Population Policy and Family Planning Programs: Trends in Policy and Administration

August 1980

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WORLD BANK

Staff Working Paper No. 411

August 1980

POPULATION POLICY AND FAMILY PLANNING PROGRAMS: TRENDS IN POLICY AND ADMINISTRATION

This study attempts to summarize recent trends in population policy and examines some of the main administrative problems likely to be encountered in the delivery of family planning services in the next few years.

Efforts have been growing to provide family planning services through channels other than physician-staffed clinics. Relying on community participation and local community workers, these channels make appropriate training and supervision an important administrative concern. Such training and supervision may become more difficult as a wider range of channels is used to deliver services -- and lines of authority become blurred. If family planning is not the main concern of the managers, management is likely to be less efficient, and the coordination of the different sectors presents a serious problem. Evaluation also becomes more problematic because it is more difficult to disentangle the effects of the various channels. In addition, medical backup will be a key consideration: although delivery systems are becoming more deeply rooted in the socio-political network, and health ministries are increasingly relegated to an advisory role, the methods gaining in importance -- sterilization and abortion -- are medical. Even if lower-grade paramedicals are eventually authorized to perform sterilizations, competent medical assistance will have to be within reach.

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We are entering the third decade in the growth of population concerns. We find there is a consensus emerging on what needs to be done. Strident conflict among different strategies and approaches to deal with population problems, which has characterized the field until recently, has softened. There is growing evidence that global fertility has declined; both statistical analysis and project experience suggest that we can attribute this, in part, to family planning programs. Agreement is widespread that the present rates of fertility decline are insufficient; that national programs need to provide both effective services and activities to stimulate the demand for those services; and that certain developmental sectors have an impact on fertility and need to be emphasized in development planning (though striking the right balance between these sectors and family planning remains difficult, sometimes contentious).

The "crisis" atmosphere that has existed over the past two decades is now fading. In many quarters, complacency is setting in, following limited achievements and demographic impact over the past 20 or 25 years. There is uneasiness about the sizable resources provided so far, and questions about increasing these resources. There are limitations of what present technologies and interventions can achieve, and there have been no dramatic technical breakthroughs or broadly successful innovative approaches to fertility reduction. Programs, to be successful, need significant investments of funds and staff, good logistics and management systems, effective and skilled motivation and organized outreach. There is a need to increase finance for population programs, but it is more important to identify how these resources can be directed to improve performance and achieve meaningful program results.

As we enter the 1980s, there is a need to recognize the continuing seriousness of the population problem and of the need to sustain strong support for population activities, to strengthen political and administrative commitment for population assistance, to continue research, and not to become discouraged at the lack of current prospects for technological breakthroughs.

There is also a need to change the emphasis from providing services to creating demand for those services -- to blend the need for continuing focus on population with the growing emphasis on health and other "basic needs". This requires efforts to broaden the approaches and integration of family planning delivery systems with health and other sectoral activities. Efforts in this direction have been underway for some time but more needs to be done.

Many people made substantial contributions to this study. Jay Satia did considerable work on the development of family planning programs and on the Bank's lending for population. Sulekha Patel furnished much of the material on population policy. Helpful comments on earlier drafts were received from Susan Hill Cochrane, Timothy King, Paul Isenman and Roberto Cuca. We alone, however, are responsible for any shortcomings that may remain.
SUMMARY

The widespread recognition that population and development were inter-related variables came at the World Population Conference in Bucharest in 1974. The idea itself was not new. The experience of the industrialized countries in the nineteenth and early twentieth centuries had shown that economic development in itself influences people’s fertility behavior and thus reduces the rate of growth of population. Moreover, the refinements in methods of delivering family planning services -- such as those which enlist the support of the local community or, instead of delivering services through a single-purpose network of family planning centers or workers, use multisectoral channels -- were already being tried in the years before 1974.

What has happened since the Conference is that increased attention has been given to developing mechanisms for both reducing fertility and encouraging development simultaneously. By 1974, direct, parallel attacks to reduce fertility and improve development had already begun. Since 1974, efforts to integrate population and development at the policy level have led to efforts to integrate activities at the service delivery level.

Before 1960 few developing countries recognized the existence of a population problem, and still fewer attempted to deal with such problems. Between 1960 and 1977, however, more than 50 of these countries introduced national family planning programs. At first these programs were based on the assumption that there was considerable latent demand for contraception, so that if supplies and advice were made available at family planning clinics, people would flock to them. This assumption proved in many cases to be exaggerated, especially in outlying rural areas, and it became necessary to stimulate demand by "information, education and communication" campaigns and to use "outreach" methods to bring services to people outside reach of clinics.

Delivery systems were at first often single purpose, consisting of a national family planning board administering a network of family planning clinics. Because health services usually had a ready-made network of clinics staffed with the doctors and nurses considered necessary to provide family planning services, these boards often found it convenient to use the health services as a delivery channel, a tendency reinforced by the fact that women attending maternity hospitals and maternal and child health clinics were likely to be particularly receptive to family planning. Moreover the many technologies available for contraception were medical or needed medical backup. Thus health and family planning services tended to be brought together or "integrated," and in many cases the administration of family planning programs was transferred to Ministries of Health.

Project experience indicates that family planning programs can also be strengthened by using, in addition to the Ministry of Health, other ministries which maintain extensive administrative networks as delivery channels for family planning information and, in some cases, supplies. Most important in this connection are Ministries of Education,
which in an increasing number of countries have introduced population education into all levels of education systems. Ministries of Agriculture, whose extension agents visit remote rural areas, and which administer rural development schemes, have also been used in family planning motivation. This multisectoral approach, however, presents considerable administrative problems, since it is difficult to coordinate a program conducted by a number of separate agencies, and officials whose main interests lie in other directions may give inadequate attention to family planning.

The objection to the merging of health and family planning services -- that family planning tended to be submerged in health -- was the danger of loss of focus and inadequate attention because of the competing claims of curative care. Some of the force of this argument was lost as "outreach" methods were introduced, since the essence of these methods was to use trained field-workers in place of scarce doctors and nurses to dispense family planning services.

The final stage of outreach is the enlistment of the services of the leaders of local communities, to organize family planning, within their villages, for example. Those local leaders can, in addition to organizing the distribution of contraceptives, influence public opinion in favor of family planning. These community methods are most likely to be successful in countries where, as in Indonesia, a strong central government commitment is effectively transmitted to local areas and efficiently administered.

The use of outreach methods increases the quantity of family planning services available to the periphery, but at the same time creates a problem of maintaining the quality of these services. Family planning field-workers are now expected to perform functions which not long ago it was thought could or should only be performed by highly qualified physicians and nurses. This means that, while they must be well-trained in these functions and learn to be self-reliant, they must at the same time be aware of their limitations and know when to refer cases to a higher level. This is turn means that they should be well-supervised and that there should be an effective system of medical backup.

Because of these needs for supervision and backup, the use of field-workers and community workers is not as economical of the services of physicians and nurses as might appear at first sight. Backup is important, not only for the treatment of complications, but also because people will refuse to accept services at the hands of lower grades of worker unless they are convinced that skilled help is readily available if needed. The need for backup extends, not only to skilled services, but also to supplies of drugs and other requisites.

The use of outreach and multisectoral approaches also increases the importance and difficulty of evaluation, an essential element of all family planning programs. It is important that workers throughout the program should be made to feel that evaluation, like supervision, is a constructive activity designed to make the system work better through feedback, rather than a fault-finding process.
INTRODUCTION

The World Population Conference held in Bucharest in 1974 was not so much a watershed as the point of intersection of a number of different approaches to the population problem that had gained currency during the early 1970s. The consensus that emerged from the often acrimonious discussions at Bucharest emphasized that population policy was an integral part of general development policy, and that an important part of the solution of the population problem lay in a reduction of social and economic inequities. The World Population Plan of Action (WPPA), drafted by the Conference to express this consensus was a first attempt to synthesize the views expressed in a way that could serve as a point of departure for subsequent policy. 1/

This did not mean, however, that countries should not also continue to emphasize family planning programs as well -- indeed most countries with population policies have done so. A recent analysis attempted to disaggregate the contributions of development and family planning programs to observed declines in fertility; it found that family planning programs had a significant effect independent of socioeconomic factors. 2/ Given, on the one hand, the difficulty of "operationalizing" the broader approaches recommended in the WPPA and, on the other hand, the testimony of this and other recent studies to the efficiency of family planning programs in reducing fertility, it is reasonable to assume that family planning programs will continue to play a key role in population policy.

Over the past twenty-five years, population policy has evolved considerably and family planning programs have become more complex. The World Bank’s projects in the sector have reflected the changing perceptions of how best to curb the growth of population. The first part of this study reviews population policy before and after the Bucharest Conference and the second part discusses some of the principal delivery system problems that family planning programs are likely to face over the next few years. The Bank’s experience in the population sector is cited throughout.

THE EVOLUTION OF POPULATION POLICY

The Population Problem: Perception and Response

Between 1950 and 1970, many developing nations came to realize the harmful effects of rapid growth of population. National development plans for the 1960s and the 1970s reveal an increasing awareness of the implication of rapid growth of population for development. 3/ As can be seen from Table 1, there was a substantial increase between 1960 and 1970 in the number of plans containing demographic data and drawing attention to population problems. In 1970, 57 of the 60 plans analyzed contained demographic data: 38 of them (63%) mentioned demographic problems, compared with 27 out of 70 (39%) in 1960. The problems most frequently mentioned were: the retardation of economic growth by increases in population, the growth of population under working age, and the pressure of population on...
food supply and on social services such as on health and education. Only 18 of the 70 plans in 1960 contained population policies, compared with 27 of the 60 plans in 1970. The aspects of population policy most frequently mentioned were: targets for the reduction of growth of population, the support of family planning for demographic reasons, the integration of family planning with health services, and population education. Some plans even contained specific recommendations: schemes for motivating people in favor of smaller families (Malaysia, 1971-75 4/); the use of mass media to disseminate family planning information (Barbados, 1967-1972; Bangladesh, 1973-1978; India, 1974-1979; Trinidad and Tobago, 1969-1973); and family planning acceptor targets (Nepal, 1970-1975; Pakistan, 1970-1975; Philippines, 1972-1975; Thailand, 1972-1976; Indonesia, 1969-1974). India’s 1974-1979 development plan advocated the postponement of marriage as a way to reduce fertility, and endorsed the use of incentives to induce people to accept family planning. Two plans urged the need to improve the status of women (Colombia 1970-1973; Guatemala 1971-1975). A summary of the population content of selected development plans is found in Table 1.

About 60 developing countries adopted family planning programs between 1950 and 1977. At first, these programs were based on an assumption that there was a strong, unsatisfied demand for their services and that all that was necessary for fertility reduction was to provide contraceptive supplies and services. The early delivery systems were based on clinics staffed with either medical or highly trained paramedical personnel, but as time went on they began to use outreach methods employing lower grades of personnel, and to combine other health services with family planning. As it became evident that the potential demand for family planning was smaller than had been expected, information, education, and communication activities designed to stimulate demand were included in the programs, and various "incentive" schemes were introduced. Delayed incentives were used to encourage acceptance to continue the practice of family planning. Under the Tea Estates Program in South India, a monthly deposit was paid into the participant’s bank account for each month she avoided pregnancy, but could not be withdrawn until she had reached the age of forty five, and then only if she had not exceeded the permitted number of births. The Education Savings Plan (Taiwan) rewarded couples limiting their families by depositing funds to be applied to their children’s post-primary education. 5/ Thus, by the time of the Bucharest Conference, family planning delivery systems with their attendant demand-creating and promotional activities, had become relatively sophisticated mechanisms.

New ideas about development and the population problem had also become familiar well before the World Population Conference. The belief that investment in key sectors of a nation’s economy would "trickle down" and improve the lot of all income groups had been shaken. In many cases, the key sectors did not grow as rapidly as envisaged; in others, the effect of increased output on income per capita was largely offset by an increase of population. Different tactics were evidently necessary if the needs of the poorest 40% of the population were to be met. Development was now seen to have a qualitative dimension, and was to be measured in terms of social progress as well as economic growth. From this point of view,
Table 1. Content Analysis of National Development Plans c. 1960 and c. 1970 with Reference to Treatment of the Population Sector

<table>
<thead>
<tr>
<th>Region</th>
<th>Number of Plans Analyzed</th>
<th>Demographic Data</th>
<th>Population Problems</th>
<th>Population Politics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Africa</td>
<td>26</td>
<td>22</td>
<td>--</td>
<td>20</td>
</tr>
<tr>
<td>Asia</td>
<td>21</td>
<td>20</td>
<td>--</td>
<td>20</td>
</tr>
<tr>
<td>Latin America</td>
<td>23</td>
<td>18</td>
<td>--</td>
<td>17</td>
</tr>
<tr>
<td>TOTAL</td>
<td>70</td>
<td>60</td>
<td>--</td>
<td>57</td>
</tr>
</tbody>
</table>

Most countries used very little demographic data in their development planning until after 1960.


the consequences of rapid growth of population considered in terms not only of the economy as a whole, but also of the welfare of the individual and the household.

Thus by 1974, not only had the discussion of population policy moved away from the "either/or" debate of earlier years (either family planning programs or development as the most efficacious means of retarding the growth of population) 6/, but action programs, too, had progressed far beyond the original static approach. Indeed, many of what would later be tagged "the new approaches of Bucharest" were familiar long before the delegates assembled. Furthermore, there was also a growing recognition that population policy and development policy were interdependent.

The Bucharest Conference

The World Population Conference marked the first time that the population problem had been discussed by representatives of governments rather than technical experts, so that the political flavor of the discussions and of the final policy instrument might have been expected. The rhetoric and resolutions of Bucharest are better understood when viewed in the context of the series of international symposia held in the early 1970s and, in particular, the May 1974 Conference on the New International Economic Order. The themes that emerged from these meetings -- the need to improve human welfare, the link between population and development, the recognition of the rights of sovereign governments to chart their own paths to development, the division between North and South -- were amplified during the debates at Bucharest. 7/

The Conference reaffirmed the sovereign right of each nation to solve its population problems in its own way, and declared that: "Population policies are constituent elements of socio-economic development policies, never substitutes for them; while serving socio-economic objectives, they should be consistent with internationally and nationally recognized human rights and individual freedom, justice and the survival of national, regional, and minority groups" (para. 14d). Frequent reference was made to respect for human rights and the primacy of human welfare, and the necessity of enabling individuals to develop their full potential. The WPPA maintained 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 responsibility of couples and individuals in the exercise of this right takes into account the needs of their living and future children, and their responsibilities towards the community" (para. 14f).

In spite of the political posturing or perhaps because of it, the Bucharest Conference introduced a needed sense of urgency into the population-development debate. It gave systematic expression to many of the ideas and approaches that had previously manifested themselves in a sporadic fashion, and thus sketched the general lines that population policy was likely to follow for the rest of the century.
Proceeding from the premise that socioeconomic development is a primary determinant of fertility, the WPPA called for a closer integration of population and development planning. The more closely measures intended to influence fertility could be identified with the pursuit of social goals, the less the chance of arousing political opposition. Closer integration would in effect shift the emphasis away from family planning as an end in itself. Population policy was henceforth to take the form, not simply of family planners, but of improvements in social infrastructure, women's status, the welfare of the family, food supply, the environment, employment, per capita income and the distribution of income. It was agreed that because fertility was determined by a wide range of social, economic and cultural factors, policy designed to influence it must correspondingly be many-faceted.

The WPPA having thus recognized that the fertility behavior of individuals was a product of their socio-economic-cultural settings, it followed that the next step was to introduce into that setting a factor -- family planning -- which would modify fertility in the desired direction. By aligning the goals of the family planning program with broader objectives, e.g., community development or the welfare of the household, the idea of family planning could be readily introduced into the community's institutions and culture. Such a close integration between "program and setting" was already to be seen in China and Indonesia. The marked declines of fertility in those countries and the rhetorical endorsement of the Bucharest Conference gave impetus to what might be termed the "environmental reinforcement" aspect of family planning programs. 8/

After Bucharest

Just as the ideas embodied in the WPPA had existed well before the Bucharest Conference, so it is difficult to isolate its impact from the natural course of social and political evolution. The recommendations of the Conference had different influence in different parts of the world. It appears to have had considerable influence in Latin America. It was, indeed, at the Conference that Brazil announced its shift from a pronatalist stance. In Mexico and Colombia, which had population programs but where the issues remained sensitive and controversial, the presentation of family planning as a basic human right may have helped to legitimize the population policies already adopted. In El Salvador, Costa Rica and the Dominican Republic there was increased interest in population issues, as exemplified by the creation of commissions or councils to bring about closer integration between population and development planning.

Bucharest had much less influence in the Middle East and Africa. Tunisia immediately applauded the WPPA as an endorsement of the approach it had been following since the mid-1960s; its Maghrebian neighbors, Morocco and Algeria, have recently begun to introduce population considerations into their development planning if they are to attain their social and economic goals. In other African countries -- for example, Ethiopia, Sudan, Zambia and Kenya -- the Conference at best succeeded in making government officials more aware of the population issue.
Many Asian countries have been pioneers in both population and development policy as well as in the integration of the two, and the most that can be said is that Bucharest reinforced and perhaps accelerated certain approaches that were already under way. In many of these countries -- for example, Korea, Thailand and Malaysia -- national planning agencies had already recognized the interdependence of population growth and economic and social development, and it is likely that these countries would have proceeded along the same lines even if the World Population Conference had not taken place.

The multisectoral approach to family planning outlined in the WPPA has proved difficult to implement. Besides creating considerable problems of administration and coordination, there are difficult problems of relevant balance. In part the question of balance depends on what is politically, administratively, and fiscally feasible. But few countries with a strong concern about population growth would accept the arguments of some delegates to the Conference that a country with an adequate development program did not need a family planning program.

Although not enough is known about the causal links between development and fertility, indications are that reducing infant and child mortality, increasing education (particularly of women), and increasing the incomes of the poor are vital (despite the possibility of temporary effects in the opposite direction). The World Bank is, however, supporting a number of research projects in this area -- both in its population projects and its research program -- which may help to identify the key link more clearly. These studies will add to the knowledge of the proper balance in different circumstances between family planning and other fertility-related programs.

**ADMINISTRATIVE ISSUES AND THE PROVISION OF PLANNING SERVICES**

The administrative problems of a national family planning program are similar in many respects to those of other sectors -- organization, staffing, supervision and financing. Yet because of the sensitivity of the population problem and the nature and range of the services provided, the successful administration of family planning programs often requires much innovation. The early family planning programs were often entrusted to agencies specially oriented for the purpose, and usually independent of the ministry of health (MOH), even though in some cases they made use of MOH staff and clinics. Over the years, however, they have gradually come under MOH control, although the manner and degree in which family planning has been integrated with the health network varies widely. In recent years, policymakers have tried to design national programs that were capable of meeting the needs of outlying areas, while at the same time were sufficiently uniform to permit central administration. Various "new integrations" have also been devised which, by linking family planning services with programs in sectors other than that of health, seek to enhance their legitimacy and to extend their reach.
While recognizing that the functional aspects of family planning programs — recruitment of acceptors, service delivery, training, research, monitoring and evaluation, and the provision of education and information — raise many issues, this study is confined to two kinds of organizational change: first, the shift to a closer relationship with health ministries; and second, the trend towards the integration of family planning with other aspects of community life through greater participation of the target group in the formulation and implementation of the program, through the grafting of family planning onto other activities, or both. Greater emphasis on activities at the community level and reliance on lightly trained workers at that level also raises a number of administrative issues, which are discussed in the final section of this paper.

The Integration of Family Planning into the Health Network

As national family planning programs first took shape, it was felt that they would be more conspicuous if they were independent of other state services. For this reason, the early programs, while largely clinic-based, were often not administered by the MOH and in some instances they duplicated activities of the health network. In many countries separate family planning coordinating boards were established both to formulate policy and to administer the program. Such bodies were often headed by a senior government official and composed of representatives of interested ministries and private family planning associations. The record of such coordinating boards is mixed. In many countries they were more prestigious than functional, although examples of effective coordinating bodies can be adduced — POPCOM in the Philippines, the National Family Planning Board in Malaysia, and the National Family Planning Coordinating Board in Indonesia.

The evolution of the organization of the Egyptian family planning program exemplifies a trend toward a greater role for health ministries. In 1965 the Egyptian government adopted a national family planning program and created a Supreme Council for Family Planning (subsequently renamed the Supreme Council for Population and Family Planning), presided over by the Prime Minister and comprising members from various ministries, to coordinate family planning activities, while a Population and Family Planning Board (PFPB) was set up to administer the program. Although family planning services were to be delivered mainly through MOH clinics, MOH had little say in program matters, and it was therefore not surprising that it did not display much zeal in the provision of family planning services. Dissatisfaction with this arrangement prompted the establishment in 1973 of a Department of Family Planning in the MOH which was placed in charge of the delivery system, while the role of PFPB was restricted to policy making. In 1977 a further reorganization took place; a post of Director-General for Family Planning was created in the MOH, and there was a significant strengthening of the support staff. The Department of Family Planning now comprises five units (program and training; field supervision; social services and communication; administration; and architecture). Thus while the Supreme Council for Population and Family Planning still has a coordinating role, the MOH — once simply a channel for service delivery — is now to all intents and purposes in charge of the national family planning program.
The Indonesian program exemplifies a different relation between a central coordinating board and the MOH. Although established as an independent program under a National Family Planning Coordinating Board (NFPCB), the Indonesian program has from its inception (1968) been closely tied to the MOH. Family planning services were delivered as part of the maternal and child health (MCH) program and, from the outset, the MOH was staffed and equipped to provide family planning services. This close link with the MOH has not, however, inhibited initiatives in the field of family planning, and Indonesia was one of the first countries to pursue on a large scale the policy of "taking family planning out of the clinic and into the village." The NFPCB is, however, the effective central administrative agency, perhaps because it has budgetary control over all family planning matters and because its authority is reinforced at the local level by provincial NFPCBs.

Although it is now accepted in most countries that family planning programs are the responsibility of the MOH, the way in which program activities are organized within the MOH varies. In some countries a separate unit in the MOH is responsible for the program; in others family planning has become part of preventive health care, and is usually delivered together with maternal and child health services. In Singapore the Family Planning and Population Board, which is responsible for all family planning activities, is a separate unit in the MOH. There is, however, a considerable interlocking between Board and MOH staff which, in the opinion of many observers, has contributed to the success of the family planning program as well as that of the other health services. In Kenya, where the National Family Welfare Center administers the MCH/FP program, the director of the Center serves concurrently as the Deputy Director of Medical Services in charge of rural health. In Morocco family planning is the responsibility of the out-patient network and is delivered by MOH staff as a routine preventive health service. Although some additional clinics have been set up as Family Planning Referral Centers in order to augment services and handle problems, they are staffed by MOH personnel and come under the jurisdiction of the MOH.

Some critics contend that the merging of family planning with health reduces the visibility of the program, and that health personnel tend to give priority to serious health problems and consequently do not devote adequate attention to family planning. In the last few years, however, these misgivings have largely been allayed. As the network for the delivery of family planning services has been extended beyond the clinic by means of village depots, household distribution schemes, and the greater use of nonmedical personnel, the pressure on health clinic staff has been eased. Furthermore, in many countries, it is neither prudent nor practical to make family planning services too conspicuous. By placing family planning squarely within the health network and identifying it as a health service, many countries have been able to placate potentially hostile political and religious groups. The success of the integration of health and family planning depends to a great extent on political commitment and program leadership, and differences in the performance of integrated programs often reflect differences in these key variables.
All population projects of the World Bank have hitherto been based upon the use of national health systems as the primary channels for the delivery of family planning services. These projects have strengthened the public health infrastructure of the borrowing countries and, in addition to reducing fertility, they have helped to improve general health. The Bank's loans and credits for population projects have largely been used to provide health centers, maternity units, vehicles, and training institutions. It is likely that the trend toward the integration of family planning with basic health care will continue.

At this stage in the history of family planning programs, the view that the MOH should have the principal role in their administration at the national level is not seriously questioned. Current discussion centers around two main questions. The first is the extent to which these services can be provided at the local level by community organizations largely independent of the specialized skills and clinical facilities of the health service, which are called on only for "backup". The second is the extent to which other ministries can be used as channels for the provision of family planning services.

The Role of Other Ministries

A number of other countries are experimenting with practical applications of the principle that not only the MOH, but any ministry that administers a wide-reaching network of posts and personnel can be used as a channel for the dissemination of family planning information and, in some cases, the distribution of contraceptives. Ministries of agriculture are particularly suitable for this purpose, since not only do their extension agents penetrate deeply into rural areas, but they are also likely to be in charge of comprehensive rural development schemes where family planning can be included among the social services provided. Thus in Malaysia, for example, family planning forms part of the social development program for settlers under the land development and resettlement schemes of the Federal Land Development Authority. Ministries of education can promote family planning by incorporating family planning education in the curricula of formal and nonformal educational institutions. In some countries military posts also serve as family planning centers.

World Bank lending reflects this trend towards the incorporation of family planning activities in the works of ministries not primarily concerned with such activities. Where appropriate, family planning components are included in urban and rural development projects. Population education is being included in education projects as well as in population projects. Population education aims at creating an appreciation of the causes of rapid growth of population and its implications for development. The population education component of Indonesian Population Projects I and II provides support for curriculum development, the preparation of instructional materials, and the training of teachers from formal and nonformal educational institutions. Similar activities are also included in Egypt Education Project II.
Several of the World Bank's population projects make use of the multisectoral approach to family planning. The two population projects in Bangladesh reflect the government's policy of introducing the promotion of family planning, for which the Ministry of Health and Population Planning is generally responsible, into the activities of five other ministries. Components of these projects provide for the introduction of family planning information into the training of "model" farmers and cooperative managers, a rural women's functional literacy program, rural mothers' clubs, a women's vocational training program, and the curricula of formal and nonformal community education, as well as the training of family welfare visitors and agricultural assistants to impart family planning information in the course of their visits. The second World Bank project in Malaysia provides support for a women's handicraft sales center and two family development training centers aimed at improving the economic and social status of women. Such components should help to answer some critical questions: how energetically ministries not primarily concerned with family planning can be expected to promote family planning activities for the kind envisaged; and how readily they will be prepared to cooperate with the coordinating ministry. The coordination of multisectoral activities, difficult enough at the national level, becomes even more difficult at the local level.

Community Participation

After years in which great efforts were made to bring about a closer relationship between family planning and health, it is ironic that the trend is now toward "new integrations," which seek to deemphasize the role of the health network in the delivery of family planning services. These new integrations are based on the idea that population policy should not be separate from general development policy that was the main theme at Bucharest. They stress the importance of community participation in the organization of family planning services and envisage the role of the MOH as largely technical. Family planning is represented, not as an end in itself, but as a means toward economic and social development. By increasing local participation in the formulation and implementation of family planning programs, by providing family planning supplies and information through local networks, and by grafting family planning programs onto broader schemes (such as, rural development), it is felt that family planning will share in the momentum of the overall development thrust.

Recent emphasis on community participation in the running of family planning programs is a consequence of three main factors. First, it is impossible in countries with scattered rural populations to provide enough clinics with trained medical and paramedical staff to reach the majority of people. Second, basic family planning information can be provided, and supplies of simple contraceptives distributed, by people with little training. Thirdly, peer pressure, especially in countries with a closely knit political structure, is an effective means of inducing people to accept new ideas and practices. Although a relatively new phenomenon in family planning, the enlistment of community participation in innovative
programs that benefit the community has a considerable history in other sectors. Although the desirability of this approach is widely acknowledged, the difficulties in applying it have yet to be resolved. What one writer has labeled "creating self-dependence of the periphery, with support from the center" is a concept that is slow to take root. Recent examples of this approach are the Saemaul Undong (New Village Movement) in Korea and the Mothers' Clubs and Women's Cooperatives in Bangladesh.

The greatest success in community participation -- at least outside China -- appears to be in Indonesia. The program began in 1968 on the islands of Java and Bali, where over 65% of the population is concentrated. It was estimated that, as of January 1978, 28% of the married women of reproductive age were using contraception, 4.6 percentage points more than the rate reported in the World Fertility Survey (1976). The total fertility rate for Java and Bali fell from 5.3 children per woman in 1965-70 to 4.5 in 1976. Part if not all of this fall can be attributed to the family planning program. Cost per acceptor is about US$11.00, well below that in Thailand, Malaysia, and the Philippines.

It is not easy to say conclusively why the Indonesian program has been so successful despite the absence of the rapid socioeconomic progress, which has contributed to a fall in fertility in some Asian countries. The strong political commitment of the government to the program has certainly been crucial. So also have effective administration and the thorough meshing of the program with community values and structures. The Indonesian program combines administrative centralization with operational decentralization. Ministries, provincial governments, and private groups draw up programs responsive to local conditions according to guidelines laid down by the National Family Planning Coordinating Board (NFPCB). Once the NFPCB has endorsed and funded these plans, their execution becomes the responsibility of the proposing agency. The main reason this operational decentralization works so effectively is a well-designed management information system, which permits the NFPCB to monitor progress closely and adjust funding accordingly.

The emphasis on community participation means that responsibility for motivation, acceptance, resupply and continuation of use is transferred as soon as possible from the local NFPCB field workers to the local community. Family planning is "marketed" as a practice which enhances the welfare of the individual family and the community. The help of local community networks is enlisted to promote the small family norm and to distribute contraceptives. By making local communities responsible for the success of the family planning program, the Indonesian system deemphasizes the roles of medical personnel and clinics.

In Bali the banjar, a kinship hamlet bound together by social, economic and religious ties, has become the vehicle for integrating family planning into the life of the community. Contraceptive practice is treated as a community concern, and at the monthly meetings each head of household reports on the family planning practice of the women of childbearing age in
his home. Banjar maps identify households according to methods of contraceptive use, and the banjar distributes contraceptives. The banjar system is less prevalent in Java, where the NFPCB has established village contraceptive distribution centers and family planning posts, staffed by villagers (usually satisfied acceptors) who are assisted by field workers of the provincial NFPCB. 14/

In extending its activities to the Outer Islands, where there were no field-workers, the NFPCB used the Camat, the provincial administrator and development coordinator, as an intermediary between the national program and local communities. To begin with, the NFPCB trained the Camat and his staff, who in turn trained hamlet officials and village leaders.

How effectively Indonesian success in reconciling central coordination with local decisionmaking can be transferred to other settings remains to be seen. The combination of enthusiastic government support, adequate funding, and highly developed local political organization is rare, perhaps unique. Certain features of the Indonesian experience can, however, be readily transferred: a program sufficiently flexible to accommodate the social, political, and religious idiosyncrasies of particular regions; a readiness to innovate; and a familiarity with local social structures which facilitates their use as networks for the promotion of family planning.

As part of the second World Bank project, the Government of Indonesia will be experimenting with a community incentive scheme, the primary objective of which is to test whether acceptance of the small family norm can be stimulated by offering rewards to communities which attain prescribed family planning targets. Under the scheme, any village attaining its target, which is set by it in consultation with the program authorities, will receive additional funds for development. The scheme is expected to start in June 1980, and will be implemented by a national committee representing the National Family Planning Coordinating Board, the National Development and Planning Agency, and the Ministries of Internal Affairs and Manpower.

The Provision of Family Planning Services at the Periphery

As the early family planning programs, based on clinics staffed by physicians, failed to attract as many people as had been hoped, it became clear that services had to be made available closer to where potential clients lived. This could only be feasible if less highly trained workers could be employed to deliver the services. Physicians are in short supply in most developing countries, as indicated in Table 2, and are usually concentrated in urban areas. 15/ This scarcity of doctors, particularly in rural areas, coupled with the fact that prolonged training is not necessary to enable workers to dispense simple contraceptives, or even to insert IUDs, made a compelling case for using a lower grade of health workers to provide services. Nevertheless, the idea was at first greeted with considerable skepticism, chiefly because of the question of safety, and a number of pilot schemes were tried before this approach gained credibility.
Table 2. Ratio of Physicians to Population for Selected Countries

<table>
<thead>
<tr>
<th>Country</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>1: 720</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>1: 15,050</td>
</tr>
<tr>
<td>Chile</td>
<td>1: 2,320</td>
</tr>
<tr>
<td>Colombia</td>
<td>1: 2,180</td>
</tr>
<tr>
<td>Egypt</td>
<td>1: 4,630</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>1: 69,340</td>
</tr>
<tr>
<td>Germany, Fed. Rep.</td>
<td>1: 520</td>
</tr>
<tr>
<td>Guatemala</td>
<td>1: 4,430</td>
</tr>
<tr>
<td>India</td>
<td>1: 4,100</td>
</tr>
<tr>
<td>Indonesia</td>
<td>1: 18,160</td>
</tr>
<tr>
<td>Ivory Coast</td>
<td>1: 15,220</td>
</tr>
<tr>
<td>Kenya</td>
<td>1: 16,300</td>
</tr>
<tr>
<td>Mali</td>
<td>1: 42,770</td>
</tr>
<tr>
<td>Mexico</td>
<td>1: 1,840</td>
</tr>
<tr>
<td>Morocco</td>
<td>1: 13,980</td>
</tr>
<tr>
<td>Nigeria</td>
<td>1: 14,810</td>
</tr>
<tr>
<td>Pakistan</td>
<td>1: 3,920</td>
</tr>
<tr>
<td>Philippines</td>
<td>1: 3,150</td>
</tr>
<tr>
<td>Sweden</td>
<td>1: 620</td>
</tr>
<tr>
<td>Thailand</td>
<td>1: 8,460</td>
</tr>
<tr>
<td>Tunisia</td>
<td>1: 4,770</td>
</tr>
<tr>
<td>Turkey</td>
<td>1: 1,800</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>1: 760</td>
</tr>
<tr>
<td>Zaire</td>
<td>1: 27,950</td>
</tr>
</tbody>
</table>

Source: Health Sector Policy Paper, World Bank, February 1980

The Koyang IUD project (Korea, 1965) proved that nurses could insert IUDs safely and that they were accepted by clients as competent to perform this task. Under the MCH Law of 1973, nurses and midwives who have undergone the two-month government-sponsored training program are authorized to insert IUDs. Between 1974 and 1976 more than 200 paramedical personnel were trained for this function. Perhaps the classic field trial that legitimized widespread use of paramedical personnel was the auxiliary nurse-midwife experiment in Thailand (1969). Midwives who had received some family planning training were permitted to prescribe oral contraceptives without first having the client examined by a physician. There was no increase in the incidence of side effects or complications when midwives gave the pill; moreover, there was a marked increase in the acceptance of pills in the experimental provinces, and midwives' clients had higher continuation rates than women who received the pill from doctors. The findings of this experiment prompted the Thai government (1970) to permit auxiliary nurse-midwives who had received the requisite basic training to prescribe the pill.

The chart on the following page summarizes the extent to which paramedical and auxiliary health workers in selected Asian countries are used to deliver contraceptive services. All of the countries named permit a wide range of personnel to distribute barrier methods and pills, although in general, permission to offer the IUD and the injectable was more restricted. In most parts of the world, sterilization can still only be performed by physicians; however, in Bangladesh, China, Indonesia and Thailand, paramedicals with between six and ten months' training are permitted to perform them.
### Types of Non-physicians Utilized In Service Delivery in National Family Planning Programmes (including private sector) in Selected Asian Countries

<table>
<thead>
<tr>
<th>Country</th>
<th>Methods</th>
<th><strong>Male</strong></th>
<th><strong>Female</strong></th>
<th><strong>MR</strong></th>
<th><strong>Early abortion</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Barrier</strong></td>
<td><strong>Orals</strong></td>
<td><strong>Injectables</strong></td>
<td><strong>IUDs</strong></td>
<td><strong>Sterilization</strong></td>
<td></td>
</tr>
<tr>
<td>Bangladesh</td>
<td>All types</td>
<td>All types</td>
<td>PPMs (2)</td>
<td>Lady Health Visitors +</td>
<td>Lady Health Visitors +</td>
</tr>
<tr>
<td>China, Peoples Republic of</td>
<td>All types</td>
<td>All types</td>
<td>Nurses Midwives Barefoot doctors +</td>
<td>Nurses Midwives Barefoot doctors +</td>
<td>Nurses Midwives Barefoot doctors +</td>
</tr>
<tr>
<td>Hong Kong</td>
<td>Nurses (4)</td>
<td>Nurses</td>
<td>Nurses</td>
<td>Nurses</td>
<td>Nurses</td>
</tr>
<tr>
<td>Indonesia</td>
<td>All types</td>
<td>All types</td>
<td>Midwives Assist midwives</td>
<td>Male PMs</td>
<td></td>
</tr>
<tr>
<td>Japan</td>
<td>Midwives +</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Korea, Republic of</td>
<td>All types</td>
<td>All types</td>
<td>Nurses Midwives (2 mos)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Malaysia</td>
<td>All types</td>
<td>All types</td>
<td>Nurses (under supervision)</td>
<td>Nurses (3 mos)</td>
<td></td>
</tr>
<tr>
<td>Nepal</td>
<td>All types</td>
<td>All types</td>
<td>Nurses (under supervision)</td>
<td>Public Health Nurses (3 mos)</td>
<td></td>
</tr>
<tr>
<td>Philippines</td>
<td>Nurses +</td>
<td>All types</td>
<td>All types</td>
<td>Nurses Midwives (6 wks)</td>
<td></td>
</tr>
<tr>
<td>Singapore</td>
<td>All types</td>
<td>Nurses</td>
<td>Nurses (under supervision)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>All types</td>
<td>Nurses Midwives</td>
<td>AMPs (5)</td>
<td>AMPs</td>
<td></td>
</tr>
<tr>
<td>Thailand</td>
<td>All types</td>
<td>All types</td>
<td>Nurses</td>
<td>Nurses (6 wks)</td>
<td>Male PMs (6 mos)</td>
</tr>
</tbody>
</table>

**Notes:**

1. This chart was adapted from one developed during discussions at the IPPF/IGCC Workshop on Policies and Programmes Utilizing Health and Auxiliary Personnel in the Delivery of Family Planning Services held 13—15 December 1978 at Pattaya, Thailand.
2. Paramedics.
3. Where known the length of the training received is noted in parenthesis.
4. Includes doctors from China not yet licensed to practice who are used as “advisors”.
5. Assistant Medical Practitioners. These are apothecaries who are authorized to practice a limited form of medicare on estates and in rural areas.

**Key:**
- Legal status: + de jure; - de facto.
- Extent of usage of non-physicians: * selected; ** widespread.

**Source:** Inter Government Coordinating Committee, "Report on joint IGCC/IPPF workshop on Policies and Programs for Utilization of Non-Physicians in Delivery of Family Planning Services." December 1978.
Thus the family planning delivery systems of the 1970s have increasingly relied on paramedical personnel to provide nonsurgical contraceptive services and on non-health personnel to serve in outreach capacities -- for example, the use of satisfied acceptors as motivators (Korea, Honduras) and local community/village leaders as contraceptive resupply points (the Profamilia program in Colombia, barrio captains in the Philippines).

The need to make services more accessible plays an important part in the design of World Bank population projects. For instance, the population project in Thailand (1979) provides support for the training of paramedical staff and for an expansion of family planning and rural health services in selected provinces. The project in the Republic of Korea (1979) provides support for the provision of maternal and child health and family planning services through clinics, mobile units, and multipurpose workers.

The most urgent question that arises as a result of the increasing use of workers with limited training is how the delivery of high-quality services at the periphery can be assured. This raises questions of training, supervision, and medical backup.

Training

Program Design: Despite considerable experience of training programs, no formula for a "model" program has emerged. There is, however, fairly broad agreement on certain points that should be considered in designing such programs.

Since training programs in family planning are usually organized on a nationwide scale, some compromise must be reached between a completely standardized curriculum for all trainees and one that can be modified according to regional and local conditions. The need for flexibility is clearly more important in countries characterized by ethnic, religious, or geographic diversity, or by wide variations in educational achievement. Some flexibility is desirable, not only in curricula, but also in the criteria for the selection of trainees.

The question of where training is carried out is important; here again, the best solution seems to be some compromise between centralization and decentralization. In many instances it is neither practical nor desirable to bring trainees to large cities. It is better to train people reasonably close to the places where they will work. In this way the curriculum can be adapted to local conditions and the culture shock often experienced by trainees from rural areas who suddenly find themselves simultaneously confronted with an unfamiliar urban environment and a new course of study can be reduced. Central training institutions are most appropriate for the training of trainers. Since they can afford to use fairly sophisticated training equipment, and also facilitate exchanges of experience and ideas among instructors from different parts of the country. A short spell at a central training institution may also be worthwhile as a second stage of training -- that is, for a refresher course or for training in a particular skill.
It is essential to evaluate any training program. Evaluation necessitates the setting up of ultimate and intermediate goals as well as defining criteria for measuring progress towards these goals. The performance of trainees, and trainers and the content of the curriculum should be periodically reviewed. Care should be taken to ensure that evaluation does not carry an "audit" connotation, since staff and students may regard it as a fault-finding process rather than a feedback device that can be used to improve the training program.

**Curriculum Content:** The length and content of training will vary according to the background of the candidates and the tasks they are to be trained to perform. Those with formal medical training, such as registered nurses and licensed practical nurses, may well require only a primer on basic contraceptive techniques. If sterilization continues to increase in popularity, it is likely that in many countries nurses will be authorized to perform it. Their training will then have to be considerably extended. If lower-level workers are eventually trained to perform sterilizations, their curriculum will have to be modified accordingly. The type of training given to primary health-care workers and traditional birth attendants must also take into consideration their level of literacy.

There is fairly general agreement that the training of family planning workers should include both classroom activity and supervised field experience. In addition to imparting the requisite skills, training programs should also give workers a sense of the importance of family planning so they, in turn, can communicate this to their clients. There is also a consensus that training programs must equip workers to be largely self-reliant, yet at the same time to recognize their limits and to know when to refer a client to the next level of assistance.

An important question is whether a training program should take the form of a full-time course taken before the worker takes up his post, or of informal on-the-job training. It seems that some combination of the two is highly desirable. Training should be continuous. Effective training programs usually provide for some supervised field experience during the full-time course and for later "on the job" refresher training.

**Supervision**

Closely allied to the question of training is that of supervision. In the early family planning delivery systems, the supervisory chain was clearly defined and supervision was fairly close. Doctors supervised nurses, and nurses supervised lower paramedics. Because services were provided outside the clinics and a greater variety of workers were employed, supervision became more difficult and at the same time more important. As the network of service points increased, the supervisory network had to be stretched wider.

Experience indicates that effective supervision is essential if family planning efforts are to be successful, particularly where much
use is made of lower grades of personnel. To offset the shortage of medical manpower in rural areas, Malaysia inaugurated in 1972 a program to train traditional birth attendants (TBAs) to provide oral contraceptives. In view of the low literacy of the TBAs and the minimal training (three weeks), Malaysian officials were keenly aware of need for effective supervision. A system was devised whereby TBAs pay monthly visits to the National Family Planning Board's local clinic. During these visits nurses review the records of the TBAs and advise them on their problems. Since the TBAs receive their monthly stipend at these sessions, attendance presents no serious problem. The successful use of auxiliary nurse midwives in Thailand is largely due to effective supervision.

On the other hand, the disappointing achievements of the programs in Pakistan and India can be attributed, at least in part, to poor worker performance which to some extent reflects deficiencies of supervision. An evaluation of the continuous motivation system in Pakistan pointed out that the supervisors lacked training and experience. They were not provided with adequate job descriptions, and thus had no clear idea of their responsibilities. Furthermore, they lacked authority to take action or to make changes. An analysis of the family planning program in Uttar Pradesh (India) found supervision deficient in both quantity and quality. A survey of primary health center staff revealed that, in 13 of the 45 health centers, the medical officers had never inspected the field operations for which the PHC was responsible. It was observed that the frequency of supervisory visits decreased as the distance from headquarters increased.

Forty percent of the family planning health assistants, 33% of the auxiliary nurse midwives, and 48% of the Family Welfare Workers reported that their immediate supervisors never expressed either satisfaction or dissatisfaction with their work. The workers soon realized that their performance was judged solely by the number of acceptors they recruited. Faced with the threat of dismissal if they failed to meet their acceptor quotas, they concentrated on enrolling acceptors and paid little attention to ensuring that they continued to practice family planning. The Uttar Pradesh study found that there was considerable discord among the supervisors themselves because of ill-defined lines of authority. Furthermore, more than 25% of the supervisors felt powerless to induce those under their supervision to do a better job.

At present a number of pilot projects are addressing the question of the degree of supervision appropriate in various situations. The "Botika sa Nayon" (village pharmacies) project in Philippines, through which "over the counter" drugs and nonclinical contraceptives are being made more readily available in remote areas, is evaluating the supervisory role of the registered pharmacist. Under the present scheme, supervision is fairly intensive, so that the number of village pharmacies that can be opened is limited. The project is, in essence, investigating whether supervision can be made less intensive so that it can be made more extensive. It is trying to ascertain whether better training of the laymen who operate the "Botika" could reduce the need for close supervision. If so, it is likely that the number of village pharmacies could be increased, making supplies available in areas that previously lacked them.
As a more diverse mix of workers is used to bring family planning services to the periphery, effective supervision will continue to be a key issue. Experience suggests the following criteria for effective supervision: supervision should be regular; it should take place in the field; it should be viewed as a feedback system and not simply as a performance audit; supervisors should be appropriately trained and should possess authority commensurate with their position. It is likely that the lines of supervision may become more difficult to define, given the wide range of "community workers," representing various agencies, who will be delivering services. It will be necessary for the community to see that there is a responsible supervisory network.

Medical Backup

As family planning services become more readily available in outlying areas, particularly if lower grade paramedicals are permitted to perform sterilizations, adequate medical backup will become even more important. At the outset, the use of persons other than physicians to provide family planning was hampered by the notion that services provided by lower grade personnel were necessarily "inferior." This perception still lingers among both policymakers and target groups. To create confidence in the system, it is necessary to assure that there will be sufficient medical backup to handle the medical complications associated with any particular family planning method.

It is not easy, however, to put this principle into practice. As family planning services are extended further into outlying areas, it becomes necessary to extend the health infrastructure in order to supervise them and to treat complications. The situation has, in a sense, come full circle. The justification for using first, paramedicals, and then lower grades of worker to deliver family planning services was the scarcity of doctors, and their reluctance to work in rural areas. Although doctors are no longer called on to provide services, they are necessary for supervision and backup. The proliferation of services at the periphery has placed a different set of demands on the center.

The medical backup system for complications arising from contraception will for the most part coincide with the normal health referral system. Thus it will be necessary to evaluate the referral system and to improve it as requested. In many countries the operation referral system is unsatisfactory. In order not to overload it with family planning cases, it is desirable to introduce a system to sort out those who really need the services of a physician. In Indonesia, the first recourse of a user who experiences difficulties is to the voluntary community-based contraceptive distributor; if he cannot solve the problem, the client is referred, first to the family planning clinic in the district health center, and then "up the line" as necessary through the provincial hospital to the top referral hospital.

The logistic system for drugs and supplies is part of the medical backup system. If family planning services are to be delivered in outlying
areas, an adequate supply of contraceptives and drugs must be available at local dispensaries and to itinerant paramedicals. Indeed, one of the reasons the referral system does not work in many countries is the lack of supplies at local first line health units. This lack of drugs and consequent limitation of services prompts clients to regard district hospitals as the normal point of access to the health system.

The above discussion has explored a number of important issues related to the delivery of family planning services. While program evaluation can hardly be considered an "issue," it is nevertheless closely related to the issues discussed. By now the need for evaluation is well recognized and most family planning programs include some provision for the evaluation of both their routine operational aspects and their long range impact on fertility. Although a number of technological and methodological problems still exist, many countries have considerably improved their data collection capacities.

To the extent that there is an evaluation issue, it centers on the use of the results of evaluation. The rationale for evaluation is to assess whether a program is achieving its objectives. It should identify factors that contribute to success as well as those that impede progress. As with supervision, it is essential that evaluation be regarded as a means of improving management rather than simply as a performance audit. Since the underlying purpose of evaluation is the improvement of programs, the results must be communicated to program managers at all levels. In many family planning programs this "feedback" has been weak. As was noted earlier, the management information and evaluation system in Indonesia has enabled administrators to identify "trouble spots" at an early stage and to take appropriate action. As family planning programs become more closely linked to other programs and as day-to-day responsibility is shifted to the community, evaluation will become more essential.

CONCLUSIONS

This study has attempted to summarize recent trends in population policy and to examine some of the major administrative problems likely to be encountered in the delivery of family planning services in the next few years. By the time the World Population Conference convened in Bucharest in 1974, the interdependence of population policy and general development policy had already been recognized, and delivery systems for family planning services were already much more sophisticated than the rudimentary systems of earlier years. Nevertheless, at Bucharest much greater political attention was focused on the problem. The stress laid on the idea that development along the right lines is itself a potent influence on fertility behavior did not lead to an abandonment of planning programs. It led to an understanding that these programs are more likely to be successful when conducted in the context of successful social and economic development. That family planning can be linked to other developmental activities or pursued as a human right gave it some legitimacy in countries where it was
still a sensitive issue because of religious or political opposition. Furthermore, by focusing attention on population problems, the Conference stimulated interest in population research. Although development itself reduces fertility, many countries with severe population problems realize that development at the rate currently feasible will take a long time to have an appreciable effect on fertility behavior, and so have intensified their family planning efforts. On the other hand, there now is widespread recognition that family planning alone is not enough to reduce fertility sharply.

In recent years there have been growing attempts to provide family planning services through channels other than physician-staffed clinics. Relying on community participation and local community workers, these channels make appropriate training and supervision an important administrative concern. Such training and supervision may become more difficult as a wider range of channels is used to deliver services and lines of authority become blurred. If family planning is not the main concern of the managers, management is likely to be less efficient, and the coordination of the different sectors presents a serious problem. Evaluation becomes more problematic because it is more difficult to disentangle the effect of the various channels of approach.

Finally, medical backup will be a key consideration in the next few years. Although delivery systems are become more deeply rooted in the sociopolitical network, and the health ministries are increasingly relegated to an advisory role, the methods gaining in importance are medical -- sterilization and abortion. Even if lower grade paramedicals are eventually authorized to perform sterilizations, competent medical assistance will have to be within reach.
Footnotes


4/ Years of plan period.


6/ By that time it was widely apparent that family planning programs in themselves were not the solution to the population problem: both India and Pakistan had long-standing programs with relatively little impact on fertility. On the other hand, the achievement of a certain level of economic growth was no guarantee that fertility would decline: for example, there was little evidence of fertility decline at that time in Mexico. Indeed, the evidence then available indicated that "success" required both an effective family planning program and the attainment of a certain threshold of development as it was apparently doing in Korea and Taiwan. Subsequent analysis by Mauldin and Berelson lends further weight to the conclusion. (cf. Studies in Family Planning, May 1978).

7/ See To Promote Human Welfare and Development: A Digest of the Basic Documents Prepared for the World Population Conference (United Nations, New York, 1974). This provides an excellent review of the events and conferences that took place as part of the preparation for World Population Year and the central event of that year, the conference at Bucharest.

8/ The Indonesian program is discussed in detail in Part II of this review.

9/ Some of these functional aspects are treated below in connection with other issues.

10/ Also, in many countries the health network was not sufficiently developed to absorb this activity.
11/ It should be noted, however, that the PFPB directly sponsors a number of what might be termed "development-cum-family planning" projects outside the MOH.


15/ In most of Asia the ratio of doctors to population is five times higher in urban than in rural areas. (IPPF, IGCC Workshop, Kuala Lumpur, Malaysia, 1978).

16/ A checklist was used to screen clients for possible conditions that would contraindicate the use of the pill.

17/ Follow-up options range from bringing "graduates" back for a brief course (few days to one week) to up-date and refresh their skills to distributing cassettes that they can use on their own.


19/ George B. Simmons, Ruth S. Simmons, B. J. Mesra, and Ali Ashrof, Organization for Change: A System Analysis of Family Planning in Rural India (Ann Arbor: University of Michigan School of Public Health).

20/ The Botika sa Nayon is a village pharmacy set up as an extension of the pharmacy in the town and it is under the direct control of that registered pharmacist. While there has been a high utilization of the existing Botikas, expansion has been slow because of the stringent supervisory requirements.

21/ Given the length of time that must elapse before changes in fertility are perceptible, intermediate measures such as number of acceptors and continuation of use are employed to estimate the achievements of the program.
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<thead>
<tr>
<th>No.</th>
<th>TITLE OF PAPER</th>
<th>AUTHOR</th>
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<td>R. Chambers (consultant)</td>
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<td>401</td>
<td>Levels of Poverty: Policy and Change</td>
<td>A. Sen (consultant)</td>
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<td>Education and Income</td>
<td>T. King, D. Jamison, A. Berry (consultant), M.J. Bowman (consultant), G. Fields (consultant), L. Lau (consultant), M. Lockheed (consultant), G. Psacharopoulos (consultant)</td>
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