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**A Study of the Integration of Family Planning
and Other Population Activities with
Health and Other Development Interventions**

Phase One Report

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I. Executive Summary

A. Purpose and Methodology of the Study

This purpose of the two-phased study undertaken by Research Triangle Institute (RTI) for the Asia Near East Bureau of the U.S. Agency for International Development (ANE, USAID) aims to (1) review concepts, feasibility, and experience of family planning and population integration with other development interventions, and (2) identify possible policy, strategy, and program implications for the Agency. The study will provide information to the ANE Bureau and Missions on the most promising population integration interventions and approaches for achieving one of USAID's strategic goals, "stabilizing world population growth and protecting human health."

Phase One (November 1993 - March 1994) entailed a review of the literature and interviews with USAID staff and other professionals in the U.S. population community. Phase Two (May - June 1994) will involve onsite in-depth analysis of integration experience and prospects in two Asian countries.

B. Concepts and Definitions of Population Integration

The study examined "population integration" in terms of two types, as follows:

Type 1 is integration of family planning and health in the provision of information and service delivery; and

Type 2 is integration of family planning and population interventions with interventions in other development areas (e.g., education, women-in-development activities, employment).

Integration as a concept has many dimensions and definitions and has been operationalized at various levels with different sets of activities. Areas of integration for population where there has been experience include reproductive health; maternal and child health including child survival; STDs and HIV/AIDS; nutrition, especially school lunch programs; female education; women's empowerment; agricultural extension; community development; and income generation.

There are two opposing philosophical views on integration. One view is that vertical programs should be used in the early stages of program development to generate and institute demand for family planning. Vertical programs should be gradually replaced by integrated programs to expand services, especially to lower socioeconomic groups. The second view is that integrated programs are necessary at the early stages of program development because the concept of family planning lacks political legitimacy and has not been internalized. Family planning, therefore, should be provided in conjunction with other health services.

C. Principal Findings from the Phase 1 Study

Type 1 Integration Experience

Type 1 integration (family planning and health information and services) is the most

common type pursued by population programs and the one most familiar to persons interviewed. Valuable lessons have been learned from Type 1 experience which can guide both design and program planning efforts. Success with Type 1 integration has been mixed and has been dependent upon the individual country's social, political, and economic environment; its local realities; and on the program's capacity, efficiency, and effectiveness. Strong political commitment, sufficient time for project preparation, carefully phased implementation, and adequately trained staff are some of the key factors identified in successful programs.

In the last 15 years there has been a clear trend towards Type 1 integration in USAID- and other donor-funded population programs, both in government and non-government (NGO) sectors. For political and economic reasons, Type 1 integration has become almost *de facto* in the public sector population programs of developing countries, although configurations vary greatly.

While vertical family planning programs have not proven more successful than Type 1 integrated programs, in a real sense the debate on vertical versus integrated family planning has been overtaken by circumstances on the ground. The more compelling issue at this time is how to provide more access and better quality care to clients of integrated family planning and health services, as well as how to implement more cost effective programs. Type 1 programs need to look beyond integration of family planning and maternal and child health to include hard-to-reach populations such as adolescents and older women.

Type 2 Integration Experience

The literature on the issues of "beyond family planning" determinants of fertility show few examples of large programs, especially public sector programs. The most notable large programs were implemented 15-20 years ago in the Philippines, Malaysia, Egypt, and Korea; their success has been mixed or offers inadequate lessons for replicability. Current Type 2 PVO activities (for example, by CEDPA in India and Egypt) seem promising in terms of cost effectiveness and replicability. Preliminary findings indicate that the optimal integration "package" for Type 2 integration is likely to be highly location-specific.

The study finds general agreement on the goals of Type 2 integration--the achievement of broad and relatively equitable social and economic development for attaining lower fertility. Although there is debate and uncertainty in the literature about Type 2 integration interventions (for example, on optimal policy, program and project design, levels and mix of sectoral investments), it is clear that some type of social sector integration at the policy level ought to be a high priority in many countries.

The experience from High Performing East Asian Economies (HPEAs) in reducing fertility and population growth, as documented by the World Bank in a 1993 study, presents a compelling case for social sector policy reform. In these countries (Hong Kong, Indonesia, Japan, Malaysia, South Korea, Singapore, Taiwan, and Thailand), the single most important key for success was getting policies right. For example, education policies that focused on primary and secondary schools, especially for females, generated rapid increases in labor force skills and contributed significantly to fertility decline. World Bank studies have also shown a generally consistent positive association between higher levels of female educational attainment, higher contraceptive prevalence rates, and lower fertility and mortality rates.

Integrated social sectors policies would create a mutually reinforcing and sustainable set of investments. The study finds increasing support for the idea that host countries and donors should stress stronger efforts towards incorporating population issues into macro policy formulation and implementation.

D. Preliminary Conclusions and Recommendations from Phase One

These conclusions and recommendations are preliminary, pending conclusion of Phase Two of the study. They address the widespread concern about the possible plateauing of family planning performance in some Asian countries.

1. Place high priority on formulating coherent and mutually reinforcing social sector policy reforms that can impact fertility and population growth.
2. Use lessons learned from past experience and test well-conceived Type 2 interventions through operations research-type or pilot activities to determine what will and will not work.
3. Reduce unmet demand for family planning by providing clients better access to quality family planning and health services, whether vertical or integrated approaches are being pursued.
4. Undertake a coordinated donor approach to the host country government to promote provision of a package of essential social services that would enhance the achievement of fertility reduction goals.

E. Next Steps: Phase Two of this Study

Phase Two of this study will enable the team to examine in greater depth both Type 1 and Type 2 issues in two key countries in the Asia region. Indonesia has been identified as one of the countries. In Indonesia (current population about 190 million), with a favorable socioeconomic environment, the total fertility rate (TFR) has declined from about six 25 years ago to about three today. Still, the country faces enormous challenges in its quest to achieve replacement-level fertility. Indonesia's current goal is to achieve a two-child family by the year 2005. There are examples of both Types 1 and 2 integration in Indonesia, and important insights will be gained from closer study of some of those experiences.

Other potential countries considered for Phase Two are Bangladesh, the Philippines, Egypt, and Jordan. Most of these countries have mature population programs and have made significant progress in increasing contraceptive prevalence and reducing fertility. Most have had both Types 1 and 2 integration, and lessons learned from a closer study of those experiences will be of benefit to other country programs.

II. Introduction

A. Background

For nearly 30 years, USAID has provided program assistance to developing countries in population and family planning. As a result of these programs, success has been achieved in some countries in reducing fertility and population growth rates. Over 30 million couples were using family planning in 1990 as a direct result of USAID assistance. In the 28 countries that have received the greatest assistance from USAID, it is estimated that completed family size has declined from an average of 6.1 children per woman to an average of 4.2. It is also estimated that, in the developing world as a whole, about 50 percent of the fertility decline is directly attributable to family planning programs and that, through 1990, about 410 million births have been averted through these programs.

Yet the global population problem remains critical. Every year, nearly 100 million people are added to the world's population. To achieve eventual global population stabilization, the total fertility rate needs to be halved, from about 4.2 to about 2.1 (replacement-level fertility). There are about 100 million couples in developing countries who want to practice family planning but do not have effective access to contraceptives. If present trends continue, the world's population will grow by an additional one billion in the next 10 years. About 90 percent of population growth occurs in developing countries. The prospects for sustainable development for these countries are dim unless population growth is reduced to more manageable levels.

The Asia region has had notable successes in family planning, such as in Bangladesh, China, several states in India, Indonesia, Singapore, Sri Lanka, South Korea, Taiwan, and Thailand. Yet there is still immense unmet need for family planning despite continuing population assistance from USAID and other donors. Of the estimated 100 million couples with unmet need for family planning, nearly half are in Asia.

USAID is redefining at this time its directions and approaches in order to generate greater development impact from its investments. "Population and health" has been recognized as one of five priority areas; the other four are environment, democracy, economic growth, and humanitarian assistance. These five areas have overarching objectives, with the ultimate goal being sustainable development. One of the requirements of achieving sustainable development is to bring about the most rapid possible declines in fertility, mortality, and population growth rates, with one ultimate goal being the achievement of replacement-level fertility.

As we assess the achievements of USAID's 30 years of family planning assistance, it has become increasingly clear that, to be able to address the population problem more cost effectively and produce greater development impact, USAID has seriously to consider broadening its conventional program approaches and interventions. Thus, USAID's new Population and Health Strategy, drafted in the fall of 1993, advocates using "integrated approaches" to enable USAID to achieve its newly articulated objectives, as follows:

We will emphasize the use of integrated approaches. . . . By "integrated approaches," USAID means that population programs should seek to provide individuals with access to a range of family planning methods; should integrate family planning programs, as appropriate, with services that enhance women's health and child well-being and survival, in order to enhance both the effectiveness and the acceptance of family planning services; should utilize family planning systems, as appropriate, to provide information and services that limit the spread of sexually transmitted diseases; and should emphasize the importance of providing education for girls and women. By addressing co-factors, and by implementing related programs at the same place and time, integrated approaches increase the impact and sustainability of population programs [USAID, January 1994: 35].

B. Rationale and Assumptions of the Study

In November 1992, the Technical Resources Office of the Asia Bureau decided to undertake a short-term study on integrating family planning and population with other development interventions to help answer the question, "How can the Bureau and its Missions achieve greater results and impact from USAID's investments in population?" Six of the 10 most populous countries in the world are in Asia, and concomitantly the largest program and resource needs are in the countries in this region. A few family planning programs in Asia are integrated in design, for example, Bangladesh, Nepal, and the Philippines. However, the scope and intensity of integrated efforts and success vary in these countries. In some countries, program planners and managers have hesitated to experiment with integration for fear that it would dilute their family planning efforts and accomplishments.

However, vertical family planning programs have sometimes failed to meet the reproductive health needs of women because the primary focus of service delivery is provision of contraceptives. Typically, side-by-side with these vertical family planning programs are vertical programs in child survival, safe motherhood, primary health care services, and education programs. This compartmentalized programming has partly evolved out of inherited bureaucratic arrangements rather than as a response to the expressed needs of clients. This results in a host of vertical programs although they inevitably approach the same target households, often with limited cooperation and coordination.

Studies of the determinants of fertility indicate that high fertility rates are not an inexorable consequence of low levels of economic development. In many settings, especially in Asia, policy and program interventions have resulted in significant fertility reduction at relatively low cost. In many situations, declines in infant mortality rates appear to have been an important precursor to fertility decline. Research on the determinants of fertility decline has also consistently identified female education as an important precursor to sustained fertility decline. Increased opportunities for women to work outside the home have also hastened fertility decline in many settings.

In the context of the above observations, this study attempts to assess the potential contributions that integrated approaches to family planning, health, and other development

interventions can make to achieving cost effective reductions in fertility and population growth rates.

C. Objective of this Study

The objective of this study is to undertake a critical appraisal of the concept, feasibility, and experience of integrating family planning and other population interventions with health and other development programs. Integration is to be assessed at two levels: (1) the integration of family planning with health care, for both information and services (Type 1 integration) and (2) the integration of family planning and population interventions with interventions in other development areas such as education, women-in-development, and agriculture programs (Type 2 integration). For both types, a range of potential integration packages are to be examined including at the levels of policy, structure and organization, resource allocation, program management, and service delivery.

D. Scope and Methodology of this Study

Research Triangle Institute (RTI) was engaged by the Technical Resources Office of USAID's Asia Bureau to conduct this two-phased study. Phase One began on November 16, 1993, and was completed in March 1994. Phase Two of the study will involve on-site visits in at least two countries by the RTI team for more in-depth assessments building upon findings from Phase One. These field visits are expected to commence in mid-May.

Under Phase One, a three-person RTI team conducted an exhaustive literature review together with interviews with knowledgeable population/family planning professionals in Washington, DC, and elsewhere. The team examined definitions and concepts of integration, forms and limits of integration, advantages and disadvantages of integration, and approaches and mechanisms for integration. Team members reviewed experiences in both Asia and in other regions of the world and extracted from these experiences principal issues, lessons learned, and implications for both Type 1 and Type 2 integration experiences. In Phase Two, the team will examine these same factors in more depth at the country level.

Findings and recommendations from the full study (both Phases One and Two) will provide the Asia Bureau and Missions with information that will be useful for strategic decisionmaking on interventions for integrating population and family planning with other interventions, approaches to sectoral and multisectoral policy, and use of USAID population resources. As USAID proceeds with its formulation of guidelines for implementing its new population strategies, especially related to integrated approaches, it is hoped that findings and recommendations from this study will make a meaningful contribution to achieving the Agency's objectives.

The purpose of this document is to describe the main findings from the interviews and the literature review that comprise Phase One of the study.

III. Definitions and Concepts

A. Integration in the Literature

We discovered many interpretations of the term "integration" both in published literature and within USAID. USAID definitions of integration derived from the literature include the following:

- the process or outcome of merging service or administrative components with each other [Phillips *et al.*, 1984:153];
- that action which brings previously separated and independent functions and organizations (or personnel, or resource, or clientele) into a new, unitary structure [Morris and Lescohier, 1978, as quoted in Simmons and Phillips, 1987:189]; and
- a multidimensional variable in which the underlying idea is the linkage of specialized tasks [Ness, 1977, as quoted in Simmons and Phillips, 1987:190].

More specifically, programmatic definitions include the following [based on Simmons and Phillips, 1987]:

- addition or initiation of family planning activities by other or multiple sectors (e.g., addition of "family planning education" activities to agricultural extension workers' tasks);
- joint administrative oversight of separate programs (e.g., when policy and/or administration of family planning rests with an interministerial committee);
- merger of vertical family planning program(s) into the wider public health structure;
- addition of health components to vertical family planning programs; and
- combined delivery of family planning and other health services.

B. Integration in USAID

There is a wide diversity among USAID staff on the meaning of integration. Some examples include the following:

- a strategy that integrates population into other issues that serve as determinants of fertility (e.g., school lunch programs, women's education, social policies regarding women);

- integration of family planning services with other service delivery to respond to client and community needs;
- use of a lifecycle approach to design programs to provide what women need (relative to family planning, health, and other interventions) at different times in their lives;
- integration of population activities with other sectors such as female education and employment generation;
- integration of family planning with "everything else," as in the early community development projects; and
- a variety of meanings, depending on when, in the history of population activities, integration has been discussed; it could refer to integration of activities in a whole project, integration of administration, or integration at service delivery level only.

One USAID staff member felt that "integration" is too loaded a term: it has a long history and can be threatening to some USAID managers. She favored the term "linkage" rather than integration and felt that linkages encompass a broader range of programs.

In discussions with the team, USAID staff who focused on family planning and women's needs or even "reproductive rights" acknowledged the demographic objectives of USAID's population mission. However, they tended to view integration from the perspective of service delivery that combines family planning with something else. Those who focused primarily on the goal of achieving rapid declines in population growth rates tended to view integration as combining population issues with factors that have been shown to be associated with decreases in fertility (e.g., including women's education or income generation in population programs).

C. Integration in Cooperating Agencies

Staff members of cooperating agencies (CAs) we interviewed also had differing interpretations of integration. The following are some examples:

- assigning to workers those tasks that include family planning as well as other activities;
- providing many services at one place or at different places but coordinated with each other, or providing care to different family members at the same place; and
- delivering family planning along with other interventions, (e.g., sexuality education and STD and HIV/AIDs prevention education and services) as well as

initiating programs that are complementary to family planning, especially those that empower women (e.g., basic education for women, street clinics for women--if that is what women feel they need--and/or childcare).

For the most part, staff members of CAs concentrated on service delivery, focusing either on the service providers or on the needs of the women and men receiving the services.

D. Integration in the World Bank

Some World Bank staff pointed out that there are two kinds of integration, based on different levels: (1) integration in service delivery, and (2) integration at the policy level. For the most part, it is the policy and practice of the World Bank to fund integrated rather than vertical service delivery projects, primarily because of the way the Bank commits funds: it lends to governments, and government family planning services are largely provided through Ministries of Health and Ministries of Social Welfare. However, the Bank is also concerned with related policy issues, and some staff members viewed population more broadly than either USAID or CA staff, e.g., "Why should population stop at fertility and mortality? Why not also include migration, aging, and population distribution?"

Another World Bank staff member felt that integration is "one of those policy words that hides more than it reveals." In this person's view, integration should be distinguished from coordination. "Coordination" refers to the synchronization of efforts and collaboration among staff of different agencies to create a synergistic effect. This coordination could occur between or among multiple projects. One project might provide contraceptive services while another project might be devoted to female education, but managers of the two projects would synchronize their efforts. In an integrated program or project, the same personnel deliver different kinds of services and/or one agency provides different services. The Bank also uses the term integration to denote a single project that contains multiple sectors. For example, the new World Bank "Intersectoral Population Project" for Bangladesh includes components in primary education, community participation, employment sectors and sites, and multiple target audiences.

E. Types of Integration for Purposes of this Study

Given the mandate for this study as well as the diversity of concepts and definitions of integration noted above, we will refer to population/family planning integration in this study as follows:

Type 1 Integration: Integration of family planning and health care (both information and service delivery); and

Type 2 Integration: Integration of family planning and population interventions with interventions in other development activities (e.g., education, women-in-development, agriculture, employment programs).

However, integration under either category may take many different forms: policies, resources, agencies, service delivery points, types of service delivery personnel, etc.

F. Dimensions of Integration

Integration has many dimensions. From the literature review and interviews, the concept of population/family planning integration can be incorporated into the six areas listed below. Specific examples of the possible content of each area are also given.

1. Program (or project) goals

- Programs that are driven primarily by demographic considerations (e.g., to reduce fertility and/or population growth rates); and
- Programs that are intended to achieve multiple goals, such as both fertility *and* health goals (and possibly also other goals such as education of girls, employment of women, empowerment of women).

2. Levels

- Policy;
- Administrative; and
- Service delivery.

3. Structure

- Vertical, but "coordinated" (at least loosely);
- Vertical, but managed by an interministerial committee;
- Vertical, but services delivered in the same location by different staff members or at the same location by the same staff members but during different hours, or by the same staff members at any time;
- Integrated at the top management/administrative level and integrated at the service delivery level; but vertical at middle management, administrative, and supervisory levels (the "broken zipper approach," as in the Government of Bangladesh system); and
- Integrated at all levels of the program.

4. Sectors

- Public
 - national
 - local; and
- Private
 - private voluntary organizations (PVOs);

- private providers; and
- social marketing.

5. Area(s) of integration

- with women's reproductive health;
- with STDs and HIV/AIDS;
- with maternal and child health (MCH), including child survival;
- with primary health care (PHC);
- with nutrition activities (especially school lunch programs);
- with female education;
- with women's empowerment issues/activities;
- into agricultural extension activities;
- into community development programs; and
- with income generation projects/activities.

6. Time

- age of the program;
- history of the program;
- years of the project; and
- project length.

The tension between approaches that are primarily demographically focused and those that are more client-centered may sometimes be the result of different program goals. Adherence to different goals often results in different program content, e.g., linking family planning/population with female education (Type 2 integration) compared to linking family planning with other health services, such as MCH, STDs and HIV/AIDS, and/or primary health care (Type 1 integration).

Which type of integration USAID promotes is a matter of internal policy. However, we recommend that any use of the words "integration" or "linkage" specify the type of integration (Type 1 or Type 2). It is also extremely important that the relationships between the integrated components be specified. For example, are the key components part of a single project and administrative/organizational structure (e.g., the Health Education and Adult Literacy [HEAL] project in Nepal which was a small component of USAID/Nepal's bilateral population program)? Or, does the integration occur more at the level of coordination between two or more administrative/organizational structures such as the Ministry of Education (providing primary education for girls) and the Ministry of Health (providing family planning and MCH services)?

IV. Type 1 Integration

Type 1 integration interventions have become relatively common, both for developing country government programs and for international donors. USAID's Offices of Health and Population are currently collaborating on a task force looking into linkages between family planning and women's reproductive health. Women's reproductive health will probably also include STDS and HIV/AIDS, prenatal and post-natal care, and other related topics.

A. Literature Review and Selected Experiences

The Integration of Services

For the most part, Type 1 integration affects the "supply" of family planning services. However, as Demeny [1992] and many other analysts have noted, supply can also affect demand. The better the quality of the services and the lower their cost (including time and psychological dimensions), the greater will be the utilization of services--i.e., a good supply of family planning services will in itself increase the demand for services.

Numerous studies have analyzed the relative effectiveness of integrating family planning services with health care services. [We found very little in the literature on the integration of family planning and health *information*.] These include Allman, Rohde, and Wray [1987] on Haiti; Caldwell and Caldwell [1992] on Bangladesh; DeGraff et al. [1986] on Bangladesh; Goldberg, McNile, and Spitz [1989] on Kenya; Phillips et al. [1984] on Bangladesh; Raikes [1990] on Kenya; Tuladhar and Stoeckel [1982] on Nepal; and World Bank [1990] on Tamil Nadu. More general, noncountry-specific reports include Files [1982]; Ford Foundation [1991]; Gillespie [1985]; Klitscha and Walsh [1988]; Lamptey and Sai [1985]; and Simmons and Phillips [1987].

Betemariam [1993] recently surveyed the literature on Type 1 integration. She reports that in the 1960s many Type 1 integration experiences were disappointments. Funds intended to support provision of family planning services often were diffused to a broad array of health services. In response, during the 1970s many family planning advocates increasingly promoted support of vertical programs, partially in response to notable vertical health program successes (smallpox, malaria). Subsequently, many vertical family planning program successes resulted.

However, in the 1980s there was a swing back toward integrating family planning services with health services. Some of this was due to accommodating service delivery realities to scarce financial, human, and physical resources; i.e., it was often clearly more sensible and feasible to add family planning services to an existing health infrastructure than to create a new and parallel system. Some of the integration was also due to the realities of international donor support for family planning. Support to those governments that chose to provide services through their Ministries of Health (MOH), and most governments did,

generally meant that public sector family planning services were provided through the government's health system, "integrated" in some fashion or another. This is especially the case for World Bank population assistance since most of it is channelled through Ministries of Health. Hence, Type 1 integration is essentially a non-issue within the World Bank since it is the norm for World Bank activities and projects.

Betemariam [1993: I-6 - I-9] summarizes evaluations of the following vertical and Type 1 integration experiences (in some cases, experiments):

- experiences in Bolivia, Ecuador, Honduras, and Peru under The Population Council's INOPAL I operations research (OR) project (the OR found "mixed" results from integration);
- USAID/Nepal's Integrated Community Health Service Delivery Project (only "limited success");
- USAID/Egypt's Family Planning Systems Development project ("MOH provision of family planning services has contributed to the success of the project");
- Burkina Faso ("This project shows that, given appropriate training, planning, supervision, and evaluation, integrating family planning with MCH provides efficient service delivery");
- Bangladesh (the results of the Matlab experience are mixed); and
- the Japanese Organization for International Cooperation in Family Planning's (JOICFP) integrated projects in several countries (usually small, pilot projects that generally show positive effects of integrating family planning with other health services).

Betemariam also reviewed the experiences of Haiti, Tunisia, Malaysia, and Korea in shifting their modes of family planning service delivery [Betemariam: I-9 - I-11]. Haiti integrated its vertical family planning program in the early 1970s, with "a detrimental impact on the performance of family planning programs" by the mid-1980s. Tunisia's initial vertical approach (early 1970s) had little success among lower socioeconomic groups. As a result of success with several Type 1 pilot projects in the 1980s, it was decided to integrate family planning and MCH services over an 8-10 year period. It is too early to assess the results. Malaysia's Type 1 program is judged a success. Korea's is judged to have been unsuccessful.

Betemariam also addresses the issue of integration within the context of "stages of family planning program development." "The first school of thought asserts that vertical programs should be used in the early stages of program development in order to generate and institute demand for family planning. . . . These vertical programs should then be replaced gradually by integrated programs . . . in order to expand services, especially to lower socioeconomic groups" [I-11]. Thailand and Tunisia are cited as examples.

"The second school of thought asserts that integrated programs are necessary at the early stages of program development because (1) demand for family planning has not yet been institutionalized; and (2) vertical family planning programs are not cost effective;" further, family planning services lack political legitimacy and, therefore, need to be provided in conjunction with other (health) services. This second school is especially common among professionals working in sub-Saharan Africa including USAID officials [a recent example is the USAID sector assessment for Ethiopia by Barbiero et al., 1993].

In summary, Betemariam finds that studies of the relative effectiveness of Type 1 integration (compared to vertical family planning programs) are inconclusive. There are examples of both successful vertical and successful integrated approaches; similarly, there are examples of unsuccessful programs of both types. "The empirical evidence does not make possible a clear assessment of the effectiveness of integrated programs" as superior to vertical programs in delivering family planning services [Betemariam, 1993: 1-6].

It is important to note that, *de facto*, most public sector programs in Africa, Asia, and the Near East are now integrated although the specific configurations vary greatly from country to country. Thus, in a real sense, circumstances "on the ground" have overtaken this debate. The real issue no longer is vertical versus integrated. The real issue is how, in the public sector, to organize and mobilize scarce resources (financial, human, institutional) to provide integrated family planning and health services that are cost effective and of the required quality. This in turn brings to the forefront issues of policy, especially as related to resource allocation and program management and, inevitably for nearly all countries, the pre-eminent issue of formulation and effective implementation of policy reforms.

The Integration of Information, Education, and Communication

An immediate problem in integrating family planning information, education, and communication (IEC) with health or other development programs is that *the term and concept of IEC is identified primarily with family planning*. Specialists in various other areas (e.g., health or education) may be unaware of what family planners mean when they refer to incorporating IEC into a project or program. Health specialists variously refer to IEC or components of IEC as health communication, health education, or health promotion, although many are familiar with the term IEC. Education specialists and women-in-development specialists, on the other hand, may be baffled by the unfamiliar term. In practice, both Type 1 and Type 2 integration occur frequently in the area of IEC.

In Sri Lanka under the Enterprise Program's Jantha Estate Development Board (JEDB) family planning plantation project, family health issues were integrated with family planning in some of the IEC materials. In the Philippines under the Total Integrated Development Approach (TIDA) project, IEC materials integrated family planning, health, education, and other development issues.

In Jordan and Yemen, where there is governmental support for family planning but where family planning has been a potentially volatile political issue, family planning information

is often couched in health terms and integrated with health information. For example, materials developed in Jordan by a USAID project first discussed breastfeeding in the context of health, as well as other MCH issues, before proceeding to a discussion of family planning. In Yemen, materials for non-literates on family planning (produced under a USAID project) also contain general MCH advice.

Regardless of whether a program contains a vertical or horizontal organizational structure, IEC services may be delivered to the public in an integrated fashion. For example, Egyptian district-level health educators report that they begin family planning health education sessions with other health topics--hygiene, breastfeeding or immunization--and ease into more sensitive family planning subjects. Similarly, Bangladeshi family welfare visitors reported in 1988 to one of the authors that they began visits to new families by discussing MCH issues. Certain subjects perform better when they have both family planning and health implications. For example, breastfeeding has positive consequences for the health of both mother and child, as well as serving as a temporary contraceptive method in the case of exclusive breastfeeding. Similarly, condoms promoted to prevent the spread of HIV still serve as a fairly effective contraceptive for heterosexuals using condoms consistently. Clients may well perceive the linkage, especially with regard to the dual function of condoms.

Unfortunately, IEC efforts sponsored by different offices within USAID have not always addressed the whole picture. For example, USAID has procured condoms separately for sexually transmitted disease (STD) prevention and family planning programs. Although potential condom users may correctly perceive that condoms have dual effects, AIDS program service delivery staff may be trained to offer condoms with STD counseling but may not be trained to provide family planning counseling. IEC, which must start from what clients already perceive and believe, may need to address both issues.

In addition to integration in IEC, family planning and health may be integrated into the pre-service educational curriculum of health professionals, such as physicians and nurses. In the Philippines, with USAID funding, health and family planning were integrated into paramedical in-service training. Outreach workers and traditional healers have also received integrated training in health and family planning. UNICEF trained traditional birth attendants in safe birthing practices and family planning. Several sub-Saharan African countries, such as Swaziland, have trained traditional healers to deliver family planning services. CEDPA staff attribute part of the success of their integrated projects (each of which includes both types of integration) to the presence of outreach workers trained to answer questions on a variety of topics of interest to women.

B. Lessons Learned

Factors Necessary for Success of Type 1 Integration

In the past 25 years, we have learned a great deal about the problems of designing Type 1 family planning programs, but we have yet to reach a consensus on a universal program package or model that encompasses all of the necessary elements for success. In

fact, research suggests that success factors may be country-specific and dependent upon the interrelationships among factors at a given point in time. For example, the earlier Matlab (Bangladesh) studies of integrating family planning and health interventions concluded that specific technologies or methods may have been less relevant for increasing contraceptive practice rates than the quality of the relationships and interactions between clients and service providers.

However, while we may be unable to specify precise predictive models. There are success factors common to many program situations, such as the following:

- a strong commitment to the program by top political and bureaucratic leaders;
- well-defined and attainable program objectives and adequate supporting budgets;
- highly trained and motivated staff at all levels of the organization;
- a concern for responding to the needs of clients through continuous quality improvement;
- a staff with doable job descriptions; and
- access to all appropriate modern technologies to improve operations and external impact.

These factors can be refined and incorporated into checklists when planning and managing programs. Many of the factors seem relevant to both USAID and host country programming and operations and useful for improving population strategies and programs.

Some elements seen as important to successful implementation of new strategies and programs are the following:

1. Motivating political leaders to take ownership of programs. National and local political elites and opinion leaders must actively support population and health programs if they are to be sustainable over the long run. Politically empowered women and women's groups can play a more active role in demanding such support.
2. Developing practical national population strategies. To get national attention, economic planners and financial decisionmakers must be required to address population and family planning needs.
3. Putting clients first. Among other things, donors and host countries must shift from a traditional supplier-dominated

orientation to one that is primarily concerned with addressing client needs and conditions (e.g., tailoring programs to women's time and income as well as soliciting women's desires before planning a project).

4. Removing traditional program baggage. Review and eliminate the multitude of nonessential political, medical, and other barriers that currently reduce access to services or discourage innovation and improvement of services.
5. Overcoming donor inertia. Donors need to take a more proactive role in illuminating quality options for cooperating countries, including removing donor-based political and bureaucratic impediments to making the widest possible range of safe contraceptive technologies available in all programs (i.e., logistics and procurement staff should not dictate program mixes).
6. Promoting and rewarding staff innovation. To prevent organizational stagnation, more must be done to develop policies, reward systems, and training to support continuous staff innovation and quality improvement.
7. Expanding channels for providing services. Much more can be done to diversify service delivery channels and thereby increase client access to quality services (e.g, using national agencies, PVOs, commercial outlets, local governments, etc.).
8. Increasing regional cooperation. Use regional bodies and conferences to more effectively assume responsibility for the long term success and viability of population and health programs.

Other Lessons for Type 1 Integration

In addition to the above, the following are additional lessons learned:

1. Do not overburden health care providers, including outreach workers. The lesson from Nepal and elsewhere is that adding family planning to the duties of already burdened front line health workers may not improve contraceptive prevalence and may earn the resentment of the health workers.

Corollary: When designing a program to integrate service delivery, conduct a situational analysis to determine what other duties the service providers already have and whether there is time to include family planning or whether resources must be provided to expand the service delivery staff.

2. Nonhealth care personnel can serve as effective outreach workers and can be trained to deliver nonclinical methods (as in PVO programs in India).
3. Female outreach workers are important to the success of projects in countries where women's movements outside the house are restricted (e.g., India and rural Upper Egypt). This may be true in both types of integration.
4. Type 1 integration may work better when individual service delivery points maintain some control as to how integration proceeds in their sites (as evidenced from projects in Burkina Faso and Bangladesh).
5. Integrating family planning services with oral rehydration therapy (ORT) services may lower contraceptive prevalence, at least for a while, because of the time staff devote to learning their new responsibilities. This was the case in Bangladesh (Matlab) and Ecuador (INOPAL).
6. Perhaps even more than other types of programs, integrated programs demand careful planning. They also require strong political and financial support for the goal of integration, phased implementation, and the full participation of both the health and family planning structures. Betemariam [1993] attributes the success of the Malaysian integration experience to the presence of all of these factors. These factors also figured prominently in the success of CEDPA's integrated projects.
7. "If a country decides to integrate its programs, it should devote adequate resources, and not automatically expect economies of scale" and "it must create mechanisms to ensure that funds earmarked for family planning will be used for that purpose" [Betemariam 1993:I-13].
8. "A family planning program that is part of a health ministry structure can have maximum impact if it retains its budgetary and management authority, while using the ministry's infrastructure to deliver services" [Betemariam 1993:I-14]. This has been the case in some service delivery programs in Indonesia.
9. "It is imperative to look beyond the integration of family planning with MCH" because this overlooks delivery of family planning to hard-to-reach populations such as adolescents and older women. It also overlooks the male population [Betemariam 1993:I-14].
10. "Congruence of organizational structures and goals is important for effective program performance" [Betemariam 1993:I-15]. In other words, integrated health and family planning structures must share the same priorities and must be able to interface in a way that enhances each other's activities rather than encouraging competition between family planning and health activities.

11. "During the process of integration, program leaders and policymakers should monitor program results and, if necessary, take corrective actions" [Betemariam 1993:1-15].
12. Few studies include collection of data on clients' and prospective clients' preferences for integrated versus vertical service delivery. It is critical to find out what clients want.
13. Type 1 integrated projects have a longer start-up period and may need a longer project life than vertical projects. This was the experience of the Enterprise Project in Egypt when family planning and health were integrated in private sector service delivery.
14. Integration must be treated on a country-by-country basis. For example, some countries have weak MOHs, and integration of family planning with health could weaken a stronger family planning program. In such cases, institutional strengthening of the MOH should be part of an integration strategy. Other sectors such as NGOs and the for-profits could be alternative vehicles for integrated programs.
15. Integrating STD diagnostic and treatment services into existing family planning services will be difficult and expensive due to the need for laboratory facilities, trained staff, and drugs.
16. In the private sector, family planning and health are more often integrated than not because provision of health care is usually highly remunerative, whereas family planning service provision usually is not.
17. Urban and rural areas often have different needs for delivery of integrated programs (e.g., a polyclinic may be preferable in an urban area, but an outreach worker might be best in a rural area).
18. In some countries (e.g., India) women may find it difficult to accept family planning services unless they are integrated with MCH.
19. Both the literature (e.g., Ness, 1984) and many interviewees suggest that a vertical program will not be integrated successfully if integration results in loss of jobs for bureaucrats. Although most interviewees were referring to host country bureaucracies, some USAID staff volunteered that this was the case in their agency as well.

V. Type 2 Integration

A. Literature Review and Selected Experiences

Supply and Demand in the Context of Type 2 Integration

Twenty years ago, Ansley Coale specified three conditions for fertility decline: (1) fertility must be within the calculus of conscious choice; (2) reduced fertility must be viewed as advantageous; and (3) effective techniques of fertility control must be available. In the context of most developing countries, the third condition largely refers to the "supply" of contraceptive services, especially family planning programs. The second can be viewed as the "demand" for smaller families (sometimes meaning the desire to use contraceptive methods, either modern or traditional, in order to control fertility).

The success of family planning programs in many developing countries, and especially in most Asian countries, demonstrates clearly that making services readily available (supply) can result in significant increases in contraceptive use and fertility decline. What about "demand creation"? Demeny [1992] argues that, despite the supply side successes, creation of demand for lower fertility and the means to achieve it has been relatively neglected by public policy, both of developing countries and of donors. Policies intended to reduce fertility "must focus on the key elements that change the micro-level incentives that determine fertility behavior" [p. 329], of which the four most important are the following:

1. the direct costs parents must incur in raising and educating their children;
2. the opportunity costs of children to their parents, that is, the earnings a couple must forgo because of children;
3. the contribution of children to family income through labor services; and
4. the contribution of children to parents' economic security in old age, compared to alternative sources of security.

Demeny believes the following are the most important macro-level conditions that create the requisite micro-level incentives to motivate parents to limit their fertility:

1. social expectations and formal institutional arrangements must place on parents the major financial responsibility for raising their own children, including the cost of education and health care;
2. women must have access to income-earning opportunities in the labor market, including jobs not easily compatible with childbearing and childrearing;

3. formal education (primary and early secondary) must be compulsory with school attendance effectively enforced;
4. child labor must be illegal (and this must be enforced); and
5. property rights must be legally guaranteed; private contracts must be legally enforced; private and public insurance and pension plans must be available that provide attractive and comparatively secure alternatives to children as sources of old-age security.

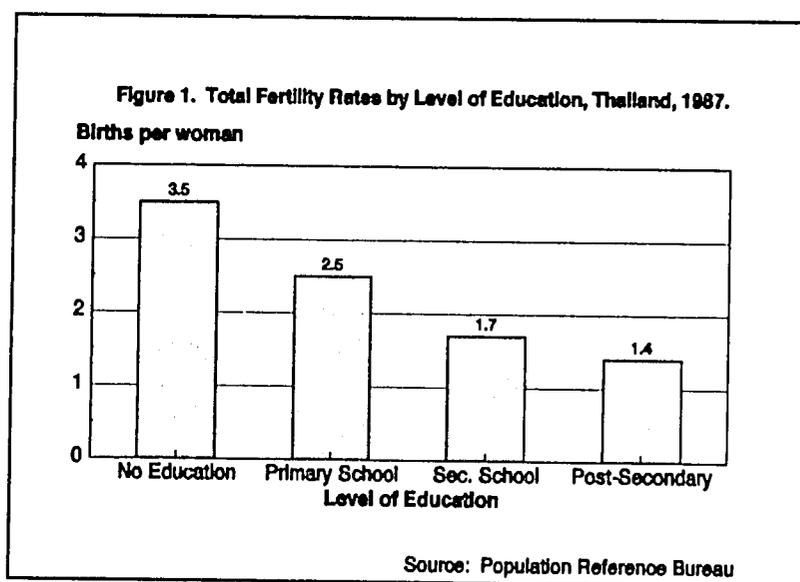
Review of the Literature

On Type 2 integration, the literature is moderately robust on the Type 2 issue of "beyond family planning determinants of fertility." However, it is sparse on examples of Type 2 program experience.

Fertility and Female Education

Over the past 15 years, considerable research effort has been devoted to the relationship between female education and fertility and, to a lesser extent, health and mortality. Notable examples include a general review and summaries by Cochrane [1979, 1988], Hobcraft [1993], Kocher and Cash [1979], Population Action International [1994], the United Nations Population Division [1993], and World Bank [October 1992; Axxin [1993] on Nepal; East-West Center [1992] on Pakistan; Jejeeboy [1991] on Tamil Nadu; LeVine et al. [1991] on Mexico; Sathar and Mason [1993] on Pakistan; Tulasidhar [1993] on India; and World Bank on Indonesia [1990, 1991] and on the "miracle" High Performing Asian Economies [1993; August-October 1993].

Without exception, these studies demonstrate a strong general negative association between average level of female educational attainment and fertility; that is, higher educational attainment is associated with lower fertility. Moreover, with the possible exception of access to family planning services, the education level of women has a more powerful impact on fertility than any other socioeconomic variables. Bongaarts, in a recent overview [1994], concluded



that *"of all the social and economic factors that have been studied for their potential effect on reproductive behavior, the level of education stands out as the most consistent."* This relationship is shown in Figure 1 for Thailand.

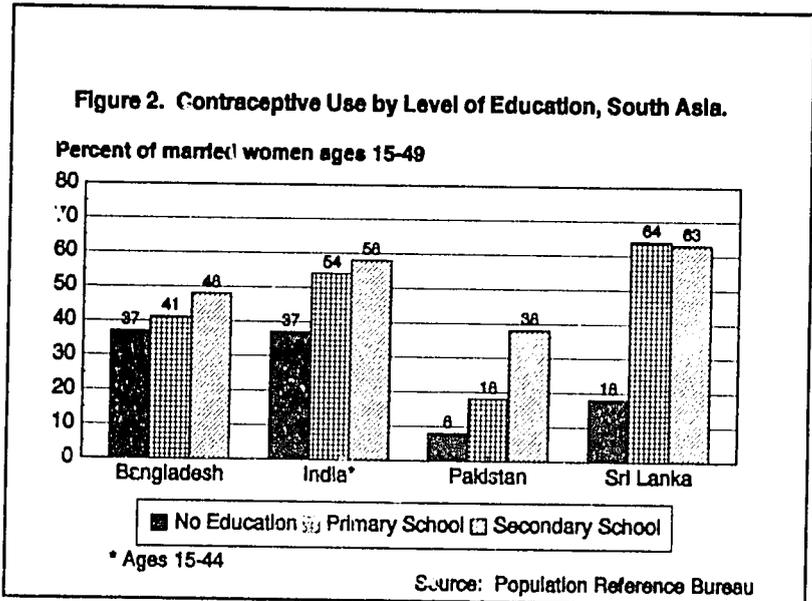
However, the relationship between female education and fertility is complex and can vary significantly from one set of circumstances to another. For example, the results of the recent United Nations study, using Demographic and Health Survey (DHS) results from 26 countries, are summarized below [United Nations, 1993: 1-4]:

1. *Advanced female education is universally linked to lower fertility. In every country examined, women with 10 or more years of schooling have much lower fertility than women who have not attended school.*
2. Fertility differentials by education are not uniform under all conditions of development. The strength of the association varies significantly across countries, suggesting the conditioning influence of socioeconomic development, social structure, and cultural context. The impact of individual schooling is generally weak in poor, rural, and mostly illiterate societies; it tends to become stronger in more prosperous societies.
3. In some of the least developed countries, the effect of education on women with incomplete primary education is fertility-enhancing. (This exception is discussed more fully below.) The slightly higher fertility among women with a few years of education should not be interpreted as evidence that education has a pronatalistic influence. Even at early stages of the fertility transition, education does not increase the demand for children. Better educated women consistently want smaller families.
4. Women's education affects not only the demand for children but also the ability and willingness to implement fertility preferences through contraceptive means.

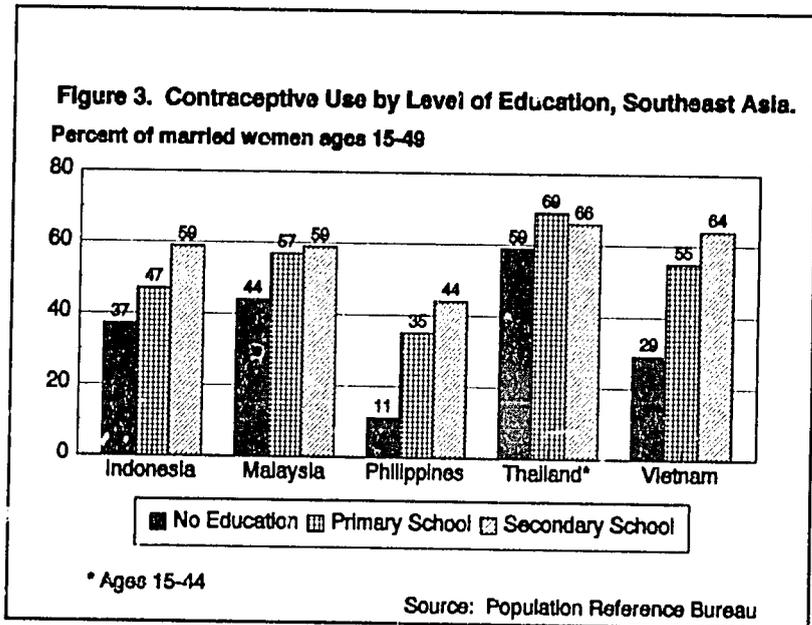
Thus, while the overall relationship between female education and fertility is unambiguous, in some countries (Costa Rica, Jordan, the Philippines, or Punjab state in India) the relationship is weak or absent. As noted in point 3 above, there is also the "primary education" exception in some countries, especially common in sub-Saharan Africa, in which fertility tends to be slightly higher for women who have some primary schooling than for women who have no formal schooling. This is primarily due to shorter average birth intervals for women with some primary schooling compared to those with no formal schooling, and these shorter birth intervals are probably largely due to shorter periods of post-partum sexual abstinence insufficiently offset by increased use of contraceptives for birth-spacing. (Prolonged post-partum sexual abstinence is common in traditional African societies but this is often not practiced by more "modern" couples such as those in which the woman has some formal schooling.)

While researchers have not found a consistently strong relationship in all countries between level of education and fertility, they have found a consistently strong relationship in

all countries between level of education and contraceptive use. This also supports the above explanation of the "primary education exception." For example, for all DHS surveys in sub-Saharan Africa, Ainsworth [1993] finds that contraceptive use increases consistently as women's educational attainment increases--including for women with primary schooling. Her analysis shows that in many African countries *women with only primary schooling have both higher prevalence and higher fertility than women with no formal schooling*. This indicates that women with primary schooling are more highly motivated to use contraceptives than women with no schooling.



Figures 2 and 3 show that for four countries in South Asia (Bangladesh, India, Pakistan, and Sri Lanka) and for five countries in Southeast Asia (Indonesia, Malaysia, Philippines, Thailand, and Vietnam) as the level of formal education attained by married women increases, the level of contraceptive use increases. The only exceptions are at the secondary school levels in Sri Lanka and Thailand. In both these countries, women with only primary school education have quite high levels of contraceptive use: 64 percent in Sri Lanka and 69 percent in Thailand. Married women with secondary education have slightly lower prevalence rates: 63 percent in Sri Lanka and 66 percent in Thailand. This may be because women with only primary education were married at younger ages than women with secondary education, and therefore the former need to have slightly higher contraceptive use rates in order to limit their numbers of births to the levels they desire.



Despite near consensus that, in most countries, women's educational attainment has a greater impact on their fertility than any other socioeconomic variables, female education programs have only rarely been combined programmatically with family planning activities.

Fertility and Empowerment of Women

There is some evidence for the hypothesis that empowerment of women leads to lower fertility as Basu [1992] discovered in comparing south Indian and north Indian women in the slums of New Delhi. Also consistent with this hypothesis is the resilience of traditional roles for women in Jordan and in Punjab state in India despite high levels of educational attainment (i.e., absence of empowerment associated with significant educational attainment, due to a rigid and largely intact culture) and continued relatively high fertility.

Fertility and Child Survival

There is also some evidence on the "child survival hypothesis;" that is, increases in infant and young child survival rates (or, conversely, reductions in infant and young child mortality rates) are associated with increased contraceptive prevalence and declining fertility, although the strength of this relationship has been very difficult to establish empirically [Ross, et al., 1992].

Cost Effectiveness of Type 2 Interventions

The literature is nearly silent on two extremely important and distinct Type 2 issues: (1) experience with large-scale Type 2 "interventions," and (2) the relative cost effectiveness in reducing fertility and population growth rates of investments in "beyond family planning" interventions (i.e., child survival programs, girls' education, female adult literacy programs) relative to investments in family planning services. Perhaps the primary reason for lack of integration of female education with family planning activities is the bureaucratic reality of governments everywhere: formal schooling in the public sector is provided by the Ministry of Education; family planning services are provided by the Ministry of Health.

As for the cost effectiveness of investments in education, relative to family planning services and other investments: it is often asserted that direct expenditures on family planning will be more cost-effective in bringing down birth rates than will investments in education although this has proven difficult to establish empirically at either global or individual country levels. However, two recent studies have attempted to calculate the costs of meeting global needs in family planning/population programs, MCH/child survival programs, and basic (primary) education programs. Kocher and Buckner [1991] estimated that it would cost about \$45 billion annually to achieve universal primary education in developing countries (excluding China) by 2000 compared to about \$12 billion annually in family planning/population program expenditures to meet the U.N.'s medium fertility decline projection (a fertility decline of about 20 percent between 1990 and 2000). Population Action

International (PAI) estimated that it would cost about \$10 billion annually in family planning/population program expenditures to satisfy all unmet need for family planning throughout the developing world by 2000, while it would cost an additional \$18 billion annually to close the existing gender gap between males and females in primary education (in addition to what is currently being spent on primary education. This would not, however, achieve universal primary education) [PAI, 1994].

Achieving either universal primary education (Kocher and Buckner) or eliminating the gender gap (PAI study) would presumably contribute significantly to fertility decline. However, neither of these studies, nor apparently any others, has concluded that a given level of additional expenditure on female education will reduce fertility more than would an equal additional expenditure on family planning programs.

Type 2 Integration Intervention Experience

Type 2 integration *interventions* (e.g., fertility, health, female education) typically seek a wider impact than Type 1 interventions and, therefore, public sector programs would generally work with multiple ministries on national projects or programs. We could not find *current* large scale, public-sector examples of this type of project. (The World Bank is now negotiating an "intersectoral population project" of this type with the Government of Bangladesh.)

Public Sector Experiences

There were relatively well known USAID-funded "integrated family planning within community development-type" programs in both the Philippines and Egypt in the 1970s. Ultimately both were determined by USAID evaluations to be unsuccessful due, in effect, to their very high cost relative to their family planning accomplishments. In both cases, the overall failure was attributed to a combination of misguided local leadership and heavy management burdens. However, since both these experiments were undertaken in circumstances very different from those prevailing now, it is probably imprudent to extrapolate results to today's environments.

In a few other countries, during the 1960s and 1970s quasi-Type 2 integrated development programs included family planning. In Malaysia, some family planning services were provided by the Federal Land Development Authority (FELDA) created in 1956 to establish new land schemes out of virgin jungles for landless rural peasants [Fong, 1987]. From 1968 to 1985, FELDA accounted for an average of about 7 percent of all family planning acceptors in government programs (which in turn accounted for about 80 percent of all acceptors nationwide) [Fong: 540-41]. Fong concludes that the FELDA program was a success in that family planning acceptance compared very favorably both to integrated family planning/MCH (Type 1) services and to vertical family planning services although he doesn't analyze the cost effectiveness (as measured by prevalence rates or fertility decline) of the programs. However, since coverage of the FELDA program was limited to the relatively

unique circumstances of the frontier areas, the experience provides little guidance for potential application elsewhere in Malaysia or in other countries.

Korea integrated its family planning activities into its community development program. Although one study judges Korea's community development program, "Saemaul Undong" (New Community Movement), a success [Turner, et al., 1993], it is not clear that the family planning component was successful. Betemariam [1993: I-11], in a review of Bang [1991], concludes that integration had a negative effect on family planning program performance. However, since "the integration of the two programs was not carefully planned, and the process did not address the specific resource and administrative problems that arise in a more complicated integrated system" [Betemariam: I-11], it is not possible to judge whether the program might have been a success had it been well implemented.

Cost Effective PVO Type 2 Experiences (CEDPA)

Dairy Cooperatives, Bihar

Although many PVOs may have carried out integrated projects, the projects are often difficult to identify given the structure of USAID funding. However, CEDPA, a USAID-funded cooperating agency (CA), has been involved in many successful integrated PVO projects. As with all USAID CAs conducting integrated projects, CEDPA uses USAID population funds only to finance the family planning portion of projects.

Bihar, India, is a poor state with very low female literacy, high crime, and political flux. Rather than attempt to address all of these issues in one project, CEDPA opted to focus on integrating family planning and some MCH services into a successful economic structure: a parastatal dairy cooperative. The project addressed family planning, immunization for children and pregnant women, health care financing, and enhancing women's status. The objectives of the project were 1) to educate all eligible couples in 245 rural Dairy Cooperative Societies (consisting of one to three villages) about the importance of family planning and immunization; 2) to provide family planning services to 8,600 acceptors; 3) to develop strategies for community financing; and 4) to increase women's participation in family planning program management and service delivery.

By all measures, the project was a success: contraceptive prevalence rose dramatically--from 20 percent at baseline to 50 percent after 18 months of project implementation. At \$0.65 per CYP (contraceptive year of protection), the project was cost effective. Unlike much of India's family planning experience, the project was able to reach lower parity women because it offered temporary as well as permanent methods. Due to the project's success, CEDPA is planning to initiate a similar project in another Indian state and is investigating use of other kinds of cooperatives to replicate the project in other parts of India.

CEDPA attributes the success of the project to several factors, as follows:

- building on an already successful grassroots infrastructure (the dairy cooperative);
- integration of family planning with MCH services to achieve increased family planning acceptability;
- provision of both temporary and permanent methods of contraception;
- use of female outreach workers in a situation where many women are in purdah, and use of male depot-holders for condom distribution;
- participation of senior government officials and full support of the General Director of the dairy cooperative (who served as the project director);
- good follow up of clients for support and assistance;
- a team approach between government auxiliary nurse-midwives and project field workers;
- community financing which resulted in better quality of services; and
- interventions were limited to a manageable number.

Gujarat State Crime Prevention Trust

The Gujarat State Crime Prevention Trust was accepted and respected in the slums of Ahmedabad. The Trust was already providing adult literacy training, family counseling, child guidance, and day care. CEDPA worked with the Trust to initiate a family planning program. Information about family planning was integrated into the Trust's ongoing activities. A corps of exceptionally well educated field workers was recruited to work in two slum areas of Ahmedabad. Field workers distributed oral contraceptives and non-clinical methods and referred clients to the project physician. They also provided information, education, communication, and counseling through their visits to each household and through events such as puppet shows, neighborhood meetings. The project provided an array of temporary contraceptive methods as well as referral for permanent methods. Field workers followed up all clients.

The project was very successful. "By the end of its third year, the project had recruited 9,070 new acceptors, surpassing its own goal. . . . A recent follow-up survey in the target communities shows that contraceptive prevalence has increased from 12 percent to 61 percent over three years and that knowledge of family planning methods and the advantages of birth spacing has become almost universal" [Kak et al., 1993:4].

Reasons for the success include the following:

- use of female outreach workers from the same ethnic groups as clients;
- committed staff and project leadership;
- integration of family planning activities into successful ongoing activities valued by the community;
- a client-centered management information system;
- consistent follow up and support for method users; and
- strong information, education, and communication; and participatory management to develop a sense of ownership among field workers.

Coptic Church, Egypt

CEDPA's Egyptian project with the Coptic Church in two Upper Egyptian governorates (Qena and Aswan) integrated family planning into the Bishopric's ongoing adult literacy program. Female outreach workers helped to motivate women and visited them in their houses, in addition to providing family planning services at literacy training centers. Literacy training gave women a legitimate reason to leave their homes, and the integration of family planning into literacy training facilitated acceptance and access. The Coptic Church in Qena and Aswan did not have any ongoing experience in women's income generation activities. Perhaps for this reason, the addition to the project of income generating activities for women was not successful.

In summary, the literature on Type 2 interventions is limited. What exists is inconclusive and mostly describes experiences from 15-20 years ago.

Type 2 Information, Education, and Communications Experience

UNFPA and UNESCO have been instrumental in Type 2 integration of "family planning/population education" into existing formal and nonformal education activities. For example, in Yemen, UNESCO sponsors drawing and essay contests for school students on Yemen's population problems and has developed a population education curriculum; in the Philippines, USAID funded the development of a population education curriculum and its implementation was funded by UNFPA; and UNFPA and the former South Yemeni government developed materials for adult female literacy campaigns on family planning and population.

It is also common for women's income generation projects to include health and family planning information in the program. For example, NGO women's income generating programs in Bangladesh also may include discussions with participants on family planning and health issues.

B. Lessons Learned

Achieving Genuine Socioeconomic Development and Low Fertility Requires the "Right" Policies

Virtually all nations at least profess to strive to achieve widespread, participatory socioeconomic development. This goal probably cannot ultimately be reached without achieving low fertility, mortality, and population growth rates. *The single most important key to doing so is getting policies right [World Bank, August 1993]. This is the most important lesson from the success of the "miracle" High Performing East Asian Economies (HPAEs): Hong Kong, Indonesia, Japan, Malaysia, the Republic of Korea, Singapore, Taiwan, and Thailand [World Bank, 1993].*

The East Asian miracle--achieving high (economic) growth with equity--is due to a combination of fundamentally sound development policies, tailored interventions, and an unusually rapid accumulation of physical and human capital [World Bank, August-October 1993: 1].

What caused East Asia's success? In large measure the HPAEs achieved high growth by getting the basics right. . . . Population growth rates declined more rapidly in the HPAEs than in other parts of the developing world. . . . Education policies that focused on primary and secondary schools generated rapid increases in labor force skills. [World Bank, August-October, 1993: 2-3].

The Process of Fertility and Mortality Decline: Supply of and Demand for Family Planning Services

By making services readily available accompanied by a strong IEC program, a strong family planning program (supply) can significantly reduce the Total Fertility Rate (TFR) from the 6-7 range to the 4-5 range independently of the amount of progress in socioeconomic development and improvements in the status of women. Bangladesh is probably the foremost example.

Early and rapid fertility declines can contribute significantly to economic growth and the capacity for a nation to then meet basic human needs for everyone (e.g., needed increases in food production and consumption, basic education, and health services). This in turn promotes the more widespread desire for smaller families and further fertility reduction. In Bangladesh, rapid fertility decline has contributed significantly to the *possibility* of meeting basic human needs. In 1993 Bangladesh became essentially self-sufficient in cereals after experiencing large deficits for decades. This certainly would not have happened had fertility and population growth rates remained at the high levels of the 1970s. Other good examples are the HPAE countries.

Although strong family planning efforts can achieve significant fertility decline in the absence of profound and pervasive socioeconomic development and improvements in the status of women, *fertility has not declined to near replacement level (e.g., TFR below 2.5) in*

any country that has not also experienced significant and fairly widespread socioeconomic development and improvements in the status of women. These improvements are prerequisites to creating a desire (demand) for small families. Therefore, "beyond family planning demand creation" is almost certainly a prerequisite for fertility, mortality, and population growth rates to decline to low levels.

If fertility decline stalls at well above replacement-level fertility (e.g., TFR of 3.5 or higher) due to inadequate availability (supply) of family planning services, absence of growing desire for small families (insufficient growth in "demand"), or both, the high population growth rate will continue to extract a high economic price and will be a formidable--and ultimately probably an insurmountable--obstacle to achieving sustained socioeconomic development and poverty reduction.

The Need for Policies that Promote Essential Social Sector Investments

For a country to achieve socioeconomic development and reduce poverty, it is crucial that fertility decline continue until it reaches near replacement-level. For fertility to decline to such a low level, the nation must also adopt and aggressively implement policies that foster achievement of "profound and pervasive" socioeconomic development and improvement in the status of women. For example, *there is no evidence of fertility declining to near-replacement level with female literacy below 25 percent--approximating current levels in Bangladesh, Pakistan, and much of North Central India--and replacement level fertility probably cannot be accomplished with female literacy below 75 percent.*

What is required for fertility to decline to near-replacement level in the most populous and impoverished world regions (e.g., Bangladesh, North Central India, Nepal, Pakistan, and much of sub-Saharan Africa)? Bangladesh demonstrates that a strong family planning effort can bring fertility down considerably--e.g., from a TFR in the 6-7 range to a TFR in the 4-5 range. *But to bring the TFR down to the 2-2.5 range will require widespread participation in socioeconomic development, widespread basic education for girls, and widespread improvement in the status of women.*

[The HPAEs] education strategy was to focus spending on the lower grades: first by providing universal primary education, later by increasing the availability of secondary education. Rapid demographic transitions facilitated these efforts by slowing the growth in the number of school-age children and in some cases causing an absolute decline. Declining fertility and rapid economic growth meant that, even when education investment as a share of GDP remained constant, more resources were available per child in East Asian regions than in other developing regions. ... What East Asia has done differently is to allocate a consistently higher share of public expenditure for education to primary schooling than elsewhere. [World Bank, August-October 1993]

If the successful formula of the East Asian miracle nations is to be emulated, the policy goal must be to "achieve rapid economic growth with equity." Investing in a strong family

planning program slows population growth and contributes to economic growth. Other social investments--especially basic education and health care--will contribute to greater equity, promote more widespread desire for small families, and produce lower overall fertility, if good family planning services are readily available. This will in turn produce increased economic growth and greater equity--the "virtuous circle" [Birdsall and Sabot, 1993].

There is now a body of capabilities and experience by which USAID and other donor agencies can effectively promote and achieve significant policy reform through policy dialogue in the health and family planning sectors (Type 1 integration) [see Hollister, 1993] and in the social sectors more generally (Type 2) [see Crouch, 1993]. This task is not easy, and in many countries, obstacles will be formidable. However, in most countries, genuine policy reform is essential if demographic, health, and other social as well as economic objectives are to be achieved. The East Asian miracle countries have accomplished this. Some other developing countries now seem to be receptive to the possibility of commitment to genuine policy reform. Bolivia is perhaps the most recent and prominent example [Government of Bolivia, December 1993]. In most settings, important roles need to be played by NGOs in promoting and achieving genuine policy reform [VanSant, 1989; Crouch, 1993].

Organization, Management, and Evaluation Lessons

In addition to the pre-eminent requirement of formulating and effectively implementing appropriate social sector policies, there are some important lessons concerning the organization, management, and evaluation of Type 2 integrated projects.

1. Type 2 integrated projects are more challenging to manage than are Type 1 or vertical projects. Type 2 integrated projects require painstaking planning, a thorough understanding of the situation before the project is planned, strong and committed political support, and sufficient resources.
2. Managing an integrated program or project takes special training, both for host country and USAID managers.
3. Type 2 projects should limit the number of elements that are integrated (e.g., to not more than three or four elements).
4. Integrating family planning into an ongoing successful PVO program appears to be easier and more effective than to develop a new PVO structure to deliver family planning and other services (e.g., CEDPA's Indian and Egyptian projects).
5. Type 2 integration should be phased in gradually (CEDPA's worldwide experience).
6. PVO projects (e.g., CEDPA in India, Nepal, and Pakistan; BRAC or the Matlab project in Bangladesh) have been more successful at Type 2 integration than public sector country-wide projects (e.g., Egypt and the Philippines).

7. CEDPA's experience demonstrates that a successful Type 2 integrated project must begin with the clients' views of which activities should be integrated with family planning.
8. Integrated female literacy and population/family planning projects have had some success (e.g., Nepal with World Education; South Yemen with UNFPA, in which engaging materials on family planning were developed for newly literate women to practice and expand their reading skills).
9. USAID's own organizational structure militates against integrated approaches with funds shared among different sectors.
10. An integrated Mission portfolio may be easier to achieve than integrated projects.
11. Type 2 integrated projects and programs may be very difficult to evaluate, particularly as results may not be manifest for many years (e.g., the effect of population education in primary school on the birth rate). Therefore, USAID will need to set clear and realistic goals and objectives at the outset of integrated projects or programs, modify these as necessary during the course of projects, and develop innovative evaluation mechanisms suited to the needs of Type 2 integration.
12. The World Bank reports that starting and implementing successful public sector Type 2 integrated projects (a) must have support and coordination at the highest government level, (b) must receive a great deal of technical assistance at the planning and implementation stages; and (c) must be part of the regular government budget.

VI. Issues and Implications

A. USAID Policy and Perceptions

Current Strategy Trends and Issues for USAID

This section discusses evolving changes in overall USAID strategy and policy that will have an important impact on population assistance programs, regardless of whether the programs are vertical or integrated. We use the term "strategy" to refer to USAID macro goals, priorities, and general resource commitments in population and health. An effective strategy should provide meaningful guidance to an organization's staff in making decisions on allocation of funds, staff, and other resources.

Currently evolving strategies elevate health and population assistance to put it among the Agency's new top five priorities, along with democratization, economic growth, environment, and humanitarian assistance. After 12 years of relative neglect as a U.S. foreign policy concern, the problems of global population growth are thus assuming new importance and priority under the Clinton administration. The conservative U.S. position taken at the 1984 Mexico City World Population Conference has been repudiated. Funding is being restored to International Planned Parenthood Federation (IPPF), the United Nations Population Fund (UNFPA), and other organizations whose support was stopped by the Reagan/Bush administrations.

The State Department unit concerned with population issues has been given new life and status. The State Department and USAID will support the United Nations International Conference on Population and Development in Egypt in September 1994. In short, USAID now has a unique opportunity to play a vital leadership role on population and health issues, in both U.S. foreign policy circles and the international arena. The Asia/Near East region should also assume an eminent position in U.S. population assistance efforts because the region has some of the world's major population problems and also some of the richest experience in coping with excessive population growth rates.

Senior management speeches and draft strategy papers suggest that USAID will take a broader and more integrated approach to cooperating country population and health needs than has generally been the case. The January 1994 version of USAID's new *Strategies for Sustainable Development* states that "ultimately, the success of USAID's population and health strategy will be measured in terms of its contribution to expanding reproductive choice and rights, improving the health of women and children, reducing the spread of HIV/AIDS, and stabilizing world population at a level consistent with sustainable development" [USAID, January 1994: 38]. The paper calls for the U.S. to assist a "global effort" to achieve a world population of 8 to 9 billion by the Year 2025 and less than 10 billion by the Year 2050.

Health goals for the next 10 years include halving current maternal mortality rates, reducing child mortality rates by one-third, and decreasing the rate of new HIV infections by 15 percent. To achieve these goals, the paper calls for USAID to concentrate on "countries

that contribute the most to global population and health problems" and "countries where population and health conditions impede sustainable development."

The draft strategy paper indicates that USAID-supported country population and health programs need to be tailored to local conditions and take into account development efforts in other sectors. USAID will also promote integrated approaches.

We will emphasize the use of integrated approaches to expand reproductive choice and rights, help slow population growth, decrease maternal and child mortality and reduce the spread of HIV/AIDS and other sexually transmitted diseases.

By 'integrated approaches,' USAID means that population programs should seek to provide individuals with access to a range of family planning methods; should integrate family planning programs, as appropriate, with services that enhance women's health and child well-being and survival, in order to enhance both the effectiveness and the acceptance of family planning services; should utilize family planning systems, as appropriate, to provide information and services that limit the spread of sexually transmitted diseases; and should emphasize the importance of providing education for girls and women. By addressing co-factors, and by implementing related programs at the same place and time, integrated approaches increase the impact and sustainability of population programs.

Integrated approaches can save resources. They also are important in addressing HIV/AIDS because this disease particularly afflicts the very people who are in their most economically productive years and who should be most active in the development process: the young, the well-educated, and people in urban centers. Care and treatment consume ever-larger portions of national resources. The progress of the disease destroys family structure and increases infant mortality and the failure of children to thrive. Limiting the spread of HIV/AIDS thus is an economical and essential investment in sustainable development.

Where appropriate, USAID will seek to integrate family planning programs with programs that enhance public health. For instance, barrier contraceptive methods, particularly condoms, are the most effective means of preventing the spread of AIDS and other sexually transmitted diseases. Similarly, mothers taking their children for immunizations may also wish to take advantage of family planning services [USAID, January 1994: 35-36].

Different Staff Perceptions of Integrated Approaches

While the population and health strategy paper (January 1994, above) as well as the earlier draft (October 1993) suggests that USAID will pursue a broader and more integrated approach to population issues, several USAID/Washington staff interviewed by the RTI Team said that specifics of the new "integrated approaches" were not included in the document but

were expected to be in the subsequent implementing guidelines document. Some staff said that recent policy statements are too vague and need to be clarified. On one hand, there is a concern that an overly broad strategy could lead to a return to USAID's previous integrated approaches to development that failed because they were too amorphous and thus impossible to support and manage. (The two most common programs mentioned here are community development and integrated area development, which USAID supported in the 1960s, but largely abandoned in the 1970s.)

However, there does appear to be rather widespread support among staff for strategies that move beyond pure (vertical) family planning programs to integrate family planning services with selected health services for mothers and children (i.e., Type 1 integration). Some staff even say that actions beyond family planning and health may be needed to address effectively the current population problems faced by many cooperating countries. They note that the vertical and Type 1 integrated approaches that were successful in getting population programs started in many countries may now need to be broadened and augmented by macro or cross-sectoral strategies and actions to achieve the desired population growth rates (i.e., Type 2 integration). This is especially the case for countries where contraceptive practice levels are leveling off or declining.

The Office of Population of the Global Bureau indicated that the USAID position on integration is articulated in a November 22, 1993, speech given by USAID Administrator Atwood to the Central Council of the IPPF. The Administrator's IPPF speech indicates that USAID will give priority to four goals:

1. supporting the right of couples and individuals to freely and responsibly determine the number and spacing of their children;
2. advancing reproductive health, particularly addressing the needs of women and adolescents;
3. achieving population growth rates consistent with sustainable development; and
4. establishing programs that are accountable and responsive to the people who use them, especially women.

The Administrator's speech describes the strategy for pursuing these goals as follows:

Family planning will remain the critical element in our population programs and we will actively support the establishment of self-sustaining family planning systems and services. And we will build on this foundation. Our concern must be to meet the unmet need for family planning, but to go beyond. Maternal health, pre-natal care, safe sex, and social education must be part of the picture. So must the empowerment of women. So must the education of girls. We cannot attack the crisis with a single arrow. We cannot go to war with a single weapon . . . [Atwood, November 1993].

The approach outlined in the Administrator's speech could encompass a rather wide range of program mixes, including both Type 1 and Type 2 integration. However, the major indicator of past program success highlighted in the speech is the decline in fertility rates (from 6.1 children in the 1960's to 4.2 today). Some staff wonder whether new interventions will be considered for funding, unless they can demonstrate that they will cost effectively achieve reduced fertility rates. In other words, is fertility reduction to be the only measure of success in addressing population issues?

Other staff indicated that earmarked funds for population have been important to USAID program success in population. It was felt that it is not appropriate to use such funds to support new initiatives in say, women's education, since education funds should be used for such purposes. However, there were thoughts that it might be appropriate to support a women's literacy program that uses materials and themes covering family planning and reproductive health. Support was also indicated for increased efforts to incorporate population concerns into macro development policy formulation and planning activities in host countries.

The Administrator's IPPF speech was interpreted as supporting the retention of family planning as the core of USAID's population program. Higher level managers stress that family planning has proven to be the most cost effective method of reducing fertility. They will support the addition of reproductive health and AIDS/HIV interventions but feel a need to study the cost effectiveness of these or related interventions.

Middle-level managers at USAID tend to be very client-focused and believe that integration of service delivery will better meet women's needs, thereby resulting in wider use of services. However, they indicated that USAID must consider logistical and local factors in integrated service delivery. Reproductive health services, they point out, require medical and laboratory staff or other facilities that may be unavailable to a family planning program or delivery site.

Regional bureau staff views on integration are more diverse:

1. Population as a Low Program Priority in USAID

Since the top U.S. political leadership gave low priority to population assistance during the past 12 years, many missions and USAID/W offices reportedly devoted little serious attention to pursuing more innovative ways of helping cooperating countries address their population problems. Consequently, there was a tendency to take the course of least resistance and fund existing programs and agencies (thus basically perpetuating the status quo in some countries). Some staff said that, if more interest in population had been exhibited by mission leadership, new and more effective projects could have been developed. Similarly, some staff observed that missions are capable of doing a better job of absorbing and using population funds *for population activities*, but senior mission managers must be persuaded that the Agency is now serious about giving population the same priority as, say, the promotion of economic growth. This doubt suggests that some field managers may be waiting to see if the new top USAID leadership is serious about giving high priority to

population assistance (e.g., by increasing population funding, staffing, and related field support).

As field initiatives in population waned during the past 12 years, control over the management of USAID population funding gravitated to R&D/POP, so that it now reportedly controls nearly 80 percent of the budget for population assistance.

While many missions now rely heavily on centrally funded projects, some staff in the regional bureaus said that the R&D/POP projects are too narrowly focused and unable to take advantage of potential benefits from more integrated approaches. Consequently, they see such projects as being of limited value in helping specific host countries focus on the broad range of issues and options needed for effective population programs. Conversely, other staff point out that the regional bureaus have not given high priority to maintaining technical staff resources so they have little current capacity to provide field support in population, health, and other technical areas. This is why missions have increasingly turned to centrally-funded staffs and projects for support on population matters.

These apparent differences in perception among some central, regional bureau, and field staff on the importance of population and health assistance suggest that senior management may need to clarify the priority and funding levels of population and health programs in bureau and mission portfolios and the role which integrated approaches will have in USAID's new strategies.

2. Integration as an Antidote to Program Plateauing

Several regional staff feel that the "plateauing" of family planning achievements in some countries indicates a need to *go beyond family planning* to address other variables affecting fertility and population growth rates. The most commonly mentioned interventions are improved MCH services (Type 1 integration) and increased education for women (Type 2). It was noted that critical economic development variables are interrelated, and the issue hinges on what evidence one uses to justify the investment in particular (integrated or vertical) program interventions. Or, in some Near Eastern countries such as Jordan and Morocco, family planning is a sensitive topic, so political considerations dictate that it must be introduced as part of a broader MCH or other health improvement effort.

While the Team found considerable interest in programs to support women's education and status improvement, R&D/POP staff rejected the option of transferring or redefining population funds for such purposes. There does appear to be some support for testing the effectiveness of integrated approaches to improving women's and girl's competencies and health status (e.g., literacy programs that provide knowledge on MCH, reproductive health, and family planning).

There also appears to be interest in the regional bureaus and among the management of R&D/POP in supporting efforts to *better incorporate population and family planning concerns into macroeconomic development policy and planning* where the host country

conditions are appropriate. Such efforts could start with identifying and supporting a U.S. and Asian talent pool to provide technical assistance to interested countries in various areas (e.g., policy formulation, service delivery systems, legal reforms, incentives for stimulating the private sector). If potential payoffs from national policy reform, planning, and coordination are evident, the various donor consortia might serve as a means for promoting more high level attention to population and family planning needs in assisted countries.

3. The Need for Continuous Quality Improvement

Some staff note that the new strategy pronouncements say little about quality although this is an important USAID and host country issue in mounting new program initiatives. Among other things, staff reflect a concern that USAID (and the State Department) may make global commitments to action without fully considering the staff, funding, and management systems needed for high quality program execution. Task groups are currently designing "centers of excellence" in population and other functional areas that will be located in the new Global Affairs Bureau. However, at the time of our interviews (December 1993), most staff indicated that they had no idea how this new Bureau would operate or relate to other bureaus and field missions. This Bureau will reportedly be the organizational home of USAID/Washington's health, population, and other technical staffs.

Some staff also expressed concern that office turf and budget allocation issues appear to be limiting the cooperation, creativity, and enthusiasm being brought to the pursuit of more innovative ways of doing business and strengthening USAID's leadership role in U.S. foreign policy circles and within the international development community. If valid, this concern needs to be addressed, so that USAID can seize the opportunities provided by a change in top Agency leadership (1) to increase the pace of policy and programmatic innovation, (2) to improve support for field programs and staffs, and (3) to develop a critical in-house mass of technical leadership talent to implement the new USAID priorities. Senior managers must create an organizational climate and reward system that enables subordinate managers to stop worrying about internal office issues and devote more energy to cooperating on broader Agency goals.

Support for Quality Family Planning and Health Services

This section outlines some issues of quality improvement in population and health programs in cooperating countries. Program managers in both USAID and host countries need to be sensitive to the impact of their decisions on service quality and client needs, regardless of whether vertical or integrated approaches are being pursued.

While there is interest in exploring broader options for addressing population problems, there also appears to be widespread support among staff for *continuing and improving the quality and availability of family planning and health services*. In many countries, the demand for service is still unmet, and much more can be done to increase the quality and availability of service. Our interviews and literature review suggest that there is no consensus on the

most effective combination or package of services. *Effectiveness of service delivery systems seems to vary significantly with individual countries (and sometimes among regions within a country)* Nonetheless, staff report that some common elements of quality and effectiveness need to be considered in planning and managing USAID-supported family planning and health projects. For example, a 1992 paper by James Shelton and Roy Jacobstein identifies many barriers to family planning access that can be addressed [Shelton and Jacobstein, 1992]. The paper suggests that the following activities could help overcome those barriers:

1. sensitize medical and nonmedical service providers to the arbitrary rules they may be imposing on clients (e.g., requiring costly but marginally relevant tests before providing services);
2. mobilize the medical opinion establishment to disseminate better knowledge and remove ultra-conservative guidelines related to contraceptives; and
3. increase the delegation of authority and empower individual choice (e.g., letting IUDs be inserted by nonphysicians).

A common perspective among operating level staff interviewed is that services (as well as decisions about which services should be integrated with family planning) should respond to clients' needs rather than to the prejudices of service providers and administrators. Some feel that clients prefer "one-stop shopping," so integrated services are better. Others suggested that, after an adequate standard of quality is achieved in particular vertical services, resources should be used to provide integrated health and family planning services to the widest population, rather than focusing on high quality services for fewer people. These staff feel that integrated programs ultimately reach communities with the greatest needs, while more focused or specialized programs cover the less needy. Others point out that these options imply that vertical programs are able to provide higher quality care sooner.

One CA staff member is uncomfortable with a current initiative to "overcome barriers" to expanding contraceptive services. She expressed the fear that the health of a significant number of women might suffer if they inappropriately received oral contraceptives, for example, without adequate medical screening. She felt that excessive elimination of medical control could result in worsened quality of care.

Service delivery and quality of program management also seem to be important considerations in maintaining adequate levels of contraceptive practice in country programs. For example, a 1992 joint US-Bangladesh assessment team on clinical methods identified both demand and supply variables impacting negatively on the Bangladesh family planning program, but concluded that "supply factors weigh more heavily than fall-off in demand" [Ahmed, et al., 1992]. Poor program quality was attributed to such factors as the following:

1. poor quality training of staff at all levels;

2. inadequate staff and staff training capabilities (including an inability to cope with staff turnover and attrition over time);
3. serious problems with medical quality in the delivery of clinical methods (including inadequate systems for infection control); and
4. various general program management problems (coordination among health and family planning units, staff motivation, equipment, and facilities).

These types of quality problems are probably common in many country programs. The need to give greater attention to the quality of program management and resultant client services is heightened by recent global trends in democratization, women's empowerment, and the criticality of customer/client satisfaction. USAID and cooperating countries need to take a fresh look at the way in which population programs are organized to provide leadership and support on continuous quality improvement to front line service providers.

Defining the Basic Elements of a High Quality Country Program

Depending on each country's conditions, our interviews and literature review suggest that the following factors are associated with high quality health and population programs:

1. Political leaders actively support the program. In successful programs, national and local political elites and opinion leaders provide substantive, positive, and continuous support for programs so that they will be sustainable. Politically empowered women and women's groups play an active role in eliciting and shaping such support.
2. The program has an ambitious but achievable implementation strategy. The strategy involves key players and stakeholders at the national and local levels in implementing actions. National economic planners and financial decisionmakers give priority to population and family planning needs.
3. Clients are actively involved in decisions. The national policy and program is primarily concerned with systematically identifying and addressing client needs and conditions (e.g., tailoring programs to times that women are available and to their income levels as well as soliciting women's desires before planning projects).
4. Flexible and cost-effective management systems are present at all levels. Managers and staff continually work to remove nonessential political, medical, financial, and other barriers that

reduce client access to services.

5. Staff reward systems promote continuous program improvement. To prevent program plateauing or regression, managers provide reward systems and training that stimulate continuous staff innovation and quality improvement at all levels, with priority given to improving client services.
6. Multiple channels are used to serve clients. Government and the private sector cooperate to diversify delivery channels and thereby increase client access to high quality information and services (e.g, using public agencies, schools, PVOs, commercial outlets, factory clinics, and local governments).

Although the following topics are not covered very extensively in the literature, our interviews suggest that they may also be important ingredients of future USAID assistance strategies, especially in the ANE Region:

7. A high level of information exchange and cooperation on program improvement exists among countries. Several Asian countries could offer valuable experience to others in the region. USAID should lead other donors in establishing regional mechanisms to promote mutual assistance for addressing the long term success and economic viability of Asian population and health programs.
8. Donor support is flexible and responsive to local needs. USAID and other donors can play a proactive role in illuminating and supporting quality improvement options for cooperating countries. This role includes removing donor-based political and bureaucratic impediments to making the widest possible range of safe contraceptives available (i.e., client needs rather than donor procurement staff biases should dictate the mix of country program contraceptive options).
9. Applied research on program innovation is supported. USAID should lead other donors and cooperating countries in supporting applied research and development efforts to identify more cost effective and innovative ways of addressing population issues. This support includes joint Asian/US exploration of Type 2 integration efforts. First priority could be given to developing Asian models for effectively incorporating population concerns into macro and cross-sector development policies and plans.

B. Management Systems to Support USAID Strategy Implementation

This RTI study began before USAID had fully formulated its new strategies and policies for broader and more integrated health and population assistance programs. After the Agency has clarified and promulgated its new strategies, new management, and leadership systems will be needed to translate these changes into program results and field impact. Given current policy guidance and top leadership pronouncements, we assume that it is now Agency (and State Department) policy (1) to give high priority to population and health assistance goals after years of low priority, and (2) to pursue broader and more integrated approaches to attaining these goals after a largely vertical approach in the past.

Staff feedback suggests that successful implementation of these new directions will require USAID to adopt new and more integrated ways of focusing scarce human and other resources and fostering broader-based internal cooperation on population and health priorities. The remainder of this section addresses a few of the components of an effective organizational system for pursuing the high levels of innovation USAID must have to achieve its new goals and to provide effective global leadership on population issues in a rapidly changing political environment.

High Levels of Top Leadership Involvement

Top Agency leadership needs to be actively and directly involved in creating the organizational climate and system needed for effective implementation of the new program initiatives. Otherwise, the pace of decisionmaking is apt to be slow and conservative. An early task for the new top team is to demonstrate success in reducing the number of overall Agency priorities and commitments to more manageable levels. In addition to removing internal procedural barriers, Congressional and interest group cooperation is needed to remove pet programs or procedures that are currently less relevant. Some staff reported that the new Foreign Assistance bill to be introduced in 1994 may provide a good opportunity to help reduce and focus USAID's portfolio to more realistic levels.

Internally, top leadership also needs to ensure that its new priority program package is really understood and accepted by key managers and all staff. Given the large number of reorganization and strategy exercises that staff have been exposed to in recent years, there may be a natural tendency to take a conservative attitude toward new pronouncements from the top. Certainly, senior and middle level Bureau and mission managers must understand and support the new population and health priorities and integrated approach before the nonmanagement staff can effectively play their roles.

Funding Allocations Consistent With Priorities

To establish credibility, top management must ensure that program and operating budget *funding allocations reflect the new program priorities*. However, staff note that arbitrarily earmarking funds among functions, countries, or USAID offices can lead to low

quality projects. Such earmarking can trigger a form of "Parkinson's Law," which means that managers design programs primarily to absorb available funds (since some consider it a bureaucratic sin to turn back funds).

To improve the quality of program proposals, perhaps some form of *internal competition* might be introduced. The first step may be to define a global package of interventions (project/program outlines) relevant to implementing the new population/health strategy and then ask concerned units to submit proposals. The objective would be to provide clearer guidelines on what is needed to meet Agency strategic requirements and then promote some competition among program proposals to achieve this.

Limited funds could also be reserved for mission proposals that do not fit strictly within the strategic framework but are still sufficiently innovative and promising to merit support. Some form of impartial "peer review" and ranking of proposals might also be pursued at the mission, bureau, and/or Agency level to promote better choices among projects.

Implications for New Organizational Structures and Procedures

To achieve the impacts that are called for in the new USAID Strategy [USAID, January 1994], it will be necessary to re-examine USAID's organizational structures and procedures in the missions as well as in Washington, DC. Below, we discuss some of the key issues.

1. Assessing the Applicability of U.S. Private Sector Trends in Managing Innovation

USAID needs organizational structures and cooperation networks in Washington and the field that will facilitate implementation of the new integrated approaches. In some missions, the PRISM and related portfolio management schemes will need to focus more attention on specific population and health goals. If recent U.S. private sector innovation management experience is relevant, then the field units and staff closest to program clients should have the greatest decisionmaking authority and resources. Conversely, headquarters units and organizational layers should be reduced to the minimum required to advise the top leadership on strategy and provide support to the field. This suggests that *USAID implementation responsibility and authority should be in the field* since this is where the new program efforts will impact. Central offices should be primarily concerned with informing overall strategies and supporting mission programs, not operating programs that compete with or duplicate field activities.

2. Recognizing the Importance of In-house Technical Capabilities

USAID leadership has committed itself to help realize several ambitious global goals in health and population during the coming years. To provide program innovation leadership and to influence host countries and other donors to move toward such goals, USAID needs to clearly demonstrate that it has a coherent and practical program strategy of its own *and* enough competent, creative in-house professionals to implement that strategy. However, the

number of USAID's in-house technical staff has steadily decreased over the years. Consequently, USAID currently lacks the depth of in-house technical leadership competence required to effectively assess Agency and host country macro and sectoral development needs, select appropriate program interventions to meet these needs, and then monitor and evaluate implementation, including oversight of contractors and other intermediaries. The technical and other tasks may become increasingly complex as USAID moves to achieve the broader socioeconomic policy and program changes required in Type 2 integration.

During the past several years, USAID has become very dependent on contract staff in Washington and the field. While some functions can and must be contracted out due to fulltime equivalent constraints, others are legally and logically the responsibility of direct-hire employees. The *continuing erosion of in-house technical capacities must be addressed* if the new USAID strategic goals are to be achieved. If staff ceilings cannot be increased, then urgent attention must be given to creating a more relevant staff mix and more effective utilization systems and structures. For example, it has been suggested that the duplication of technical positions between central and regional bureaus be eliminated. The reported absorption of all technical staff by the new Global Affairs Bureau may address this issue. However, this new bureau must be structured so that it does not solve one problem (staff duplication) and create another (decreased technical support for specific country programs, due to a preoccupation with "global" issues).

Since USAID goals call for increased integration in population, health, and nutrition programs, the *specific competencies should be first identified* for each position. Then appropriate staff need to be recruited and/or trained to perform their new roles. Such staff training and development efforts should encompass not only cross-sectoral technical or functional competencies, but general skills in teamwork, leadership, and project/program design and management systems.

C. Real Integration versus Pseudo-Integration

Projects and programs may be classified along a continuum of integration, from strictly vertical to integration of family planning with one or more sectors. However, there is a distinction between projects that appear to be integrated but in reality embrace two or more vertical programs (the pseudo-integrated) and those that are actually integrated. The literature indicates [Betemariam, 1993] that, overall, the outcomes of both fully integrated Type 1 and pseudo-integrated Type 1 programs and projects are mixed. It is impossible at this point to say that integrated programs are more effective than pseudo-integrated programs or vice versa. However, the distinction between integration and pseudo-integration is important to USAID for at least two reasons: 1) it helps to specify which type of integration is under consideration; and 2) it helps in evaluating projects to pinpoint more precisely what has or has not worked in a given situation. In other words, in claiming that an "integrated" approach is or is not successful, it is useful to know whether the structure was actually integrated or just appeared on paper to be integrated (i.e., "pseudo-integration").

Since integration may take any of several forms, "pseudo-integration" may be difficult to differentiate from real integration. Pseudo-integration occurs, for example, when a clinic delivers both family planning and health services, thus appearing to be integrated. However, closer examination may reveal that family planning services are delivered only during certain hours or by staff who work only in family planning, or in a separate portion of the clinic. A woman, therefore, might bring her child for immunization but not be counseled by the service provider about her family planning intentions because MCH and family planning services are not simultaneously available from the same provider. However, in other pseudo-integrated programs, a client coming to the clinic for another reason might receive a referral to family planning staff to answer her family planning questions. Clients may or may not find this pseudo-integrated service arrangement to be desirable.

Pseudo-integration of Type 2 programs or projects commonly occurs when heads of various ministries or representatives from different sectoral departments meet periodically in a joint committee to discuss integration issues, but no integrated activity emerges from the discussions.

D. Donor Collaboration and Partnerships for Integration

Implications for Donor Collaboration

Through collaboration with other donors, USAID could effectively promote and support Type 2 integrated policies and programs (integrating family planning services into activities such as population education, girls' education, women's literacy programs, promoting women's employment, legal support for improving the status of women, etc.) without the requirement that each project, or the entire mission portfolio, be integrated. For example, USAID could take the lead in collaborating with other donors to influence both social policies and social sector programs in the above areas. In some countries a coordinated donor approach to the host country government could increase the probability of achieving the goals of fertility reduction *and* provision of a package of essential social services. Currently, there is a movement within USAID for stronger coordination and collaboration among donors at the mission level.

Collaboration among donors is partly affected by the level of resources provided by each donor. USAID has many more funds, for example, than European donors (some of whom spend much or all of their population budgets through their contributions to UNFPA). On the other hand, in many countries USAID's population budget is smaller than the level of population and health funding provided by the World Bank. However, regardless of the level of USAID funding relative to that of other donors, in most countries it would be highly desirable for USAID to assert greater leadership within the donor community. Unlike some donors, USAID has traditionally enjoyed a strong field presence that would enable the Agency to assert a greater leadership role among both bilateral and multilateral donors, especially in promoting the formulation and implementation of more appropriate social sector policies.

UNFPA is another major population/family planning donor. USAID is again providing significant funding to UNFPA. Some of those interviewed felt that the U.S. has insufficient control over the spending of the U.S. contribution. Increased collaboration among donors might give USAID more influence in the use of UNFPA funds in individual countries and might assure that USAID and UNFPA work toward similar goals, although perhaps dividing the areas to be funded.

Current Efforts in Donor Collaboration

A senior population advisor at the World Bank reported that USAID and the Bank are talking more frequently now on population issues. He also remarked that the Bank, USAID, UNFPA, and the World Health Organization (WHO) are trying to design a joint strategy for population. The tension that has been reported between USAID mission population officers and World Bank task managers surely detracts from USAID's desire to collaborate with other donors at the mission level and with the Bank's desire to collaborate with USAID.

World Bank staff strongly advocated increased donor coordination. However, one Bank staff member added the caveat that donor coordination should occur in a "country-specific fashion," possibly through increased technical collaboration. As an example of one area where greater USAID-Bank collaboration on technical matters could be mutually beneficial, a Bank staff member pointed out that because the USAID-funded Demographic and Health Surveys (DHS) does not gather information on household income, it is often not possible to use DHS data to evaluate the extent to which donor-funded population projects or country programs have impacted on the targeted segment of the population (e.g., people in the lowest 30th percentile of income). Greater USAID-Bank collaboration could result in joint funding of DHS surveys which might be redesigned to obtain such data that could be valuable for all parties. As another example, the economics expertise of the Bank could be used by USAID in some countries to improve policy and program assessment. On a positive note, some technical sharing between USAID and the Bank is already occurring. For example, Bank staff members recently gave a seminar at USAID on the relationship of female education and fertility.

Another example of donor collaboration is the relationship of the U.S. government's ambassador and delegation to the Asian Development Bank (ADB). The ADB is currently planning to become more involved in population and is developing a framework for an ADB integrated population policy to assist member countries. The policy will most likely be based on Type 2 integration with the goal of providing reproductive health and family planning care, in addition to addressing other determinants of fertility (e.g., education of girls and employment opportunities for women).

The Japanese government, another major donor, recently announced that it would provide up to \$3 billion over the next several years for population and health assistance in collaboration with the U.S. government. This announcement followed high-level discussions between the Japanese government and senior USAID officials. The German government (especially through GTZ) has been a major population donor; in some countries, collaboration

between GTZ and USAID occurs at the mission level. The UK's Overseas Development Agency (ODA) is attempting to increase spending in reproductive health--especially in their categories of (1) access to contraception; (2) safe motherhood; and (3) STDs, sexual violence, infertility, and female "genital mutilation." ODA reportedly would like to encourage other donors to adopt this reproductive health package. ODA views special issues, such as male participation, adolescents, and female education, as cutting across the three principal areas of reproductive health (child health, maternal health, and family planning). ODA is interested in various forms of collaboration with USAID. Recently ODA representatives met with members of the USAID Offices of Population and Health.

Another dimension of donor collaboration and USAID's experience with integration is provided by USAID's CAs, some of which receive funding from other donors in addition to USAID. Due to the programs and experiences of its CAs, USAID may have more current experience in integration than would appear through a casual examination of USAID programs and projects. Some CAs leverage USAID and other donor funds to carry out integrated projects, with the USAID Office of Population typically providing funds for only the population/family planning portion of a given project. Similarly, USAID CAs may rely on other donors to fund integrated projects, but they could also bring this experience to bear on USAID-funded integrated projects. For example, with ODA funding, the Program for Appropriate Technology in Health (PATH) trained Zambian family planning outreach workers and clinic counselors to deliver HIV/AIDS information to clients and families of people with AIDS (PWAs) and to refer PWAs and their families for HIV counseling.

CEDPA has many integrated projects, for example, combining family planning with female literacy training in Nepal or Egypt (see chapter V, section A). CEDPA has used USAID Office of Population money to fund only the family planning portion of the projects and, with one exception, has used funds from local governments or private sources to fund the remainder of the project. The one exception is a project in Mali that first integrated family planning into government MCH services in one village, and then, six years later, added women's income generation activities. The monies for income generating activities were provided by the USAID Women-in-Development Office.

VII. Preliminary Conclusions and Recommendations

A. Preliminary Conclusions

Type 1 Integration

The issue of "vertical versus integrated-with-health" family planning services has become one of diminishing general significance (although it may still be a highly significant issue in selected specific locations). Over the past decade, Type 1 services (family planning and health) have increasingly been integrated. This is not necessarily because integrated services have proven to be inherently and inevitably more cost effective than services provided through vertical channels. In fact, integrated approaches have generally become the dominant public sector approach. This is primarily a reflection of bureaucratic and organizational realities: most public sector health and family planning services are provided through MOH systems and it is therefore organizationally easier to incorporate public sector family planning services into existing MOH services rather than to develop separate, parallel systems.

For somewhat different reasons, family planning services in the private sector generally are provided through facilities that also provide significant health services. Often this is because the provision of family planning services, to the exclusion of at least some health care services, is unlikely to be sufficiently remunerative to the provider to be financially viable. Thus, almost inevitably, private sector service providers will offer selected health services as well as family planning services.

Type 2 Integration

This study has found persuasive evidence that a comprehensive set of social sector investments, together with supporting social policy, is essential for fertility and mortality rates to decline to low levels and for sustainable development to be achieved.

B. Preliminary Recommendations

Based on the first phase of this study, we have the following preliminary recommendations. There appears to be interest in the ANE Bureau and among G/Pop to support these conclusions and recommendations. These recommendations are also intended to respond specifically to widespread concern about the possible plateauing of family planning performance in some Asian countries.

1. "Integration begins with policy" [USAID, January 1994: 6]. The top priority for USAID, other donors, and host countries should be formulating coherent and mutually-reinforcing social sector policy reforms that can impact on fertility and population growth and the implementation of these policies. Examples are

policy reforms that promote rapid progress toward universal primary education (especially for girls) and universal provision of readily accessible basic family planning and health services. In some countries, other related sectors may also be candidates for policy reform.

2. USAID should support well-conceived Type 2 operations research-type experimental or pilot programs to learn what will work and under what circumstances. One example might be village-based, intensive, focused literacy training programs for women that would feature materials on family planning, practical home economics, and preventive health behaviors. Adaptation and expansion of the successful PVO Type 2 activities to larger scale programs that have potential for national impact should be emphasized. Examples are the CEDPA projects, described earlier, that integrated family planning with activities such as women's participation in program management and service delivery, maternal and child health services, and adult literacy training, and income-generating activities.
3. Through appropriate collaboration with other donors, USAID could effectively promote and support Type 2 integrated policies and programs integrating family planning services into areas such as population education activities, girls' education, women's literacy programs, promoting women's employment, and legal support for improving the status of women. This could be achieved without the requirement that each project, or the mission portfolio, be fully integrated. In some countries, undertaking a coordinated donor approach to the host country government can promote provision of a package of essential social services which would enhance the achievement of fertility reduction goals.
4. Accessibility to quality family planning and health services is essential whether vertical or integrated approaches are being pursued. Program managers in both USAID and host countries need to be sensitive to the impact of their decision on service quality and client needs. In many countries, the demand for services is still unmet, and much more can be done to increase the quality and availability of services.

Following completion of Phase Two, more definitive recommendations will be provided in the Final Report.

VIII. Next Steps

A. Overview of Phase Two

Phase Two of this study will include an in-depth, in-country study conducted in two countries. Phase Two is especially important, for it will permit more country-specific assessment of Type 2 integration--both at the policy and program level. Five countries in the Asia and Near East region have been seriously considered for the Phase Two study: Egypt and Jordan in the Near East; and Bangladesh, Indonesia, and Philippines in Asia. These countries are recommended because each would be expected to offer important insights about both Type 1 and Type 2 integration.

During Phase Two of the study, we will interview key people in both public and private sector organizations, in USAID and other donor agencies, and in community positions. We will also review relevant documents that are not readily available outside the country. Our focus will be on what works and why, what doesn't work and why, what the requisite conditions are for successful replication of those successful approaches, and what new Type 1 and Type 2 interventions are being considered (and by whom). Overarching all these efforts will be specific attention to the goals of integration and to the issue of cost effectiveness.

The following sections briefly describe the current situation in the recommended countries and explain why they are potential candidates for the Phase Two study. The final section describes additional components of the Phase Two report.

B. Potential Countries for Phase Two of the Study

Bangladesh

In the past 15 years, Bangladesh has made enormous strides in family planning and fertility decline. Modern method prevalence has increased from less than 10 percent to over 30 percent. The total fertility rate (TFR) has declined from the 6-7 range to the 4-5 range. Yet socioeconomic indicators remain very low in Bangladesh, and many experts worry that the environment is highly unfavorable for sustained declines in fertility, mortality, and population growth rates. Only about 20 percent of females are literate; the infant mortality rate is not much below 100. There is also concern that contraceptive prevalence may be beginning to plateau.

Over the past 15 years or so, the Government of Bangladesh (GOB) family planning program has evolved into a "broken zipper" Type 1 integrated approach (integrated at the top and bottom of the system but separate or vertical in between). The family planning program is administered vertically with both integrated and vertical types of service delivery.

Many unresolved issues will affect future directions of Type 1 integration in government family planning and health services. The consideration of Type 2 interventions

requires a comprehensive assessment of the current program and Bangladesh's population policies and strategies.

USAID/Dhaka is currently carrying out a comprehensive population sector review, the results of which are expected to guide the formulation of its population and health program for the next several years. The World Bank is initiating a \$60 million intersectoral population project that will cross economic sectors and fund both private and public implementing agencies. Bangladesh's participation in Phase Two of this study will provide an opportunity for the team to contribute information and perspective on integration that could be useful for these initiatives.

Bangladesh is also a compelling country for in-depth study because it has many non-government projects and programs from valuable lessons can be derived. Moreover, many of the non-government projects have been supported by USAID. One interesting example is the child survival project implemented by the World Relief Corporation (WRC) in five rural unions. In this project, which had both Type 1 and Type 2 elements, WRC utilized a network of village outreach workers for interventions focusing on immunizations, family planning, oral rehydration therapy, growth monitoring, and other nutrition interventions. These activities were part of a more comprehensive village development program, the cornerstone of which was income generation activities. Loans were given first to families with children under five, widows, and families who participated actively in the child survival activities. Although one evaluation found that integration was successful at the field level, the issue of the sustainability and replicability of this project and approach were not satisfactorily addressed.

Egypt

Egypt's family planning program made only slow and disappointing progress during the 1970s and early 1980s. Modern method prevalence increased from 24 percent in 1974 to only 29 percent in 1984. However, performance seemed to pick up in the mid-1980s and to accelerate during the late 1980s and early 1990s. By 1988, modern method prevalence was 35 percent, and by 1992 it was 45 percent. Public sector family planning services are currently provided by the Ministry of Health (MOH) in both integrated and vertical (family planning clinics) modes, but the MOH is increasing integrating its family planning services with its MCH services.

Despite the considerable achievement in prevalence, fertility remains rather high with a TFR of about 4.5. [In comparison, with about equivalent modern prevalence, Indonesia has a TFR of about 3--see below.] The program is heavily dependent on the IUD as the dominant method, with serious under-representation of both spacing methods and other long-lasting methods. In general, the program needs improved efficiency and cost effectiveness. In addition to these issues and questions, Egypt has a diversity of integration experiences (including Type 2) that may be applicable to our study.

The Population Development Project (PDP) of the late 1970s to mid-1980s was both a vertical and a Type 2 integrated project. The project operated in about five governorates

(approximately equivalent to states or provinces) in Lower Egypt and two governorates in Upper Egypt. The project was initiated by the National Population and Family Planning Board which was under the jurisdiction of the Supreme Council for Population. Funding for the PDP came from United Nations organizations as well as USAID.

PDP was based on a community development model that sought to mobilize villagers and respond to their felt needs in a wide range of areas, one of which was fertility regulation. The project emphasized controlling the determinants of demand for fertility regulation, rather than supplying family planning methods (which were supplied by the MOH and the private sector). Each village in the project areas had a committee that met regularly and oversaw project activities. In addition, each village had at least one part-time community outreach worker. The outreach workers' job descriptions reportedly contained 80 separate tasks, e.g., animal husbandry, sewing, women's health, child development, and motivation for family planning.

The project was evaluated in its fourth year, and results were mixed in terms of reduction of fertility. Some districts within PDP governorates had modest increases in contraceptive prevalence, but some districts in governorates where PDP did not operate showed even higher increases in contraceptive prevalence. Furthermore, the interaction with the MOH, which delivered public sector family planning services, was not always cordial. Eventually (in the mid-1980s), the head of the National Population and Family Planning Board was replaced and the new head, Dr. Maher Mahran, had a different vision of how to help Egyptians to reduce their fertility. Consequently, the project was scrapped.

Under Dr. Mahran's leadership, the structure and name of the National Population and Family Planning Board was changed to the National Population Council (NPC) and under a new structure, the MOH became much more active in promoting and providing family planning methods, largely with funds from USAID. Dr. Mahran remains as head of the NPC, and his position has recently been elevated to Minister of State for Population and Family Welfare.

The notable lack of success of the PDP seems to have been due to several factors: (1) the project attempted to do too much in community development and not enough in family planning; (2) integration of multiple sectors was attempted simultaneously; (3) the project separated delivery of family planning motivation activities from delivery of contraceptive services, without good coordination between the two; (4) the staff was too small to carry out all the planned activities; (5) sufficient political support was lacking at the national level; and (6) village outreach workers were assigned far too many tasks in too many different areas.

In contrast to the PDP experience, there are examples of successful integrated PVO projects in Egypt (see chapter V, section A). USAID/Cairo's Office of Population has funded many population projects over the years, and in general family planning, even when it appears vertical, is often "pseudo-vertical."

USAID has funded an apparently vertical family planning project, the Systems Development Project (SDP), within the Ministry of Health. However, in practice service delivery is most often integrated. Primary health care providers, for example, have been

trained by SDP to deliver family planning care in rural health units. Special hours for family planning usually do not exist at rural health units. In addition, as is the case in many countries, government physicians often have their own private clinics during the evenings during which they provide general health care, including family planning. Furthermore, some gynecologists, who supposedly only provide family planning care in hospital family planning clinics, provide full reproductive health services in other parts of the hospital and in their private clinics outside the hours of the government family planning clinic. Patients with gynecological complaints may seek out their gynecologists wherever they are working in the hospital or polyclinic, so that in practice family planning clinics may deliver the full range of reproductive health services.

The Health Insurance Organization (HIO) is a large, parastatal health care delivery agency to which all employed Egyptians belong. In 1987, USAID helped HIO to establish a vertical family planning program because HIO had external legal constraints to funding family planning. The organization insisted on keeping HIO funds in a separate account from family planning funds. USAID had assisted HIO to prepare, equip, and train the staff of special family planning clinics within HIO polyclinics. However, clients complained about having to go to another part of the polyclinic to get family planning needs met, when the gynecologists they were seeing for other problems could easily take care of their family planning needs. Providers also objected to the vertical structure. By 1991 the administration of HIO had changed and *de facto* integration had taken place.

Indonesia

Indonesia is one of the great family planning success stories of our era. Twenty-five years ago, Indonesia was one of the world's most impoverished nations. Yet in the past 20 years, modern contraceptive prevalence has increased from about 15 percent to nearly 50 percent. The TFR has declined from over six to about three. Until recently, the bulk of all family planning services were provided by government. The Indonesian government program has both vertical and Type 1 integration features. The National Family Planning Board of Indonesia (BKKBN), which is in most respects vertical, is acknowledged as one of the world's most effective and successful government family planning programs. However, most family planning services are provided by MOH personnel, and most family planning services are provided through multi-service (integrated) health facilities.

USAID was instrumental in promoting a Type 1 integrated approach in Indonesia through its support of the Village Family Planning/Mother Child Welfare Project. The first step towards integration of family planning and health services began in 1979 when nutrition services were linked to the previously established family planning network. Services included weighing monthly children under age five, educating mothers, giving food preparation demonstrations, supplying nutritional requirements for the children, referring severely malnourished children to health centers, and educating mothers to increase the productivity of home gardens. Family planning services were also provided. The second step toward integration came in 1984 with the signing of an agreement between BKKBN and the MOH creating the legal basis for joint projects and cooperation in family planning and health. Five

major areas for integration were identified: family planning, nutrition, immunization, diarrheal disease management, and mother-child health care. Most observers in recent years have assessed this collaboration between BKKBN and MOH as highly successful.

Over the years, BKKBN has also experimented with some Type 2 activities, especially Type 2 integration of information, education and communications (IE&C). World Bank studies have concluded that investments in education (especially female) and related human resource development Type 2 interventions (though not integrated programmatically) have made significant contributions to the family planning success.

However, there are now many reasons for concern about the future of family planning and fertility decline in Indonesia. Prevalence seems to have plateaued in the past few years. Long-lasting methods, especially female sterilization, account for too low a proportion of total prevalence. Also, financial sustainability of family planning is of great concern to both donors and government, and the government has committed itself to increasing the proportion of services provided by the private sector to 50 percent within a few years. Moreover, despite sustained high rates of economic growth (the World Bank considers Indonesia one of the "miracle" HPAEs), income inequality has apparently increased in recent years. Both donors and some government officials worry that prevalence will not continue to rise and fertility to fall (to replacement-level) in the years ahead under these circumstances, especially if the proportion of the population served by the public sector is drastically reduced.

Both Type 1 and 2 issues are now highly relevant in Indonesia. Moreover, as a demographically advanced developing country, Indonesia potentially offers many lessons for other countries.

Jordan

Until about six years ago, Jordan did not have a public sector family planning program. When the program was finally initiated in 1987-88, it was explicit government policy to develop a Type 1 service delivery system. Limited information reviewed in this study indicates that integrated health and family planning services are widely and readily available. Female educational attainment is among the highest in the developing world. The population of Jordan enjoys relatively good health (the infant mortality rate is reported to be 34--roughly half the level of both Egypt and Indonesia) with life expectancy at birth of 71. However, modern contraceptive prevalence is below 30 percent (lower than in Bangladesh, Egypt, and Indonesia), and the TFR is over six.

It is unclear why prevalence is so low and fertility so high despite a Type 1 public sector program and socioeconomic characteristics that should be favorable to low fertility. One reason may be because Jordan contains a large refugee population. While many of these refugees, particularly those from earlier immigrations (pre-1948, and 1948 to 1956), have been fully integrated into Jordanian society, others retain a separate Palestinian refugee identity. Since refugee populations often have higher levels of fertility than does the local non-refugee population (e.g., Afghans in Pakistan and Iran; refugees from Central American

and the Caribbean in the U.S.), this factor may be a stronger predictor of fertility than women's education. The issue is understandably sensitive. Although further study would be necessary to understand the influence of migration on fertility in Jordan, it may not be best to study it at this time. However, closer study could contribute to better understanding of other Type 1 and Type 2 integration relationships in Jordan as well as produce program recommendations for USAID/Jordan. It could also offer information that may be useful for developing programs for the West Bank and Gaza.

Philippines

The lack of success in the Philippines is a great family planning and demographic mystery. During the 1970s, there was considerable enthusiasm and optimism about family planning among both government and USAID officials. Prevalence of modern methods increased from 2 percent in 1968 to 16 percent in 1977. However, in the late 1970s and throughout the 1980s, the program was relatively moribund and modern prevalence increased only 5 points in 11 years (to 21 percent in 1988). This trend occurred despite the fact that the Philippines has had a relatively rapidly growing economy (per capita income is higher than in both Egypt and Indonesia and almost 4 times higher than in Bangladesh) with among the highest levels of female education and professional attainment in Asia.

The government and USAID are now trying to reinvigorate the population/family planning program while the government is embarked (with the strong support of USAID) on an ambitious devolution (decentralization) program that will place responsibility for virtually all public sector family planning and health services with local governments. Both the Asian Development Bank and the World Bank are also supporting new and larger health projects. It is unclear what the implications of these important developments might be for both Type 1 and Type 2 policies and programs.

While many different types of interventions have been tried during the life of older population programs (e.g., Korea, Taiwan, Philippines), information on Type 2 activities is not easy to come by. The following Philippine examples are based on staff memory and the 1992 CDIE evaluation of the Philippine Family Planning Program [Schmeding, et al., 1992].

The Population Commission (POPCOM) was created in 1970 as an inter-ministerial group reporting to the Office of the President. Depending upon the interest and assertiveness of the Executive Director and the Chairperson (Secretary of Social Welfare), POPCOM had ready access to the President in the early years. During the initial years of martial law (1972-74), interdepartmental groups were organized to speed up action on development programs, including population. The POPCOM management did not fully exploit this new access to political support, but did, however, make some impact on national laws and policies affecting population planning. During the 1970s, changes to encourage smaller families were made in laws on income tax, labor, and paid maternity leave. Applicants for marriage licenses were required to undergo family planning counseling by a POPCOM-approved counselor. Private companies with 200 or more employees were required to provide on-site family planning services. In 1976, the Medicare Law was amended to authorize reimbursement for voluntary

sterilizations (this program covered about 15 percent of the total number of married women of reproductive age). Several USAID-supported pilot efforts were undertaken to increase the use of commercial distribution channels. Fertility reduction targets were put in the National Development Plan, but removed in 1981, reportedly due to increased Catholic Church opposition to the population program. However, while the Catholic hierarchy exerted strong political influence during the Aquino Presidency (1986-92), the 1987-92 Development Plan called for a population growth rate aligned with replacement fertility by the year 2010. The 1987 draft Constitution contained rather strong language on family planning rights, but that was watered down in the approval process. Nevertheless, it still contains provisions on the right of married couples to make fertility decisions.

We did not identify any specific evaluations of the effects of these policy innovations or the population education program mentioned elsewhere in this report. The "lessons learned" may be that dynamic national programs must work on all types of variables and constraints to affect the supply of and demand for population services.

Moreover, program managers need to devote adequate time to anticipating and addressing changes in the political environment that may affect program progress. This includes being sensitive to the role that clients may play, particularly if they are organized. President Aquino gave little support to the population program, reportedly because of her close connection to the Philippine Catholic hierarchy that strongly opposed family planning. Some observers suggest that the program would have been completely terminated except for the national leadership's fear of a political backlash from the cut-off of services to a sizeable number of clients.

One other "integration effort" was reported to the Team. During the mid-1970s, a new POPCOM Executive Director decided that POPCOM's field outreach workers should also become leaders of broad-based community development in their areas. USAID agreed to fund part of this effort on a trial basis in 8-12 provinces (out of 70 plus provinces). However, as it became evident that this approach was impacting negatively on family planning work, USAID raised objections. For reasons not entirely clear, the Philippine political leadership removed the Executive Director and the community development experiment gradually came to an end.

C. Final Report

The Final Report will be submitted after completion of Phase Two. It will include a checklist or matrix of questions that program planners can use when assessing population and health options and integration feasibilities for cooperating countries.

The RTI Final Report will also summarize lessons learned. Finally, it will make recommendations to the Asia Near East Bureau for consideration in strategic planning and program formulation in integrating family planning and population with health and other development interventions.

Appendices

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Appendix 2. List of Persons Interviewed

USAID

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Dr. Barbara Crane, Policy and Evaluation Division, R&D/Population
Mr. David Frederick, Bangladesh Desk Officer, ANE/NE/SA
Ms. Phyllis Forbes, Deputy Associate Administrator for Management

Dr. Duff Gillespie, Acting Deputy Associate Administrator, R&D
Ms. Nancy Hardy, India Desk Officer, NE/Asia/SA
Dr. Marjorie Horn, R&D/Population
Dr. William Jansen, PHN Officer, ANE/NE

Dr. Pamela Johnson, R&D/Health
Mr. William Johnson, Chief, Regional Coordination Division, R&D/Population
Ms. Kerri Ann Jones, Chief, Technical Resources, Asia
Mr. Lenni Kangas, Population Advisor, Africa Bureau

Ms. Elizabeth Maguire, Acting Director, R&D/Office of Population
Ms. Elizabeth Keys McManus, Regional Coordination Division, R&D/Population
Mr. Frank Method, Senior Advisor, R&D/Education
Ms. Vivvika Moldrem, ANE/NE Program

Ms. Margaret Neuse, Associate Director, R&D/Population
Dr. Estelle Quain, Communications, Management and Training Division, R&D/Population
Dr. Scott Radloff, Chief, Policy and Evaluation Division, R&D/Population
Ms. Lee Ann Ross, Acting Chief, ANE/Asia/Southeast Asia

Ms. Jinny Sewell, Chief, Family Planning Services Division, R&D/Population
Mr. John Silver, Deputy Chief, ANE/Asia/South Asia Desk
Mr. Robert Thurston, Indonesia Desk Officer, NE/Asia/SA

Others

Dr. Judith Fortney, Senior Scientist, Family Health International
Ms. Carolyn Hart, Deputy Director, Family Planning Logistics Management Project, JSI
Dr. Lily Kak, CEDPA
Ms. Barbara Kwast, JSI

Ms. Mary Luke, Director of International Programs, CEDPA
Ms. Sheila Maher, Director of International Marketing, The Futures Group
Dr. Thomas Merrick, Senior Population Advisor, The World Bank
Dr. W. Henry Mosley, Professor and Chairman, Department of Population Dynamics, The
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Mr. Eric Palstra, Population Specialist, Population and Human Resources Division,
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Mr. William Smith, Senior Vice President, Academy for Educational Development
Dr. Susan Stout, Project Officer, Population and Human Resources Operations Division,
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