to work with a bi-lateral government group or work with private agencies. The relationship between the Population Council--Mr. Keeney and Cy Segal and Mr. Levin, actually came out and got manufacturing started for us and with us. This was a constant give and take. We had Howard Taylor, a top-flight obstetrician and gynecologist, and this was an enormous help, thanks to the Population Council, because we did not have anybody on our staff like that.

As an aside, may I say, if you can get the kind of person that Dr. Howard Taylor is, who has written a good book that most everybody has read, and he can say, "In the Columbia University Clinic at P&F, 50 per cent of the women we deliver have loops put in them six weeks after delivery." You can just see what that does to the professional people that Dr. Taylor met as he

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went around India. It was very, very good.

Similarly the relationship of the Ford Foundation and the relationship of U. S. AID in Delhi were very great. We did a little work with the British while we were there. Not as much as I was able to do in Africa, but Sir Andrew Cohen is interested in getting British help out to the countries where they have had some kind of influence in the past and Sir Devrill has already sent him to London to see what can be done about India.

I think the other thing that was significant about this particular mission was the value of coupling the economic approach with the family-planning approach. The fact that we had collaboration with the World Bank team, the fact that we were talking about economic developments with the people that are at the top of their economic planning unit in the Planning Commission, I am sure made a great deal of difference. The fact that their top theoretical economists were talking to us and asking questions and we were working with them, I think made a considerable amount of difference.

I think we learned something about the adverse side of that, however. Although you talked to top officials about what family-planning means to the economic development of the country, you certainly fall on your face if you bring this up with the village "ponchia". If you talk to them you talk only about the health of mothers and children and families and that is the approach that those family-planners take. You do not bother talk-

c13 ing about the other.

I think the other thing that I have already indicated is I would say the obvious value of working at the top level as well as getting a grass roots approach so you really know what you are talking about. We also made some recommendations about supervision, evaluation, and incentives, and what may be done about international assistance. I know of nothing to help the Indian program better than if they knew how to supervise anything. Supervision is an activity in which somebody writes down that they got so many of this and they do not have so many of this, and it goes on to somebody else and somebody else. But supervision does not include finding out where the bottlenecks were. There is no problem-solving, teaching, and research or helpful attitude in supervision.

We did make some very real suggestions, and we are already trying to help them on evaluation in one way or another.

To go on to Dr. Balfour's question, about what happened since then, I guess I am a turtle with wings at the moment too, because in the first place they are manufacturing loops in the public sector since the beginning of March, and I think this is amazing. Any of you that know the difference between the public and private sector in India--it usually takes you three years to get anything started in the private sector. This was with the help of Mr. Keoney and Mr. Levin. They waited for three years to sanction new training centers. They do have 28 new training

c14 centers established and sanctioned. They have been given the money for them and they have stepped up the staff in the existing training centers. Rumor has it that the new organization structures --one of the 2 or 3 new organization structures that were recommended--will be approved. The only thing is they do not know the cast of characters that they are going to put into that structure, so they are unwilling to say anything about the new structure until they decide on the cast of characters.

I think it is anybody's guess as to what happens on the administrative structure. The emphasis on the loop is definitely here. They have already had a manual that is out, and I think I saw a copy of it, a manual for doctors. They have an experimental manual for family-planning workers, of various kinds, giving their duties and specifying how to do it. It is the information kind of thing, and as you heard this morning, 15 of them went to Korea with Dr. Derryberry. This was amazing because we had one Korean on our staff and it seems to me every time he said, "In Korea" every Indian plugged up his ears. They went to Korea and they learned a lot. The fact that they were willing to go any place was the fact that they learned a lot. Their point of view was, "We have been at this since 1951. We know a lot about this because we have the biggest program in the world." These things are all true, but it does not mean that you cannot learn by going someplace else. They have also launched an experiment in the Calcutta district, using a lot of mass media with the help of

c15 some mass media people. I think the Ford Foundation largely. They have gotten some help to launch a big mass media campaign and they have put in 2,000 loops in a matter of some weeks since then.

They also had a training program for all the lady doctors in one state, and they trained at least one doctor in IUCD insertions in each state. That is supposed to help set up training for other doctors in the state.

There is some evidence that there is activity in other agencies except the Ministry of Health which may mean this has spread out a bit, so it is not just going to be a Ministry of Health which you need. It cannot be if it is going to be helpful at all.

In the evaluation field, I don't know what they are going to do. Mr. Thacker is coming next week to talk about evaluation in the Planning Commission, because we thought that was a good place to put an evaluation unit. We also hope AID Washington is going to have a contract signed before too long. It is going to help do some experimental work to set up some experimental work on criteria. All programs need experimental work for criteria. Now, I think a curtain pulls down on UN and we will go on to WHO.

DR. STEBBINS: We will withhold questions and discussions until after our next speaker.

I just want to point out, Leona suggested a useful tech-

c16 nique when you have the top ministries and the village leaders together, that is one way to make ends meet.

Our next subject is the World Health resolution, which I am sure most of you have heard of.

This will be discussed by Dr. James Watt, Assistant Surgeon-General and Director, International Health Division of the U. S. Public Health Service. He also is a permanent member of the Delegates to the World Health Assembly, and a member of the Executive Board. More importantly, he was Chairman of the drafting committee of the resolution which he will discuss.

DR. WATT: Thank you very much.

I would like to go back just a little bit in history for the benefit of those of you who are not familiar with the World Health Organization and the question of population.

Some 2 or 3 years ago a very mild, mild resolution was introduced asking that the World Health Organization give thought to providing some technical advice on the question of population.

The net result of quite a lot of discussion was that the Director General at that time felt it necessary to get the proponents of this resolution off in a room somewhere and persuade them, please, if they did not want to wreck the organization, to withdraw it. This was the way that particular resolution was disposed of.

There were discussions on the floor which led to statements by many members nations, the delegates there, to the effect

cl7 that if this subject ever came up again, they might just as well close up shop because they were leaving, going home.

With that type of background it is not too surprising that the Director General of the World Health Organization, in the last few years, has been somewhat constrained to take it easy when it came to getting forthrightly into the question of population.

I think the next step on this road that you need to keep in mind was, two years ago, as a part of a continuing support or research by the United States Government, at the end of five years of contributing a half million dollars a year for research without any earmarking, the fifth year, the contribution was offered--and incidentally it might be accepted by the organization, it must have acceptance by the Assembly---we offered the final half-million dollars contribution to the fund in order to facilitate the organization beginning to make studies on human reproduction. This caused a few eyebrows to be raised. There were a number of individuals who sought us out, wanted to see the resolution we proposed to submit, or the effort, and in fact we spent quite a little bit of time in getting advice from many of the countries that had been previously so vehement in their opposition as to the language of the offer itself, so it could be done in such a way that it would be appropriately presented and accepted. It was.

As a result, the Director General has, for the last

c18        year and a half been in a position to convene scientific groups to look at, prepare documents, and bring to his Research Advisory Committee defined questions in the field of research in human reproduction.

      The next force, if you will, that brought this into being was the one that Dr. Baumgartner gave you a history of. That was the ECOSAC (?) resolution on the health aspect of world population.

      In my event that resolution of course, came before the Assembly, under the agenda item which is always a part of the World Health assembly. It is an agenda item which is called "Decision of the United Nations, Specialized Agencies, and the International Atomic Energy Commission, Affecting WHO's Activities." This is a standard agenda item which occurs at all times and wherever and whenever there is an action by ECOSAC (?) by the UN, by the specialized agencies which impinge on the work of WHO. This is brought up for information, discussion and general action is indicated on the part of the Assembly.

      This resolution, having been adopted, of course was well-known and had been distributed to all the member nations, and all of us were aware of the fact that this was going to come up for discussion. We did not know the exact setting under which it would come up, but there was no doubt in anybody's mind that we were in for a rather interesting session on the part of the agenda that is usually somewhat less than exciting.

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Usually these actions of these various agencies, they sort of go through and come to the last of the meeting when nobody really cares, and by that time it is pretty much the dead duck of the affair.

Actually, it was quite obvious from the day that the assembly opened, that, other than this following a relatively normal course, that this was going to be the one that would build up because the discussion started in the halls the very first day as to who had what position on this particular resolution and what they were going to do. Dr. Cando had not distributed, before we got there, a document which he did distribute within a day or two, so it was available for discussion by all of the delegates well before this came up for its discussion in the program and budget committee the last two and one-half days of the three-week session.

This document is one that goes into considerable detail on what Dr. Cando has done. A great deal of the report itself has to do with what he has done with the half million dollars that were given to support research. It also goes into certain aspects of what has happened in the Research Advisory Committee and then, after some 11 pages of more or less reportorial activity--a little bit of talk of expansion--there finally ends up a paragraph four lines long that is one that of course had all of the fireworks, because it has to do with advisory services. The statement reads as follows:

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"WHO should be prepared to give advice on request to the health administration of its members and associate members on the medical aspects and treatment of sterility, the medical aspects of family planning. It should also be in a position to advise on the place such subjects should have in the health services of the community."

Seemingly a rather innocuous statement, one rather consistent with the World Health Organization's role in relation to its member governments, but nonetheless within that were quite a lot of opportunities for people to conjure up visions of what might happen the minute WHO was in a position to go the whole hog on this question of advisory services and what it might mean.

Suffice it to say that when Sir Arkut Mudaliar, who was Chairman of the Program and Budget Committee, opened this subject up, he used some of his best and undoubted very real abilities to sort of point out that this was a subject of great importance and one in which he expected a very lively but nonetheless a very sober debate.

I think that his introduction and the introduction of Dr. Cando both set the stage very effectively for what did take place over the next two days or so.

I don't believe I have ever been in a discussion of this subject where there was greater evidence on the part of a very widely-divergent group of people of an attempt to face the problem so seriously, soberly, and with a very real intent that out of

c21 this should come some sort of action by the Assembly which would put the WHO in a position to work effectively with this problem.

I have been asked by several people where the opposition came that led to so much time in the drafting committee and it really was not opposition. The word "opposition" is really not a right one. It was people trying to define a consensus, hoping for a consensus, worried by certain pressures that they would feel having determined that consensus, when they got home, but nonetheless throughout there was a consistent and concerted drive to find that consensus with which they could live. So much so that I, when I supported the US on this particular subject, I quoted from a paper that Dr. David Price had given some three or four weeks ago in which he spoke about the consensus in the democracy and the importance of not only achieving it, but maintaining it, and the work that must be focused on maintaining that consensus.

He used as an example a law that that did not have in it, prohibition. There were similar dealings throughout and I felt, after having listened to the debate--we came into it late--that that probably typified, what feeling I got from the room, as well as anything that I had seen. So I quoted from it. We had a lot of work, and in the halls people were seeing each other about draft resolutions and all kinds of things, but the only thing we had to say in public was an appeal really based on that last paragraph, that in the Director General of WHO we had a man who had been written up in many places as the doctor to the world,

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and that he did have some 124 odd patients, and that it seemed to me that as a part of letting him be the doctor to the world, we must assure that he not turn his back on any of his patients when they were seeking his assistance, and that really I felt that as this group had discussed it, it was quite clear that this was the consensus and that therefore it was thought that we do pass a resolution which would in fact enable him to render such assistance as he could, as a physician to all of those patients that might request it.

After about two days, three full sessions, I believe it was, of this discussion some very strange statements were made. Jamaica gave one of the most resounding, effective presentations of the "whys" of some type of family planning activity, of any member nation who was there. They made it quite clear what the problem was as seen in their little island. A number of other people made it equally clear, from their viewpoint, as they view population problems that they were not really concerned about numbers except insofar as they were untrained, unskilled, and needed something that would increase their productivity in an area where there was a lot of land and a lot of resources, but people were not trained to really use those skills or did not have the skills to use.

There were variations all over the place, on what was the real impact of population on the particular member nations. There was one little parenthetical remark of the surgeon-general in his opening statement to the Assembly at the time, of what is

c23 called euphemistically, the general debate. This was in response to the Director General's presentation. He had spoken of the importance of population and the words "population explosion" have been part of a paragraph--it was not highlighted, but it was in there, and I was a little surprised to see from how many different directions that I got a negative reaction to that point.

In general, the speech was well accepted. The idea of facing up to the population problem, nobody was objecting, but the feeling as it was put to me by one man was that this was a Madison Avenue approach to population explosion. "It is too much a trigger word" said a number of them. These were people who were quite seriously of major importance in getting this resolution through. They were bothered by this opening statement. It is a point that stuck pretty hard, because I had missed that one. I had gone over the speech and thought it was a pretty good speech and had not anticipated this, and I got a little red-faced at having that pointed out to me later on.

But to get back to what happened. Sir Arlut, to summarize it, said that he wanted us to have a drafting party. He sensed that from the meeting there have been several suggestions. There have been two resolutions presented, one presented by Brazil, Chile, Panama, Paraguay, Peru and Venezuela. The other one had been presented by Ceylon, Denmark, Finland, Ireland, India, Korea, Norway, Pakistan, Sweden, Tunisia, the United Arab Republic, the United Kingdom, Great Britain, and Northern Ireland.

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There had been two amendments formerly submitted, one by Turkey and one by Iran. The two amendments were designed to sort of somehow stitch these two resolutions together. So they wound up a drafting party made up of Brazil, Chile, India, Iran, Iraq, Italy, Malaya, the Philippines, Sweden, Turkey, UKAI (?), USSR, and the U. S. A.

I think that the reason I wound up as chairman of the drafting committee was the fact that we had earlier on in this meeting decided that we could probably accomplish more as a delegation by listening sympathetically to the various resolutions, steering it as best we could, or commenting as best we could.

Incidentally we had made some rather serious changes and some fast comments on the original Chilean resolution. It was really bad to start with and we worked with them to get it modified, but in general we had been as helpful as we knew how to be for everybody around doing it, and I think that is the way we happened to wind up in this position of Chairman. Because while we had taken a positive position to get a resolution, we had not taken sides between one or another of the contending forces.

Eleven-thirty in the morning we quit talking on the committee and started on the drafting session. Later, at 2:25 we adjourned for a planning session and had finished the preambulatory part which amounted to attaching together the two resolutions and putting in a little more order.

As you see, as you look at it, it moves from an international to a national to a family individual type of idea, and

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then throws in one clear restriction, namely, that it is not WHO's responsibility to endorse or promote any particular population policy. This was very clear in the debate. This was not something that was in any of the other resolutions, but it was something that was made repeatedly clear in the debate, that there was a need for WHO to maintain a position of a judicial attitude that some way, somehow, this is the health organization for the whole world, had to maintain the ability of being a judge and not a jury, not of committing itself of particular areas, but of being in a position to evaluate, advise and to help modify those areas and those developments which were undertaken by the individual countries.

There was some talk about the importance of family medical advisors in contrast to the guy that actually does a technical job once that advice had been given and accepted by the patient.

This point was put in as a way to try to make clear this general feeling. At the time we broke up it was anybody's guess as to whether or not we were going to get together on a series of paragraphs at all. By this time they were not sure whether they were going to be able to make these/fit/together, but what we did, just before we broke, was to agree that everybody would try his hand at drafting something that would in turn be a basis for discussion when we got back instead of this business of trying to put four different ones together anymore. In the course of the two and one-half hours which we luckily got, because it was

c26 a fight on the floor about the credentials of a country, some had a two and one-half hour wait while the Credentials Committee hassled over that, so we had a chance to have a series of subcommittee meetings during that period and we went back in with a draft which had finally been put together with the Italian delegation, and with the assistance of a number of other people in doing this.

But it was tabled and with very little change. In fact, almost no substantive change. Two and one-half hours later it was accepted. Now I am not--I am still not quite sure just exactly why, since there was so little change, it took quite that long for us to reach the final point of everybody saying, "That is it." And being ready to back it. Maybe it was just the fact it was a long day and it was getting late in the evening. Maybe it was also the fact that they had to say some of these things in order to see the reaction around the world as to just what the message was of some of the generalities that were listed.

But if you will go into it, you will see that again, this is almost exactly what the Director-General said with one limitation, and it is a limitation only in the sense that it states, "A rule" rather than "Imposing a rule". It simply says that the WHO, in the field of advisory services, can go ahead, as the Director General said, on the understanding that such services are related within WHO's responsibility to technical advice of the health aspect of human reproduction and it should not involve operational activities in the WHO lexicon.

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This simply means they do not take over and run the health services of the country. That is what is called operational activities. Countries carry out operational activities. WHO carries out advisory services. The only operational activity that WHO has carried out are those in the Congo where they pulled all the Congolese physicians to the left and at that point, somebody had to take care of the health services, and the UN gave 5 or 6 million dollars a year to WHO to hire physicians to put in there to run the services. This is the only operational activity so far, as I am aware of, that they have ever become involved in, and in this particular paragraph, what this would mean in terms of a prohibition, is that were the UN to pass a \$10 million appropriation or the like for the purpose of running birth-control clinics and turn to WHO and say, "You do it" they would have to take this back to the Assembly, or the Director General would say, "I do not have the authority under the legislative enactment that I have."

This, turned around the other way, simply means "WHO can now plan in the field of population to develop programs in a way that is quite consistent and is in harmony with what they have done in any other field of endeavor in the health area."

Now, one more point in conclusion. What does this mean in terms of immediate action. In U. S. Government jargon you would have to say "nothing", in the sense that this is authorizing, enabling legislation, but it is not appropriating legislation. This is a law of Congress which authorizes the Administration to

c28       begin to do something but it has not gone through the needle's eye, called the Appropriations Committees, and there is no budget to back this and it is quite obvious why Dr. Cando would not have included that in his 1966 budget document since with all the background there has been, he would have been premature to have any budgetary request fitting into this setup.

      Just what his plans are for the development, what he plans to do in having his 67 budget itself for this amount, I do not know. I doubt if he does. I doubt if he did at the time this was passed. He might have a clearer idea now because after the Assembly he met with the regional directors and found out what we can anticipate in the way of requests. At this time he usually gives them the feeling of the ceiling within which they will have to operate for developing their plans. So I suspect there have been some decisions made which will now go back to the country.

      I think the other point that is the imponderable and the reason I say I cannot answer you in any definitive way as to what this means in the way of action, is again no countries have asked for assistance as of the time this was passed. They had pulled back from this on the basis of the previous activity. There had been a little bit of work by country representatives, but basically and formally the kind of country requests which would be the basis for any budgetary planning and development on Cando's part obviously are not there and it will take whatever time the various governments concerned need to crank up their machinery and put in such requests, should they intend to do so

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at all.

I think the third imponderable as to how much this means will depend to no small degree on what the various governments who have funds and have the ability to support this decide in their wisdom should be their course of action in supporting activities to the World Health Organization in this field.

There is no question that the amount of increase in the regular budget, the annual increment of the regular budget, if that is the only basis on which WHO moves in this, then it will not be a very rapid advance, because there is, from all over the world, a great deal of pressure to hold down the increase of the regular budget of the WHO, not because it is WHO, but because there are 50 or 60 or 70 or more international organizations all of whom have a special interest and all of whom are trying to get money from the various countries.

This adds up to substantial dollars when one begins to take--as for example, Mr. Harlan Cleveland presides over the affairs of 53 international organizations to which the Government of the U. S. belongs--each of these is growing at a pace that many people say is too fast, and others say is too slow, but in the aggregate it adds up to a good bit of money, and there is a lot of pressure developing, not just in the U. S. but in all of the other major contributors to somehow find a way to hold that down.

Here's a new initiative which says, "Move Ahead". There were several other initiatives. A resolution was passed on Small

c30           pox eradication to finish that job in 10 years' time. This again is going to mean more money to put into the WHO. We passed a couple of resolutions on research in general. These again are going to be demanding, needing support from the countries, so I think that the important thing for you here, and all of us in this country is to recognize that the regular budget--as a way of moving this-- has a very finite and very limited amount it can do in a given fiscal year, because they are the demands from all over the world, and even with rigid priorities set the amount that can go into it.

          It does not add up to a whole lot of money because the WHO base is only around \$40 million for everything. The home base is there, and when you begin to play this numbers game with people who worry about increases on a percentage basis, well-- so what is the percentage? You have a 25 per cent increase, and you split that around the whole series of problems and you still don't have very much money in actual dollars to be able to put in any programs of any kind.

          So I think if this resolution is going to mean that WHO is going to be involved on a very broad front in other than a few selected areas something other than the regular budget will have to be found as a way of support. I mention this because at this Assembly we did pass a resolution which, for the first time, does something inbetween the voluntary contribution on the one hand and the regular budget on the other. The so-called voluntary help for funds.

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Something in between had to be devised and the thing that is worth a little study from those who worry about bureaucratic things of this sort is the resolution which was passed creating the National Cancer Agency, the World Research Agency on Cancer, by the Assembly. There the funding is being done by some half dozen countries, each of whom have agreed to put in the kitty a specific amount of money on an annual basis which will provide for a secretary, a central staff, and a certain amount of on-going services while at the same time allowing within that framework, through its scientific council, the development of projects which would be funded by various national cancer efforts.

Now this was adopted at this assembly. It was the first time that any such consortium or any activity of this sort had been put into it. It was thoroughly discussed over a two-year period. I think that there is reason to believe that it is well understood now, at least enough so, that no one is worried about it as a way, and I think, given a year of experience and seeing how it operates there may well have been created a mechanism whereby this government along with others who are interested, can begin to support particular programs of a high-priority nature for which they can provide certain resources and which will be of extraordinary value to other countries who might not have the financial means of support but who would have the will and ability to participate through their own national health administrations.

I think that covers what I wanted to tell you. I can

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summarize it by saying this, there was an extraordinary strong feeling to see a subject as explosive as this, and it had the complete seriousness of all the countries participating in trying to get what I believe we can say without any worry, is a very solid resolution putting the World Health Organization clearly in this problem.

Thank you very much.

DR. STEEBINS: I am sure we all appreciate very much Dr. Baumgartner's comments on the program of the United Nations and Dr. Watt's discussion of the resolution of the World Health Organization.

We are running behind schedule, but I would want to hear anyone who has a burning question.

DR. BAUMGARTNER: There is a possibility I did not mention. There are about six African countries that are purchasing service and health planning from the WHO on a mission basis. I see no reason whatsoever why they cannot purchase advisory services in the population field from WHO and that should be pointed out to the people in this room. In other words, there is no reason why the mission itself, if the country so wished to, could not fund advisory services from WHO.

I have also discussed with Mr. Cleveland and Dave Bell the possibilities of voluntary contributions directly so that I think this may not take as long as we think. I guess I am being on the optimistic side.

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DR. STEBBINS: If there are no questions or comments, I think that before we go into the afternoon session we will take a short recess.

(A short recess was taken.)

DR. FLORIO: We will start off with Professor Mauldin.

DR. MAULDIN: I would say that Turkey has a policy but no program as yet. Tunisia has a program but no policy. The UAR has neither a program nor a policy in this field. These are over-generalizations of course, and all are wrong to some extent.

I should like to make a few general remarks about this area.

First of all, all of these countries are Moslem, two are African, and two are Arab. Two occupy very strategic geographic locations. The Moslem religion is not strongly supportive of family-planning but I think it is a mistake to think of it as being a major hindrance to it.

Alazhar University, the famous old university in Cairo, has initiated--these are not quite the same as the Papal Encyclicals, but, the closest thing to it in the Moslem religion, was issued in '37. The other in 1963. Each supported family-planning.

Each supported family-planning. In 1963 when a group of us were in Turkey, we talked to the head of the Moslem religion in Turkey and he and his colleagues said they would support family-planning providing it was not abortion. There are a number of other well-known Moslem authorities who have spoken out in

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support of family-planning.

In spite of this, however, at the village level I think that the folk culture is such that the local religious leaders frequently are not very progressive and they need it as well as the people involved.

Let me quickly talk about Egypt, Tunisia and Turkey.

Because of the time, if I do not fully cover Turkey, we will ask Mr. Hamer to finish on that. In Egypt, I said that there is no policy. In spite of that fact the charter of the UAR as set forth on page 13 of this paper, reads:

"The objectives set by the Egyptian people, through the revolution, to double their national incomes at least once every ten years, was not a mere slogan. It was the result of calculating the amount of the force required to face under-development and rush for progress, keeping in mind the increasing rise of the population.

"This increase constitutes the most dangerous obstacle that faces the Egyptian people in their drive toward raising the standard of production in their country in an effective way."

This is one of the strongest statements to be found in an official document of the government, with which I am familiar.

President Nasser presented this point of view and, on numerous occasions, has spoken strongly in favor of family planning.

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As late as May of this year he indicated that of course we are having economic difficulties and as long as you have 7, 8, 9, 10 children, we may continue to have trouble. If you had 3 or 4, it would be much easier for us.

Kissiny, when he was the head of the Secretariat of Finance, spoke out very strongly in favor of family-planning and some of his remarks are reproduced on the bottom of page 13 and the top of page 14. Dr. Ali Al Gristly, who is head of the Bank of Alexandria, wrote a document for the Egyptian Association for Population Studies in 1955, which analyzed the impact of population growth on Egyptian economy, taking into consideration the expansion of arabic land as a result of the High Dam. He indicated that during the period of building the dam the population would have increased so that the standard of living would not increase as a result of this if that were the only thing that were done. He updated that document in 1963, I think it was, and there seems to be general agreement with the point of view that perhaps the population growth is an impediment to economic development, but in spite of these many statements there is not a coherent policy. I have talked to some of the Egyptians and asked whether or not these statements constitute a policy and they say no. The activities in this field can be classified into several groups, 4 or 5.

The Egyptian Association for Population Studies, that's history is described herein, was set up in the late Fifties and Hosel Shafey (?), currently one of the Vice Presidents of the UAR,

then Minister of Social Affairs, headed this association. Initially they had a budget of 10,000 pounds from the Minister of Social Affairs, from which they opened 28 clinics. These clinics are described in the document along with the type of contraceptives that were offered. Briefly, these were part-time clinics run by part-time personnel, after hours without publicity. They were intended only for women although they required the written permission of the husband in order to receive contraceptive advice and supplies.

No condoms were offered by that association nor are they today. They say Egyptian males will not use condoms. They've been a highly-conservative though highly-prostitigious outfit. Their budget continued at the level of 10,000 pounds until a year before last when the Minister of Social Affairs now headed by Dr. Buza (?), had the first woman minister in the UAR, which gave 50,000 pounds to the Association, intending for it to open up 100 additional clinics. At the end of the year they had opened only 10 additional, bringing the total to 38, and part of these were opened only on paper.

So during the current fiscal year, which ends June 30, they have not received additional funds from the Ministry of Social Affairs, although the Ministry of Social Affairs again had a budget of 50,000 pounds.

The Association's activities have been run by medical personnel from the Ministry of Public Health. The people, the

c37 doctors, the nurses, the midwives, the helpers in the family-planning clinics, receive a small amount of money for their extra activities. This is set forth in the document.

The Ministry of Social Affairs, feeling somewhat unhappy with the activities of the Association, has begun to provide some services of its own in a quite limited way. In addition, the Ministry of Public Health, for the first time this year, had a budget of 38,000 pounds. Incidentally, I was told last month when in Egypt, that the figure was 39,000, but 38,000 is the figure I had been given earlier.

It appears in this document, and according to the Director-General of Health--I am sorry--Director-General of Maternity and Child Health--that they opened 40 clinics. How active these clinics are is not clear to me. Some observers stated they have not found any evidence of activity, but the Director of the Pharmaceutical and Chemical Industry, told me he had given them a million oral tablets which are manufactured in Egypt and had been requested for an additional million, because according to the Ministry of Health, the first million is almost used up.

So it looks as though the Ministry of Public Health is beginning to develop a program. The head of Maternal and Child Health, who is also in charge of the family-planning program of the Ministry of Public Health, says that by the end of the next fiscal year, they will have 1833 clinics in operation.

But based on what they have done in the past, and what

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they are doing today, it is still a small effort. The ministry of Social Affairs has given 500 pounds to 15 clinics run by another private association called the Joint Committee for Family-Planning. This is really an association of womens organizations concentrated in the larger cities, and they have developed a moderately active family-planning program during the past year, 15 of their clinics having been recognized by the Ministry of Social Affairs. They have about 20 in all.

In addition to these activities the Medical Schools, or personnel of Medical Schools in Cairo, Asyut and Alexandria, have, for the past two years or so, had a great deal of interest in family-planning activities, working partly with joint committees. Some of their personnel have been working with the Egyptian Association, though not to a very large extent. Some have been running clinics on their own, and with the help of the Ford Foundation, I think that grant has been announced. The Universities of Alexandria and Cairo are developing a family planning research and action program so that there is a lot of activity, but still not a coherent program for the country as a whole.

So let me pass quickly to Tunisia which has a fairly vigorous program for such a small country. When they first began to talk in terms of developing a family-planning program in 1962, they talked in terms of opening 1 or 2 clinics, but Sir James Hardy, the Ford Foundation representative, and some of us from the Council, the Population Council, talking with people

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there, persuaded them to start with 12. The history of this is that in 1963, the Ford Foundation made a grant of \$200,000 to help them get started in 12 clinics in maternal and child-health centers, these being located at different stages throughout the country, giving fairly-good geographic coverage.

A mission of Tunisia came to the United States and Asia in the fall of '63. A seminar was held in Tunisia in the beginning of '64. Their program got underway about a year ago. Their original intention was to offer IUDs in about one-half of the clinics. They started very slowly but interest in the IUD program has picked up a great deal, and at the present time, IUD clinics are operational in 16 centers. For April we have reports from 15.

It is very interesting that the IUDs inserted--the program started in July when there were about 100--and it increased to 400 in January. Beginning in February, one of the most interesting educational or propoganda developments took place with which I am familiar. There had been a split in the Ministry of Health and social Affairs, with the health educators going to the Ministry of Social Affairs and though in the original program it had been envisaged there would be enacted a health-education program; in fact, there has been none.

The Destarian Party (?), a political party being interested in family-planning, started in February, in two areas to hold small group meetings. Some of their workers visited homes

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and they began to work in clinics, and the number of IUD insertions jumped to 663 in February and to a little more than 2,000 in March.

Ramadan came in January or February this year, so there had been some holdover, I think, with that, and this is the reason I think for the large numbers involved for Tunisia, with a smaller number of clinics in March.

In April, 1555 were inserted. Of the total of 5,800-plus IUDs inserted to date, 2,350 have been inserted into clinics in areas where the Destarian Party has been most active.

Discussions are now underway with reference to expanding this program throughout the entire nation, although no policy decision has been made as yet to undertake a national family-planning program. But it looks as though they will move in that direction.

In Turkey, the State planning organizations, the first state planning organization, was particularly instrumental in developing a population program and policy. In the first five year plan they included an analysis of population growth and economic development and I reproduced a good bit of this in my paper. They said, and you will see this on page 6, that the following measures are designed to implement this policy. Laws prohibiting the spreading of knowledge about contraceptives and the import and sale of contraceptives should be repealed.

It fixed a fairly long time to repeal the law, but it was done on April 15th of this year. I would point, at the pre-

c41 sent, only to Item B, and the second paragraph on page 6 in which they talk about the training of personnel in the education of people in population planning.

"This would be done, not only by putting new courses into the curriculum of the related schools in short-term educational programs---", et cetera. They have felt that it is very important to bring in the Ministry of Education and to use the educational apparatus in an important way in their programs.

And it had a budget, even as early as 1963, for family-planning, a budget of 4-1/2 billion Turkish Lira which amounts to about 1-3/4 cents per person. They were unable to spend all of this because the law was not passed. It is anticipated that the budget for the current year will be about 4.9 million Turkish Lira or 1.8 cents per capita with the expectation this will increase to about 15 million Lira within three years which would then be about 5 cents per capita.

They have set up a Director to Family-Planning. A doctor has been appointed along with several other professional workers and plans are underway for a training program for governmental doctors to start in mid-June.

A variety of material relating to family-planning have been produced or translated into Turkish. This includes the report and recommendation of the Population Council Advisory Mission, June '63, the proceedings of the Conference on Family Planning in Turkey, translation of a report on what we call a "cap" study,

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a knowledge, attitude, practice study with relation to family planning; the Mary Calderon manual on contraceptive practices, articles on IUDs, a book on birth control, and a variety of other things.

I am not sure, Bob, whether it is by law or by agreement that it was decided not to implement the program for 90 days after passage of the law. So that there would be no education, no propaganda, no action until July 15, with the exception of the training program.

Bob can comment on this in a moment.

In part this restriction is to enable a scientific advisory board to give them advice with reference to criteria for therapeutic abortion, for sterilization, and to establish details of the family-planning program.

So when I said that there is no program for Turkey, it is only a historical accident. It seems to me their plans are moving ahead moderately well and that this has the promise of becoming a very vigorous program.

Insofar as I know, U. S. AID has not been involved in the programs such as it is in Egypt and the one in Tunisia, but it is likely that it will be very much involved in Turkey. At least the Ministry of Public Health was very much interested to receive help from U. S. AID and because of time, I would leave that to Bob to talk about.

Thank you.

**DR. FLORIO:** Mr. Robert Hamer of the mission in Turkey will continue what has been started in the discussion we already heard about Turkey.

**MR. HAMER:** I need to make one small comment about the postponement for 90 days. The law consists of three articles. The basic provisions are contained in Articles I and II. I in effect, sets the principle of family-planning. II talks then of the educational part of the program and how it shall be carried out and the steps that shall be taken.

Beginning with Part 2 in Article III, all deals with provisions in connection with sterilization and ending pregnancies under medical necessity. It is this last part, under the law, that cannot start for 90 days.

Article X of it says: "All or part shall be effective on date of publication," which is April 15, but Article X refers to the "cooling" period. What it says is that the old restriction against sterilization shall be continued as shall be the restriction against abortion unless there are medical necessities for them.

Beginning with Article III and going on, there are some strict rules that must be followed as to how you have various medical councils and commissions to pass on sterilization or evacuating the uterus. I think it is important to realize that we are no longer an underdeveloped country.

Dr. Baumgartner made the comment that pills are not being used in any of the underdeveloped countries and here is the current best seller in Turkey. It sells for 9 Lira, which is

c44 about \$1.10 for a month's supply, but I have had two reports indicating that it is on permanent display in all of the leading drugstores and selling rather well. Something very important was not mentioned, population count.

Dr. Berizon made a fine survey in Turkey and I was surprised by the acceptance figures that came out of that survey, in the villages. If you read Parker's speech you will realize there is a conflict in the range between the religious leader and the Mayor in their attitude toward family planning. According to the figures we are getting out of the survey, more than 50 per cent of the village people were in favor of family-planning. In the towns about 80 per cent, and in the metropolitan areas somewhere between 84 and 85 per cent, with 75 per cent of what one might consider the rural areas, outside the villages and towns.

I got a set of statistics which are separate from Parker's. Parker talks in terms of 50 million people in the reproductive age. I talked to some of the staff before I left Turkey and they are talking in terms of 4 million women in the ages of 20 to 39 with the hope that in this first year they would have 400,000 women practicing family-planning, 400,000 the second year, and then 300,000 each year thereafter, roughly having half of them participating in family-planning at the end of their present second-five-year plan. Someone mentioned yesterday the fact that they had heard for a long time that the law was pending in Turkey. What suddenly got it through the Parliament I am not sure, when the revolutionary government came into power.

c45 In the early session of the state planning organization, in the spring of 1962, there were many pronouncements in favor of family-planning. Parker points out in his paper, this was tied in to the five-year plan. There was a great deal of opposition last fall, and there was a family-planning conference called in which all the proponents and opponents were invited to speak. I made one small note coming out of that that I felt would be of interest to AID personnel. Three of the secretaries—and very few spoke against the plan or against the proposal—but three of the speakers put some of the blame or onus for pushing this bill on the United States Government, saying we were interested in keeping down the population so we could reduce our AID to Turkey. I am not sure how we came out of that.

During that conference an interesting thing came up. Among the people who spoke either against it or did not speak in favor of it, were some leading members of Parliament and an interesting statistic was presented to Parliament for their consideration.

If members of Parliament were against family-planning then something strange was going on in Parliament, if these statistics were correct, because some 59 per cent of the members of Parliament had 2 or less children, so somebody was practicing family-planning.

Of almost 492 members only 18 per cent of them had 4 or more children. What was AID going to do with a program in

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Turkey is an unknown quantity at the moment, and we hope to prove this from the visit of three leading experts in the area. We are hoping Dr. Baumgartner, Dr. Taylor and Dr. Mauldin or someone of equal talent from the Population Council will come up to Turkey late in June, look at the total health program, and look at the part that family-planning shall play in it.

We have several basic problems that we hope they will look at and solve for it.

One is, that given the present structure of the Ministry of Health, they must concentrate on providing medical services in Eastern Turkey. If you took the map of Turkey and drew a line from Beirut into the Red Sea, you would break Turkey into two equal halves, east and west, the west being the highly-developed part of Turkey where most of the population is located, and the area to the East of this line is for the most part, high plateau, rising to still higher plateaus, and then he joins the lower half of it with people in a nomadic group of tribes. This part is difficult to get into in the winter. It has long heavy winters that last late in April or early May, and it is an area where there are few services of any kind. No home services. The eastern section has only one automobile in the province, one power plant for about 7-1/2 kva worth of power, one high school and three elementary schools. An area where medical services must be provided, an area where government has established a socialization of health practices in an integrated program in which young doctors coming out of the university are paid at rates which are

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comparable to senior doctors earning in government service in the more pleasant parts of Turkey, in the west.

The big drive is to build up the rural health integrated program in the East. We're agreed this is not the area we want to start out in family-planning, since the success will be minimal there, so we have to balance ourselves between the Turkish government's own drive to push forward in the East, and the belief of all experts, including Turkish experts, that the East results to meet this goal of at least 400,000 per year in the first two years, will be in the West.

They have asked for a tremendous amount of support for their world health program, 1100 vehicles in the first two years, about 220 of these for direct family-planning and another 100 for being/ related activities, the idea/that we will go forward with some support to them in the area of transportation.

They have asked us for assistance in other related areas, of equipment, primarily for their world health integrated program.

Then they come to the perennial program all Turkish governments have. Their personnel structure is such that their per diem personnel, away from their home stations is such that personnel never leave the home stations. They get the equipment of about 81 cents a day to leave their home station, and most senior Turkish officials just don't travel.

The Ministry has said, "is there any way you can help us with additional funds to resolve this problem of getting our personnel out of their headquarters sites and into the provinces?".

648 We are looking at this. It is a never-ending road once you get into it. The obvious solution would be for a central personnel board to realize the real problem that is here and do something about per diem rates, but this is considered part of the reform program which probably will not take place for a long time.

We are pleased with the efforts of the Population Council. Russ Davis is the representative in Turkey. We have been working very closely with him, and I have a strong feeling that after Dr. Baumgartner and Dr. Taylor and Dr. Barison come, we will have some of the action we are waiting for and we will have one of the best programs in the world.

DR. FLORIO: Now, we are going to change directions a little bit and I will leave it to George.

DR. INADA: Actually, I do not represent AID Libya, because there is no AID Libya. Second, I am not quite sure whether I am with AID right now or not, because I am being separated or have been separated. So Dr. Jessup asked me to give this talk, so I will give it.

I feel out of place too that I am giving a talk that goes like the "Wrong Way" Corrigan, going the other way. Actually Libya does not have a specific program to increase population, but in their first five-year plan this is the official kingdom of Libya.

It must be realized that the limiting factor in economic developments in the next five to 10 years will be the

649 small population rather than the support of financial resources.  
This is summarizing.

Special reference to support of trained and experienced persons and the fact that the services of these at present available are not fully utilized, severely handicaps the work in general, as shown by a 1964 manpower survey made by an ILO manpower expert.

It even goes further and states that even at the expense of a temporary postponement of the rising of standards of living, the main objective of the government of Libya, as they state it, is to raise the standard of living of the people. One of the first objectives of the government is in education and learning, and learning must be given priority as education and training are in fact one of the prerequisites for a place in the standard of living.

There are a few other sentences that emphasize the need for education and training, and the encouragement to provide this for the boys and girls coming into education, into their educational system.

For the last few months they have been emphasizing quite a bit a crash program to increase their educational training facilities. One of the examples they do use is that when Libya gained their independence, there were just a handful of college graduates. Now they have at least a thousand in their colleges.

The interesting factor is that now they are talking about quality of university students rather than just quantity.

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Some of the methods they have used indirectly in trying to increase the population is that they have increased the family allowance. Previously I think it was two pounds. This is equivalent to <sup>two/</sup> Sterling pounds for a wife and one pound per child up to four children. The new allowance runs four pounds for the wife, two pounds for each child with no limitation. I assume that also means that the second wife gets four pounds up to the legal four wives, and I think the concubines are out of luck, as they usually are, unless they work out their own private arrangements.

Also, there was a general rise in pay to all government employees. Since it is now the Kingdom of Libya, instead of the United Kingdom of Libya, all government employees come under one government. That is, in December of '64 a raise of 70 to 100 per cent salary increase was given. Let us say the Undersecretary used to get 1200 pounds; this is his base salary. He now gets a minimum of 2340 or up to 3000 pounds. Minimum wages for laborers have been raised, and not 100 per cent, but they have different classes of laborers. They have made efforts to fix the price of the essential commodities, especially since the raise in government salaries.

Also, in this same economic aspect they have cut quite a bit of the custom duties, especially on food products or canned goods. Let us say a can of milk had a custom duty on it. Now there is no custom duty on this. Many of the other food items are very similar. Many of the other manufactured items--the costs have gone down. Exactly how much, I do not know, because my fig-

c51 uses are in Libya yet.

Generally speaking, the development budget is like a special budget and they have a regular operating budget too.

I am restricting myself to the development budget. In the first five-year plan they have proposed and passed through all the government agencies and have been signed by the King. They proposed roughly 170 million pounds, it breaks down roughly with much emphasis on agriculture because 75 or 80 per cent of their people are in agriculture. Emphasis on communication, public works, education and health; there are many elements of an underdeveloped country in Libya yet. For example, in the manpower survey, this does not cover all industry, but it covers what they could get data on.

About one third of the staff personnel are non-Libyans. This includes primarily the technical editor, and quite a bit of the craft area. Generally we figure that 30 per cent technical and managerial, 30 per cent sort of inbetween people, and 30 per cent the unskilled labor. The 30 per cent unskilled labor is primarily all Libyans. On the Government side, the survey showed 10 per cent of the total governmental staff is so-called experts. Many of them are not advisors. They are more operators or have executive functions or a combination thereof.

Let me just say 2 or 3 more additional factors. In the last--since their independence--their per capita income has gone up at least tenfold. The population in 1954, approximately

c52 1,000,100. The '64 census preliminary figures show about one million and a half. This is a muddled figure because it includes all the foreigners in it. The population is a fairly young population, over 55 per cent under 24. This is the 1954 census. '64 should, I think, show a higher figure than that. Of course, as most of the people know, most of the revenue is coming from oil. Out of 250 million exported in '64, 248 million comes from oil export, so here you have what I call a windfall of money coming in, and yet you have many of the underdeveloped elements in the country.

DR. FLOREIO: I am going to take some time for discussion. These gentlemen are ready to try to answer any questions you might have or listen to your points of view.

DR. MAULDIN: In Tunisia they have passed a regulation exempting all materials for family-planning, from customs. This relates not only to contraceptives but anything being imported for the family-planning program. This has aided them a great deal in the early stages.

Secondly, I mentioned very briefly that in Egypt they manufacture the orals. I think Dr. Abdul Saylan (?), President of the Pharmaceutical and Chemical Industries there, is probably responsible for the major price break for orals. A couple of years ago he got Scherring of Germany and Orgenon of Holland and as he told the story they bid against one another and he was able to buy orals for 42 cents for a month's supply, and they are sold in Egypt at that price at the present time.

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They ran out a short time ago, just before they started to manufacture and he upped the manufacturing to 8 million pills in one month, 10 million the next. He thinks it may stabilize at around 5 million pills a month.

There is some suspicion that people were hoarding for a while and there may have been some exports to nearby countries, but I think this is the best price on the orals with which I am acquainted.

FROM THE FLOOR: The bulk material from Scherring is equivalent to 63 cents for the raw material, and you have the packaging and the cost of the pill-making.

DR. MAULDIN: Dr. Abdul Saylan said he would be glad to sell to Turkey.

DR. SMYTH (AID): I would like to ask a clarification of Dr. Hamer, of what he said about concentrating medical attention in Eastern Turkey and then you say by far the largest part of the population was in Western Turkey. Are you describing Turkish policy or what?

DR. HAMER: Turkish policy is more political policy than one might say is good planning policy.

DR. MAULDIN: The doctors are concentrated in Western Turkey, so the health services are better in Western Turkey than in Eastern Turkey. The situation has to be improved in Eastern Turkey.

DR. HAMER: It has only been in the last six months that

c54 you had a total change in Eastern Turkey and everything that went on in Turkey was under control of the Third Army. All of a sudden a decision was taken with the government that the Third Army would not play the main role in the East and all of the things that were under the bed at that time came out in the open, so there was nothing in many of those provinces. That was intensified by the measles epidemic we had in December, January, and February, so the drive will be to build a true socialized health program in the 31 Eastern Provinces as the drives in this five-year plan.

FROM THE FLOOR: Doesn't it make sense to concentrate the family-planning effort in the West, where most of the people are?

DR. HAMER: Definitely.

FROM THE FLOOR: Will that be done?

DR. HAMER: I think this is Parker's and my problem that we detect in the Ministry the idea that they should mount the family-planning programs along with the other programs in the East.

DR. MAULDIN: Some say as soon as you offer the family-planning services in the West, where the standard of living is higher, that you will have lines forming in the streets to that clinic, and so on, so they feel it will take care of itself automatically, and the real educational effort will have to be in the East. But they expect it to move more rapidly in the West than in the East; until they get into the program, we don't know.

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DR. HAMER: Not to belabor the point, but the East tends to look to what the West is doing, and if something is taken by the West, that brings part of the East to the point where-- pressure cookers which have started to be made in Turkey and are selling well in the West--there is now a distribution in the East and I have never found a stove that could be used in the East, but they are still selling the pressure-cookers. It is prestige.

DR. FLORIO: Like refrigerators for the Eskimos.

Are there any other questions?

FROM THE FLOOR: 8 to 10 million pills a month ought to make some difference. Is there any evidence that it does?

DR. MAULDIN: There are no data at all on the number of users. They have no idea whether half of this, to use an arbitrary figure, is going out of the country and being smuggled into the whole surrounding area, or if there is no proportionate number of users.

They suspect that there is leakage to other countries and there has been some hoarding because women who start using the pill are afraid that supplies might run out. But there are no studies. We made a national sample survey.

DR. FLORIO: Are there any other questions?

(No response)

DR. BAUMGARTNER: I think I would like to make one comment on the East-West Turkey thing. It seems to me that this is a problem. This is a problem that is found in a good many places and we talk of it as an either/or problem and maybe we

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are wrong. I think it is a question of the factor of time and none of us know how fast these things are going to move. I think it is also a question of trying to do the things in line with some of the political realities instead of the clearly-scientific realities, and I think these are very interesting balances that make decisions much easier to make at the table in Baltimore than they are in Turkey, if you want to get something done.

DR. MAULHIN: We have not talked about it as either/or or at least we have not meant to. We are talking about the concentration of effort. Certainly there should be a program in the East, but should it take one-third or two-thirds of the resources, it is the type of issue we are talking about.

DR. FLORIO: I think it is time for our coffee break.

(A brief recess was taken.)

DR. ANDERSON: The next discussion is Africa below the Sahara, and my role is brief. I will merely introduce the Chairman, Mr. Robert Wright, professor of Public Health Administration at the School of Hygiene, who also is in the very fortunate position of living abroad and representing the International Health Division in Africa.

Mr. Wright?

MR. WRIGHT: On my right is Mrs. Jean Pinder, who will participate, and Mrs. Pinder has had 12 years of experience in West Africa, seven years in Ghana and five in Liberia. She is

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c57 a health educator. On my left is Dr. Franz Rosa who has had 4 or 5 years of experience in Ethiopia with the Gandor School and is now with the National Institute of Child Health and Human Development. On my left also is Dr. Robert Morgan, who came down from Harvard and is heading out to Nigeria where he has already spent a year and he is a sociologist.

Now, "Geographers in Africa, Maps With Savage Pictures Fill their Gaps, and in Uninhabitable Downs Place Elephants for Want of Towns". These lines were written Jonathan Swift over 200 years ago and are more true than we would like to be for sub-Saharan Africa today.

I think the first thing that has to be said in any discussion about demography in sub-Saharan Africa is that so-called numerical facts, until proved otherwise, are best considered as guesstimates. There are very few reliable figures and I think it would be safe to say none on a national basis.

I am going to confine my remarks to Nigeria with which I have had some first-hand experience, and the other speakers will talk about some of the other countries south of the Sahara. I am merely talking about one-fourth of the population of Africa, south of the Sahara, when I speak about Nigeria, if their recent two censuses can be accepted as fact.

But there again, taking a census in Africa is fraught with great hazards. One being transportation, trying to get to the people and another with illiteracy, because only a small part

e58 of the population is literate, and another is the difficulty of getting people to tell anything about themselves, because of their fear that this means new taxes. Finally, because there are very real taboos against counting anything, including children.

So that we have to take these things into account, if we are going to talk about numbers. In 1952, Nigeria held a nationwide census which was the first one since 1932 or 31 and the population had gone up from 16 million to 31 million--32 million. Then in 1962 they took another census and the population, according to that census, was 52-1/2 million. So the population went up approximately 20 million between the two censuses.

Well, there was so much commotion over that that they decided to do another census, so the next year they did it over again and that one showed 55.6 million. Now, actually the increase in population between 1952 and 62 showed an increase of 6.2 per cent per year and the increase from 62 to 63 also showed approximately 6.2 per cent in that one year. So were we counting cattle or were we counting people, and is it possible to have 6 per cent per year increase in the population? I don't know. It just does not seem possible to be, because Harold Dorn in his presentation of figures on Africa, suggested that the death rate was something around 27 per cent per thousand. If you add that on to 60 per thousand, you would have a birth rate of 87--88 per thousand per year. I know of no population--and maybe some of you do, where any population has maintained such a birthrate for 10 or 11 years running, so that we have real problems in trying to decide what

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actually is the situation in Nigeria and I have no doubt that this is very likely too for most of the countries of Africa south of the Sahara.

Now, in Nigeria, despite this apparent "explosion"--we do not ever use that word in Nigeria--there is very little awareness of any population problem. When I first went to Nigeria I was asked to speak to the Nigeria Health Society, and before I got out there I had the feeling that here was an important problem for anyone interested in health. So, I talked on the subject of the portent to international health, and went into the explosion figures.

They went over like a lead balloon. The chairman of the meeting was the president of one of their universities and former health officer of the city of Lagos and he took a great deal of time, after I had spoken, to rebut every idea that Nigeria has a population problem. In fact, he said: "In Nigeria there is an old saying that you do not count children." He said women like to be pregnant and men like to have them pregnant, and that is the Nigerian way of life.

I learned a lot, quickly. I have not used the words "Population problem" again, or "population explosion". But we do have a program in Nigeria in spite of all this, that has been growing quite rapidly in the last few months. There are some Nigerians who are aware of this problem and are willing to move ahead on it. And I might just outline very briefly what I have

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tried to do to indicate that our program is in harmony with some of the ideas that have been expressed around this room during this meeting.

We don't talk about a national problem. Our approach to this is strictly in terms of family welfare. We take the position that, although we don't want to talk about it, that there is a population problem whenever a family is threatened with too many or too few members. The decision thereby is with the family. I think that is very important and I think it is important in the long-range success of any activity that AID may engage in in this area.

It is a real tendency on the doctors, and I do not think bureaucrats are immune from it, to try to play god with other people's lives and it is one thing to talk about family-planning as if you are planning for somebody's family and another thing to talk about family-planning if you are providing the resources by which the family can make meaningful choices about planning. And this is the approach that we are using in our program now.

We are merely out to provide the resources for the people to make their own decision about this. It is a real approach because we are also providing sterility services, sterility correction services, as well as contraceptive services. We have the "cafeteria" approach as far as contraceptives are concerned, and all the women who come in and say, "I want a child and we can't get it" are referred to the University Medical School Hospital

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for examination and treatment if it is possible. So I think we are in a good position to avoid any political repercussions.

We have approached this without involving the Government at the beginning and this was the idea of the local health officer. We had that support from the Unitarian Service organizations for supporting the personnel, and we have got the supplies from the Pathfinder fund. We have four clinics going in Lagos in the new health centers that have just been completed. The program is so new that I don't have any statistics that are worth quoting at this time.

Well, we are also in the process of organizing a demographic study so that we can find out what is happening with the program.

Does Nigeria really have a population problem? I am sure there are more and more people realizing it, although nationalism does not want them to talk about it, but approximately one-third of the working force is out of work and as one Nigerian said to me, "The other two-thirds are unemployed."

They have this population of 58 million people and a gross national product of approximately 3 billion dollars, which figures out at about \$60 per capita of income, so that they have an overall problem that they have got to face in terms of high density of people per unit of capital investment.

They also have huge concentrations of population in three different areas, and in these areas some places have rural

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areas of 700 people to the square mile. This does not compare to the Nile Delta but it is high density in terms of the lack of fertility of the land, so this is a real problem.

I have a few slides to emphasize these points that I would like to project for a minute.

(Slides were shown)

This is the kind of thing that does not do the program any good. It has too much the connotation of the White man's burden and I don't think it is the approach we should mention in the country where we are working.

This I am showing to point up the fact that even though Africa is now a vast open space for the most part with about 200 million people scattered over 8-1/2 million square miles, the changes can come very rapidly. This shows how much faster the population changes are taking place. Here is a decline in the mortality rate that occurred in Sweden from 1771 to 1780 and from 1871 to 1880, and you will see here is where it was in the 18th Century. Here's where it was in the 19th Century (indicating) with only this much fall in the whole century. Where as here, among the Moslems in Algeria it was here at 1946 to 1947 and by '54 it was down here. So they made more progress in lowering the death rate in just this small eight years than have been made for the whole century by the Swedes in the previous time. So that changes are going to be much more rapid than we have been accustomed to think.

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Here, I just project this to show that there has been a slow beginning or a retarded beginning of change in population as far as Africa is concerned, as compared with Asia, Europe and so on, but you see the curve is much sharper as we come into the 20th Century, so we can expect the African increase in population is going to be very rapid.

This will give you an idea—these are births, these are deaths, and added together it gives you the total birth rate.

As you see, Africa has such a high death rate, but has a very high birth rate, and if we should suddenly decrease this death rate, we would stand to have a very rapid increase in population so that now is the time to get ready to do something in Africa. The problem is not nearly as pressing as it is in Asia, but unless we start now we are going to have the same problem that they have in Asia.

This gives you an idea of the comparative densities in the various parts of the world, and Africa of course, has a very low density as far as the total area is concerned. But much of Africa is just not inhabitable. Out of 336,000 square miles in Egypt, for instance, 11,000 square miles are inhabitable. I put this on just to show these areas of density in Nigeria.

Of course, Lagos has the highest. Lagos Island has 25,000 people per square mile all living on the ground floor and it is a very densely populated—I'm sorry, the whole of Lagos

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Territory has 25,000 people per square mile. 250,000 people on Lagos island on an area one mile wide by two miles, all on the ground floor.

This is a newspaper spread that occurred just before I left in which the newspapers show what the crowding is doing on Lagos island with the very bad housing conditions that exist there. There is no water borne sewage disposal in Nigeria, so they are recognizing the fact that at least in Lagos they have a problem. Fortunately they have a free press and they feel free to criticize their Ministers and themselves very readily. That at least is helpful.

This last one (slide) is just another with the officials and they are giving the business about get busy and do something.

Now, I would like to call on Mrs. Pinder to tell us a little about what is happening in Ghana.

MRS. PINDER I am going to stick to Ghana. I have been away from Liberia for a number of years. First I want to take issue with Dr. Wright here on census figures in Africa. In Ghana we think we have something--we think we have some good census figures. I talked with the UN census advisor a short time ago in regard to the 1960 census figures and he assured me that they were reasonably accurate. Regarding the question of whether or not Ghana has a population problem, I don't think that Government feels that they have a population problem, and on the basis of surface area in relation to population, probably they don't but there are

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some other factors which should be considered.

In the 1960--the 1960 census--showed a population of 6,726,000. In December of 1964, the population was estimated to be 7,637,000, which showed a rate of population growth of about 2.7 per annum. The accrued birth rate on a provisional estimate is 48 per thousand and the accrued death rate, 21 to 23 per thousand. These are provisional estimates. 44 per cent of the population is under 15 years of age, and 70 per cent of the total population lives in rural areas. The population density is about 81 people per square mile.

In terms of food supply, Ghana does have a population problem right now. The increase in the production of food is not keeping pace with the increase in population. Therefore, Ghana has to import a considerable amount of its food supplies. However, the government still does not see this as a very significant problem. The demographic section of the division where the census bureau is<sup>is/</sup> interested in initiating some studies in regard to the rate of growth of population and the general population structure. However, the government has not indicated any particular policy in regard to population control.

The people apparently though are interested in family planning. Now, this is based on reports from obstetricians in the urban areas. They indicated that the people whom they see, patients, are clamoring for information regarding family-planning.

I have noticed too in moving about in the rural areas,

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that the people are interested. They have asked; they asked a question about where can they get information in regard to family-planning.

Interesting enough in Accra, the Christian Council has established a clinic and also in the second largest urban areas, Comosi(?). They call them Medical Advice Centers, and not family-planning clinics. The most significant service which they render is in the area of fertility, infertility, maybe I should say. That is, the women who have difficulty in conceiving come to these clinics for advice and assistance, but they also do provide birth control information and give some supplies. I think they primarily give the foam. In talking with the people of the Christian Council who are concerned with this, they are interested in opening additional medical advice centers in some of the urban areas of the country. If they can find doctors who will service these centers. At the present time they pay a small fee to physicians who will come and run the clinic in off-hours. I should indicate that practically all of the medical services and health services in Ghana are Government-operated. There are a few private physicians and private practice, but the greater percentage of them are in government service. The government has indicated, as its policy, that it would like to have a complete program of socialized medicine.

I did a rough calculation of the ratio of doctors to population, and I think I come out with the figure of about ap-

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proximately one doctor to a population of 17,000. Ghana has the same problem that most other developing areas, and not only developing areas, but other areas of the world have--and that is that the medical profession is concentrated in the largest centers. As you travel around Ghana you will find that practically all of the physicians who are in the more remote sections of the country are ex-patriots; a large percentage of the medical profession in Ghana is made up of Indians, Ceylonese, a few eastern Europeans, --well, I think that is it. And the rest of course are Ghanaian, and all of these are employed by the Government of Ghana working on contract for the government of Ghana.

You see I have been running close to my time here. If there are questions, I will be glad to try to answer them.

As yet, at the present time, I see no sign of Ghana developing a national program of population-control. However, one interesting thing about Ghana is nobody can predict 24 hours in advance what may happen. When I get back to Ghana in a few weeks they may have decided they do have a population problem and are interested in doing something about it.

DR. ANDERSON: Can we hold the questions until the others have been heard. Dr. Rosa.

DR. ROSA: One calculation on your Lagos island. I figure if Texas had the same population density there would be 31,250,000,000 Texans. A horrible thought!

(Laughter)

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The demography of Ethiopia--we have no census, no registration--based on a tax figure and other speculations, the calculation is something in excess of 20 million. I would speculate that Ethiopia, like a large part of Africa, is a balance between man and anthropoids. We have problems with Malaria. The Ethiopians have made a better adjustment to the louse than they have to the anopholes. The lowlands are largely devoid of population, although they represent potentially some of the richest parts of the country. In fact, some parts of the lowlands in the provinces that I worked in, have what I like to think of as the permanent silent spring which I always wanted to show Dr. Rachel Carlson.

The highland above the Malaria land contains all but one of the six towns. It has population pressure, and this is manifested by food and land shortages which lead to immigration from the highlands to the lowlands.

Several respective surveys that we made show that the ordinary prevailing infant mortality is intermediate for an underdeveloped country, around a hundred. Sometimes in places with an unusually unsettled or famine conditions, it will exceed 500.

Fertility is also intermediate. In general, we hear more concern for more babies. Large families are not prevalent. I will say a little more about families though. The unwed pregnancy is desirable in our area, proving that the woman is fertile and making her more of a bet on the marriage market. Fertility under 10 is fairly low. One remarkable thing about that demo-

c69 graphic feature in Ethiopia is we apparently have a low fertility after the age of 30. This was a marked contrast with the situation that I was used to in Pakistan. I have not heard any evidence of induced abortion or infanthicide and there is very little child-abandonment. However, the requirements for child-raising are minimal. They are turned loose to herd the cows. The family structure is quite different from ours, and to speak of family-planning would be a misnomer.

We do not know how much demand there is for child-spacing but the impression is that the demand is exceptional. In general, the population is apathetic, fatalistic, and little concerned about managing that aspect.

Contraception is not apparently practiced. We did have some inquiries about birth-control, mainly from family friends who observed that "My wife was not having babies every other year". The Church attitude, again there is little concern or awareness among the abundant priests in Ethiopia. I have talked it over among the religious leaders and teachers, in the Christian church, and they say there are no barriers at present to contraception. However, in the absence of an active contraceptive practice and program, it is hazardous to say what might develop unless the church was handled.

Health workers--ethiopia has less than African countries, with only 40 Ethiopian doctors and some 200 additional international doctors--most of these in the city. With this aspect, I

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was working in the training program in Ghana. I think that about does it.

DR. ANDERSON: Dr. Morgan, have you anything to say on the tribal efforts of this as far as the hope for family-planning?

DR. MORGAN: I will try to be brief and tell you something about the sociological and tropological aspect of this. Sometimes people wonder what a sociologist is doing in Africa. When I left Boston there were four anthropologist and one sociologist working at a hospital researsh project. When I got to Africa, I discovered there were four sociologists and one anthropologist working in the research institute in Nigeria. So I guess times are changing.

I am going to try to make a couple of points that I think might refer to all African societies south of the Sahara before my four minutes are up. Probably 10 or 12 of you will be on your feet saying that this is not so in the place you happen to be. But let us go ahead and see what happens.

First of all this is what we call kinship society, and they have been this for maybe a thousand years, maybe tens of thousands of years, and maybe more. This means that a man's status in society is determined by the number of children he has, or more broadly by the size of his family which he presides over. Something that has been going on for thousands of years is not going to change in a hurry. Some people may feel that the so-called educated elite may be changing, and maybe they are, but we

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certainly have no data on that. I had the pleasure and privilege of interviewing 100 residents, internes and clinical students at the University of Abingdon two years ago. Just about half of these gentlemen came from polygamist families. The average number of symblings (?), according to the figures they gave to me, were about seven, and when I probed insistently, I could always get 3 or 4 more.

When I asked them "Is your father a wealthy man?", the answer is always "In your sense or in my sense?", and I would say, your idea. Then they said by your way of thinking he was not particularly wealthy, or he is not, but by my way of thinking he is very wealthy. He has lots of cows, lots of wives, lots of children.

I think you are not going to get people to place this kind of value on families to change their thinking about family-planning very quickly.

However, my second point--~~these~~ are more positive aspects of the situation. It may be that you can approach people according to the things which they do desire, and three things they do desire in addition to large families are, I am quite certain, very good medical services for one. I think the demand for medical services in the Western sense far exceeds the supply at present in many areas of Africa. This might surprise a lot of health planners, but I am convinced it is so.

Secondly, the demand for education, I think that probably

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virtually every father and mother in West Africa at least would like to see their children go to school. Thirdly, the growing demand for urban jobs. You could approach government people and say, "Look, if you want to improve the population ratio, if you want to improve the teacher and pupil ratio, if you want to improve the urban job pattern, you have to do something about population.

It might be that some change of feeling or some kind of program might be put on that basis, starting from the poorest structure and working down to the largest segment of the population in that way.

I might note that a great many people in West Africa, particularly in Nigeria, expressed concern that a revolution of sorts might develop over this problem of school-leaving--semi-educated young men who are roaming the streets of Lagos and many other cities of West Africa and probably other parts of Africa looking for work.

I guess I will skip my third point, but I will just say I did not know Professor Wright was running sterility services in Lagos as well as population-planning. I am sure this will be a very popular facility.

What are universally referred to as native doctors do their biggest business in advising people who are not able to have as many children as they would like on what kind of gimmicks they might go through with in order to rectify this situation.

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I don't know what kind of response you are getting on this, but I am sure it is good.

DR. WRIGHT: It is very popular.

DR. ANDERSON: Are there any questions for the group?

(No response)

DR. BAUMGARTNER: I spent 10 days with leaders from 21 African countries. I have long since learned--and I trust everybody in this room has--never to use the words "population explosion", but I thought one could talk about population problems and I thought one could talk about the balance of natural resources, people's ability to use them, and the numbers of people you could support, and I thought one could talk about a family's ability to educate and so forth, it's children, and I had very rough going in our session until the coffee break when it was said to me, "Will you come back and talk about population dynamics?". I did and everybody was much happier. I don't know if that is a hint for everybody or not.

The second thing I do think, what has been said about education is important because as soon as we got on to the subject --health was all right, but as soon as we got on to how many you/schools are/going to have to have--how many teachers are you going to have to train in order to have to educate a child in this school, then we had a very lively discussion.

DR. JESSUP: Would Dr. Anderson say a word on Kenya?

DR. ANDERSON: There was a mission sent to study the popu-

c73           lation, to study the rate of growth, and the mission was expected to leave at the end of June, but it was delayed probably until the end of July.

DR. JESSUP: Is this the first request?

DR. ANDERSON: Yes.

DR. MONSANO (Colombia): You are working with a population of low motivation. Two questions have come to my mind. One if they are practically any type of family or fertility-control, what are they doing? What is accepted and what techniques are they accepting?

Secondly, what is being done about this if not, and how do you go about arousing interest, motivation under those circumstances?

MRS. PENDER: May I comment only about Ghana, and I should point out that Ghana is really not typical, in any respect, of the other countries. They probably have, or they have had, I won't speak of right now, but they have had a higher per capita income of any other country south of the Sahara excluding South Africa. They probably have had a better educational system than any other country. Again, all of my remarks are excluding South Africa. I would say that the Civil Service type of class in Ghana, the educated class, has been practicing in many instances birth control. There is also evidence that there is a fair number of abortions that occur. They are illegal, but nobody pays a great deal of attention unless the persons happen to come into the

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hospital because of complications arising. Again, another factor which I think does contribute to the interest in Ghana is that it is becoming more a money economy, and I have had several people indicate to me that this extended family business, where all of the relatives come and park on the working member of the family, is becoming a burden to them.

Again, in Ghana, you have, in one particular group, a sort of matriarchal social system and there has been a sort of business of nephew inheritance rather than son and daughter inheritance, and the women are becoming concerned about this. They want to change this inheritance policy.

This has to go through Parliament. They operate on two sets of legal procedures really. The Parliamentary-legal areas and then the tribal-legal areas. Again, the women are becoming concerned about the husband having so many wives, and they want the legal right to have certain recognition and certain privileges that these tribal wives do not have.

I think all of these factors indicate an interest in limiting the family size, not only in regard to how many children but in regard to bringing this extended family into the home.

DR. MONSANO: But when they do practice birth-control, what methods are they more likely to use?

MRS. PINDER: I don't know that I can answer that beyond abortion.

DR. MONSANO: You did mention foam.

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MRS. PINDER: That is probably the more elite group because they are in the urban centers where this is available. I have noticed in some of the department stores ortho-diaphragms, et cetera, on sale.

DR. WRIGHT: In Lagos we are using the IUD and diaphragms have been used widely and the foam quite frequently, but less and less.

MR. MONSANO: Is the interest more on the women's side to prevent or is it shared by the man?

DR. WRIGHT: Mostly the women.

FROM THE FLOOR: One comment. The educational aspects. In talking of education in Africa, it is absolutely crucial because a great many of the French African parts that are never talked about in Anglo-Saxon countries are Catholic-educated in their leadership. That is an only comment.

The second, a question for Dr. Rosa, this fertility problem after the age of 30, do you have any data as to whether this involves the age of Menopause, amenorrhea?

Do you know of any studies testing that particular population?

DR. ROSA: Any real studies, no. The evidence at hand would leave me to believe that it is not due to the prevalence of venereal disease. I do not know why the low fertility after age 30.

DR. ANDERSON: Can we cut this to one more question? We

have one more panel.

**FROM THE FLOOR:** In Ghana is there any government policy for population increase?

**MRS. PINDER:** No, there is no government policy in regard to population at all that I know of. I might point out one thing. I just received a copy of some of the parliamentary debates recently held, and one member made a motion that subsidy be given to parents that have multi-births because of the economic problems arising out of having twins, triplets or quadruplets, et cetera, at the same time. There are a few other interesting items in regard to that debate, but I won't go into them.

**DR. ANDERSON:** Since our time is brief, may we start with our last panel? I will try to make my introduction brief. I think you know, many of you know, and most if not all of you know the people on the panel. One of them suggested, which pleased me very much, that they had said they agreed they would limit each discussion to about 10 minutes so that would leave us about 15 or 20 minutes for discussion at the end and we would still be able to close on time.

Starting at my far right, I would like to introduce Dr. Paniagua who is well known in Puerto Rico. He is an endocrinologist and a member of the Family-Planning Association. Next is Dr. Eduardo Arandes, Professor of Gynecology and Obstetrics at the University of Puerto Rico, and very significantly he is also the Director of Obstetrical Services for the Northeast Region of the Commonwealth of Puerto Rico. As he will mention, this is an area

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where the medical school has taken responsibility for medical care, which we understand is now beginning to include some family-planning.

On my immediate right is Dr. John Whitridge, Associate Professor of Obstetrics at Johns-Hopkins. He is also Chief of the Bureau of Preventative Medicine of the Maryland State Department of Health.

On my immediate left is Dr. Arthur J. Lesser who is a graduate of Washington University with an MPH at Harvard and he is now Deputy Chief of the Children's Bureau.

On my far left Don Bogue of the University of Chicago who is one of those interesting demographers who not only likes to study population but likes to do something about it.

I guess we will start with him since he is first on the list of the program.

DR. BOGUE: The topic at this time is "Relevant Developments in U. S. AID." The sequence of events in U. S. AID has been one from taking inventory of what people think about family-planning and do about it, through actual experiments. This is the same sequence that has taken place in most developing countries. Only in this country it began earlier and has been a pattern that has been followed elsewhere.

There are six of these inventories that have been taken in the United States. You should know about them.

Professor Harper can give you the detailed references.

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I will go over them briefly. First, the Indianapolis City study in the city of Indianapolis in 1939. Secondly, a program called the Growth of the American Families, sponsored by Milbank Memorial Fund. The Chief Author is Professor Ronald Freedman, whose book "Growth of American Families" is a classic that everyone should read in this area.

There is a sequel to it now in the press that I understand will be out, by Professor Campbell, and there is a third round just being planned. This is a national sample survey of American attitudes, knowledge, and practice.

Princeton University did a very comprehensive study in five metropolitan of couples that had two children and they followed them up to see which one had gone ahead to have the third. There are two monographs from this study which are very excellent.

Then there have been questions on public opinion policy taken at various intervals which, when pieced together present some information. The University of Michigan, under the leadership of Professor Hauptmann again has been invited to take soundings of attitudes to a family-size in two areas. First, Detroit and also a national sample survey which the survey research center would undertake. Also, I would like to add the work of Christopher Falkey (?). He has done superb work, taking the records of hospitals, clinics and private physicians and has dug up very much information of a background type on the use of various types

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of contraceptives and their effectiveness and so forth. If you write to him you can get complete bibliography in this area. He keeps a mailing list and if you have an interest in this area, you should get on his mailing list.

Then I would add as a seven, this transfer from navigators to experiments. In Chicago we have been trying to duplicate some of the work that has been going on in several countries. We have three family-planning experiments where we try to bring down the birth rates. One is in the city of Chicago itself. One is in the eastern hills of Kentucky, the poverty-stricken area, and the third is in the vicinity of Montgomery, Alabama, the so-called "black belt", the poorest part of the Negro section of the South.

Of these six inventories, what have they shown in major high points? They have shown that the practice of family-planning requires a knowledge of family = planning and practice of it at some time during the marriage career is almost universal, irrespective of race or religion. Some type of family-planning is attempted by more than 90 per cent of the people. The intensity of practice and the success in this practice is directly associated with the number of children. As the number of children increases, the couple shifts to better methods. They are more regular in the use of these methods, so, although they may be quite unsuccessful at the beginning, at the end of the family cycle, it becomes quite effective and this again tends to be irrespective of religion or

c80 socio-economic status. The methods, another finding which Hauptmann and his associates made, is that an amazing proportion of the American population is surgically sterile. I think something like 9 per cent because either intentional sterilization or hysterectomies are sterile or for other reasons.

The methods that are being used, the condom is still substantially the leader, but this is not very well appreciated, in Europe. In the United States the condom is the principal method of fertility control and it is the condom which is, of the device methods, the one that has been primarily responsible for the decline in fertility.

At the present moment the pill would be second. There is still a substantial use of less-effective methods, the diaphragm, suppositories, withdrawal. The evidence is not very good of trends over a period of time, because we do not have much data for the early period, although there were some studies earlier.

It looks as if the rhythm method has not declined in popularity. Over a period of time it has remained rather constant, about 30 per cent. The theory is that people use it in combination with other methods. They learn the rhythm method and they rely on the rhythm method during the safe period to get some relief from the appliance methods. At the present moment fertility differentials have almost disappeared from the population. The socio-economic differential, the income differential between the poor and the rich is much reduced. The differential between

c81 urban and rural is there, but much reduced, between the white collar and the blue collar--almost all of the differentials that used to be sharp are much reduced.

The major one exists between the well-educated and when you make allowances for the fact that in order to get a college education, a woman has to start later, even this is not very pronounced.

The major differentials are in the Negro population. Rich Negroes have fewer children than the poor, and so forth. The old differentials that we used to know in the white population are still present there.

With respect to the Chicago experiments, you might have gathered from my comments we emphasize handling large populations with mass communication with small budget. We started in Kentucky with a program a year ago. We have, in these eastern hills, 500 very poorly-educated farm women from the hills, on the pill now.

In Alabama, we started a year ago and have 2,000 farm women, Negroes, on the pill, and another thousand on other methods.

In Chicago we work with the Planned Parenthood Organization. They have now something like 18,000 patients, most of them from the slums with very high emphasis on the pill. One experience that is coming from our investigation is that the pill, although it is expensive, now is a very acceptable method of people of low education and low income. So that it could be used, I believe, in conjunction with the IUD, where the IUD cannot be used for some

reason. There is 25 per cent which cannot, which do not or cannot, make use of the IUD.

I would like to close by announcing that thanks to the Population Council, and some additional support from the Ford Foundation, we are able to offer a workshop on mass communication in motivation for family-planning once each year. We invite and receive acceptances from some of the world's leading experts to come and spend a day at this workshop. So it consists of a parade of one full month of experiments. The program is posted to the blackboard back here and if any of you happen--it begins on June 21--and if any of you happen to be passing through Chicago and want to come out and attend one of these sessions, you will be more than welcome.

DR. ANDERSON: Thank you.

We will go to the next speaker.

Dr. Lesser will tell you about the public program in the USA.

DR. LESSER: We are in the process in the United States of evolving a public policy with regard to family-planning and I think for the first time, we have very definite signs of encouragement with respect to a sound expression of policy.

I think the evolution of policy is in three steps. The first steps I would call one of planned-ignorance or studied avoidance of information, because during this period we just didn't want to know what State governments, for example, State and local govern-

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ments, were doing with Federal grants-in-aid in the field of family-planning. But if we were asked we would be able to say they are free to use these funds for family planning services if they choose, but we do not have information about this. And this went as far as the maternal and child-health planning, which comes in each year from the State Health Department, the basis of which is the grant-in-aid which we provide. This went so far as that we would request a State which was foolish enough to include references in family-planning in their plan--we would request them to take it out.

We moved from that to a position which I would call passive acceptance, and the difference, even though it does not sound like very much is very significant. We were greatly helped in moving to the second step by a letter which was written by Dr. William Stewart in the Secretary's office. This came about after Senator Gruening of Alaska sent a letter to the Secretary on June 19, 1964 requesting information regarding the extent to which grants of funds for State and local programs are used for family-planning. Dr. Stewart, writing in his own name, wrote: "We have regarded the question of family planning as one for individual decision and would raise no question about the provision of such services by a physician to his patient within the normal scope of the doctor-patient relationship. Whether or not a State chooses to include such services as a part of the scope of medical care for which the State will pay, using Federally-matched funds, is

entirely a matter of State discretion.

"Under the circumstances we have no definitive data as to the extent to which services are going to individual patients by physicians under Federal-State programs."

What I have been saying is, the significance of the letter is that this was the first time we had a written policy representing the Department's policy with respect to family-planning services. Up until then everything we did was by word of mouth. It was unwritten. This had further significance because along about this time we began to approve the first projects for maternity care and instant care under new legislation which was enacted--the so-called 1963 mental retardation planning and maternal and child-health amendment--in which project grant of authority was given to the Childrens Bureau for the support of medical care for pregnant women with complications of pregnancy.

These programs came in with family-planning frequently included in them and on the basis of this letter after an inquiry--which really was foolish because we did not get any answer--but on the basis of this letter, we decided we could approve these projects without asking them to take out references to family-planning, so this was a real step.

Now, the third step in our evolution is the most significant of all and actually occurred, as far as we are concerned, only yesterday when, after all these years of deliberately not knowing what was happening we received an inquiry, a memorandum

c85 addressed, it was addressed to the Public Health Service, Bureau of Family Services, asking for information in accordance with the following subject: What States have laws regarding family-planning? What States have policies and regulations with respect to family-planning and with respect to State health and welfare programs? How many people, families or individuals are receiving family-planning services in these Federal-State grants-in-aid programs, and how much money is being spent for these purposes?

This we are supposed to supply--this information--by June 22. I feel that this is like moving from the Stone Age to the Space Age in the course of a couple of weeks. Of course, the information is not available and we won't have it, but the mere fact that we are now asked, opens up the door you see for us to go out and get the information and also for us to begin to include it in family planning and State planning materials.

It is really a very significant development.

Now, in 1963, the Association of State and Territorial Health Officers, which meets with the Surgeon-General of the Public Health Service and the Chief of the Childrens Bureau every year, passed a recommendation in the area of family-planning which says--addressed to the State Health Officers--that its members recognize the importance of family-planning, and that States desiring to do so should be encouraged to proceed in planned developments.

We were asked to find out what States actually were doing

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in this respect and we learned that approximately one-half of these States were engaging in some kind of activities, from the formation of policy or the written expression of policy, to consultation, to the full support of clinical services.

The American Public Health Association has been making surveys, has made a survey twice, and will do this again, and in their 1964 survey they found that in about 20 States, local health departments were supporting family-planning services, either in family-planning clinics as such, but more typically, as part of maternity clinics and many of these States are in the South.

As a matter of fact, we had known that a number of States, such as Virginia, North Carolina and a number of others--we had know that for at least 20 years they had been using Federal NCH money for these purposes. The American Public Health Association is now in the process of sending out a 1965 questionnaire which will give us much more information than we have had in the past.

Now, I want to move on quickly.

With respect to some of the activities that we are supporting, the Public Health Service at NIH, of course, has an appropriation of about \$1 billion a year for research. They identify about \$7 million currently being used in the program of research in the field of reproductive biology with 224 research grants and 64 training grants and scholarships. Reproductive biology, a broad field, in which of this \$5 million, approximately

c87 \$500,000 a year is directly related to population research. This will increase.

With respect to the support of services, this is largely through the Childrens Bureau grants for maternal and child health. I have indicated that half the States are involved, but the biggest step forward came with the provision, with the authorization for maternity care programs which are supported on a project basis. This is medical care, not research. It is especially to meet the emergency programs in larger cities, and we have, within the past 14 months, approved 21 such projects and most of these are now including family-planning services.

And it was to a considerable extent the availability of these funds in the formation of programs in large cities that helped develop the public policy in these cities to make it possible to use funds for this purpose. One direct result we have learned from a meeting with our obstetricians, that advise us--one direct result of this shift in public policy regarding the issue of public funds in local areas has been a doubling of attendance at post-pardon clinics. They attribute this directly to their discussion with patients in the pre-natal period about family-planning. It is a significant development in the field of family-planning, as the Office of Economic Opportunity has made several grants in this field.

I want to say that in the Childrens Bureau, in our grants, we are not supporting family-planning clinics as such.

c88 We encourage it, very passively to be sure, but I think we could be a little more outspoken about the inclusion of this as part of comprehensive maternity care. I agree with comments made by others that truly the best occasion to discuss this with patients is when they are pregnant and we would like to see this included as part of maternity care, and where they are including it, they are offering the patient a variety of methods to be followed.

Two other points I wish to make. One is bills have been introduced--typically H. R. 7073--to set up a commission. Also a Secretary and Assistant Secretary in the Department of Health, Education, and Welfare, to deal with family-planning. This particular one was introduced by Mr. Udall. Senator Gruening has also introduced such a bill for the creation of an office for population projects in the Department of Health, Education, and Welfare. It is a very interesting bill.

Finally, I call your attention to this publication recently received from the National Academy of Science, the growth of U. S. population. It has recommendations regarding education and training. It recommends, for example, that the PHS Childrens Bureau start world-wide training and research in this field. It says, "Family planning should be an integral part of public health training and individual medical care" and it goes further into detail in other government publications which only skirts the surface.

I was interested enough in this to look up in the government manual exactly what the auspices of the National Academy of

c89 Science is. It is listed as a quasi-official organization, so this gives them somewhat greater freedom than some of the rest of us have had. But there is no question in my mind that we are definitely moving ahead in this area.

The press has been kind to us. Time and others have said, "Federal government says little but supports a whole lot." I think they were generous, but I think in the future we will be able to say a little more than we have in the past.

DR. ANDERSON: The Supreme Court has been kind also, I might add.

The next speaker will be Dr. Whitridge who will tell us about public programs in the District of Columbia and the Maryland, and Virginia.

DR. WHITRIDGE: My assignment is to tell you about programs in these three sub-divisions. I will have to concentrate more on Maryland than the other two, because I happen to know more what goes on in Maryland than I do either in Virginia or the District of Columbia.

First, let me start by telling you what I am not going to be able to do. I am not going to be able to give you any evaluation or statistics indicating either very much about the extent of programs in these three subdivisions nor their effectiveness. So that in essence, all I can do is summarize for you in about 8 or 9 minutes the historical developments, the factual historical things that have happened in these three sub-divisions.

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Incidentally, it was included in the material that you got in your yellow folder, so I will simply summarize that. I will start chronologically with Virginia, because Virginia was one of the earlier states in the union to enter into this type of program activity, actually dating back as far as about 1936 or '37. At the time in the State of Virginia, the State Health Department in Virginia, began its state-wide maternity clinics, for indigent, medically-indigent patients--they authorized at that time the inclusion of family-planning services for people coming to such clinics.

In 1945 they entered into a rather firm working agreement with the Virginia Planned Parenthood organization and as nearly as I can determine, it was that later organization that was really sparking the program and spearheading the effort more than the Virginia State Health Department.

The Health Department more or less said, "Go ahead and do what you can." But I do not think from what I have learned, that they really pushed it very vigorously until about 1961.

At that time, in 1961, in Virginia, the State Commissioner of Health sent out a directive to all local health officers and health departments more or less saying, "Let us get something done now. We have been doing this in a rather modest fashion." But they urged every health officer to have services available to make the educational program--to get that into high gear. So at the present time, the report I have from one of the health officers in

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Virginia is to the effect that every county and every city in the entire State of Virginia is in the business of providing family planning services through health department facilities. The health officers further reported, however, that naturally the scope of activity, the emphasis given to it, varied tremendously from one county to another, which is what one would expect.

Now, crossing the Potomac River and coming toward the North, let us come into Maryland, and here I can tell you more of the details. There are essentially three important dates that sort of divide what has been going on here in Maryland. Put in historical perspective the first is 1952. Prior to 1952 there had been an unwritten policy in the State Health Department that State health officers and State employees should not engage in the provision of any advice or services relating to birth control or family-planning. The reason for that, I think, is significant. That was mainly that the health department did not wish to become involved in controversy. We had enough controversial topics on our hands already without getting into this one. So each time it was brought up prior to 1952, the Director of Health would say, "Let's don't get into that. That is too controversial. We have enough problems. Let's go merrily on our way."

In 1952, however, the Board of Health agreed to review this unwritten policy and passed a very neutral sort of resolution which, in effect, said that any health officers who wished to include family-planning as part of their maternity program may do so.

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It is legal, but it did not urge them. It did not appropriate any funds.

You can imagine that the results of this neutral resolution in 1952, did not lead to any wild development of family-planning services. No, sir. Health officers were rather reluctant again to get into a controversial area, and since no one had specifically made any funds available to them to do much about the program, in the succeeding ten years there were only about three or four counties that undertook a very modest program of family-planning.

Again, a second significant date. Exactly 10 years later, namely, 1962, and in September of that year, the State Board of Public Welfare reversed completely its previous policy. The previous policy had been one of forbidding all of its case workers from making any mention of family-planning or making any referral of welfare clients to a planned-parenthood clinic or to a health team or to a physician. In 1962, they removed this prohibition and said that any married clients, having indicated their desires, could be referred to a physician or a clinic for appropriate family-planning advice.

That unlocked the door because immediately following that action, of the Board of Public Welfare, the State Health Department immediately sent out a directive to all its health officers urging them for the first time to establish family-planning services.

As a result of this directive from the Commissioner of Health, the progress, in my opinion, has been rather gratifying.

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At the present time we now have family-planning services provided in health centers, some 55 or 60 of them, in 21 of our 24 political subdivisions. Putting this in other terms it means that 90 per cent of the population of Maryland resides in a subdivision where such services are available through the health department. This does not mean that 90 per cent get it, but they live in communities in a sub-division where the health department is providing the services.

Now, I hope that maybe during the discussion period you will ask questions about how it has developed, but in essence the standard methods are being offered. The exact mechanics of how the program has been developed from one county to another in Maryland differs. We have a great deal of autonomy and independence among our local health officers, so one health officer may decide to develop a program one way and another a rather different way. But, we have developed a State guide for them of all the policies and all the methods that are being offered, and we have urged and particularly recommended that each health department includes the rhythm method among others.

I will give you one illustration of how it has worked. In Washington County, the county seat of which is Hagerstown, about 80 miles West of us here, the program began about a year and one-half ago with a clinic once a month in conjunction with the postpartum clinics. It has become so popular in Washington County that they now have two family-planning clinics a week, not in

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connection with a maternity clinic, but two separate family-planning clinics a week in the town of Hagerstown. Problems have been remarkably few. We have had no organized opposition in any of our counties to the programs that have been going on, so I would say in summary then we feel we have made progress. We think we will have the remaining two counties in the State in business by the end of this calendar year.

The only bit of statistics I can give you on what is going on in Maryland is for the calendar year of 1964. On a very rough kind of form that we asked our health officers to fill out it appears that approximately 3,000 women were served through Health Department facilities, and that includes the city of Baltimore.

Our next move is to set up some mechanism for evaluating what is going on. We do not want to dump too much new on the health officers at one time, so we asked them in the beginning to make a copy of people served and the type of method prescribed. The next move is to have a follow-up made to see how long the people stay with the method, the --what failure rate has been, and we hope we get into that next year.

A word or two about the District of Columbia. Congress appropriated \$25,000 to the District of Columbia Health Department to establish a birth control program. This went into operation in April of 1964. The health officer reports there are currently seven centers in the District of Columbia that are providing services to indigents, medically-indigent patients in the district.

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Most of these patients are referred, either by the local welfare department or they have been discharged from, I think it is, the District of Columbia Hospital--I don't remember the exact name, but it is in there--yes, the District of Columbia General Hospital.

During the first year of operation they served also approximately 3,000 women. The health officer reports that the program has been well-accepted. It caught on very rapidly. He now has developed a waiting list of people for these clinics. He is proposing in his next year's budget--he's asking for funds to set up a full-time birth-control team. He did not spell out what a birth-control team is, but it indicates that the personnel that he has are insufficient to take care of the needs. I hope you will have some further questions during our discussion period.

DR. PANIAGUA: I am going to take some of the time allotted to my friend, Dr. Arandes, to comment on the general background of Puerto Rico. I took the liberty of putting on the board these data and I was struck this morning when I was listening to the presentation on Taiwan, to the similarity of their circumstances to ours, with the exception that Taiwan is about five times larger, but you will see that the population density, birth rates, death rates, rate of population increase should be 2.3 per cent. Literacy is higher, but the urban population--and that is not on the board--and the age distribution is about the same too.

About 45 per cent of the total population of Puerto Rico is under the age of 15. With that short background I will next

say that in Puerto Rico there is no program and no policy in connection with birth control. At best the attitude of the government has been similar to what Dr. Leszer has just told us it used to be for the Federal Government.

This practically forced the creation of a volunteer agency in 1948, originally for the study of population problems, but later changed to an action program under the name of the Family-Planning Association of Puerto Rico. The funds for operating came from St. Louis, Missouri, from a foundation and they were allotted because of the personal interest of Mr. Joseph Simon (?) on this population problem, and because there was no way that we, in Puerto Rico, could do anything since local philanthropy is non-existent and the government had a hands-off policy about anything that had to do with what they called controversial subjects like birth control.

Of course I do not have the time to go into all the details of how the association implemented its program. I can make reference to the presentation I made in this same room a little over a year ago when I went into the details of how it was organized and how it operated for a while. All I can tell you is that now the Association was practically reduced and nearly folding up its service program due to the lack of funds. The Simon (?) Foundation has practically withdrawn all their funds by this time and the Puerto Rico Family-Planning Association is only doing research, which is self-supporting. It has a few areas

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for demonstration purposes and for teaching purposes, carried on with the help of a national planned parenthood association, the International IPPF, and the Population Council and other agencies of the same category.

Now what has been accomplished in Puerto Rico is very little from the practical viewpoint of reducing the birth rate. This drops from the previous decade when it was about 40 in the birth rate to around 30, in 10 or 15 years, was analyzed by Hamer and his coworkers. It was demonstrated to be due mostly to the change in age of the average population with the massive immigration-- especially during the decade of the 50's to the United States, of mostly young men in the reproductive ages. When the accrued birth rates were adjusted to the change in age, the population came out to about practically the same.

No where has there been such failure, relative failure of birth-control as in Puerto Rico. There are several reasons. I would like to quote some of the ones that I mentioned here last year and which I believe still hold true, for the time being anyway.

The first one, in my opinion, has been the lack of leadership on the part of Puerto Rican government. It has maintained the policy that has varied from strict neutrality to mild hostility to contraceptives. At best it has supplied the contraceptive services on the premise if and when they were requested and if the local incumbent physicians were willing to give the services--

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and it can easily be seen how the overworked physician who is poorly-paid and conservatively-trained and having several kinds of pressure, social, religious and familial--he needs an extraordinary amount of special sanction to give all these necessary services.

Only recently is the government beginning to do something about it, but Dr. Anderson will tell you more about that.

Almost as important has been the effectiveness of opposition of the Catholic Church. I don't think that could be underestimated, especially when it has worked by convincing the people who were in a position to give the services, namely physicians, nurses, social workers, and people in key government positions. In that way it has, up until very recently, been able to retard considerably the birth-control movement, if you want to call it that.

The third factor has been a real overtaking of the public health facilities. Actually, of course, most of the facilities are needed for more important or more emergent procedures and therefore there is legitimate reason for giving a relatively low priority to these services in many of the public hospitals and institutions.

However, we can say that our experience has served some practical purposes.

In the first place the mere fact that the program had been carried out in Puerto Rico is proof and it has destroyed the myth that these programs cannot prosper in Catholic countries. That

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is, where the population is overwhelmingly Catholic. In the second place, this same controversy has kept interest and it has kept people informed. It has kept the program in the foreground. It has also indirectly helped the self-supporting research programs by providing congenial environment, and of course, finally it has provided a place where people confronted with similar problems can send a representative to observe, and if necessary to be trained.

Finally, I would like to summarize our personal opinion, that is, the opinion of the Puerto Rico Family-Planning Association, about what should be the role of a private agency in the overall population program of any country. We believe that because of the magnitude of the task of giving services, the government of a particular community, region, or country, is best equipped to handle such program. The services should be integrated into the education, health, preventative and welfare measures, although it may be wise to have some board or committee to integrate the various phases of a program responding to different growth agencies.

In countries where there is political instability it may be preferable that the program be administered by autonomists subsidized if necessary institutions, as free from partisan politics as possible. In any case, it is necessary to have some private institution to act as trailblazers in orientation and research and serve as watchdog over the public or semi-public agency which should supply the services and to reinforce them

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whenever necessary.

I am sorry, my time is up, but I am sure we can hear from Dr. Arandes.

I would like to quote a question I just posed a year ago and which may be answered by Dr. Arandes. That relates to what the future may be. What will happen in the near future in the contraceptive field is anybody's guess. Will the Government assume a more positive attitude?

Now that immigration has practically stopped and unemployment is rising, will the mortal ranks, the trend of the so-called liberal segment of the Catholic Hierarchy, defuse to Puerto Rico? What would be the position of the Catholic independents, the nationalist groups, or are the precedents set against any form of population control as national suicide?

The answer to all these questions would necessarily be highly-speculative and would fall outside the scope of this presentation. That was said a year ago. I wonder if, now, we have an inkling about the possibility of answering some of these questions.

DR. ANDERSON: Dr. Arandes?

DR. ARANDES: Dr. Paniagua has given the very positive role that the Family-Planning Association has had in Puerto Rico. The Government has been empowered to carry out a contraceptive program since 1937 when the legislature passed laws authorizing the Secretary of Health to present a program for family-planning.

c101      Actually at that time there was a lot of enthusiasm about the program, using the health facilities, and they were quite active for about two years, opening up clinics, setting a time for "methods clinics" and buying the available contraceptives.

At that time the contraceptives that were available were inefficient and no great amount of positive results were obtained, in these clinics. As time went by the enthusiasm for this program gradually was lost. 25 years have gone by and really, although the structure of the program is there, and there are clinics available in each of all of the health centers in the island, actually very little use is made by the patients, because at first there were no available contraceptives. After a while they did not buy anymore and simply the public was non-receptive to the type of contraceptives that were available. Usually they were the foams.

The one aspect of the program that did grow in size was the sterilization which showed that there was a definite consciousness of the need for contraception by the families, but they wanted a sure method and the request for sterilization was very great. Actually this could be done only in the big hospitals which were about six in number throughout the island, the amount of sterilizations done during the decade of 1945 to 1955 in these hospitals was appreciable, running up until about 1,000 a year or more.

As the hospitals took more personnel, better-trained

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personnel, and the surgical facilities were limited because more serious operations were being done in these hospitals, gradually the sterilizations fell, the rate of sterilization operations fell down to the point that in the last few years they have been negligible because the available operating room facilities are used for more serious operations.

The government really failed to establish any enthusiasm in its program, and this has been the condition, like Dr. Paniagua described, up to this moment. Now, why the government did this-- we have had a lot of evidence here that the governments are very reluctant to enter into controversial fields of this nature, and especially in Puerto Rico, the role of the Catholic Church was very active and may have contributed more "political" influence to explain the governmental apathy in this field. The government also relied in the economic solution to its population problem on the solution of the immigration problem which cannot exist alone. They have to be accompanied by a demographic solution to the problem by birth-control methods. I think this realization has finally come home, because over the last year the Health Commissioner has decided to assign funds from the Childrens Bureau matching funds on going service grants to open up clinics in the different health centers.

The northeast region of the island which takes care of about one-third of the population has been opened up for these services. They are being given in the different public health

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units. About 18 clinics have been opened up since January, to provide "method clinics" there. All the methods are offered and there is an emphasis on free choice of methods. The post-pardon clinics have grown--like I think Dr. Whitridge mentioned--in the Maryland area, they have grown geometrically from five per cent attendance that we used to have to about 40 per cent attendance. In the 4 or 5 months that the program has been running we have noted that increase. Actually we had the statistics for the first three months of the program and we had taken care of about 15,000 patients, about 1,000 which have chosen the IUCD method for contraceptions.

About one-third have chosen the pills and very few, in spite of the emphasis that we make on referring the Catholic patients for rhythm, chose that method.

Actually I think we have had 14 patients in the six-month experience that we have had in these clinics. The projections for the future lie along the same grounds. We hope now to get support to include what we call family educational activities in this northeast region. This would involve the use of a public health physician in each of the public health centers which would not only give the family--would not only hold the child-spacing clinic--but they would become involved in sex education with the children in school and the high school kids and they would be involved in pre-marital counselling clinics, at least one each week in each of the municipalities.

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This we sort of like to call a preventive family service instead of the remedial type which we are doing now. In other words, most of our population gets to the family-planning clinics only after the problem of their individual family population explosion has occurred. After the difficulty is in. We are trying to build, if possible, a program where we can prevent this, tackling the younger people and the about-to-get-married people, and instruct them in family responsibility, parental responsibility, before marriage and in the early, the very early phases of marriage.

I think in this way we would prevent having to give so much remedial service and actually do some prevention.

This program--if we get it started it would be getting started now in July and would require, like I said, physicians and social workers, and these are hard to come by at home.

We are hopefully trying to get some help from some of the solitary agencies, to help us in recruiting this type of personnel.

This is the gist of the program that has developed up to now and the projection for the near future. We don't like to see the voluntary associations disappear from this field, because I believe the government needs continuous fires built under them to get action going, so I think there is a role for both the government and the voluntary association in any program of this sort.

DR. WHITRIDGE: One thing I left out. I left out the fact that in March of 1965 the State Board of Public Welfare went

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the final step with its referral of clients and removed the provision that married clients only could be referred, so that at the present time in Maryland, welfare workers are now enabled--and a directive has gone out to all of the local welfare departments--that any mother who it is deemed necessary should have such services maybe referred. That was the third significant date.

FROM THE FLOOR: In mentioning the reasons for the holding up of the Family-Planning Association in Puerto Rico, Dr. Paniagua mentioned three reasons. All it seems to me were functioning during the time of the real activity of the program, namely, the lack of leadership of the Puerto Rican government, the opposition of the Church, and the over-taxing of the public health facilities. Shouldn't we look at some other factors to explain what I understand is almost complete collapse of the EMKO program in Puerto Rico?

DR. PANIAGUA: May I clarify that. What I meant to say is those three things, those three reasons, explain why the birth rate did not drop considerably, which was Mr. Simon's (?) criterion for the success of his program. So, when he saw that his program was not succeeding according to his ideas, he decided to withdraw his financial help and that is a real reason why the Association is trimming its sails. Nothing but lack of financial help. We can continue with research because it is self-supporting. We can continue with small projects, educational projects, because of the help of the different voluntary agencies but the big service

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program had to be curtailed because of lack of funds and also now because the Government is beginning to do that.

FROM THE FLOOR: I understand that the women can buy EMKO now if they wish to, so apparently during the program not enough motivation was built up to continue buying EMKO when they had to pay for it.

DR. PANIAGUA: The latest policy has been a reversal. EMKO is given free again. It all depends on whether the Association could get it free. Whatever we get free we can pass free to the people, but the other contraceptive methods that we buy at cost we have to sell at cost too.

FROM THE FLOOR: I would like to ask about the effectiveness of EMKO in Puerto Rico, and the pill, in these studies that Don Bogue mentioned in the thousands of low-income areas. Has the effectiveness been studied and do you know what the results are?

DR. PANIAGUA: We published a paper with the results. It was published--I don't remember the date. It was over two years ago, on the pilot experiment done in a slum area called the Boston Braves. And of course it was not the best place to test any contraceptive, because it was a very uncooperative population.

The results were that the pregnancy rate had been decreased to--I don't remember the exact figures--but by about half of what it was before the use of EMKO. Even in these most adverse circumstances, Dr. Achilles (?) at Margaret Sanger Research Bureau in

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New York, with a very highly-selected group of college graduate couples found nearly a 100 per cent effectiveness using the same stuff and same technique.

Now, as far as the oral contraceptive is concerned, our results have also been published and it is nearly 100 per cent effective. Again, among those who take the medication. But we had a considerable rate of dropout for some reason or another, because they could not tolerate the medication or they were afraid of it or changed their mind or whatnot.

FROM THE FLOOR: Not enough people were using it to effect the birthrate. That was the reason Mr. Simon (?) pulled out.

DR. PANIAGUA: That is right. In the Simon (?) project we were not giving the pills. The pills were only given in the research project to a small sample population.

DR. BOGUE: This analysis was done by a study at the University of Chicago by Dr. Vasquez(?), and I think he said that the decline in the birth rate was significantly less than people believed because of migration to the Mainland, but nevertheless, there had been a genuine decline in fertility in Puerto Rico. Even after you make an adjustment for this, and the fact that the birth rate is still staying low, even though the migration to the Mainland has been down now for about three years, there is growing birthrate in Puerto Rico has been permanently effected even without EMKO.

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DR. PANIAGUA: That is true. We hope it stays like that. That is only the last two years.

FROM THE FLOOR: Your picture is darker than the actual fertility situation in Puerto Rico.

DR. MAULDIN (Population Council): Mathew Teback (?) here in Baltimore has done an analysis of the decline in birthrate in Puerto Rico. I do not recall whether or not it has been published but he found about one-half of the downtrend over 10 or 12 years could be traced to migration of the young couples, and about half was for some other reason or reasons. I have never examined those data carefully, but I would think, as you have said, Don, that a considerable part of it is certainly due to things other than migration.

DR. PANIAGUA: There is also another reason for that, I believe. In the first place the Vascus (?) studies were two years ago, when he wrote his doctoral thesis. I just went through a part of it during the past few days preparing this report. But since he wrote that, since you mentioned very well, the birthrate has become more or less stationery despite of the fact that immigration has practically ceased.

Now, I wonder about the fact that surgical sterilization, although now it is being done, may be in fewer quantities at least in the public hospitals; it is on the other hand done a little earlier than it used to be done before. When Hill & Steiger published their first study they found out that sterilization did not

c109 help greatly to reduce the accrued birth rate because it was resorted to usually after five or more children, while studies done later by us and cases sponsored by the Family-Planning Association, which came out last year in the Journal of Obstetrics and Gynecology, showed that the average parity at the time of operation among the women whose operations had been sponsored by the Family-Planning Association, had gone down to about 3.4, something like that. That may have had something to do with the gradual lowering and the staying low of the birth rate.

DR. TAEUBER: I don't know if there are any lessons to be learned out of history. If so, I think I would like to emphasize and perhaps expand a bit on what Dr. Paniagua said. I happened to go to Puerto Rico in the 30's. I know the extent to which the Childrens Bureau supported contraception in the 30's and 40's in Puerto Rico. I remember the days when the health department had over 100 clinics. I remember seeing people waiting to come into those clinics. I remember when the government had a perfectly good deal--if I may call it so--with the Bishops, whereby they could actively participate in such activities so long as they were not discussed in the newspapers. I can remember the change when the subject began to be discussed in the newspapers, and I can remember some changes in the attitude of the Church and also I believe there were changes in the particular leadership of the Church at that time.

I don't know what this adds up to, but I think if one

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looks at Puerto Rico, one perhaps ought to go back to the very early days. I do think that one thing you said, sir, ought to be emphasized. That is, it is probably very difficult to maintain enthusiasm in any kind of a family-planning program or any kind of family-planning activities if you are not using a very satisfactory method.

DR. ANDERSON: I think it is a little past 5:30 and I believe at this time we had better conclude our program.

(Whereupon, at 5:30 o'clock p. m., the meeting was concluded.)

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