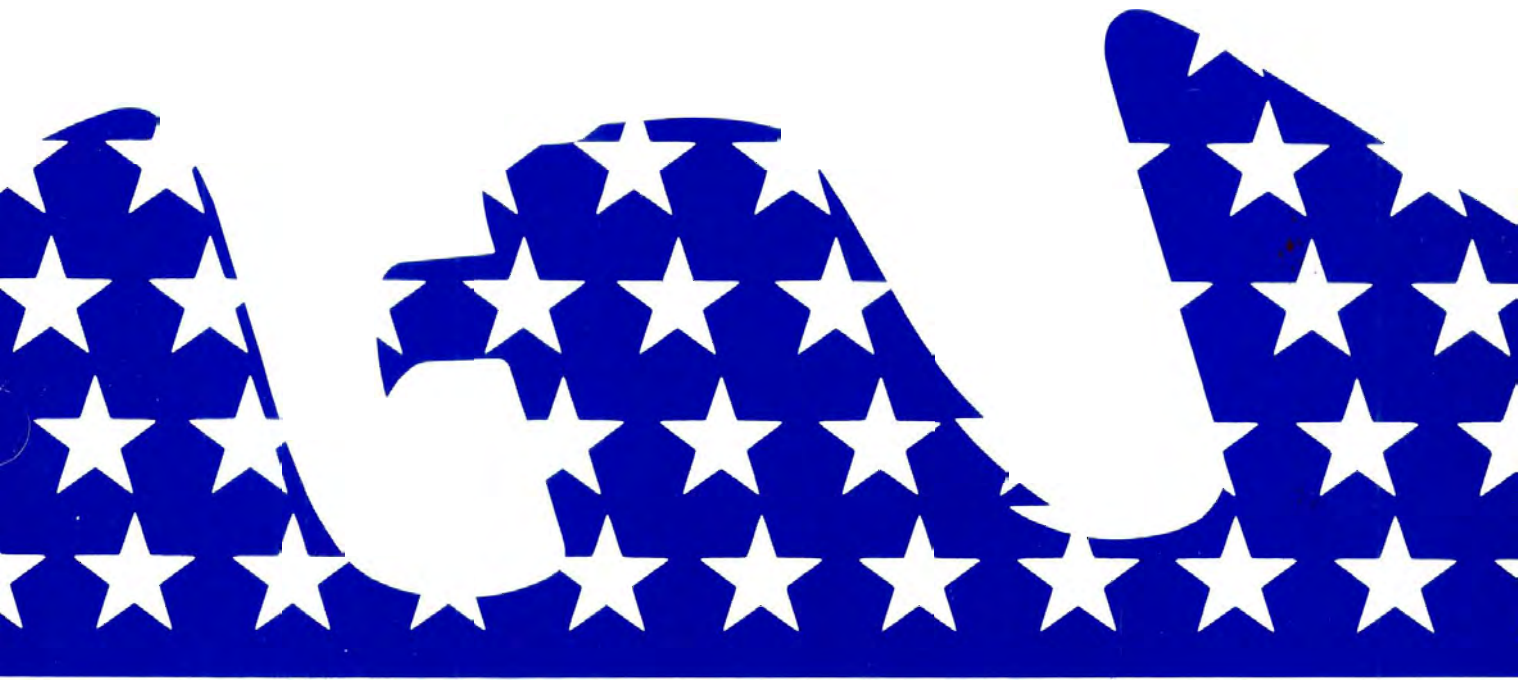
A.I.D. Policy Paper

POPULATION ASSISTANCE



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A.I.D. Policy Paper

Population Assistance

Bureau for Program and Policy Coordination
U.S. Agency for International Development
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Executive Summary

Assistance for voluntary population and family planning programs is an essential part of a cost-effective program of U.S. development assistance. Continued high rates of population growth significantly increase the cost and difficulty of achieving basic development objectives by imposing burdens on economies presently unable to provide sufficient goods and services for the growing population. Family planning assistance materially advances social and economic development; enhances individual freedom to choose voluntarily the number and spacing of children; and, provides critically important health benefits for mothers and young children.

Although only one of many challenges confronting less developed countries (LDCs), rapid population growth compounds the already serious and costly problems faced by LDC public and private sectors. Population and family planning policies and programs alone will not achieve economic miracles; they must be undertaken in conjunction with other economic and social measures to promote comprehensive development.

The need for voluntary family planning has never been greater. In the next twenty years, the world's population is projected to grow by almost 2 billion, and 90 percent of that growth is expected to occur in developing countries. There are already hundreds of millions of couples in the Third World, most of whom do not currently have access to modern family planning methods, who want smaller, healthier families. Twenty-five years ago only a handful of developing countries explicitly recognized the problems posed by rapid population growth; today over 60 LDCs, containing over three-fourths of the total developing world population, have adopted policies which address population growth.

A.I.D's experience in countries such as Thailand, Colombia, South Korea, and Indonesia demonstrates that a balanced program which provides modern contraceptive services and information, combined with strong community and family support for family planning, is the most effective way of helping couples achieve their fertility goals.

The underlying principles of U.S. assistance for family planning are voluntarism and informed choice. The implementation of A.I.D. assistance for population activities is governed by legislative requirements as well as A.I.D. policies. Specific legislation prohibits the use of U.S. government funds for abortion-related activities and requires all sterilization programs supported by A.I.D. to be shown to be truly voluntary. U.S. development assistance is not conditioned on the host government adopting a particular population policy; nevertheless A.I.D. actively seeks and responds to opportunities for policy discussions on voluntary family planning. A.I.D. intends to capitalize on the flexibility and innovativeness of the private sector as an important channel for the development and delivery of safe, effective contraceptives. A.I.D. also stresses the involvement of local institutions, and supports efforts to strengthen them.

The major focus of the U.S. program is voluntary family planning service delivery. The U.S. also supports dissemination of family planning information and education, including natural family planning; training for service providers; research on new contraceptive methods and improved delivery systems; and demographic and social science research and analysis designed both to improve voluntary family planning programs and to assist LDCs develop and improve their development policies and programs. U.S. population assistance supports the work of private voluntary and profit-making organizations and universities; multilateral and international population agencies; and LDC governments through bilateral agreements.

I. Background

A. Population Growth in Developing Countries

The 1982 world population is 4.6 billion and is growing at an increment of about 78 million annually. Ninety percent of this growth is occurring in less developed countries. Indeed, between 1980 and 2000, the number of women of child bearing age will grow by more than 60 percent or 480 million. The developing world's population of about 3.4 billion is growing at 2.1 percent annually; at this rate, it will double in 33 years. By contrast, the population of the developed countries will double in 116 years at the present rate of increase.

The world's rapid population growth is a recent phenomenon. Only several decades ago, the population of developing countries was relatively stable, the result of a balance between high fertility and high mortality. Life was a high risk proposition. Often, only one in two children survived infancy and early childhood. Epidemics, debilitating diseases exacerbated by chronic malnutrition, and extremely poor public health conditions all made early death an ever-present threat. Against these risks, fertility had to be high in order to assure that families survived. High fertility, far from being a problem, was a necessity.

More recently, developing countries have experienced extraordinary changes in their societies and economies, and the changes have been, for the most part, destabilizing ones—both demographically and socially. Death rates have dropped dramatically as nutrition has improved and the major causes of population-wide epidemics have been brought under control. Birth rates have also risen in some areas, as the traditional customs and taboos which tended to space and limit births have been dropped by the younger generation whose values and prospects differ from those of their parents. Populations began to expand rapidly as the traditional short and rather risky life expectancy gave way to one where the chance of staying alive had never been better.

B. Implications for Economic Development

Sustained economic development and the achievement of a decent life for LDC citizens can only occur when population growth no longer outpaces economic progress. The factors that can inhibit progress toward self-sustaining economic growth as well as frustrate individual and national aspirations include the following problems associated with high birth rates and rapid population growth:

- high dependency ratios;
- excessive exploitation of existing resources;
- low levels of household savings and investment which in turn can slow the development of markets for domestically produced and imported consumer goods;
- low labor productivity as the labor force expands more rapidly than the demand for new workers;
- inability to maintain, much less improve, basic services and human capital investments (health, education, technical training) which not only can diminish the future productivity of the country but can also result in both social and political instability;
- inability to take advantage of new technologies because the infrastructure and the financial and human capital necessary to make effective use of technological advances are lacking.

To speak of the impact of population growth in global terms alone, however, is to fail to appreciate the real impact on individuals, families and nations. The demographic transition (high to low rates of population growth) is characterized by unevenness, both between and within countries. The process of modernization, hastened in some countries by sound government policies, a vigorous private sector, and effective development assistance, has brought with it dramatic changes in many aspects of public and private life, among them a desire for smaller families and declining birth rates. In other less developed countries, or even in remote areas of countries which have enjoyed substantial economic progress, high fertility and lack of adequate resources may place severe strains on individuals, families and communities. In such circumstances population growth can inhibit improvements in living conditions and economic progress; at the same time, the options open to individuals to plan the number and spacing of their children may be circumscribed by lack of family planning information, education or services or by social and economic conditions which militate against understanding and effective use of modern family planning methods. Finally, especially in poor areas, the health and nutrition status of women and children is linked to their ability to regulate their fertility safely and effectively. Maternal mortality rises with the number of births and in-

fant mortality with births too closely spaced. Complications of pregnancy are more frequent among women who are very young or at the end of their reproductive years. While medical problems are associated with frequent and numerous pregnancies in all countries, in societies with wide-spread malnutrition and inadequate health conditions these problems are exacerbated. In turn, under such conditions, numerous and closely spaced births lead to even greater malnutrition of mothers and infants.

C. Family Planning in the LDC Setting

Developing countries vary considerably, not only in their socioeconomic settings and the type of infrastructures through which basic services, including organized family planning services, may be delivered, but also in their official policies on population. However, the vast majority of LDC governments support or accept family planning services, both as a means of lowering population growth rates and stabilizing the absolute size of the population, and as a means of improving maternal and child health through birth-spacing. Presently, over three-fourths of the people in the developing world live in countries with policies supporting the provision of voluntary family planning services.

The concept of spacing or limiting births is not new, nor is it Western. Traditionally, for instance in Africa, birth spacing has been ensured by long periods of abstinence or separation following a birth, and extended breastfeeding. Abortion and infanticide (or neglect of children leading to death) have been and continue to be means by which family size is limited in many places where modern family planning methods are unavailable. Modern family planning services provide a safe, effective and humane substitute for traditional methods which are no longer practicable or are less effective, safe or humane.

Demand for and effective utilization of family planning services tend to accompany progress in other development sectors. Among the factors that have been most responsible for the dramatic and rather rapid changes in attitudes about family size have been improvements in health, education, and employment opportunities (especially for women), and the ubiquitous phenomenon of urbanization. Additionally, modern family planning services, where accompanied by information and education about the concept and methods of birth spacing, contribute to increased demand for services.

D. Factors Influencing Fertility

Demographers agree that four direct biological factors determine fertility patterns: breastfeeding and lactation patterns, age at which sexual activity is initiated, contraceptive utilization and induced abortion. These determinants control the initiation of sexual activity, conception following intercourse, or births resulting from conception. A wide range of social, economic and cultural factors in turn influence fertility through one of these four "direct" determinants. Perhaps the most significant of these socio-economic or "indirect" determinants are health, female education, employment/income and urbanization. The interaction between the direct and indirect determinants of fertility is complex; however, on-going research and the evidence from field programs are beginning to offer some rather specific programmatic suggestions.

(1) Health

One of the reasons for high fertility levels in LDCs is high infant and child mortality. Traditionally, as discussed above, couples in LDCs wanted and needed large families. Where 20-30 percent of infants died before their first birthday, parents chose to have a certain number of "insurance births" to assure that a critical number of children would survive to adulthood. As general health conditions improve and infant mortality declines, the need for insurance births is greatly reduced and interest in family planning increases.[1] The relationship works the other way as well; family planning helps to lengthen the time between births, which in turn promotes the health and survival of both mother and infant.

(2) Education

Education of females appears to have a profound effect on fertility, especially when girls are able to complete the primary grades. Where initial improvements in female enrollment result in less than primary school completion, fertility tends to rise with rising educational attainment. Although the pattern varies greatly from country to country and region to region, and exceptions can be cited, it appears generally to be the case that where additional schooling takes girls beyond primary school, fertility tends to fall as

[1] The initial result of lower infant mortality may be a higher number of living children per woman since more infants survive. Fertility declines follow this initial rise.

education rises. As women become better educated, enter the wage economy, and have some measure of control over their earnings, their role in the family and the community changes. Education broadens women's horizons and predisposes them to accept new ways and ideas. Preference for smaller families, use of family planning, and later marriage all appear to be more acceptable to women who have been educated beyond the primary level, and all are correlated with lower fertility.

On the other hand, the prospects for education and training of women and girls can often be thwarted by their own fertility. Delay of childbearing either through postponement of marriage or the birth of the first child can allow girls the chance to complete higher education or training. And, with a smaller family size there is less need for girls to stay out of school to care for younger siblings.

(3) Income/Employment

Employment of women, especially outside the home, increases the opportunity costs of raising children, makes a smaller family a more attractive option, and heightens interest in the use of family planning to achieve the desired family size. The role of income *per se* in bringing birth rates down is less well understood. As aggregate income rises initially so does fertility, but with further increases in income the trend reverses, and fertility begins to drop. The threshold at which the trend reverses varies from country to country, and unfortunately has not been well defined.

(4) Urbanization

Urbanization brings with it more education, higher net costs of children, lower infant mortality, greater access to modern sector employment for women, and easier access to contraceptives. The result is a consistently lower incidence of births among urban women, who have roughly 25 percent fewer children on average than do women in rural areas. Probably the most significant difference between urban and rural women is their use of contraceptives. Contraceptive use is a function both of the desire to space births or limit family size and the availability of and access to appropriate modern methods of family planning. In urban settings those factors affecting demand for, as well as supply of, modern contraceptives are likely to encourage voluntary family planning.

E. The Role of Modern Contraception

Of the four "direct" determinants mentioned above, contraceptive use has the greatest potential impact on fertility; indeed, in the absence of modern family planning services, some socioeconomic changes (e.g., improved child health and changing patterns of breastfeeding) may actually lead to higher birth rates. In short, modern contraceptives provide the means by which individual couples can achieve their desired family size most effectively, safely, and humanely.

Existing demand for modern family planning services is not currently being met by programs in the developing world. World Fertility Survey data from 29 countries indicate that 48 percent of married women 15-49 years of age want no more children. A study of 18 of those countries suggests that the average birth rate of 32.3 per 1000 would drop to 23.5 births per 1000 population if all unwanted births were prevented. To summarize, existing demand for family planning services is great and is likely to become greater as development brings about improvements in socioeconomic conditions throughout the developing world.

II. The U.S. Population Assistance Program

A. A.I.D. Policy Objectives

Family planning programs are an essential element of the U.S. development assistance strategy, and this Administration has reaffirmed a 20-year U.S. commitment to voluntary family planning efforts. The objective of the A.I.D. population assistance program is twofold: (1) to enhance the freedom of individuals in LDCs to choose voluntarily the number and spacing of their children; and (2) to encourage population growth consistent with the growth of economic resources and productivity.[1] The two parts of this objective are reciprocal. The ability to determine freely the number and spacing of one's children allows the individual greater potential to take advantage of opportunities for improving skills, seeking employment and increasing income. Experience has shown that when couples can freely determine the number and spacing of their children, they tend to have smaller families and population growth rates tend to decline. Further, when aggregate national wealth and

[1]Rural to urban migration and the problem of refugees are population related issues, but they are being addressed in separate policy papers.

population are in balance, individual families tend to have better prospects for education, employment and health. Such increased opportunities and improvements in the standard of living tend to raise individual and family aspirations, and couples tend to prefer to have fewer children whom they can educate and care for well, rather than many to whom they cannot offer these advantages.

The basic premises of U.S. population assistance are the following:

- individuals and couples should be able to decide freely the size of their families;
- voluntary family planning programs are needed and wanted by the citizens of the Third World;
- it is in line with U.S. strategic as well as humanitarian interests to help LDC governments achieve economic development, and to support their citizens' efforts to attain a better life for themselves and their children;
- sustained economic development and the achievement of a decent life for all LDC citizens can only occur when population growth no longer outpaces economic progress;
- the impact of development resources is maximized through coordination of policies and programs that broaden access to education and employment, especially for women, with the provision of modern family planning services; and
- the U.S. has unique strengths in this area of international development assistance.

A.I.D. support for family planning service programs is based on two fundamental principles: voluntarism and informed choice. A.I.D. does not support programs in which there is any element of coercion of individuals to practice family planning or to accept any particular method of contraception. In fact, A.I.D. supported programs must include a description of the effectiveness and risks of all major methods of family planning and an agreement either to provide other family planning methods if requested or to refer couples to programs offering other methods as appropriate. A.I.D. supports the provision of family planning methods within the medical and cultural context of each particular country.

B. Population Program Assistance Activities

The Agency for International Development has traditionally played a strong role in supporting population programs, consistently leading bilateral and multilateral donors in program initiatives and in funding. A.I.D's cumulative population assistance since the mid-1960's exceeds $2 billion, and constitutes about half of all population assistance provided to the developing world. On an annual basis, it is estimated that donor assistance and host country government (excluding China) expenditures for population programs total something over one billion dollars. For the past several years, A.I.D's population account has represented about 20 percent of these aggregate budgets.

A.I.D's allocation of population funds reflects Agency priorities in the population sector. Voluntary family planning service delivery and related supplies form the heart of the program and consistently absorb the greatest proportion of population assistance. Support for service delivery systems includes: commodities, training for physicians, paramedicals and fieldworkers and technical assistance in the design and improvement of services. Innovative field oriented research to improve existing delivery systems and to develop new "outreach" programs for delivering family planning and health services that are less expensive and more appealing are also important A.I.D. supported activities.

A.I.D. has led the way among donors in developing and disseminating the most widely used high quality contraceptive methods in the world today; the U.S. will continue to support the development of promising new contraceptive methods and improvement of existing methods, as well as research on the safety and effectiveness of contraceptives under actual conditions in developing countries.

Accompanying the provision of services is dissemination of information and education on family planning and population, both for individual users and also for government policy makers. Where requested by governments, the U.S. provides technical assistance to help analyze government policies which may affect the availability of, and the demand for, family planning services, as well as to analyze the impact of rapid population growth on other development sectors, such as food, health and energy.

The U.S. population assistance program does not operate in isolation from our other development

efforts, but takes into account the linkages between population, health, nutrition, education, employment and agricultural productivity. A.I.D. has led the way in developing and applying new ways to measure program impact and the degree to which fertility and the use of family planning services is influenced by women's education and employment opportunities, child health and other social and economic conditions. Based on our knowledge of the relationship between population and other development factors, we seek to make our total development strategy for each country one in which the objectives and activities in all areas, including population are mutually reinforcing.

Successful family planning programs tend to occur in countries where there is a strong commitment by the host government, an infrastructure with the capacity to deliver services throughout the country, and social and cultural acceptance of the concept of family planning. The largest share of U.S. population assistance is directed to countries where these three conditions exist. In countries, notably but not exclusively in Africa where awareness of the impact of rapid population growth on sustained economic development and of the need and demand for modern family planning services is more recent, A.I.D. works closely with host governments and private organizations to help them analyze and strengthen their policies and programs. Where infrastructures are weak or inadequate, A.I.D. supports activities to strengthen local service delivery institutions and also works with the private sector.

In recent years, A.I.D. has increased the proportion of population funds allocated to bilateral family planning programs, reflecting not only the Agency's commitment to integrate family planning programs into overall country development assistance programs, but also the growing interest of LDC governments to collaborate with the U.S. in developing strong national family planning programs.

Among A.I.D.'s major strengths in assisting LDC population program efforts are its strong field presence and its early and sustained leadership in developing innovative approaches to low-cost service delivery that are responsive to particular country requirements. A.I.D. has also been a leader because of its strong analytical orientation, whether in the testing of outreach systems for delivery of family planning services, in analysis and interpretation of survey findings to measure program impacts, in biomedical research or in developing overall family planning strategies. The very size of the U.S. supported family planning effort is also one of its strengths; the U.S. provides about half of the Development Assistance Committee (DAC) assistance for population and is the principal donor to the United Nations Fund for Population Activities (UNFPA) and the private intermediaries. This preeminence gives the U.S. a unique voice in encouraging high quality voluntary family planning services for interested couples throughout the world. AID's population program in the 1980s is rooted in this highly successful past.

C. Specific Policies Governing U.S. Population Assistance

Beyond the fundamental principles of voluntarism and informed choice upon which U.S. population assistance is based, specific legislative requirements and A.I.D. policies govern assistance under this account.

(1) Abortion

In accordance with authorizing legislation adopted in 1974, A.I.D. must not provide support for abortion services or a number of other abortion-related activites, such as the provision of abortion equipment, or the motivation of persons to practice abortion. In January, 1981, A.I.D. discontinued funding of research on methods of abortion as a means of family planning. Funding of all such research was terminated in 1981, although A.I.D. continues to gather descriptive epidemiological data to assess the incidence, extent or adverse consequences of abortion.

All A.I.D. funded population contracts and grant agreements with private and voluntary organizations (PVOs) and with host governments incorporate language to prohibit use of A.I.D. funds for abortion-related activities; PVO subgrant agreements also incorporate such prohibitions.

Such prohibitions include:

- Procurement or distribution of equipment intended to be used for the purpose of inducing abortion as a method of family planning.
- Procurement or distribution of Menstrual Regulation (MR) kits.

- Special fees or incentives to women to coerce or motivate them to have abortions.
- Payments to persons to perform abortions or MR procedures or to solicit persons to undergo abortions or MR procedures as a means of family planning.
- Information, education, lobbying, training or communication programs that seek to promote abortion as a method of family planning.
- Funding of biomedical research which relates to methods of abortion as a method of family planning.
- Training of individuals for the performance of abortion as a means of family planning.

(2) Voluntary Sterilization

Section 104(f) of the Foreign Assistance Act enacted in 1978 prohibits the use of U.S. funds for *involuntary* sterilization. It states:

> None of the funds made available to carry out this part may be used to pay for the performance of involuntary sterilizations as a method of family planning or to coerce or provide any financial incentive to any person to undergo sterilization.

A.I.D. Policy[1] governing the use of Agency funds for sterilization provides that A.I.D. funds can only be used to support voluntary sterilization activities if the following six conditions are met:

1) *Fully Informed Consent.* An explanation must be made to the client in his or her own language of the nature of the procedure, its risks and benefits, and its irreversibility. The client's witnessed signature or mark is required on the consent document, which must be retained for three years.
2) *Availability of Other Methods.* Other family planning methods must be readily available to insure that the client has a free choice of approved methods.
3) *Incentive Payments.* No A.I.D. funds can be used to induce clients to accept voluntary sterilization; also the cost of the procedure must be such that it does not favor voluntary sterilization over other methods.
4) *Quality of Services.* The medical personnel must be well trained and the surgical equipment should be the best available that is suitable to the field situations in which it will be used.
5) *Integration with Health.* To the fullest possible extent, voluntary sterilization programs shall be conducted as an integral part of the total health care services of the recipient country and shall be performed with respect to the overall health and well-being of the prospective acceptors.
6) *Country Policies.* A.I.D. funded sterilization programs should be carried out in full cooperation with host country officials, and particular care must be exercised to avoid undue emphasis on any ethnic, political or religious minority.

Regulations setting out requirements for informed consent are included as part of all grants, contracts and subordinate agreements between A.I.D. and implementing organizations. Adherence to these guidelines and regulations is constantly monitored by A.I.D. to insure full compliance.

(3) Natural Family Planning

In 1981, Section 104(b) of the Foreign Assistance Act was amended to ensure that information and services relating to natural family planning (NFP) methods be included among the population activities supported by A.I.D. A.I.D. missions have been informed of this legislative amendment and of A.I.D.'s intention to see that natural family planning methods, defined to include all those methods which rely on periodic abstinence, are integrated into all relevant forms of population assistance, including research, training, service delivery and information programs, wherever this is appropriate to the culture and desires of the recipient population and its government.

Although natural family planning itself is not a new concept, it has received increased attention and interest in the last decade. A.I.D. missions should continue to explore ways of encouraging the inclusion of natural family planning approaches within the programs of public and private family planning agencies working in the country. A.I.D. policy governing the funding of natural family planning activities is based on the same principles of voluntarism and informed choice which govern activities related to other methods of family planning. A.I.D. gives preference in its funding to programs which provide a wide range of choices in family planning methods (excluding abortion) and strongly encourages such programs to include information

[1]Policy Determination (PD) 3 *(formerly PD-70)* summarized below is attached as an Annex.

and/or services related to methods of natural family planning. All A.I.D. supported population programs must demonstrate that they are free of coercion regarding not only the practice of family planning, but also the choice of a particular family planning method.

(4) The Relationship Between Population and General Development

Recognition of the reciprocal links between fertility and other aspects of development led Congress to amend the Foreign Assistance Act to include Section 104(d). This section states that:

> (1) Assistance under this chapter shall be administered so as to give particular attention to the interrelationship between (a) population growth, and (b) development and overall improvement in living standards in developing countries, and to the impact of all programs, projects, and activities on population growth.

Implementation of 104(d) requires A.I.D. to maximize the impact of scarce development resources, not only by avoiding support to development programs that appear to work at cross-purposes, but also by building upon what is known about the links between social and economic progress and fertility decline. A.I.D. has interpreted 104(d) as a mandate to work for improvements in the socioeconomic setting within which voluntary family planning services are provided, (an important development goal in its own right) in order to support parents' growing interest in smaller families as well as their ability to utilize modern, effective contraceptives to achieve their desired family size. In implementing this mandate, A.I.D. does not seek to tie assistance to fertility reductions, but rather to coordinate development activities and the availability of family planning services so that they are mutually reinforcing.

(5) Contraceptives

It is A.I.D.'s general practice to provide to other countries only those contraceptives approved by the Food and Drug Administration for use in the U.S.

III. Factors Affecting Policy Implementation

Constraints to the achievement of population assistance policy objectives include:

- weak or inconsistent government policies;
- regulations which inhibit efficient distribution of contraceptives;
- inadequate infrastructures for service delivery; and
- social and economic conditions, e.g., poor health, low educational levels, and low income levels, especially for women, which militate against the acceptance or effective use of modern family planning methods.

There are a variety of government policies and socioeconomic changes which often tend to encourage (or at least not discourage) high fertility; for example, the breakdown of traditional practices which have served to ensure child spacing; protective labor legislation making it more difficult for women to work; the lack of regulations prohibiting child labor; the settlement of nomadic people; and the trend away from prolonged breastfeeding (one of the most important traditional means of postponing the next pregnancy) to intermittent breastfeeding and early weaning. There are also a variety of socioeconomic changes which are associated with higher fertility in their early stages, although over the long term they are associated with smaller families (increased female education, improved health and increased family income, for example).

Most LDCs, often with U.S. or other donor assistance, are currently investing heavily in development activities in a number of sectors; most LDCs also have stated policies to reduce population growth. However, often there is little attention to integrating or coordinating these development programs and policies so as to maximize their combined impact. For instance, in some countries, family planning services are virtually unavailable outside the major cities; at the same time, governments are investing in family income generation and education programs in rural areas—programs that are likely to foster couples' interest in limiting family size and thereby increase the demand for modern family planning services. In many areas, family planning services have not been integrated with existing maternal/child health programs, although the former is a critical factor in improving health status in most LDCs.

Where the constraints to acceptance or effective use of modern contraception are rooted in the lack of improvement in basic living conditions and economic opportunities, A.I.D. is careful to coordinate its development activities in other sectors with its support for family planning pro-

grams so that the two are mutually reinforcing. A.I.D. also works with LDC countries to help them analyze and strengthen their policies, which may in some cases include modification of regulations that inhibit contraceptive distribution, and in others focus on improved maternal and child health or education opportunities for females. Where infrastructures are weak or inadequate, A.I.D. supports institutional development activities or works with the private sector which often has more efficient channels for delivery of services than the government. The major priority emphases of the Agency—an expanded role for government-to-government discussions on country policies, the private sector, institutional development, and technology transfer—are particularly relevant to overcoming major constraints to successful implementation of U.S. and LDC population policy objectives.

A. Host Country Policies

A.I.D.'s experience has been that family planning programs are most successful where governments support strong service delivery systems, are committed to curbing excessive population growth through provision of voluntary family planning services, and where this commitment is translated into a clear population policy, backed by policies stressing improved education, health and employment opportunities, especially for women. In countries where continued high population growth rates appear to be eroding economic development, A.I.D. includes this factor in its policy discussions with the government. While the U.S. does not and will not make development assistance conditional on the host government adopting a particular population policy, A.I.D. will continue to seek and respond to opportunities for policy-level discussions on voluntary family planning. Indeed, many of the family planning program "successes" in Asia and Latin America involved not only substantial bilateral support for expansion of quality family planning services, but also a continuing official dialogue on the policy and institutional reforms needed to improve the quality and coverage of the programs. A.I.D.'s application of Section 104(d) of the FAA is an important element in ongoing discussions on population and development policies. In addition, A.I.D. will continue to sponsor the development and use of a variety of tools for analyzing and demonstrating the impact of rapid population growth on economic progress, making these programs available to interested LDC governments as they examine the full range of their development objectives, programs and problems.

B. Private Sector

In most countries, the distribution of contraceptives began through the private sector: private physicians prescribed contraceptives for their patients; some methods of family planning were available over the counter; and private voluntary organizations offered services, most often in urban areas. The private sector has acted as an important "supply side" force, responding to demands for services and also demonstrating to the government how efficient contraceptive distribution systems could be implemented. After governments begin to provide services, there remains a mix (which varies by country) of public and private sector delivery systems. In a number of countries, the government relies on the private sector to provide all or a large proportion of the services available.

Over the past several years, A.I.D. support to private voluntary organizations has amounted to roughly one-third of the population assistance program. This support is channeled for the most part through large U.S. based or international intermediaries that implement programs in LDCs through or in collaboration with local organizations.

Family planning service delivery, whether private or public, has typically involved clinic-based physician-oriented services. Although effective, such programs are costly and often biased toward urban consumers. In an effort to reach the rural population, and the poor in particular, modified programs have been developed to meet the needs and circumstances of isolated areas. Increasing the number of distribution points and types of contraceptive methods offered is critical to expanding the accessibility of services. In an attempt to increase services and stimulate greater private sector involvement in the delivery of family planning A.I.D. is placing greater emphasis on community based distribution involving paraprofessional and volunteer personnel. Additionally, in many developing countries, A.I.D. supports commercial retail sales (CRS) programs under which family planning is delivered through the commercial sector. A.I.D. will stress the need for family planning delivery systems to become less dependent on external resources, by systematically encouraging

greater local fundraising, voluntarism and community participation, fee-for-services, and improved management efficiencies in all programs. The Agency will also support efforts by U.S. private firms involved in the manufacture and distribution of contraceptives to promote similar development in LDCs. To the extent practicable, the methods, research, and experiences of such firms should be adapted and utilized in developing countries.

C. Institutional Development

Strengthening and fostering the direct involvement of local institutions in the development process will continue to be actively pursued under the A.I.D. population assistance program. Both public and private institutions are involved in the delivery of family planning services in LDCs. The magnitude of effort needed to make services available to all individuals who want them, and the inadequacy of infrastructures to deliver such services in the majority of countries, point to the importance of strengthening a variety of types of local institutions which are or could be effective service providers.

Appropriate institutions range from local women's groups, to private family planning associations, to Ministries of Health. In many countries it is important to have family planning services included as part of government maternal and child health (MCH) services, due to the real as well as perceived links between MCH and the spacing or limiting of births. Increased effort is also being directed to the involvement of local community organizations in the delivery of services as well as in the dissemination of information and education about both the concept of family planning and contraceptive methods. The mobilization of community resources (labor, materials, money, leadership) as a contribution to government-financed or private sector projects is an important means of encouraging community interest in a service, as well as fostering initiative and building local management capabilities.

The population assistance program seeks not only to involve local institutions in service delivery, but also to build or strengthen the capacity of local demographic and social science research institutions, government units responsibile for policy analysis and development, training institutions, and systems through which information, education, and communications about family planning reach potential clients.

The effectiveness of local organizations depends on such things as sound allocation and use of resources; quality of leadership; clarity of articulated goals and programs; and flexibility in implementation of programs. Improving organizational effectiveness may require changes in structure and function, in management systems, or in people's knowledge and skills. For this reason, greater attention must be given to building management and skills-training capacities into local organizations.

While it is generally understood that public policies affect the success of development efforts, less well understood are the ways in which government policies may handicap the effectiveness of local institutions. For instance, government policies may regulate the import and/or distribution of contraceptive supplies, fix prices at levels that militate against cost recovery, or define, in a limiting way, the role and functions of a private organization.

D. Technology Transfer

One of the strengths of the U.S. population assistance program has been the transfer of U.S. scientific and technological know-how to LDCs implementing family planning programs. The U.S. has led the way in developing, testing and disseminating the most widely used contraceptives and family planning delivery systems. A.I.D. is increasing the amount of its support for the development of promising new contraceptive methods and for research on the safety and effectiveness of contraceptives tested under actual LDC conditions. In addition to the transfer of technology directly applicable to the delivery of contraceptives, A.I.D. has sponsored the development and dissemination of a variety of technologies for analyzing and demonstrating the impact of rapid population growth on economic progress, making these tools available to LDC governments as they examine their policy and program goals. Demand from LDCs for technologies developed by the U.S. continues to be high. Our ability to transfer technology appropriate to various country needs has given the U.S. a longstanding leadership role in this field.

IV. Conclusion

Population Assistance will continue to be an essential element of U.S. development assistance. The content and direction of the U.S. program is guided by a number of factors:

- the commitment to helping LDCs achieve self-sustaining economic growth;

- the belief that individuals and couples should be able to decide freely the size of their families;

- the conviction that sustained economic development and the achievement of a decent life for all LDC citizens can only occur when population growth no longer outpaces economic progress;

- the evidence that voluntary family planning programs are needed and wanted by citizens of the developing world;

- the belief that it is in line with U.S. strategic as well as humanitarian interests to help LDC governments achieve national economic goals, and to support the efforts of their citizens for a better life for themselves and their children; and

- the growing evidence that the U.S. has unique strengths in this area of international development assistance.

Strengthening and fostering the direct involvement of local institutions in the development process will continue to be actively pursued under the A.I.D. population assistance program. A.I.D. will capitalize on the flexibility and innovativeness of the private sector in the search for new and better ways to make safe, effective and acceptable contraceptives widely available. There will be increased attention to the needs and interests of the consumer of the services, so that the services will meet, to the fullest extent possible, the cultural preferences of both current and potential users. Finally, A.I.D. will stress in its programming the integration of family planning services with health and other development activities.

V. Annex

PD-3 (September 1982) *(formerly PD-70 June 14, 1977)*

A.I.D. Policy Guidelines on Voluntary Sterilization

I. Overview

The *World Population Plan of Action* of the World Population Conference of 1974 observed that; "All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children, and to have the information, education and means to do so...."

The Foreign Assistance Act (FAA) of 1961 (as amended) reflects additional considerations:

(1) the process of economic and social development which is in turn affected by the pace, magnitude and direction of population growth; and,

(2) in many LDCs high rates of population growth limit attainment of broader development goals, contribute to economic hardship and hazardous health conditions, and deny opportunities for improved quality of life for many parents and their children.

In carrying out a comprehensive population assistance program *authorized by the FAA*, A.I.D. has responded to the growing number of LDC requests for assistance and has helped to make the various methods of family planning permitted by our legislation available on a broader scale to the rural and urban population for use on a strictly voluntary basis.

More recently, LDC governments and non-government organizations have requested assistance to extend the availability of voluntary sterilization (VS) services.* Such requests are partially in response to the preparatory work conducted by various organizations which have received A.I.D. support, including the Association for Voluntary Sterilization (AVS), the Pathfinder Fund, the International Fertility Research Program (IFRP), and the Johns Hopkins University Program for International Education in Gynecology and Obstetrics (PIEGO) as part of its broad program of advanced training in obstetrics and gynecology. These organizations have contributed to signifi-

*VS service programs include those activities which are primarily intended to provide voluntary male and female sterilizations to persons requesting this type of contraceptive procedure. For purposes of this discussion, however, VS training programs are included, since training generally requires that trainees conduct supervised procedures on patients who have voluntarily presented themselves at a service/training facility for sterilization.

cant advances in the development of new surgical techniques which make sterilization safer, simpler and less expensive as an outpatient procedure. They have developed specialized equipment and given LDC medical personnel specialized training in the practice of obstetrics and gynecology, including endocrinology, identification of cancerous conditions, maternal care, and the management of infertility and fertility, including sterilization procedures.

In providing support for sterilization services, A.I.D. must reaffirm its long-standing and complete commitment to the basic principle of voluntary acceptance of family planning methods and determine basic conditions and safeguards within which A.I.D. support for sterilization activities can be provided. These conditions and safeguards are needed because of the special nature of sterilization as a highly personal, permanent surgical procedure and to ensure that the needs and rights of individuals are scrupulously protected.

The official positions of national governments are mixed. While voluntary sterilization has become a basic part of comprehensive family planning services in many countries, in some there is only unofficial approval for action by non-government agencies while in other countries there is opposition to the method. A.I.D. staff and A.I.D.-funded grantees and contractors must be fully aware of national sensitivities and must receive AID/W and mission approval before making any commitments on commencing support for sterilization activities in any context.

II. General Guidelines

A.I.D. acknowledges that each host country is free to determine its own policies and practices concerning the provision of sterilization services. However, A.I.D. support for VS program activities can be provided only if they comply with these guidelines in every respect.

A. Informed Consent: A.I.D. assistance to VS service programs shall be contingent on satisfactory determination by the USAID (bilateral programs) and/or A.I.D.-funded grantees or contractors that surgical sterilization procedures, supported in whole or in part by A.I.D. funds, are performed only after the individual has voluntarily presented himself or herself at the treatment facility and given his or her informed consent to the sterilization procedure.

Informed consent means the voluntary, knowing assent from the individual after he or she has been advised of the surgical procedures to be followed, the attendant discomforts and possible risks, the benefits to be expected, the availability of alternative methods of family planning, the purpose of the operation and its irreversibility, and his or her option to withdraw consent anytime prior to the operation. An individual's consent is considered voluntary if it is based upon the exercise of free choice and is not obtained by any special inducements or any element of force, fraud, deceit, duress or other forms of coercion or misrepresentation.

Further, the recipient of A.I.D. funds used all or in part for performance of VS procedures must be required to document the patient's informed consent by (a) a written consent document in a language the patient understands and speaks, which explains the basic elements of informed consent, as set out above, and which is signed by the individual and by the attending physician or by the authorized assistant of the attending physician or (b) when a patient is unable to read adequately a written certification by the attending physician or by the authorized assistant of the attending physician that the basic elements of informed consent were orally presented to the patient, and that the patient thereafter consented to the performance of the operation. The receipt of the oral explanation shall be acknowledged by the patient's mark on the certification and by the signature or mark of a witness who shall be of the same sex and speak the same language as the patient.

Copies of these informed consent forms and certification documents for each VS procedure must be retained by the operating medical facility, or by the host government, for a period of three years after performance of the sterilization procedure.

USAID Missions should note their responsibility to monitor A.I.D.-assisted VS programs-whether such programs are funded bilaterally or by A.I.D.-funded grantees or contractors—to ensure continuing adherence to the principle of informed consent. In order to carry out this monitoring function effectively, all proposed programs—either bilaterally funded or funded by A.I.D.-supported intermediaries—shall be approved by the mission and AID/W prior to any commitment of funds or promise to commit funds for VS activities. In carrying out this responsibility, USAID staff should be thoroughly familiar with local circumstances and government administrative patterns and be able to communicate effectively with host country representatives.

B. Ready Access to Other Methods: Where VS services are made available, other means of family planning should also be readily available at a common location, thus enabling a choice on the part of the acceptor.

C. Incentive Payments: No A.I.D. funds can be used to pay potential acceptors of sterilization to induce their acceptance of VS. Further, the fee or patient cost structure applied to VS and other contraceptive services shall be established in such a way that no financial incentive is created for sterilization over another method.

D. Quality of VS Services: Medical personnel who operate on sterilization patients must be well-trained and qualified in accordance with local medical standards. Equipment provided will be the best available and suitable to the field situations in which it will be used.

E. Sterilization and Health Services: To the fullest possible extent, VS programs—whether bilaterally funded or conducted by A.I.D.-funded private organizations—shall be conducted as an integral part of the total health care services of the recipient country and shall be performed with respect to the overall health and well-being of prospective acceptors. In addition, opportunities for extending health care to participants in VS programs should be exploited to the fullest. Consideration must also be given to the impact that expanded VS services might have on existing general health services of the recipient country with regard to the employment of physicians and related medical personnel and the use of buildings or facilities.

F. Country Policies: In the absence of a stated affirmative policy or explicit acceptance of A.I.D. support for VS activities, USAIDs should take appropriate precautions through consultation with host country officials in order to minimize the prospect of misunderstandings concerning potential VS activities. In monitoring the consistency of A.I.D.-supported VS programs with local policy and practices, USAIDs and A.I.D.-funded donor agencies shall also take particular note of program activities among cultural, ethnic, religious or political minorities to ensure that the principles of informed consent discussed under "A" above are being observed and that undue emphasis is not given to such minority groups.

Addendum to PD-3 *(formerly Addendum to PD-70, 2/9/81)*
Additional A.I.D Program Guidance for Voluntary Sterilization (VS) Activities

1. **INTRODUCTION:** The previously provided Policy Determination No. 3 (PD-3), remains in effect. However, in light of several years experience, additional clarification of a number of points relating to the application of PD-3 and specific interpretation of its provisions appears to be needed.

2. **APPLICABILITY OF PD-3:** PD-3 states "A.I.D. support for VS program activities can be provided only if they comply with these guidelines in every respect". This means that the provisions of PD-3 must be applied if A.I.D. funds are used for whole or partial direct support of the performance of VS activities. However, as also noted in PD-3, "A.I.D. acknowledges that each host country is free to determine its own policies and practices concerning the provision of sterilization services". The provisions of PD-3 do not apply if A.I.D. provides support for population and family planning programs within a country and provision of VS services is not called for in the support agreement, i.e., VS activities may be a part of the host country's program, but A.I.D. funds are not used to support such services. For example, if A.I.D. support for VS program activities is geographically confined to particular parts of a country, PD-3 applies only to those areas with VS program activities supported by A.I.D. PD-3 does not apply if activities and projects are only peripherally related to provision of VS services, for example, A.I.D. support for construction of multipurpose buildings or broad-based training in reproductive health which includes VS techniques. Finally, in A.I.D.-supported population and family planning programs in host countries which use A.I.D. funds for activities other than VS and support VS activities with their own or other non-A.I.D. funds, PD-3 does not apply.

3. **INFORMED CONSENT:** The recipient of A.I.D support used fully or in part for performance of VS procedures must obtain and document voluntary informed consent as part of the conduct of any VS procedure. A.I.D. does not require any specific format for this procedure. However, the elements of the procedure described in PD-3 (i.e., an explanation of the nature of the procedure, the attendant risks and benefits, availability of alternative methods of

family planning, that the procedure is irreversible, and that the patient may withdraw consent) all must be part of the process of obtaining informed consent.

4. METHODS OF PAYMENT: All acceptor and/or provider payments in cash or kind beyond VS service costs as well as fees charged for VS and other contraceptive services shall be established in such a way that no financial incentive is created for sterilization over another contraceptive method.

(A) Payment of Acceptors: It should be noted that guidance differs for payments which may be made to acceptors of VS as contrasted to payment to providers of VS (guidance applicable to providers of VS services is described in para 4.B. below). As stated in PD-3, para C, "no A.I.D. funds can be used to pay potential acceptors of sterilization to induce their acceptance of VS". Further, A.I.D. support generally cannot be provided to VS services which include incentive payments paid to potential acceptors. For example, a VS program supported by A.I.D. cannot be supplemented with acceptor incentives to induce acceptance of sterilization services. Determination of what constitutes an incentive must be made locally based on thorough knowledge of social and economic circumstances of potential acceptors. In general, recompense to acceptors for legitimate, extra expenses related to VS program services such as transportation, food during confinement, medicines, surgically related garments and dressings and the value of lost work are not considered incentive payments and are eligible for A.I.D. support. It should be emphasized that these payments must be of a reasonable nature and aimed at making VS services equally available at the same cost as other contraceptive services. For example, payment for lost work must correspond to a reasonable estimate of the value of lost labor over a reasonable duration of convalescence.

(B) Payment of Providers of Services: In light of experience, it seems desirable to modify the previous A.I.D. program guidance relating to reimbursement for VS services as defined in AIDTO Circular 393 (10/27/77), page 6, section 3, "operating service costs", para. 4. The suggested prohibition of reimbursement to providers of VS services on a per-case basis has not proven practical in that payment per case or procedure is the time-honored method of paying for surgical procedures both in developed and less developed countries. Reimbursement of physicians, paramedical and other service personnel on a per-case basis can be an acceptable procedure. Compensation to providers for items such as anesthesia, personnel costs, pre and post-operative care, transportation, surgical and administrative supplies, etc., on a per-case basis is also generally acceptable. These payments to providers must be reasonable relative to other medical and contraceptive services provided so that no financial incentive is created for the providers to carry out VS procedures compared to provision of other methods of family planning. As in the case of payments to acceptors, this is a judgment which will have to be made on a country and program specific basis. However, in both cases, AID/Washington will provide assistance and guidance in making such determinations, and decisions relating to application of PD-3 should be submitted to AID/Washington for review. Even though payment on a per-case basis is often customary, A.I.D. Missions are advised to encourage patterns of service delivery and methods of payment which do not unduly emphasize VS procedures compared to other methods of fertility control. For example, if physicians who carry out the surgery are paid on a per-case basis and they have no role in the selection or counseling of patients, these service providers cannot induce additional patients to accept sterilizations over other contraceptive methods. Payments of physicians on a per-session rather than a per-case basis may also serve the same function. Since payments on a per-case basis do raise questions, often of a complex nature, beyond those raised by other types of compensation, where a mission can persuade a government to use such other frameworks for payment, whether immediately or phased-in, it should do so.

(C) Payment of Referral Agents: In some countries fieldworkers are employed to inform and refer potential acceptors of contraceptive methods including VS. When extra expenses are incurred in informing and referring VS acceptors, a per-case payment of these costs is acceptable. Again, as is the case with payments to providers and/or acceptors, a country or program specific determination that the payment is for legitimate extra expenses or activities associated with VS referral must be made. The aim is to make all available contraceptive methods available at the same cost to the acceptor.