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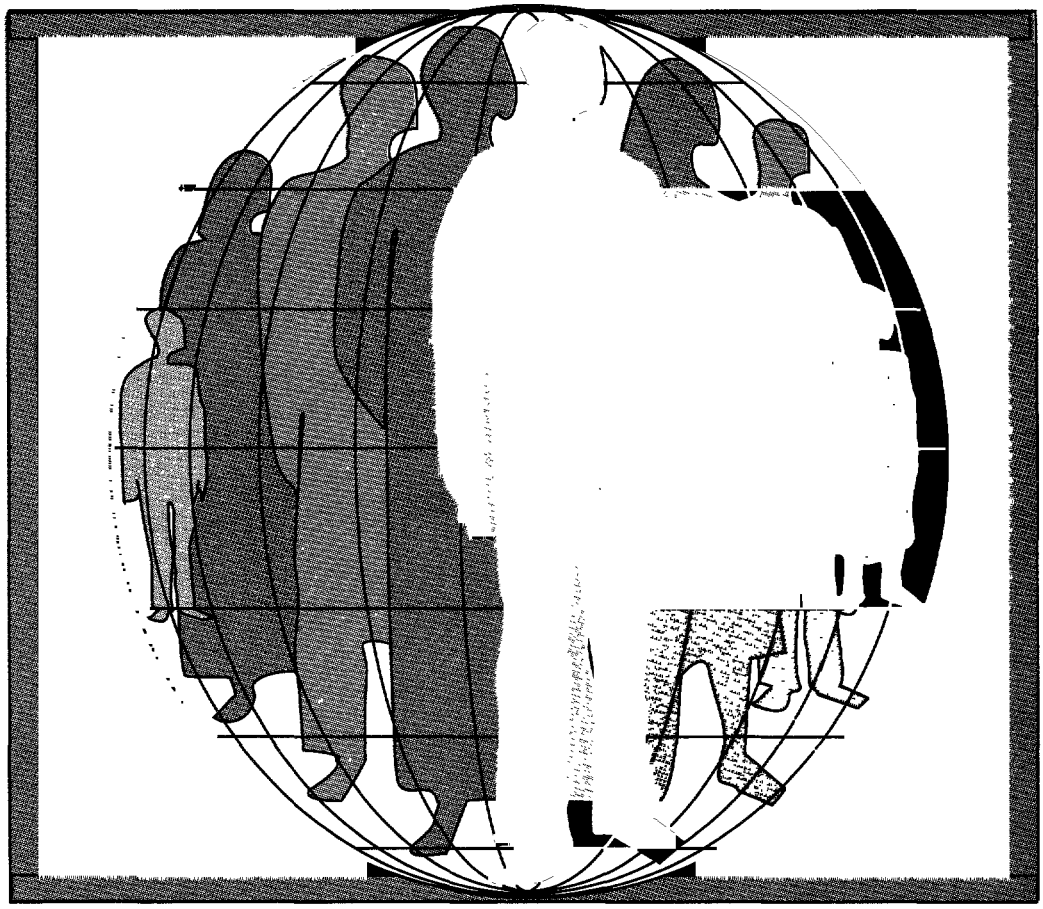
IMPLICATIONS FROM EIGHT CASE STUDIES



Operations Evaluation Department

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Population and the World Bank

IMPLICATIONS FROM EIGHT CASE STUDIES

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Operations Evaluation Department
The World Bank
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Foreword

This is the first assessment that the Operations and Evaluation Department has undertaken of the Bank's role in the population field. It differs from evaluations undertaken by others over the past 25 years in that it is based on a series of detailed case studies of experiences in individual countries. This allows the authors more scope to investigate reasons for decisions and outcomes, and it provides a more solid foundation on which to build a picture of what can be done to improve performance in this area.

The study begins by reviewing and assessing developments in eight countries, in each case asking how demographic and related social and economic developments unfolded during the last 20-25 years and what role the government, other donors, and the Bank played during this period. It tries to bring the picture up to date, asking whether recent changes in Bank approach adequately take the lessons of earlier experience into account. Using these materials as a starting point, the last section discusses major issues of concern to the Bank that have implications for its future efforts in this field.

The picture that emerges is one of considerable diversity of activities and experiences, from which it is not easy to generalize. The presentation tries to give some feel for this diversity without overburdening the reader. Nevertheless, the study offers concrete suggestions for a shift in emphasis that should make the Bank's future population activities more effective.

The study was written by Ronald Ridker of the OED with substantial contributions from Ronald Freedman. It is based on a set of detailed case studies prepared by consultants working under Mr. Ridker's direction: Ronald Freedman (Indonesia), Jay Satia (India). James Phillips (Bangladesh), Warren Robinson (Kenya), Sara Seims (Senegal), and Thomas Merrick (Colombia, Brazil, and Mexico). John Kantner provided valuable comments, especially on the India case study. The major sources for these studies were Bank documents, both published and internal, non-Bank studies and reports, field visits, and interviews with government officials and the staffs of both the Bank and other donor organizations. Governments of all countries included in this study have had an opportunity to comment. This study, plus two of the case studies, have been distributed to and discussed by the Bank's Executive Directors; all three are presented in this document.

Yves Rovani
Director General
Operations Evaluation
February 1992

Prologo

Esta es la primera evaluación que realiza el Departamento de Evaluación de Operaciones sobre la función del Banco en el sector de población. Difiere de otras evaluaciones efectuadas en los últimos 25 años en que se sustenta en una serie de estudios detallados de casos prácticos en determinados países. Esto permite a los autores un mayor campo de acción para investigar las razones en cuanto a decisiones y resultados, y proporciona una base más sólida para establecer una visión de conjunto de lo que puede hacerse a fin de mejorar el desempeño en esta esfera.

El estudio comienza por examinar y evaluar los cambios demográficos y socioeconómicos conexos que se han producido en ocho países en los últimos 20 a 25 años y la función que han desempeñado los gobiernos, otros donantes y el Banco en este período. Se intenta actualizar esta visión general, y se plantea el interrogante de si los últimos cambios en el enfoque empleado por el Banco toman en cuenta en forma adecuada las enseñanzas derivadas de experiencias anteriores. Utilizando esta información como punto de partida, en la última sección se analizan los principales temas que revisten interés para el Banco y que tienen repercusiones en sus programas futuros en este ámbito.

El panorama resultante es de una considerable diversidad de actividades y experiencias que hace difícil llegar a una generalización. La presentación trata de dar una idea de esta diversidad sin abrumar al lector. Sin embargo, el estudio ofrece sugerencias concretas para un cambio de orientación en las actividades futuras del Banco en materia de población, lo que redundará en una mayor eficacia de dichas actividades.

El estudio fue preparado por Ronald Ridker del Departamento de Evaluación de Operaciones, con la importante colaboración de Ronald Freedman. Se basa en un conjunto de estudios detallados de casos prácticos preparados por consultores bajo la dirección del Sr. Ridker: Ronald Freedman (Indonesia), Jay Satia (India), James Phillips (Bangladesh), Warren Robinson (Kenya), Sara Seims (Senegal) y Thomas Merrick (Colombia, Brasil y México). John Kantner proporcionó valiosos comentarios, en especial sobre el estudio de casos de la India. La principal fuente de información de estos estudios fueron los documentos del Banco, tanto publicados como internos, estudios e informes ajenos al Banco, visitas en el terreno y entrevistas con funcionarios de gobierno y del Banco y de otros organismos donantes. Los gobiernos de todos los países incluidos en este estudio han tenido la oportunidad de formular comentarios. Este estudio, más dos de los estudios de casos prácticos, se han distribuido a los Directores Ejecutivos del Banco quienes los han examinado; los tres se presentan en este documento.

Yves Rovani
Director General
Departamento de Evaluación de Operaciones
Febrero de 1992

Avant-Propos

C'est la première fois que le Département de l'évaluation rétrospective des opérations (OED) entreprend d'étudier le rôle joué par la Banque dans le domaine de la population. Cette étude diffère de celles qui ont été effectuées ailleurs au cours des 25 dernières années en ce sens qu'elle se fonde sur une série de monographies détaillées consacrées à divers pays. Les auteurs ont eu ainsi plus de latitude pour examiner les raisons qui sont à l'origine des décisions et de leurs conséquences. Le résultat obtenu constitue une base de départ plus solide pour la recherche des moyens d'améliorer les programmes de population.

L'étude commence par un tour d'horizon et une analyse de la manière dont la situation a évolué dans huit pays. Les auteurs ont suivi le déroulement des événements dans les domaines démographique, social et économique au cours des 20 à 25 dernières années, et le rôle joué par les autorités nationales, les autres bailleurs de fonds et la Banque pendant cette période. Ils ont tenté de donner un aperçu de la situation actuelle en se demandant si les changements apportés récemment à l'approche de la Banque tiennent compte comme il convient de l'expérience acquise. A partir de cela, la dernière partie analyse les principales questions qui se posent à la Banque dans l'optique de ses interventions futures.

Il apparaît que les activités et les résultats présentent une diversité considérable, si bien qu'il est malaisé de tirer des conclusions générales. Les auteurs se sont efforcés de dépeindre cette diversité sans lasser le lecteur. Ils proposent toutefois des suggestions concrètes en vue d'infléchir l'action de la Banque et d'accroître son efficacité future.

L'étude a été établie par Ronald Ridker, de l'OED, qui a bénéficié d'un apport substantiel de Ronald Freedman. Les monographies détaillées sur lesquelles elle s'appuie ont été rédigées par des consultants dirigés par M. Ridker. Ce sont: Ronald Freedman (Indonésie), Jay Satia (Inde), James Phillips (Bangladesh), Warren Robinson (Kenya), Sara Seims (Sénégal) et Thomas Merrick (Colombie, Brésil et Mexique). John Kantner a présenté des observations précieuses, particulièrement sur le cas de l'Inde. Les principales sources utilisées sont des documents internes et des publications de la Banque, des études et des rapports externes, des observations sur le terrain et des entretiens avec des membres du gouvernement intéressé et des agents de la Banque et d'autres organisations donatrices. Les gouvernements intéressés ont tous eu la possibilité de formuler leurs observations. La présente étude, ainsi que deux des monographies, qui sont incluses dans ce document, ont été distribuées aux Administrateurs de la Banque et examinées par eux.

Yves Rovani
Directeur général
Evaluation rétrospective
des opérations
Février 1992

Contents

Acronyms

ADB	Asia Development Bank
ASCOFAME	Association of Colombian Medical Schools
BAPPENAS	Indonesia National Development Planning Agency
BEMFAM	Brazil's IPPF affiliate
BFS	Bangladesh Fertility Survey
BKKBN	Indonesian National Family Planning Program
BR	Crude birth rate (total live births per 1,000 population)
CONAPOP	National Population Commission of Senegal
CPR	Contraceptive prevalence rate (percent of married couples in reproductive age group using some means of contraception)
DHS	Demographic and health surveys
DR	Crude death rate (total deaths excluding stillborn per 1,000 population)
FP	Family planning
GDP	Gross domestic product
GOB	Government of Bangladesh
GOK	Government of Kenya
HRD	Human resources development
IDA	International Development Association
IEC	Information, education, and communication
IFS	International financial statistics
INPRES	Indonesia National subsidy for local governments
IPPF	International Planned Parenthood Federation
KAPS	Knowledge aptitude and practice survey
KDHS	Kenya Demographic Health Survey
LDC	Less-developed country
MCH	Maternal and child health
MIES	Management information and evaluation system
MIS	Management information service
MOH	Ministry of Health
MOHFW	Bangladesh Ministry of Health and Family Welfare (formerly Ministry of Health and Family Planning)
MOHPP	Bangladesh Ministry of Health and Population Planning
MSD	Ministry of Social Development
NCPD	National Council on Population and Development of Kenya
NICIPS	National Indonesia Contraceptive Prevalence Survey
NGO	Non-governmental organization
NPCC	Bangladesh National Population Control Council
NPFP	National Program in Family Planning
NRR	Net reproductive rate
OECD	Organization for Economic Cooperation and Development
OED	Operations Evaluation Department
ORG	Operations Research Group, Baroda, India
PAIP	Population Action and Investment Plan
PCR	Project completion report
PHC	Primary health center
PHN	Population, health and nutrition
PHR	Population & human resources
PPAR	Project performance audit report
PROFAMILIA	Colombia's IPPF affiliate
REPELITA	Five-Year Development Plan
RMB	Resident Mission in Bangladesh
SMP	Social Marketing Project

TFR	Total fertility rate (number of live births per woman expected over a women's lifetime if her child-bearing experience at each age is the same as that of existing women at various ages)
UNESCAP	United Nations Economic and Social Commission for Asia and the Pacific
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCDC	Village contraceptive distribution centers
WHO	World Health Organization
WID	Women in Development

Executive Summary

This study examines the Bank's activities in the population sector by reviewing its role in eight countries. For each country, it begins by asking what demographic and related socioeconomic changes have occurred since 1968, when the Bank announced that it would begin lending for this sector. It also asks what government policies affecting these trends were instituted and what role was played by the Bank vis-à-vis other donors during this period. The conclusions reached are based on field visits, interviews, and a review of operations documents and literature.

The picture that emerges is one of considerable diversity of activities and experiences, from which it is not easy to generalize. Leaving this diversity and the qualifications aside for the moment, the study's overall conclusion is that, after slow, halting, and sometimes faulty starts, the Bank has become progressively more effective in this field, though it could have done and achieved more. From this point onward—assuming forceful and consistent implementation of recent changes in the Bank's mode of operating in this sector—most of what is required to effect the desired demographic changes implicit in Bank sector policy involves re-orientations and shifts in emphasis rather than radical departures from recent practices and levels of funding.

Demographic and Socioeconomic Trends

Total fertility rates (TFRs) have declined in all case study countries: marginally in Senegal; 20 percent of the distance between the peak level of eight children per woman to a replacement level of 2.1 in Kenya; 40 percent in Bangladesh; 50 percent in India; 60 percent in Indonesia; and more than 70 percent in Brazil, Colombia, and Mexico. This news is particularly encouraging in the case of Bangladesh and Kenya where, until very recently, there has been little to show for the efforts that have been made over the last 20 years to reduce population growth rates. Mortality rates, infant and child mortality in particular, have also declined substantially—in the Latin countries, by about 50 percent since 1960. However, fertility, mortality, and population growth rates remain high by most standards, especially in Asia and Africa. Given the very young age structure of these countries, plus present rates of change in fertility and mortality, their population growth rates are likely to remain near or above 2 percent per year for some time to come.

Between two thirds and three fourths of this fertility decline has been due to increased use of modern contraceptive methods. Most of the remainder of the decline is accounted for by increasing age of marriage. These changes, in turn, have resulted from a combination of improvements in social and economic characteristics favoring smaller families and later age of marriage. These include, for example, improvements in the educational, employment, and social status of women; declines in infant mortality; decreasing opportunities for child labor; and decreasing dependence on children for old age security. They also include family planning (FP) programs which endeavor to make modern contraceptives readily available and provide information and education about them.

In the three Latin countries, both factors—significant improvements in these social and economic indicators and sizeable and effective family planning services, in these cases provided by non-governmental organizations (NGOs), quasi-public organizations, and commercial channels—have combined to bring about the observed demographic changes. Indonesia has also experienced sizeable social and economic improvements, but remains a more rural, traditional society with higher maternal and child mortality rates. Its government-sponsored family planning program has compensated for this difference in a variety of ways. Perhaps the most important of these is the large and effective network of outreach workers extending down to the smallest village. The Indian program has also compensated for even more modest social and economic progress, but in

a different way: by focusing quite narrowly but effectively on sterilization. Its program, however, has been set back at times by political backlash resulting from periodic coercive campaigns. Because of its success in reaching a large fraction of couples desiring to terminate the reproductive phase of their lives, the Indian program is now reaching a point of diminishing returns. The Kenyan case is interesting because the substantial social and economic progress of the last 25 years seems to have built up a pool of latent demand for limiting family size which has not become operative until very recently. A long period of program development which has finally reached a critical threshold of effectiveness, plus active encouragement from the President and other major leaders, finally appears to be making a difference. Senegal provides an example of a country with too little social and economic development and too little program development to have a significant impact on fertility.

The Bangladesh case is particularly interesting because there has been substantial program development but very little social and economic progress—an almost classic case in which a supply side approach was utilized in a situation in which one would not expect to find much demand. Sufficient latent demand must have been present even here, however, to lead to the contraceptive prevalence and fertility decline that have occurred so far. Just how much longer progress can continue in the absence of significant structural changes that affect demand is an open question.[1] The paper considers several possible explanations and calls for an investigation. Such research is important for the future of the Bangladesh program and also for what it might say about appropriate programs for countries with similar circumstances.

The Bank's Role in Individual Countries

Indonesia. While the Bank has provided quite substantial financial assistance to Indonesia's overall development effort, lending for population has amounted to just 1 percent of the total. This amount has contributed about 10 percent to the total expenditures of the Government on its population program. Other donors, including NGOs, have contributed another 20 percent. In providing these funds, the Bank played a fairly traditional role, in the sense that it operated more as a bank than as a development institution. That is, by and large, it reacted to project proposals submitted to it by the Indonesian authorities in an "arms-length"-fashion; provided little in the way of technical assistance in the preparation or implemention of projects in this field; and within projects, focused on providing civil works and hardware. The Bank did help develop and support a major population education program. In other software areas however, it tended to support implementation of projects developed by the Indonesian National Family Planning Program (BKKBN) with the technical assistance of other donors. For most of the period covered, there was no resident technical staff member responsible for this sector and sector work was limited.

Except perhaps for the first few years of its involvement with the program, the Bank's approach was perfectly appropriate. The Indonesian authorities knew what they wanted and proved to be good at implementation. Indeed, the BKKBN is commonly considered one of the most effective family planning organizations in the world. Other donors—in particular, the United States Agency for International Development (USAID)—were very active in developing operational policies and implementation tactics. This proved to be a good *de facto* division of labor which was well-appreciated by the Indonesian authorities.

The report discusses five areas in which the Bank might have done more or operated differently in Indonesia. (1) A Bank specialist resident in the country for a longer period of time and with a mandate to become actively involved in program development and implementation would have been useful. (2) Cooperation and collaboration with other donors could have been better during the first 15 years of Bank participation. Since then, this aspect of the program has improved substantially. (3) The Bank could have encouraged earlier and stronger initiatives in the health sector, especially by more forcefully promoting maternal and child health (MCH) and its integration with family planning. It is just now beginning to do this. (4) The Bank could have encouraged the development of non-family planning strategies to enhance demand for smaller families, for example, by helping develop projects aimed at improving women's educational and employment opportunities. Substantially more effort is still needed in this area. (5) Research and evaluation continues to need strengthening for at least two reasons: to extract lessons from this successful case for use elsewhere[2] and to build research and evaluation capacity into BKKBN where this function has been neglected.

Improvements in these areas were obviously not required, however, for the substantial progress that has been made so far. Moreover, Bank efforts in these spheres might have been resisted by BKKBN and other donors who pre-

1. This way of stating things implicitly classifies information, education, and communications (IEC) programs as being a part of a family planning program; that is, a supply-side measure. The idea behind this is that while IEC can disseminate information and encourage demand, there must be some proclivity already present—some latent demand created by more fundamental cultural, social, or economic forces—for these efforts to work on.

2. For example, what factors explain this country's successful community-based operations? Are they unique to Indonesia, or can they be applied to assist other countries?

ferred the Bank to focus mainly on provision of resources for buildings and equipment. The Bank responded specifically to the client's desires, and in this case, it was the right response, because of the considerable capacity of the client and the assistance of other donors.

In Indonesia, the future may require different approaches from those of the past in three important respects. First, there is much less need for massive infrastructure programs. Second, USAID has signaled its intention to scale back its inputs, in part because it believes Indonesia now needs less technical assistance and grant funds. BKKBN, with USAID assistance, has responded by establishing programs to promote private marketing and service delivery. Third, the formula that has worked to bring fertility down from 5.5 to 3.5 children per woman may not work to lower it further to a replacement level of 2.1. The Bank could adjust to these changes by scaling back its activities as USAID is doing or by trying to fill the gap left by USAID. The report suggests that, depending on the issue, both approaches are needed.

India. As in Indonesia, until recently, the Bank has performed more like a traditional bank in India than a development institution. In this case, however, this role was much less appropriate because of strategic problems with the program. These problems include: excessive focus on sterilization, which ignores younger couples' needs for spacing and (as noted above) is running into diminishing returns; insufficient attention to program operations and quality (as opposed to program expansion); excessive centralization and reliance on a single delivery system; and neglect of factors that can influence demand. These problems have persisted and been recognized for at least as long as the Bank has been involved in the Indian program.

The Bank's failure to have a significant influence on the Indian program is attributable to a variety of factors. (1) The Bank's first population project in India started in 1972, long after the country's approach was firmly entrenched. (2) While the amounts lent constituted 28 percent of the Bank's entire population portfolio up to 1988, these sums represented a small fraction—3.6 percent between 1980 and 1988—of total expenditures on India's Family Welfare Program. All donors together contributed 12–14 percent of government expenditures but have never formed themselves into an effective coalition. (3) The nature of the first five projects, called area projects, inhibited the Bank from becoming involved in policy issues lying outside these (geographical) areas and discouraged experimental innovations even within those areas.[3] (4) Both sector work and staff inputs into the program have been inadequate. Prior to 1988, little sector work was done—certainly not enough to provide the Bank with a basis for proposing tactical changes, for example, suggesting just how the program could change its incentive, monitoring, and accountability structure to give more weight to non-terminal methods. Nor were there sufficient staff inputs—not in residence and also not in Washington—to do much more than pursue an arms-length approach.

Since 1987, several significant changes have occurred. Both the Government and the Bank appear to have become disappointed with results of the area projects and are willing to try a different approach. The sixth and seventh projects, started in 1989 and 1990, reflect this through their focus on priority program components at the state level. They also include support for NGOs and social marketing. Second, since 1987, several good pieces of sector work have been produced which appear to be having an effect on Indian thinking and the nature of the dialogue. The proposed Child Survival and Safe Motherhood Project for the first time focuses major attention on health issues of importance for influencing fertility decisions. It also includes more detailed attention to field-level operations, which in the past have proven a major bottleneck to implementing policy changes. Finally, Bank efforts in the education field—paying particular attention to women—have increased substantially.

While these are all promising initiatives, much will depend on how forcefully and consistently they are pursued. The Bank will have to continue producing sector work and research aimed at developing practical ways to resolve structural problems; continue arguing—forcefully when necessary—for the application of the results of such work; put more effort into enlisting the help of other donors in this process; and increase the amount of time and effort devoted to supervision of field-level operations. All this is likely to require more inputs by staff conversant with the substantive issues, both at headquarters and in the field.

Bangladesh. The Bangladesh program suffers from many of the same weaknesses as the India program. While there has been less focus on sterilizations, the quality of family planning services is poor, the MCH program is weak and not well- integrated with family planning, and scarce managerial talent plus ingrained administrative patterns make improvements difficult. In addition, of course, the program operates in an extremely difficult physical environment in which periodic crises which require priority constantly threaten to wipe out progress.

Nevertheless, most of the progress achieved in increasing contraceptive prevalence and reducing fertility is attrib-

3. This is a disputable point. The original argument for this approach was that the Bank would have more influence within these areas than it could have in the overall program. It is more likely that it did not happen this way, not because the concept was wrong, but because it was never accepted on the Indian side that Bank-supported areas could be different from others, and because the Bank never took the initiative to develop detailed designs for these projects that would have spelled this point out prior to implementation.

utable to program inputs. The outreach program, which is more extensive and active than that in India despite its limitations, is probably the feature that makes the difference. In addition, donors have played a more intensive and active role in both planning and operations; in effect, expanding the Government's implementation capacity many-fold. The Bank, which in this case has played an active, leading role, deserves considerable credit.

The report lists seven factors that appear to have been critical. (1) The Government is clearly committed to solving its population problem; has devoted a sizeable percentage of its limited budget and managerial talent to the program; and has actively requested and utilized foreign assistance and advice. (2) The magnitude of foreign financial and technical assistance has been substantial. (3) A considerable amount of the financial assistance, even within the five Bank-assisted population projects so far agreed to, has been in the form of grants provided by co-financiers. This has allowed more flexibility and greater focus on software components and has helped pay for additional Bank staff inputs, both at headquarters and in the field. (4) With these additional staff inputs and with the encouragement of the Government, the Bank has played an active role in all phases of these projects—design, fund-raising, donor coordination, implementation, and evaluation—far more active than is typical in Bank- assisted projects. (5) Collaboration amongst donors has been substantial and co-financiers, who have typically provided more than half the funds in these projects, have played an increasingly active role. Their involvement has now reached the stage where the fourth project can be described more accurately as a consortium project than a Bank project. (6) With the help of the grant funds, flexibility has been built into the program by, among other things, establishing an "Innovative Projects Fund"and a "Project Finance Cell."(7) Advantage has been taken of findings from pilot projects to improve program performance.

In this case, there are reasons to believe that program efforts should continue along present lines for the next few years. Surveys indicate the existence of a pool of potential users who have not yet been reached and evidence that prevalence is higher where density of service points is greater, where frequency of contacts with family planning workers is greater, and where better-quality services are provided. However, even if prevalence is increased from its current level of 35 to the 50 percent level obtained in the Matlab pilot area—very unlikely on a national scale—the total fertility rate would be about 3.7, still well above replacement. To achieve lower levels in a reasonable period, a change in program directions to include more than the supply-oriented approach currently in use is likely to be needed. While desired family size appears to have decreased in Bangladesh even without significant social and economic improvements, further declines would be more certain and more rapid if structural changes could be achieved that enhance the demand for smaller families.

Brazil, Colombia, and Mexico. In contrast to other countries, these countries received only a small part of their expenditures on family planning from external sources, and most of that was provided by NGOs rather than multilateral or bilateral agencies.[4] Bank inputs were minimal. There have been no Bank- financed population projects in these countries. (One was prepared for Mexico, but was withdrawn when a new government came to power.) Little was done to implement the few family planning subcomponents included with MCH in Bank-funded health projects, and policy dialogue seldom raised the topic. At least up to 1989, there has been very little sector work focused directly on population or family planning. In addition, lending to other sectors, while it undoubtedly has had some indirect impacts, was never undertaken with demographic considerations in mind.

Three factors appear to account for this apparent neglect. (1) Political sensitivities about "population control"policies of foreigners made it difficult for Bank staff to broach the topic with governments. These governments viewed Bank management as holding an unacceptable view and Bank staff, caught in the middle, reacted by doing little. (2) By the time the Bank began lending for health services, which might have provided a more acceptable approach to FP, contraceptive prevalence was already comparatively high and the structure of service delivery well-established. (3) The lead agencies in these countries were NGOs or semi-public agencies. Given government attitudes, the Bank lacked a way (unlike USAID) to work directly with these agencies or even to work indirectly with them, as it has found in Kenya and elsewhere.

The Bank's current approach in Latin America is to focus on reproductive health and safe motherhood as the rationale for family planning. This seems to be appropriate. A more aggressive approach is unwarranted and politically unwise. However, important issues of equity, service quality, and choice remain and are, in any case, part of a broader set of issues the Bank is working on in the health sector.[5]

These Latin American cases are important because they bring to the fore questions about the rationale of Bank lending for population. If the Bank wants to work in countries that do not accept population control as the rationale, it must base its population program on a broader and more flexible set of principles. This could start from a recognition

4. Some international NGOs, however, have been supported from bilateral and multilateral sources; in particular, USAID and United Nations Fund for Population Activites (UNFPA).

5. One dimension of such issues is the very high numbers of illegally-induced abortions in these countries. See Singh and Wolf, 1991.

that the overall objective is promotion of sustainable improvements in living standards, and that family planning programs assist at the micro level—by improving family health and choice—as well as at the macro level. In this context, these programs are appropriate topics for policy dialogue and sector analysis to determine how, if at all, they should be developed and used in specific circumstances. In addition, these cases raise questions about the advisability in some circumstances of lending for free-standing population projects, as opposed to health projects that include family planning components. Had this approach been used earlier and more consistently, the Bank may not have faced so much opposition and suspicion of its motives in these countries.

Kenya. This case study provides a good illustration of the virtue of—and need for—patience and perseverance in the population field. While donor efforts to persuade the Government to establish a major program have been substantial since the late 1960s, it was only in 1988-89 that clear evidence of the beginnings of a fertility decline began to emerge.

Besides supporting general economic development that included substantial education funding, the Bank's inputs have proceeded along two general lines. Starting in 1974, four projects have been funded. The first two provided funds to the Ministry of Health (MOH) to establish a network of rural health facilities and training schools; family planning components in these projects were weak and largely ignored during implementation. During this period, the population growth rate actually increased. The third and fourth projects have had more substantial components related to population and family planning, but were initiated too late (1988 and 1990) to have influenced the change in fertility trends. The second strand of Bank inputs has involved policy dialogue, sector work, and efforts to influence the evolution of the program in a variety of ways. Examples of the latter included successful efforts to persuade the Government to establish an inter-ministerial coordinating agency for population outside the MOH (included as a condition in the second structural adjustment loan), and then to provide it with more responsibilities; and efforts to persuade the MOH to liberalize guidelines for providing contraceptives, to integrate FP into the mainstream of MOH activities, and to offer sterilization services. Both strands of work have been important components of an overall package that included technical assistance and commodity support from other donors and, perhaps most important, clear signals from Kenya's president that family planning was to be taken seriously.

Could the Bank have done anything to speed up this process? While far more effort could have been made to develop effective IEC, outreach, monitoring, evaluation, and research components, the Bank pressed the Government fairly strongly on many of these issues and seems to have taken advantage of opportunities as they emerged. In this case, the absence of resident staff assigned to the sector does not appear to have been a serious barrier to progress, given the liberal budgets for supervision and travel and inputs from other donors with technical staff in the field.

The program appears to be more or less on the right track for the time being and should continue to expand, though with substantially more emphasis placed on quality of services, outreach, and IEC. However, even if the gap between desired and actual family size were totally closed, the TFR would decline to only the 4-5 child range, which implies a population growth rate that is still above 2 percent per year. Between 1984 and 1987, the mean desired number of children decreased from 5.8 to 4.4. To accelerate such change, something more than supply-side changes are needed. The report suggests some possibilities, but also indicates that research and pilot studies are extremely important in this case because of our limited knowledge about how to make significant progress in reducing desired family size in the face of a strong, pro-natalist family system.

Senegal. Apart from a rural health project designed in 1982 that focused on the provision of buildings and equipment for expansion of basic health services, the Bank, until recently, concentrated its efforts on helping the Government develop a comprehensive population policy. A 1985–86 sector review, which concluded that USAID and UNFPA were doing as much as could usefully be done to develop FP services, recommended this focus. It was implemented, among other ways, by making development of such a policy statement a condition of a structural adjustment loan. While some government officials may have gone along with this request because it appeared innocuous enough, the policy statement and the process of developing it have taken on a life of their own and resulted in substantive progress that would have occurred more slowly in its absence, given stagnant social or economic development in recent years. This strategy may be especially important in Francophone Africa, because of its pro-natalist colonial heritage that had to be explicitly and publicly broken with to legitimize family planning activities.

The decision by the Bank to focus on policy development was probably correct at the time because the Bank, unlike other major donors, lacked field staff to help implement more complex operations, but did have access to senior policy circles because of its much broader policy agenda. More recently, the Bank has decided to become more pro-active by developing a project that, among other things, aims to extend family planning and other services to the lowest tier in Senegal's health delivery system. This is a risky approach. USAID, for example, has restricted itself to operating at the next level up because the Government's capacity to administer and deliver services is so limited. Given the

urgency of the problem, these risks are probably worth taking and can be kept within acceptable bounds by starting on a small scale and escalating slowly; but they require much more intensive and more intimate supervision than has been typical of Bank projects in Senegal.

Major Issues for the Bank

The experience of the past 20 years clearly demonstrates that even in poor countries that have not experienced much social and economic progress, a process of fertility decline can be initiated by a typical family planning program that focuses on the provision of contraceptive supplies, services, and associated information. It will proceed more rapidly if that program includes a strong outreach component and provides high-quality services based on clients' perceptions of needs. This requires good field supervision, good training, and good motivation—all features that are difficult to develop in poor, rural areas.

However, there is little evidence that even the best run of such programs can do much more than meet the needs of those who are already predisposed to accept family planning services.[6] In all the cases studied, even if all such persons were enrolled in a family planning program—or even if the highest contraceptive prevalence rates achieved in the best-run pilot programs were achieved throughout the country—there is no country in the group of eight, except perhaps the three Latin American countries, in which the total fertility rate would drop to acceptable levels.[7] Other kinds of interventions will be required to go farther. Supply-oriented strategies may be sufficient to reduce the total fertility rate from six to four, but in the absence of strong social and economic change, a different strategy is likely to be needed to reduce it from four to two.

The Bank has been remiss in failing to develop programs that focus on this issue. The most important thing it has done in this direction has been to promote general social and economic development. Above all else, this is probably the strongest force we know of to reduce desired family size and encourage spacing. However, these efforts were not undertaken with their potential demographic effect in mind. Had that been done—had the Bank searched for selective interventions into the development process that had the possibility of changing implicit benefits and costs of large families—far more might have been accomplished. It is well established, for example, that educating women—or simply keeping them in school for a few more years—encourages later marriage and lower fertility rates within marriage. Other promising interventions include programs specifically directed to raise the probability that children will survive to adulthood, opening up job opportunities for women in occupations that are competitive with child rearing (e.g., factory or office jobs rather than farm jobs), and improving social security programs so that adults feel less need of large families to provide such security.

Previous reviews of the Bank population program have called for more emphasis on such demand-oriented factors, but very little has been done to turn this call into operational programs. Reasons include skepticism about the importance of the argument for the necessity of demand-side interventions; doubts about what can be accomplished; and staff compartmentalization and inertia. Underlying these factors may be the fact that population is typically treated as a sector with responsibility assigned to a specific administrative unit, implicitly leaving other sectoral units free from this responsibility. Population is not a discrete sector any more than economic development or poverty alleviation. All three are more in the nature of strategic objectives that should be the responsibility of all sectors.

Since 1987, several changes have occurred that are having promising impacts on this situation within the Bank. The administrative integration of education, population, health, and nutrition has allowed and encouraged thoughts about how each sector can help achieve the others' goals. The *Women in Development* and *Child Survival* initiatives are forcing a focus on two of the most important possibilities.[8] A few promising components are beginning to show up in education projects. Much more can and should be done. The Bank is uniquely qualified to do it.

Besides pointing up the need to broaden the scope of population activities, the case studies suggest several improvements that can be made within population projects and more traditional lines of activity. Early projects tended to emphasize expansion of the physical infrastructure at the expense of "software"elements, the implicit assumption being that the latter would be provided by government or other donors. This assumption is now recognized as wrong in more instances than it is correct and steps have been taken to right the balance within projects. The case studies suggest, however, that there is still a way to go in some

6. Study of the Bangladesh case may require modification of this statement. It is plausible that in this case, the successful IEC efforts and the demonstration effect of increasing prevalence played a role in decreasing desired family size, despite the absence of social and economic change.

7. There are, however, regions within some of these countries where fertility has approached replacement: Yogyakarta (2.1), Bali (2.5), East Java (2.6), Kerala (2.2), and Tamil Nadu (2.6). In all cases, social and economic development and/or administrative capacity is above the national average.

8. Another recent initiative—the effort to develop integrated human resource projects—is worth trying, but in the end may not bear much fruit. The danger is that such projects may end up being "Christmas trees"of independent components that are administrative nightmares to implement. A more practical approach may be to develop separate projects which incorporate population concerns—for example, education projects that include concentrated efforts on enrolling and keeping girls in school for a longer period of time, industrial projects that set aside specific jobs for women, etc.

countries. The tendency for population projects to grow in size and fund increasing quantities of recurrent costs needs careful monitoring to ensure that absorptive capacity and sustainability limits are not being overwhelmed. For associated reasons, more concern about cost containment and internal efficiency within family planning projects and programs is needed. Before becoming heavily committed to funding contraceptive supplies, more thought should be given to funding contraceptive production facilities in larger countries. Bank and country ability to assess project and program effectiveness is poor and will continue to be poor as long as project components associated with monitoring and evaluation and the establishment of research capacity are neglected.

The case studies also suggest several broader lessons. Efforts in the population field require patience but eventually pay off. This fact should influence the way targets and criteria for assessment of population activities are established. Non-project activities—dialogue; sector work; efforts to establish policies, improve organizational arrangements, and change rules and regulations—are very important. At some stages, they are more important than development of a project. Such activities need to be specifically rewarded and encouraged. An impressive example is the Bank effort of the past year to establish a policy consensus in Africa, which incidentally is now bearing fruit in proposals for useful projects. The Bangladesh case is especially important in suggesting the value of joint programming of loan and grant funds and ways that it can be done. All these points suggest that the population "sector" is more staff-intensive than most others and that greater allowance needs to be made for this difference.

Finally, what can be said about the overall level of Bank effort in this field, an issue that has resulted in substantial criticism of the Bank in recent years? In judging this issue, it must be remembered that financial input alone is a poor indicator of level of effort, especially in the population field, and that the Bank's efforts cannot be assessed independently of what other donors, with grant funds at their disposal, are doing.

Within the case study countries we find no evidence that additional financial resources for the type of projects the Bank is currently funding in these countries would have made much difference. Some additional funds could be usefully used in specific instances: to allow more staff inputs for supervision and technical assistance functions; to undertake more non-project activities (more sector work, more collaboration and coordination with other donors, and a more pro-active role in some countries); to expand population-related activities in non-population sectors. Additional resources will also be necessary to develop activities in countries in which the Bank does not now have programs. But such changes would represent a modest reorientation and expansion of a program which, on the whole, appears to be on the right track.

Resumen Ejecutivo

En este estudio se analizan las actividades que ha venido cumpliendo el Banco en el sector de la población de ocho países. Se comienza por indagar, en el caso de cada uno de ellos, acerca de los cambios demográficos y socioeconómicos conexos que se han producido desde 1968, momento en que el Banco anunció que comenzaría a otorgar préstamos para dicho sector. También se identifican las políticas oficiales establecidas que influyeron en estas tendencias y la función que cumplió el Banco frente a otros donantes durante el período mencionado. Las conclusiones a que se ha llegado se basan en viajes de observación, entrevistas y un análisis de documentos y trabajos en materia de operaciones.

El panorama resultante es de una considerable diversidad de actividades y experiencias que dificultan hacer una generalización. La conclusión general del estudio, dejando de lado esta diversidad y sus distinciones por el momento, es que, después de unos primeros pasos lentos, vacilantes y a veces equivocados, el Banco se ha vuelto cada vez más eficaz en este ámbito, pero su labor y logros podrían haber sido mayores. De ahora en adelante —en el supuesto de una aplicación firme y homogénea de las últimas innovaciones en materia de operaciones del Banco en este sector— la mayor parte de lo que hace falta para lograr las reformas demográficas pretendidas implícitas en la política sectorial del Banco comprende cambios de orientación y del énfasis puesto, en lugar de apartamientos radicales de las prácticas y niveles de financiamiento recientes.

Tendencias demográficas y socioeconómicas

Las tasas de fecundidad total han bajado en todos los países objeto del estudio de casos: marginalmente en Senegal; 20% de la distancia entre el nivel máximo de ocho niños por mujer a un nivel de reemplazo de 2,1 en Kenya; 40% en Bangladesh; 50% en India; 60% en Indonesia, y más del 70% en Brasil, Colombia y México. Estas noticias son particularmente alentadoras en los casos de Bangladesh y Kenya, países en que, hasta hace muy poco, no se habían logrado muchos resultados en relación con los esfuerzos desplegados durante los últimos 20 años a fin de reducir las tasas de crecimiento de la población. Las tasas de mortalidad, especialmente en la infancia y en la niñez, también han disminuido considerablemente, en un 50% en los países de América Latina a partir de 1960. Sin embargo, cualesquiera sean las pautas que se utilicen, las tasas de fecundidad, mortalidad y crecimiento de la población siguen siendo altas, especialmente en Asia y Africa. Habida cuenta de la estructura demográfica de estos países en la que predomina la población joven, además de las tasas actuales de variación de la fecundiad y la mortalidad, es probable que en esas naciones las tasas de crecimiento de la población se mantengan en un nivel anual cercano al 2% o aun superior durante algún tiempo.

Entre las dos terceras y las tres cuartas partes de esta disminución de la fecundidad ha obedecido al mayor uso de los métodos anticonceptivos modernos, en tanto que casi todo el resto de esta reducción se debe a que las personas se casan a una edad cada vez mayor. A su vez, estas modificaciones obedecen a la combinación de mejoras registradas en las características sociales y económicas que propician la reducción del tamaño de la familia y una edad mayor para contraer matrimonio. Se trata, por ejemplo, de mejoras de las condiciones de la mujer en cuanto a educación, empleo y situación social; la disminución de la mortalidad infantil; menos oportunidades de trabajo para los niños, y una menor dependencia de éstos para la seguridad en la vejez. Dichas mejoras también comprenden programas de planificación familiar con los que se procura que los anticonceptivos modernos sean más accesibles y se suministre información y educación a su respecto.

En la producción de los cambios demográficos observados en los tres países de América Latina se han combinado ambos factores —es decir, mejoras importantes en estos indicadores sociales y económicos y servicios de planificación

familiar apreciables y eficaces suministrados, en estos casos, por organizaciones no gubernamentales (ONG), organizaciones semipúblicas e intermediarios comerciales. Si bien en Indonesia también se han registrado mejoras sociales y económicas importantes, la sociedad en ese país sigue siendo más rural y tradicional con tasas más altas de mortalidad derivada de la maternidad y en la niñez. Su programa de planificación familiar auspiciado por el Gobierno ha compensado esta diferencia de diversas maneras. La más importante de ellas tal vez sea la red importante y eficaz de agentes de planificación familiar que llega hasta las aldeas más pequeñas. Con el programa de la India también ha compensado un progreso social y económico aún más moderado, pero de distinta manera: centrándose estrictamente pero de modo eficaz en la esterilización. Sin embargo, dicho programa se ha visto frenado a veces por la reacción política que han provocado las campañas coercitivas periódicas. Debido al éxito que ha tenido en llegar a una gran proporción de parejas que querían poner fin a la etapa reproductiva de sus vidas, el programa indio está ahora alcanzando su punto de rendimientos decrecientes. El caso de Kenya es interesante puesto que el considerable progreso social y económico de los últimos 25 años al parecer ha dado lugar a que se hiciera latente la necesidad de limitar el tamaño de la familia, la que recién se manifestó hace muy poco. El largo período de *preparación del programa que finalmente ha llegado al umbral crítico de eficacia, sumado al estímulo que le infundieron el Presidente y otros dirigentes importantes, al final parece estar dando resultados. Senegal es un ejemplo de país que tiene muy poco desarrollo social y económico y donde se preparan muy pocos programas como para que se pueda ejercer una gran influencia en la tasa de fecundidad.

Bangladesh constituye un caso de especial interés debido a que se trata de una nación en la que ha habido una formulación importante de programas pero muy poco adelanto social y económico, y es casi un caso clásico de aplicación del enfoque de la oferta en condiciones en que no se preveía encontrar mucha demanda. Sin embargo, aun así debe haber existido suficiente demanda latente como para redundar en la prevalencia del uso de anticonceptivos y la disminución de la tasa de fecundidad que se han registrado hasta ahora. Queda sin contestar el interrogante de cuánto más se puede avanzar sin contar con cambios estructurales importantes que influyan en la demanda[1]. En el estudio se consideran varias posibilidades y se propugna una investigación. Dicha investigación reviste importancia para el futuro del programa de Bangladesh y también por lo que podría revelar acerca de cuáles serían los programas adecuados para países en circunstancias similares.

La función del Banco en los distintos países

Indonesia. Si bien el Banco ha prestado considerable asistencia financiera a las medidas de desarrollo generales de Indonesia, las operaciones crediticias para el sector de la población han ascendido a tan sólo el 1% del total. Esta suma ha aportado los fondos necesarios para sufragar aproximadamente el 10% del total de gastos públicos en el programa referido a la población, en tanto que otros donantes, incluidas las organizaciones no gubernamentales (ONG) han aportado otro 20%. Al suministrar estos fondos, el Banco desempeñó un papel bastante tradicional, en el sentido de que se trataba de operaciones de un banco más que de una institución de desarrollo. Es decir, en general reaccionó con cautela ante las propuestas de proyectos presentadas por las autoridades de Indonesia; fue poco lo que proporcionó a modo de asistencia técnica en la preparación o ejecución de los proyectos en este ámbito, y en los proyectos mismos se centró en la construcción de obras civiles y el suministro de componentes físicos. Sin embargo, el Banco sí contribuyó a la formulación y el respaldo de un programa importante de educación de la población. Empero, en otras esferas de componentes lógicos tendió a apoyar la ejecución de proyectos preparados por el Programa Nacional de Planificación Familiar de Indonesia con la asistencia técnica de otros donantes. Durante la mayor parte del período comprendido, no hubo ningún miembro del personal técnico residente que fuera responsable de este sector y los estudios sectoriales fueron limitados.

Salvo, tal vez, en los primeros años de su participación en el programa, el enfoque del Banco era perfectamente adecuado. Las autoridades de Indonesia sabían lo que querían y demostraron ser capaces de una buena ejecución. De hecho, el mencionado programa de planificación familiar normalmente es considerado como uno de los más eficaces en el mundo. Otros donantes —en especial, la Agencia para el Desarrollo Internacional EUA (USAID)— participaron activamente en la formulación de políticas operacionales y tácticas de ejecución. Esta resultó ser una buena división de hecho de las tareas que mereció el elogio de las autoridades de Indonesia.

En el informe se analizan cinco esferas en las que el Banco podría haber hecho más o actuado de manera diferente en dicha nación. 1) Habría sido útil contar con un especialista del Banco residente en el país por un período más largo y con la función de participar activamente en la preparación y ejecución del programa. 2) La coordinación y

1. Esta modalidad de presentación entraña una clasificación implícita de los programas de información, educación y comunicación como partes del programa de planificación familiar; es decir, una medición desde el punto de vista de la oferta. Ello se basa en la idea de que si bien se puede difundir la información y alentar la demanda a través de las actividades de información, educación y comunicación, ya debe existir cierta proclividad —cierta demanda latente generada por fuerzas culturales, sociales o económicas más esenciales— para que estas medidas produzcan algún efecto.

colaboración con otros donantes podría haber sido mejor durante los primeros 15 años de participación del Banco. Desde entonces, este aspecto del programa ha mejorado considerablemente. 3) El Banco podría haber propugnado en forma más temprana y decidida proyectos en el sector de la salud, en especial promoviendo más enérgicamente la salud maternoinfantil y su integración en la planificación familiar, lo que recién está comenzando a hacer ahora. 4) El Banco podría haber estimulado la formulación de estrategias de planificación no familiar a fin de incrementar la necesidad de reducir el tamaño de la familia, por ejemplo, contribuyendo a preparar proyectos destinados a mejorar las oportunidades de educación y empleo de la mujer. Aún es preciso realizar esfuerzos considerables en este ámbito. 5) Sigue siendo necesario el fortalecimiento de las actividades de investigación y evaluación, al menos por dos razones, a saber: para extraer enseñanzas de este caso en el que se obtuvieron buenos resultados a fin de aplicarlas en otros países[2] y para fortalecer la capacidad de investigación y evaluación dentro del Programa Nacional de Planificación Familiar de Indonesia, en el que esta función ha sido desatendida.

Sin embargo, evidentemente el mejoramiento de estos ámbitos no era necesario para lograr los considerables progresos que se han registrado hasta el momento. Asimismo, la labor del Banco en estas esferas podría haber topado con resistencia por parte del Programa Nacional de Planificación Familiar de Indonesia y otros donantes que preferían que el Banco se centrara principalmente en el suministro de recursos para edificios y equipo. El Banco dio respuesta específica a los deseos del cliente, y en este caso fue la respuesta adecuada en razón de la gran capacidad del cliente y de la asistencia de otros donantes.

En Indonesia, en el futuro tal vez hagan falta enfoques distintos de los aplicados en el pasado en lo que hace a tres aspectos importantes. En primer lugar, hay mucha menos necesidad de programas masivos de obras de infraestructura. En segundo lugar, la USAID ha mostrado su intención de disminuir progresivamente sus aportes, en parte porque considera que Indonesia ahora necesita menos asistencia técnica y fondos a título de donación. El Programa Nacional de Planificación Familiar de Indonesia, con la asistencia de la USAID, ha reaccionado estableciendo programas encaminados a promover la comercialización y la prestación de servicios por parte del sector privado. En tercer lugar, la fórmula que ha servido para bajar la tasa de fecundidad de 5,5 a 3,5 niños por mujer puede no servir ya para reducirla aún más, a una de reemplazo de 2,1. El Banco podría adaptarse a estos cambios reduciendo progresivamente sus actividades como lo está haciendo la mencionada USAID, o bien tratando de llenar el vacío dejado por ésta. En el informe se indica que, según el problema de que se trate, es preciso aplicar ambos métodos.

India. Al igual que en el caso de Indonesia, hasta hace muy poco el Banco ha desempeñado más las funciones tradicionales de un banco que las de una institución de desarrollo en la India. Sin embargo, en este caso, el papel que cumplió fue mucho menos adecuado en razón de los problemas estratégicos del programa. Estas dificultades consisten en: excesiva atención prestada a la esterilización, con lo que se ignora la necesidad de espaciar los nacimientos que tienen las parejas jóvenes y (como se señaló antes) se están observando rendimientos decrecientes; falta de atención a las operaciones y la calidad de los programas (por oposición a la expansión de éstos); excesiva centralización y dependencia de un único sistema de prestación, y la omisión de considerar los factores que pueden influir en la demanda. La persistencia e identificación de estos problemas data, por lo menos, desde que se inició la participación del Banco en el programa de la India.

El hecho de que el Banco no haya podido ejercer una gran influencia en el programa de la India puede obedecer a diversos factores. 1) El primer proyecto del Banco en materia de población en la India se inició en 1972, mucho después de haberse afianzado firmemente el plan del país. 2) Si bien los montos entregados en préstamo constituían el 28% de la cartera total del Banco para el sector de la población hasta 1988, estas sumas representaban una pequeña proporción—3,6% entre 1980 y 1988— de los gastos totales en el Programa de Bienestar Familiar de la India. Si bien el total de donantes aportó entre el 12% y el 14% de los fondos necesarios para sufragar los gastos públicos, nunca se constituyeron en una coalición eficaz. 3) La naturaleza de los cinco primeros proyectos, denominados proyectos zonales, le impidieron al Banco participar en cuestiones de políticas que excedieran del marco de estas zonas (geográficas) y desalentaron las innovaciones experimentales incluso dentro de dichas zonas[3]. 4) Tanto los estudios sectoriales como los aportes de personal para el programa han sido insuficientes. Fueron pocos los estudios sectoriales realizados antes de 1988—sin duda no fueron suficientes como para proporcionar al Banco un fundamento para proponer cambios tácticos como, por ejemplo, recomendar siquiera cómo

2. Por ejemplo, ¿cuáles son los factores responsables del éxito de estas operaciones del país basadas en la comunidad? ¿Son exclusivos de Indonesia, o pueden servir de ayuda a otros países?

3. Se trata de un aspecto discutible. En un principio el fundamento de este sistema era que la influencia que ejercería el Banco dentro de estas zonas sería mayor que la que habría tenido en el programa general. Lo más probable es que no haya sucedido así, y ello no se debe a que el concepto estuviera equivocado sino a que la India nunca aceptó que las zonas respaldadas por el Banco pudieran ser diferentes de otras y porque el Banco nunca tomó la iniciativa de elaborar estudios técnicos detallados para estos proyectos, en los que se hubiera explicitado minuciosamente esta cuestión antes de la ejecución.

podría modificarse la estructura de incentivos, seguimiento y rendición de cuentas del programa a fin de dar mayor importancia a métodos menos drásticos que la esterilización. Tampoco hubo suficiente aporte de personal —en condición de residente ni en Washington— como para hacer mucho más que emplear un enfoque distante.

A partir de 1987 se produjeron varios cambios importantes. Al parecer el Gobierno y el Banco se sintieron decepcionados con los resultados de los proyectos zonales y están dispuestos a probar un método diferente. Esto se refleja en el sexto y el séptimo proyectos, iniciados en 1989 y 1990, por la atención que se presta en ellos a los componentes prioritarios del programa a nivel de los estados. En ellos también se incluye el apoyo a las ventas subvencionadas y las organizaciones no gubernamentales. En segundo lugar, a partir de 1987, se han hecho varios estudios sectoriales buenos que al parecer están influyendo en el modo de pensar de la India y la naturaleza del diálogo. El Proyecto de Supervivencia Infantil y Maternidad sin Riesgos que ha sido propuesto presta por primera vez gran atención a los problemas de la salud que revisten importancia como para influir en las decisiones en materia de fecundidad. En dicho proyecto también se presta atención minuciosa a las operaciones a nivel de poblado, que en el pasado han demostrado ser un punto de estrangulamiento importante para la aplicación de los cambios de políticas. Por último, han aumentado considerablemente los esfuerzos realizados por el Banco en el ámbito de la educación, prestándose atención especial a la mujer.

Si bien las mencionadas son todas propuestas que prometen dar buenos resultados, mucho dependerá de la decisión y homogeneidad con que se las aplique. El Banco deberá continuar realizando estudios sectoriales y de investigación con miras a encontrar maneras prácticas de resolver los problemas estructurales; deberá seguir defendiendo —enérgicamente cuando sea necesario— la aplicación de los resultados de dicha labor; deberá poner más empeño en captar la ayuda de otros donantes en este proceso, y dedicar más tiempo y esfuerzos a la supervisión de las operaciones a nivel de poblado. Es probable que todo ello requiera un mayor aporte por parte de funcionarios familiarizados con los problemas de fondo, tanto en la sede como en el terreno.

Bangladesh. El programa de Bangladesh adolece de muchas de las deficiencias del programa de la India. Si bien se ha centrado menos la atención en las esterilizaciones, la calidad de los servicios de planificación familiar no es buena, el programa de salud maternoinfantil es endeble y no está bien integrado en la planificación familiar; además, la falta de talento en la dirección sumada a estructuras administrativas profundamente arraigadas dificultan las mejoras. Por añadidura, desde luego que el programa se desarrolla en un medio físico sumamente difícil en el que las crisis periódicas que exigen prioridad ponen constantemente en peligro el provecho de los adelantos alcanzados.

Sin embargo, la mayor parte del progreso logrado en materia de aumento de la prevalencia del uso de anticonceptivos y reducción de la tasa de fecundidad puede atribuirse a los aportes del programa. Es probable que la diferencia radique en el programa de divulgación que, pese a sus limitaciones, es más amplio y activo que en la India. Además, los donantes han desempeñado una función más intensa y activa en la planificación y las operaciones, ampliando en la realidad la capacidad de ejecución del Gobierno. Debe atribuirse un gran mérito al Banco, que en este caso ha cumplido un papel activo y de liderazgo.

En el informe se enumeran siete factores que al parecer han tenido importancia trascendental. 1) Es evidente que el Gobierno está empeñado en resolver el problema relacionado con la población; ha dedicado un porcentaje apreciable de sus escasos presupuesto y talento directivo al programa, y ha procurado con ahínco y utilizado asistencia y asesoramiento externos. 2) La asistencia financiera y técnica externa ha sido de considerable magnitud. 3) Gran parte de la asistencia financiera, incluso dentro de los cinco proyectos para la población respaldados por el Banco que han sido aceptados hasta ahora, consiste en donaciones proporcionadas por los cofinanciadores. Ello ha permitido una mayor flexibilidad y una mayor concentración de la atención en los componentes lógicos y ha contribuido a sufragar los gastos por concepto de aportes adicionales de personal del Banco, tanto en la sede como en el terreno. 4) Gracias a estos aportes adicionales de personal y con el estímulo del Gobierno, el Banco ha desempeñado un activo papel en todas las etapas de estos proyectos —diseño, captación de fondos, coordinación de la ayuda de los donantes, ejecución y evaluación *ex post*—, mucho más intenso de lo que suele serlo en los proyectos que respalda. 5) La labor de coordinación entre los donantes ha sido importante y los cofinanciadores, que por lo general han suministrado más de la mitad de los fondos para estos proyectos, han desempeñado un papel cada vez más activo. Su participación en estos momentos ha llegado a la etapa que permite describir con mayor precisión al cuarto proyecto como de un consorcio y no del Banco. 6) Con la ayuda de los fondos de donación se ha dotado de flexibilidad al programa gracias a que, entre otras cosas, se ha establecido un "Fondo para proyectos novedosos" y una "Unidad de financiación de proyectos". 7) Se han aprovechado los resultados de proyectos experimentales para mejorar el desempeño del programa.

En este caso, hay motivos para considerar que las medidas del programa deben seguir la misma orientación actual durante los próximos años. Según las encuestas, hay un núcleo de usuarios potenciales a los que aún no se ha llegado y hay pruebas de que la prevalencia es mayor cuanto mayor es la densidad de los puntos de servicio, cuanto más

frecuentes son los contactos con los agentes de planificación familiar y cuanto mejor es la calidad de los servicios suministrados. Sin embargo, incluso si aumentara el nivel de la prevalencia al 50% que se obtuvo en la zona experimental de Matlab, frente al actual nivel de 35% —lo que es poco probable a escala nacional— la tasa de fecundidad total sería de un 3,7, aún muy superior al nivel de reemplazo. A fin de obtener niveles más bajos en un período razonable, es probable que haga falta un cambio de orientación del programa a fin de abarcar más que el enfoque orientado hacia la oferta que se utiliza actualmente. Si bien al parecer en Bangladesh el tamaño aconsejable de familia se ha reducido aun sin que existieran mejoras sociales y económicas importantes, sería más seguro y más rápido lograr una mayor reducción si se pudieran concretar cambios estructurales que aumentaran la necesidad de reducir el tamaño de la familia.

Brasil, Colombia y México. A diferencia de otros países, sólo una pequeña parte de los gastos de estas naciones en planificación familiar provinieron de fuentes externas, y en su mayor parte la ayuda recibida provino de organizaciones no gubernamentales en lugar de organismos multilaterales o bilaterales[4]. Los insumos aportados por el Banco fueron mínimos. En estos países no hubo proyectos para la población financiados por el Banco. (Se preparó uno para México, pero fue retirado al asumir un nuevo Gobierno.) No fue mucho lo que se hizo por aplicar los pocos subcomponentes de planificación familiar comprendidos en el componente de salud maternoinfantil de los proyectos relativos a la salud financiados por el Banco, y en los diálogos sobre políticas rara vez se trató el tema. Al menos hasta 1989 fueron muy pocos los estudios sectoriales centrados directamente en la población o en la planificación familiar. Además, si bien sin lugar a dudas las operaciones crediticias destinadas a otros sectores han producido algunos efectos indirectos, nunca se emprendieron teniendo en cuenta consideraciones de orden demográfico.

Al parecer son tres los factores responsables de este aparente descuido. 1) La sensibilidad de orden político en torno a las políticas de "control del crecimiento de la población" propuestas por extranjeros dificultaba al personal del Banco empezar a hablar del tema con los gobiernos de estos países, que consideraban inaceptable la posición adoptada por la administración del Banco y el personal de éste, que se encontraba en el medio, reaccionaba haciendo muy poco. 2) Para cuando el Banco comenzó a otorgar préstamos para los servicios de salud, lo que habría hecho más aceptable el enfoque relativo a la planificación familiar, la prevalencia del uso de anticonceptivos ya era comparativamente elevada y la estructura de prestación de servicios estaba bien afianzada. 3) Los principales organismos de estos países eran organizaciones no gubernamentales o instituciones mixtas. En vista de la actitud de los gobiernos, el Banco (a diferencia de la USAID) no disponía de una manera de trabajar en forma directa, ni siquiera indirecta, con dichos organismos, como lo ha logrado hacer en Kenya y en otras naciones.

El enfoque actual del Banco en América Latina consiste en centrarse en la salud para la procreación y la maternidad sin riesgos como fundamento de la planificación familiar, y ello parece lo correcto. Un método más agresivo no se justifica y no es aconsejable desde el punto de vista político. Sin embargo, siguen existiendo problemas importantes de equidad, calidad de los servicios y opciones que, de cualquier manera, son parte de un conjunto más amplio de problemas que el Banco está tratando en el sector de la salud[5].

La importancia de estos casos en América Latina radica en que ponen en evidencia cuestiones relativas al fundamento de las operaciones crediticias del Banco para el sector de la población. Si el Banco quiere trabajar en países que no aceptan el control del crecimiento de la población como fundamento, debe basar su programa para la población en un conjunto de principios más amplio y flexible. Esto podría partir del reconocimiento de que el objetivo general es la promoción de mejoras sostenibles en el nivel de vida, y que los programas de planificación familiar son una ayuda tanto a nivel microeconómico —mejorando la salud de la familia y las opciones— como macroeconómico. En este contexto, estos programas son temas adecuados para un diálogo sobre políticas y un análisis sectorial a fin de determinar de qué manera deberían formularse y utilizarse en situaciones específicas, si es que debe hacérselo. Además, estos casos plantean interrogantes acerca de la conveniencia en determinadas circunstancias de otorgar préstamos para proyectos de población independientes, frente a los proyectos de salud que contienen componentes de planificación familiar. Si este enfoque se hubiera utilizado con anterioridad y de manera más armónica, es posible que el Banco no se hubiera topado con tanta oposición y desconfianza acerca de sus motivaciones en estos países.

Kenya. El estudio de este caso es un buen ejemplo de la virtud —y la necesidad— de tener paciencia y perseverancia en la esfera de la población. Si bien desde los últimos años de la década de 1960 han sido considerables los esfuerzos desplegados por los donantes para persuadir al Gobierno de que estableciera un programa importante, no fue

4. Sin embargo, algunas organizaciones no gubernamentales internacionales han recibido ayuda de fuentes bilaterales y multilaterales; especialmente, la Agencia para el Desarrollo Internacional EUA (USAID) y el Fondo de las Naciones Unidas para Actividades en Materia de Población (FNUAP).

5. Uno de los aspectos de dichos problemas es el elevado número de abortos provocados ilegales que existe en estos países. Véase el trabajo de Singh y Wolf, 1991.

sino hasta 1988-89 que se vieron pruebas claras de que la tasa de fecundidad había comenzado a bajar.

Además de respaldar el desarrollo económico general, apoyo que comprendía sustanciales fondos para la educación, los aportes del Banco han seguido dos líneas generales. A partir de 1974 se han financiado cuatro proyectos. Con los dos primeros se suministraron fondos al Ministerio de Salud para establecer una red de instalaciones rurales de salud y hospitales clínicos; los componentes de planificación familiar de estos proyectos eran deficientes y se ignoraron en gran medida durante la ejecución. En este período, la tasa de crecimiento de la población aumentó en realidad. Si bien el tercero y cuarto proyectos han tenido componentes más importantes relativos a la población y a la planificación familiar, se iniciaron demasiado tarde (1988 y 1990) como para influir en un cambio de tendencia de la tasa de fecundidad. La segunda etapa de aportes del Banco ha comprendido el diálogo sobre políticas, estudios sectoriales y medidas encaminadas a influir en la evolución del programa de diversas maneras. Entre los ejemplos de esto último se encuentran los esfuerzos desplegados que lograron persuadir al Gobierno de que creara un organismo interministerial de coordinación en materia de población fuera del Ministerio de Salud (que se incluyó como condición en el segundo préstamo para fines de ajuste estructural), y de que luego pusiera a su cargo más responsabilidades, así como medidas encaminadas a persuadir al Ministerio de Salud de que liberalizara las pautas para el suministro de anticonceptivos, integrara la planificación familiar en la principal corriente de actividades del Ministerio de Salud y ofreciera servicios de esterilización. Ambas etapas del trabajo han constituido componentes importantes de un conjunto general que comprendía asistencia técnica y financiamiento en especie de otros donantes y, lo que tal vez sea más importante, indicaciones claras del Presidente de Kenya en el sentido de que la planificación familiar iba a tomarse en serio.

¿El Banco podría haber hecho algo por acelerar este proceso? Si bien se podría haber puesto mucho más empeño en formular componentes eficaces de información, educación y comunicación, divulgación, seguimiento, evaluación *ex post* e investigación, el Banco presionó con bastante firmeza al Gobierno respecto de muchos de estos temas y al parecer ha aprovechado las oportunidades a medida que éstas iban surgiendo. En este caso, la falta de personal residente asignado al sector no parece haber sido un obstáculo grave para los avances, en vista de los presupuestos liberales para tareas de supervisión y los viajes y aportes suministrados por otros donantes que tenían personal técnico en el terreno.

Al parecer el programa por el momento está en la buena senda y habría de seguir ampliándose, aunque poniéndose considerablemente mayor énfasis en la calidad de los servicios, la divulgación y las actividades de información, educación y comunicación. Sin embargo, aun cuando se cerrara totalmente la brecha existente entre el tamaño aconsejable de familia y el real, la tasa de fecundidad total disminuiría a la gama de tan sólo 4 a 5 niños, lo cual entraña una tasa de crecimiento de la población aún superior al 2% al año. Entre 1984 y 1987, el número medio deseado de niños bajó de 5,8 a 4,4. Para acelerar dicho cambio se necesita algo más que modificaciones desde el punto de vista de la oferta. Si bien en el informe se recomiendan algunas posibilidades, también se señala la suma importancia que revisten las investigaciones y los estudios experimentales en este caso, toda vez que no se sabe bien de qué manera lograr avances importantes en materia de reducción del tamaño apetecido de familia dentro de un sistema familiar muy favorable a la natalidad.

Senegal. Aparte de un proyecto de salud rural diseñado en 1982 que se centraba en el suministro de edificios y equipo para la ampliación de los servicios básicos de salud, el Banco hasta hace muy poco había concentrado sus esfuerzos en ayudar al Gobierno a formular una política integral en materia de población. Este tema central se recomendó en un análisis sectorial realizado en 1985–86, en el que se llegó a la conclusión de que la USAID y el Fondo de las Naciones Unidas para Actividades en Materia de Población estaban haciendo todo lo que podía hacerse para promover servicios de planificación familiar. Una de las maneras de ponerlo en práctica fue establecer la formulación de dicha declaración de políticas como condición de un préstamo para fines de ajuste estructural. En tanto que algunos funcionarios del Gobierno pudieron haber aceptado este pedido en razón de que parecía bastante inocuo, la declaración de políticas y el proceso de formularla han cobrado vida propia y redundado en un avance importante que de otro modo se hubiera producido en forma más lenta, teniendo en cuenta el estancamiento de la evolución social o económica de los últimos años. Esta estrategia puede revestir especial importancia en los países de Africa de habla francesa, debido a su herencia colonial favorable a la natalidad con la que hubo que romper en forma explícita y pública a fin de legitimizar las actividades de planificación familiar.

Es probable que en ese entonces la decisión del Banco de centrarse en la formulación de políticas haya sido la correcta puesto que si bien dicha institución, a diferencia de otros donantes importantes, carecía de personal en el terreno para ayudar en la ejecución de las operaciones más complejas, sí tenía acceso a los círculos superiores de formulación de las políticas debido a sus actividades mucho más amplias en esta esfera. Hace muy poco, el Banco ha decidido volverse más activo preparando un proyecto que, entre otras cosas, está orientado a extender los servicios de planificación familiar y de otra naturaleza al estrato más bajo del sistema de prestación de servicios de salud en Senegal. Se

trata de un enfoque peligroso. Por ejemplo, la USAID se ha restringido a desarrollar sus actividades en el nivel inmediatamente superior en razón de que el Gobierno tiene una capacidad muy limitada de administración y prestación de servicios. En virtud del carácter acuciante del problema, es probable que valga la pena asumir estos riesgos, que pueden mantenerse dentro de límites aceptables si se empieza a pequeña escala para ir avanzando lentamente; sin embargo, se requiere una supervisión mucho más intensa y más estrecha de la que normalmente ha existido en los proyectos del Banco para Senegal.

Principales problemas para el Banco

La experiencia de los últimos 20 años demuestra claramente que aun en los países pobres en los que no se ha registrado mucho progreso social y económico, el proceso de disminución de la tasa de fecundidad puede iniciarse con un programa de planificación familiar típico que se centre en el suministro de materiales anticonceptivos y la prestación de servicios e información conexos. Los avances serán más rápidos si en dicho programa se incluye un componente de divulgación intensa y se prestan servicios de alta calidad basados en las percepciones de los clientes acerca de las necesidades. Para ello se requiere una excelente supervisión en el terreno, buena capacitación y sólidas motivaciones, aspectos que son muy difíciles de generar en las zonas rurales pobres.

Sin embargo, hay muy pocas pruebas de que incluso el mejor administrado de dichos programas pueda hacer algo más que satisfacer las necesidades de aquellos que ya están predispuestos a aceptar los servicios de planificación familiar[6]. En todos los casos estudiados, aun si todas las personas participaran en un programa de planificación familiar —o aun cuando se alcanzaran en todo el país las tasas más altas de prevalencia del uso de anticonceptivos obtenidas con los programas experimentales mejor administrados—, no existe ningún país en el grupo de los ocho mencionados, salvo quizás los tres de América Latina, en el que la tasa de fecundidad total pudiera disminuir a niveles aceptables[7]. Hará falta otro tipo de medidas para lograr un avance mayor. Si bien tal vez las estrategias orientadas hacia la oferta resulten suficientes para reducir la tasa de fecundidad total de sies a cuatro, a falta de un gran cambio social y económico, es probable que se necesite una estrategia distinta para reducirla de cuatro a dos.

El Banco se ha mostrado remiso a formular programas que no se centraran en este tema. Lo más importante que ha hecho en este sentido ha sido promover el desarrollo social y económico general. Quizá sea éste, por sobre todas las cosas, el impulso más fuerte que se conozca para reducir el tamaño de familia apetecido y alentar el espaciamiento entre los nacimientos. Sin embargo, estas medidas no se emprendieron teniendo en cuenta sus potenciales efectos demográficos. Si se hubiera hecho así —si el Banco hubiera procurado incorporar medidas selectivas en el proceso de desarrollo que tuvieran la posibilidad de modificar los beneficios y costos implícitos de las familias grandes— se hubieran alcanzado muchos más logros. Es bien sabido que, por ejemplo, la educación de la mujer —o simplemente su asistencia a la escuela durante unos pocos años más— promueve su casamiento a una mayor edad y tasas más bajas de fecundidad dentro del matrimonio. Otras medidas que prometen dar buenos resultados comprenden programas específicamente destinados a aumentar la probabilidad de que los niños lleguen a la edad adulta, crear oportunidades de empleo para las mujeres ajenas a la crianza de los hijos (por ejemplo, en fábricas u oficinas en lugar de tareas agrícolas), y mejorar los programas de seguridad social para que los adultos no sientan tanta necesidad de tener familias grandes que proporcionen dicha seguridad.

Exámenes anteriores del programa del Banco en materia de población han exigido que se prestara más atención a dichos factores orientados hacia la demanda, aunque se ha hecho muy poco para plasmar esta exigencia en programas operacionales. Los motivos para ello son el escepticismo reinante acerca de la importancia del argumento que fundamenta la necesidad de medidas orientadas hacia la demanda; dudas acerca de los logros que pueden alcanzarse, y la compartimentación de funciones e inercia del personal. Estos factores se sustentan en el hecho de que por lo general se ha tratado a la población como un sector que es de responsabilidad de una unidad administrativa determinada, liberando así tácitamente a otras unidades sectoriales de esta función. El sector de la población no es más independiente que el desarrollo económico o el alivio de la pobreza. Los tres conceptos se encuadran más en la naturaleza de objetivos estratégicos que deberían ser responsabilidad de todos los sectores.

A partir de 1987 se han producido varios cambios cuyos efectos están dando buenos resultados en esta situación dentro del Banco. La integración administrativa de educación, población, salud y nutrición ha promovido y ha dado lugar a ideas acerca de la manera en que cada sector puede ayudar a alcanzar las metas de los demás. Las propuestas acerca de *La función de la mujer en el proceso de desarrollo* y la *Supervivencia infantil* están obligando a centrar la atención

6. El estudio del caso de Bangladesh puede exigir la modificación de esta afirmación. Es posible que en este caso, el éxito de las tareas de información, educación y comunicación y el efecto de demostración del aumento de la prevalencia desempeñaran su función en la reducción del tamaño apetecido de familia, pese a no existir modificaciones sociales y económicas.

7. Existen, sin embargo, regiones dentro de algunos de estos países en las que la tasa de fecundidad se ha acercado a la de reemplazo: Yogyakarta (2,1), Bali (2,5), Java Oriental (2,6), Kerala (2,2) y Tamil Nadu (2,6). En todos los casos, el desarrollo social y económico y/o la capacidad administrativa son superiores al nivel medio nacional.

en dos de las posibilidades más importantes[8]. Si bien están comenzando a salir a la luz algunos componentes que prometen dar buenos resultados en los proyectos de educación, aún puede y debe hacerse mucho más y el Banco está singularmente capacitado para ello.

Además de señalar la necesidad de ampliar el ámbito de las actividades relacionadas con la población, los estudios de casos recomiendan varias mejoras que pueden introducirse en los proyectos relativos a la población y actividades más tradicionales. En los primeros proyectos se tendió a poner énfasis en la ampliación de la infraestructura física a costa de los "componentes lógicos", con lo que implícitamente se suponía que estos últimos serían proporcionados por el gobierno u otros donantes. Sin embargo, fueron más los casos en que este supuesto demostró ser erróneo y se han tomado medidas para lograr un equilibrio dentro de los proyectos. No obstante, los estudios de casos indican que aún queda mucho por hacer en algunos países. Es preciso seguir con detenimiento la tendencia de los proyectos para la población a crecer en tamaño y en necesidad de financiamiento de los costos ordinarios, a fin de asegurar que no se sobrepasen la capacidad de absorción y los límites de sostenibilidad. Por razones de la misma índole es preciso prestar más atención a la restricción de los costos y a la eficiencia interna de los proyectos y programas de planificación familiar. Antes de redoblar el empeño en el financiamiento de elementos anticonceptivos, se debe pensar más en el financiamiento de las instalaciones de producción de anticonceptivos en países más grandes. La capacidad del Banco y los países para evaluar la eficacia de los proyectos y programas es deficiente y seguirá siéndolo en la medida en que sigan descuidándose los componentes de los proyectos vinculados con el seguimiento y la evaluación *ex post* y el fortalecimiento de la capacidad de investigación.

Los estudios de casos también revelan varias enseñanzas de mayor alcance. La labor desarrollada en el ámbito de la población exige paciencia pero en definitiva da resultado. Esto debería influir en la manera en que se fijan las metas y las pautas para la evaluación de las actividades en materia de población. Revisten mucha importancia las actividades que no son específicas de los proyectos, a saber: el diálogo, los estudios sectoriales, las medidas encaminadas a fijar las políticas, mejorar las estructuras orgánicas y modificar las normas y reglamentaciones. En algunas etapas, ellas son más importantes que la preparación de los proyectos. Es preciso recompensar específicamente y fomentar dichas actividades. Excelente ejemplo de ello es el intento realizado por el Banco el año pasado por lograr un consenso en materia de políticas en Africa, que dicho sea de paso ahora está dando resultados al surgir propuestas para proyectos provechosos. El caso de Bangladesh reviste especial importancia al señalar el valor que tiene la programación conjunta de los préstamos y las donaciones y la manera de hacerlo. Todos estos aspectos indican que el "sector" de la población hace un uso más intensivo de personal que la mayoría de los demás y que se debe tener más en cuenta esta diferencia.

Por último, ¿qué puede decirse acerca del nivel general de la labor del Banco en esta esfera?, cuestión ésta que ha provocado importantes críticas hacia el Banco en los últimos años. Al analizar este tema debe recordarse que los aportes financieros por sí solos son un indicador deficiente del nivel de empeño puesto de manifiesto, especialmente en el ámbito de la población, y que la labor del Banco no puede evaluarse sin considerar lo que están haciendo otros donantes que tienen a su disposición fondos para otorgar en calidad de donación.

En los países que fueron objeto del estudio de casos no se han encontrado pruebas de que los resultados hubieran sido mejores si se hubiera contado con recursos financieros adicionales para el tipo de proyectos que el Banco financia en estas naciones. En casos específicos se podrían utilizar algunos fondos adicionales a fin de permitir un mayor aporte de personal para las tareas de supervisión y asistencia técnica, emprender más actividades no relacionadas con los proyectos (más estudios sectoriales, más colaboración y coordinación con otros donantes, y un papel más activo en algunos países), y a fin de ampliar las actividades relacionadas con la población en otros sectores. También se necesitarán recursos adicionales para desarrollar actividades en países en los que el Banco actualmente no tiene programas. Sin embargo, dichos cambios representarían una reorientación y ampliación moderadas de un programa que, en general, parece estar bien encaminado.

8. Si bien vale la pena intentar otra propuesta reciente —la labor encaminada a preparar proyectos de recursos humanos integrados—, es posible que en definitiva no sea de mucho provecho. El riesgo que se corre es que dichos proyectos pueden terminar siendo "árboles de Navidad" de componentes independientes que constituyen pesadillas administrativas en el momento de su ejecución. Tal vez sea más práctico el método de preparar proyectos independientes que incluyan aspectos de interés concernientes a la población, por ejemplo, proyectos de educación que abarquen la concentración de esfuerzos en la matriculación de las niñas y en su asistencia a la escuela por un período más largo, y proyectos industriales dentro de los que se reserven determinadas tareas para las mujeres.

Résumé analytique

La présente étude analyse les activités menées par la Banque dans le secteur de la population en examinant le rôle qu'elle a joué dans huit pays. Pour chaque pays, elle commence par identifier les changements démographiques et les transformations socioéconomiques connexes survenus depuis 1968, date à laquelle la Banque a annoncé qu'elle commencerait à accorder des prêts pour ce secteur. L'étude cherche également à identifier les mesures gouvernementales qui ont pu influer sur ces tendances et le rôle que la Banque a joué à l'égard des autres bailleurs de fonds pendant cette période. Les conclusions de l'étude reposent sur des visites sur le terrain, des entretiens et l'examen d'un certain nombre de documents et publications opérationnelles.

Le tableau qui se dégage de cette étude est un kaléidoscope d'activités et d'expériences qui ne se prête guère aux généralisations. Si on laisse de côté pour le moment cette diversité et ces réserves, l'étude arrive à la conclusion générale que la Banque, après un démarrage lent, hésitant et parfois mauvais, est devenue de plus en plus efficace dans ce domaine, même si elle aurait pu faire et accomplir davantage. Dorénavant — à supposer que les changements récents apportés aux modalités d'action de la Banque dans ce secteur soient appliqués avec vigueur et cohérence — ce qu'il faut, essentiellement, pour opérer les changements démographiques souhaités qu'implique la politique sectorielle de la Banque, c'est une réorientation et une refocalisation des efforts, et non une modification radicale des pratiques et des niveaux de financement récents.

Tendances démographiques et socioéconomiques

Les indices synthétiques de fécondité ont diminué dans tous les pays ayant fait l'objet d'études de cas : marginalement au Sénégal; 20 % de l'écart entre le maximum de huit enfants par femme et un niveau de remplacement de 2,1 au Kenya; 40 % au Bangladesh, 50 % en Inde; 60 % en Indonésie et plus de 70 % au Brésil, en Colombie et au Mexique. Cette évolution est particulièrement encourageante dans le cas du Bangladesh et du Kenya où les résultats, tout récemment encore, étaient très modestes malgré les efforts déployés depuis 20 ans pour réduire les taux de croissance de la population. Les taux de mortalité, en particulier la mortalité infantile et juvénile, ont également fortement baissé dans les pays d'Amérique latine, soit d'environ 50 % depuis 1960. Les taux de fécondité, de mortalité et de croissance démographique n'en restent pas moins élevés, selon la plupart des normes, surtout en Asie et en Afrique. Compte tenu de l'extrême jeunesse de la population de ces pays et des taux actuels de variation de la fécondité et de la mortalité, il est probable que leurs taux de croissance démographique resteront pendant encore un certain temps aux alentours ou au dessus de 2 % par an.

Cette baisse de la fécondité est due, pour les deux tiers ou les trois-quarts, à un recours accru aux méthodes contraceptives modernes. Pour le reste, elle est essentiellement imputable au recul de l'âge au mariage. Ces changements résultent à leur tour d'une série d'améliorations d'ordre socioéconomique qui tendent à encourager des familles moins nombreuses et un recul de l'âge au mariage. Citons, par exemple, les progrès constatés dans le niveau d'instruction, les possibilités d'emploi et la condition des femmes; la baisse de la mortalité infantile, la diminution des possibilités d'emploi pour la main d'oeuvre enfantine et une moindre dépendance à l'égard des enfants en tant qu'assurance-vieillesse. Il convient également de mentionner les programmes de planning familial (PF) dont le but est de diffuser largement des contraceptifs modernes et de fournir des services d'information et d'éducation dans ce domaine.

Dans les trois pays d'Amérique latine, ce sont les effets conjugués de ces deux facteurs une amélioration sensible des indicateurs sociaux et économiques et l'existence de services de planning familial bien développés et efficaces,

en l'occurrence fournis par des organisations non gouvernementales (ONG) et quasi-publiques, et par des voies commerciales qui ont engendré les transformations démographiques observées. L'Indonésie a elle aussi connu des progrès socioéconomiques appréciables mais, dans ce pays, la société est plus traditionnelle et rurale, et les taux de mortalité maternelle et juvénile y sont plus élevés. Le programme de planning familial lancé sous l'égide du Gouvernement a compensé cette différence de diverses façons, dont la plus importante peut-être est le vaste réseau efficace d'animateurs qui s'étend jusqu'au plus petit village. Face à des progrès socioéconomiques encore plus modestes, le programme de l'Inde à également compensé ce manque d'amélioration mais de façon différente, en focalisant l'effort, de façon très étroite mais efficace, sur la stérilisation. Ce programme a cependant essuyé des revers à cause des répercussions politiques qu'ont suscité des campagnes périodiques de coercition. Ayant réussi à toucher une grande proportion de couples désirant cesser de procréer, le programme de l'Inde a maintenant atteint le stade des rendements décroissants. Le cas du Kenya est intéressant car les progrès socioéconomiques importants des 25 dernières années semblent avoir engendré une forte demande latente de limitation des naissances qui n'a commencé à se manifester que très récemment. Une longue période de gestation aboutissant à un programme efficace, ajoutée aux encouragements énergiques du Président et d'autres dirigeants, semblent finalement avoir fait une différence. Au Sénégal, par contre, le développement socioéconomique et l'état d'avancement du programme ont été insuffisants pour avoir un impact sensible sur la fécondité.

Le cas du Bangladesh est particulièrement intéressant dans la mesure où il y a un programme bien développé mais des progrès socioéconomiques très modestes — cas quasi classique d'un pays qui a décidé d'agir sur l'offre dans une situation où l'on ne s'attendait pas à trouver beaucoup de demande. Or, même dans ce cas, il devait exister une demande latente suffisante pour aboutir aux taux de prévalence de la contraception et à la baisse de la fécondité enregistrés jusqu'à présent. Reste à savoir jusqu'à quand ces progrès pourront se poursuivre en l'absence de modifications structurelles profondes modifiant la demande[1]. Le rapport envisage plusieurs explications possibles et préconise une action de recherche. Des travaux de recherche sont importants non seulement pour l'avenir du programme du Bangladesh, mais pour les enseignements qu'on pourra en tirer pour des pays dont la situation est analogue.

Le rôle de la Banque dans chaque pays

Indonésie. La Banque a beaucoup contribué, sur le plan financier, à l'effort global de développement de l'Indonésie, mais ses prêts au secteur de la population n'ont représenté que 1 % de son aide totale. Ce montant a contribué pour environ 10 % aux dépenses totales consacrées par l'Etat à son programme de population, la part des autres bailleurs de fonds, y compris les ONG, s'élevant à 20 %. En fournissant ces fonds, la Banque a joué un rôle assez traditionnel en ce sens qu'elle a agi plus comme une banque que comme une institution de développement : dans l'ensemble, c'est comme une banque commerciale qu'elle a réagi aux propositions de projets qui lui étaient soumises par les autorités indonésiennes; elle n'a fourni qu'une assistance technique limitée pour la préparation et l'exécution des projets dans ce secteur et, pour ces projets, elle s'est contentée de financer les travaux de génie civil et le matériel. La Banque a cependant élaboré et financé un vaste programme d'éducation en matière de population, mais, pour les autres aspects non matériels, elle a généralement soutenu l'exécution des projets mis au point par le BKKBN (Programme national de planning familial de l'Indonésie) avec l'assistance technique d'autres bailleurs de fonds. Pendant presque toute la période à l'étude, la Banque n'avait aucun spécialiste résident responsable de ce secteur et le travail sectoriel a été limité.

Sauf peut-être pendant ses premières années de participation au programme, l'approche suivie par la Banque était parfaitement justifiée. Les autorités indonésiennes savaient ce qu'elles voulaient, et elles s'étaient montrées compétentes au niveau de l'exécution. Le BKKBN n'est-il pas généralement considéré comme l'une des organisations de planning familial les plus efficaces dans le monde. D'autres bailleurs de fonds — en particulier l'Agence des Etats-Unis pour le développement international (USAID) — jouaient alors un rôle très actif dans l'élaboration de principes opérationnels et de tactiques d'exécution. C'était-là, de fait, une division du travail rationnelle, qui était bien appréciée par les autorités indonésiennes.

Le rapport examine cinq domaines dans lesquels la Banque aurait peut-être pu faire davantage, ou agir différemment, en Indonésie. 1) Il aurait été utile d'avoir dans le pays un spécialiste résident qui reste plus longtemps et prenne une part active à l'élaboration et l'exécution des programmes. 2) La collaboration avec d'autres bailleurs de fonds aurait pu être meilleure durant les 15 premières années de participation de la Banque. Cet aspect du programme s'est fortement amélioré depuis. 3) La Banque aurait pu encourager les autorités à agir plus tôt et plus résolument dans le

1. Cette façon de présenter les choses implique que les activites d'information, éducation et communications (IEC) font partie intégrante des programmes de planning familial, c'est-à-dire qu'il s'agit de mesures axées sur l'offre. On suppose en effet que si les services d'IEC peuvent diffuser l'information et encourager la demande, il doit y avoir d'ores et déjà une certaine prédisposition — une demande latente créée par des forces culturelles, sociales ou économiques fondamentales — pour que ces efforts puissent aboutir.

secteur de la santé, surtout en contribuant vigoureusement à promouvoir la santé maternelle et infantile (SMI) et son intégration avec le planning familial. Elle vient seulement de commencer à le faire. 4) Pour stimuler la demande de familles moins nombreuses, la Banque aurait pu encourager l'élaboration de stratégies autres que le planning familial, par exemple, en aidant à mettre sur pied des projets visant à améliorer les possibilités d'éducation et d'emploi offertes aux femmes. Il reste encore beaucoup à faire dans ce domaine. 5) Il est toujours nécessaire de renforcer le travail de recherche et d'évaluation, et ce pour au moins deux raisons : pour tirer de cette expérience concluante des enseignements utilisables ailleurs[2] et pour bien intégrer les moyens de recherche et d'évaluation dans le BKKBN, cette fonction ayant été jusqu'ici négligée.

Cependant, des améliorations n'étaient manifestement pas nécessaires dans ces domaines étant donné les progrès notables réalisés jusqu'à présent. En outre, les efforts de la Banque auraient pu se heurter à l'opposition du BKKBN et des autres bailleurs de fonds qui préféraient que celle-ci se borne essentiellement à financer les constructions et le matériel. La Banque s'est conformée aux voeux de son client, ce en quoi elle a eu raison car l'Indonésie avait des moyens considérables et recevait en plus l'assistance d'autres bailleurs de fonds.

En Indonésie, une approche différente pourrait s'avérer nécessaire à l'avenir, et ce pour trois raisons importantes. Premièrement, le pays a beaucoup moins besoin de programmes massifs d'infrastructure. Deuxièmement, l'USAID a indiqué son intention de réduire sa contribution, en partie parce qu'elle estime que l'Indonésie a maintenant moins besoin d'assistance technique et de dons. Avec l'assistance de l'USAID, le BKKBN a déjà réagi en prenant des dispositions pour encourager le secteur privé à promouvoir et à distribuer les services. Troisièmement, la formule qui a permis de ramener le taux de fécondité de 5,5 à 3,5 enfants par femme ne permettra peut-être pas d'atteindre le niveau de remplacement de 2,1. Face à ces changements, la Banque peut faire deux choses : réduire le champ de ses activités, à l'instar de l'USAID, ou essayer d'occuper le vide laissé par cet organisme. Selon le rapport, ces deux approches sont nécessaires, en fonction des problèmes en jeu.

Inde. En Inde, comme en Indonésie, la Banque jusqu'à récemment s'est comportée davantage comme une banque traditionnelle que comme une institution de développement. Dans ce cas, ce rôle était cependant beaucoup moins justifié à cause des problèmes stratégiques liés au programme, à savoir : une concentration excessive sur la stérilisation, ignorant la nécessité pour les couples jeunes d'espacer les naissances et (comme il est noté plus haut) aboutissant maintenant à des rendements décroissants; un manque d'attention accordée au fonctionnement et à la qualité du programme (par opposition à l'expansion); une centralisation excessive et le recours à un système unique de prestation; et un désintérêt pour les facteurs pouvant influer sur la demande. Ces problèmes ont persisté, et sont connus depuis au moins aussi longtemps que la Banque participe au programme de l'Inde.

Le manque d'influence de la Banque sur le programme de l'Inde s'explique par divers facteurs. 1) Lorsqu'elle a lancé son premier projet de population en Inde en 1972, la stratégie du pays était déjà bien établie. 2) Si les montants prêtés ont constitué 28 % de la totalité de son portefeuille au secteur de la population jusqu'en 1988, ces sommes ne représentaient qu'une petite fraction — 3,6 % entre 1980 et 1988 — des dépenses totales consacrées au Programme de protection de la famille de l'Inde. Les bailleurs de fonds, pris ensemble, ont contribué pour 12 à 14 % aux dépenses publiques, mais ils n'ont jamais formé une coalition efficace. 3) La nature étroitement régionale des cinq premiers projets a dissuadé la Banque d'intervenir dans des questions de politique générale qui dépassaient ce cadre régional (géographique) et a découragé l'innovation, même dans ces régions[3]. 4) Tant les études sectorielles que le temps de travail consacré par le personnel de la Banque au programme ont été insuffisants. Avant 1988, peu de travail sectoriel a été fait — certainement pas assez pour que la Banque soit en mesure de proposer des changements tactiques, par exemple, de suggérer comment on pourrait modifier les structures du programme — incitations, suivi et responsabilités — pour donner plus de poids aux méthodes non irréversibles. Le temps de travail consacré par le personnel de la Banque — sur place comme à Washington n'était pas non plus suffisant pour permettre à la Banque d'intervenir de plus près.

Depuis 1987, plusieurs changements importants se sont produits. Le Gouvernement comme la Banque semblent avoir été déçus par les résultats des projets régionaux et sont prêts à adopter une approche différente. Les sixième et septième projets, amorcés en 1989 et 1990, témoignent de cette évolution puisqu'ils portent sur des volets prioritaires du programme au niveau de l'Etat. Ils prévoient également un appui pour les ONG et le programme de ventes subventionnées. Deuxièmement, depuis 1987, la Banque a produit

2. Par exemple, quels sont les facteurs qui expliquent le succès des opérations communautaires de ce pays? Ces facteurs sont-ils uniques à l'Indonésie ou peuvent-ils être appliqués à d'autres pays?

3. C'est là un point contestable. L'argument au départ était que la Banque aurait dans ces domaines plus d'influence qu'elle n'en pouvait avoir dans le programme global. Il est probable que cela ne s'est pas passé ainsi, non pas parce que le concept était mauvais, mais parce que les interlocuteurs indiens n'ont jamais accepté que les domaines d'action appuyés par la Banque puissent être différents des autres, et parce que la Banque n'a jamais pris l'initiative d'élaborer, pour ses projets, des plans détaillés qui auraient explicité ce point avant l'exécution.

plusieurs études sectorielles de qualité qui semblent avoir un effet sur les attitudes en Inde et sur la nature du dialogue. Le Projet survie de l'enfant et maternité sans risque envisagé pas la Banque focalise pour la première fois l'attention sur des questions de santé qui ont une grande influence sur les décisions en matière de fécondité. Ce projet s'intéresse également de plus près aux opérations sur le terrain qui, dans le passé, se sont révélées un gros obtacle à la mise en oeuvre des réformes. Enfin, la Banque a beaucoup intensifié les efforts qu'elle déploie dans le secteur de l'éducation, en particulier en faveur des femmes.

Toutes ces initiatives sont encourageantes, mais le résultat dépendra pour beaucoup de la vigueur et de la constance avec lesquelles elles sont menées. La Banque, pour sa part, devra continuer, par ses études sectorielles et ses travaux de recherche, de chercher des moyens pratiques de résoudre les problèmes structurels; continuer de militer — énergiquement lorsque c'est nécessaire — pour que les résultats de ces travaux soient appliqués; faire plus d'efforts pour mobiliser l'appui d'autres bailleurs de fonds dans cette entreprise; et accroître le temps et les efforts consacrés à la supervision des opérations sur le terrain. Pour cela, la Banque aura probablement besoin d'utiliser tant au siège que sur le terrain, plus de personnel connaissant bien les problèmes en jeu.

Bangladesh. Le programme du Bangladesh souffre à peu près des mêmes faiblesses que celles qui caractérisent le programme indien. Si le pays fait une place moins importante à la stérilisation, la qualité des services de planning familial est médiocre, le programme de SMI est déficient et mal intégré au planning familial, et la pénurie de gestionnaires et de traditions administratives enracinées rendent toute amélioration difficile. En outre, il ne faut pas oublier que le programme opère dans un environnement physique extrêmement difficile où des crises périodiques exigeant une attention prioritaire des autorités menacent constamment les progrès accomplis.

Néanmoins, les progrès réalisés pour accroître la prévalence de la contraception et réduire la fécondité sont, pour la majeure partie, imputables au programme. Les activités de vulgarisation, qui sont plus étendues et plus dynamiques qu'en Inde malgré leurs limitations, sont probablement l'élément qui fait la différence. En outre, les bailleurs de fonds ont pris une part plus active à la planification et aux opérations, ce qui a en fait démultiplié les moyens d'exécution de l'administration. Il convient à cet égard de louer la Banque qui, en l'occurrence, a joué un rôle actif et influent.

Le rapport énumère sept facteurs qui semblent avoir été essentiels. 1) Le Gouvernement est manifestement résolu à résoudre son problème de population : il a consacré une part appréciable de ses ressources budgétaires et gestionnelles limitées au programme, et a sollicité et utilisé activement l'assistance et les conseils de l'extérieur. 2) Le volume de l'assistance financière et technique extérieure a été substantiel. 3) Une part considérable de cette assistance financière, même dans le cadre des cinq projets de population appuyés par la Banque, a été fournie sous forme de dons par des cofinanciers, ce qui a permis d'agir avec plus de souplesse et d'axer les efforts sur les éléments non matériels, et en même temps de financer un un apport supplémentaire de personnel de la Banque, tant au siège que sur le terrain. 4) Avec ces ressources additionnelles en personnel et les encouragements du Gouvernement, la Banque est intervenue activement dans toutes les phases de ces projets — conception, mobilisation des fonds, coordination avec les bailleurs de fonds, exécution et évaluation — beaucoup plus activement qu'elle ne le fait normalement dans les projets qu'elle soutient. 5) La collaboration entre les bailleurs de fonds a été très étroite, et les cofinanciers, qui ont généralement fourni plus de la moitié du financement de ces projets, ont joué un rôle de plus en plus actif. Leur degré de participation est maintenant devenu si étroit qu'il serait plus juste de voir le quatrième projet comme un projet consortial que comme un projet de la Banque. 6) Grâce aux dons qui ont été fournis, on a pu intégrer une certaine souplesse dans le programme, notamment en créant un Fonds pour les projets novateurs et une Cellule de financement des projets. 7) Les enseignements tirés des projets pilotes ont été mis à profit pour améliorer la performance du programme.

Dans ce cas, il y a lieu de penser que le programme devrait être poursuivi dans le sens des orientations actuelles pendant les années à venir. D'après certaines enquêtes, il existe une masse d'utilisateurs potentiels qui n'ont pas encore été touchés par les services, et il est prouvé que le taux de prévalence est plus élevé là où la densité des points de services est grande, où les contacts avec les agents du planning familial sont fréquents et où les services sont de qualité. Toutefois, même si l'on portait le taux de prévalence actuel de 35 % au niveau de 50 % obtenu dans la zone pilote de Matlab — ce qui est peu probable à l'échelle nationale — l'indice synthétique de fécondité serait d'environ 3,7, ce qui est encore bien supérieur au niveau de remplacement. Pour abaisser encore ce taux en un laps de temps raisonnable, il faudra probablement réorienter le programme de façon à compléter l'approche actuelle axée sur l'offre par d'autres types d'action. Si le nombre d'enfants idéal par famille semble avoir diminué au Bangladesh, même en l'absence de progrès socioéconomiques sensibles, une nouvelle diminution serait plus sûre et plus rapide si l'on pouvait opérer des changements structurels tendant à accroître la demande de familles moins nombreuses.

Brésil, Colombie et Mexique. A la différence des autres pays, ces pays n'ont reçu de l'extérieur qu'une faible part des fonds consacrés au planning familial, et ce sont des

ONG, et non des organismes multilatéraux ou bilatéraux, qui ont fourni la majeure partie de ces fonds[4]. La contribution de la Banque a été minimale. Elle n'a financé aucun projet de population dans ces pays. (Un projet a été préparé pour le Mexique, mais il a été arrêté lorsqu'un nouveau gouvernement est arrivé au pouvoir.) Peu d'efforts ont été faits pour mettre à exécution les quelques éléments de planning familial inclus avec la SMI dans les projets de santé financés par la Banque, et ce sujet a rarement été abordé dans le dialogue avec les pouvoirs publics. Au moins jusqu'en 1989, très peu d'études sectorielles ont porté directement sur les questions de population ou de planning familial. De surcroît, si les prêts aux autres secteurs ont sûrement eu des effets indirects, ils n'ont jamais pris en compte la dimension démographique.

Trois facteurs semblent expliquer ce désintérêt apparent. 1) A cause des résonnances politiques des politiques de régulation des naissances préconisées par l'étranger il était difficile pour le personnel de la Banque d'aborder cette question avec les gouvernements. Aux yeux de ces derniers, les positions de la direction de la Banque étaient inacceptables; pris entre deux feux, le personnel de la Banque a réagi par l'inaction. 2) A l'époque où la Banque a commencé à prêter pour les services de santé — ce qui aurait pu être un véhicule plus acceptable pour promouvoir la PF — la prévalence de la contraception était déjà relativement élevée et la structure de prestation des services bien établie. 3) Dans ces pays, les organismes chefs de file étaient des ONG ou des organismes semi-publics. Compte tenu de l'attitude des gouvernements, la Banque (à la différence de l'USAID) n'avait pas encore trouvé le moyen de travailler directement, ou même indirectement, avec ces organismes, comme elle a su le faire au Kenya et ailleurs.

L'approche actuelle de la Banque en Amérique latine consiste à mettre l'accent sur l'hygiène de la reproduction et sur la maternité sans risque comme justifications des activités de planning familial. Cette approche semble appropriée, et une attitude plus agressive ne serait ni justifiée, ni judicieuse sur le plan politique. Il n'en reste pas moins d'importants aspects — équité, qualité des services et choix — à résoudre, et ces aspects s'inscrivent de toute façon dans le contexte plus large des questions sur lesquelles la Banque travaille actuellement dans le secteur de la santé[5].

Ces cas d'Amérique latine sont importants car ils mettent en cause le bien-fondé des prêts de la Banque au secteur de la population. Si la Banque veut travailler dans des pays qui n'acceptent pas la limitation des naissances comme finalité de son action, elle doit alors fonder son programme de population sur des principes plus généraux et plus souples. On pourrait, par exemple, commencer par reconnaître que l'objectif global est de promouvoir une amélioration durable du niveau de vie et que les programmes de planning familial sont utiles au niveau microéconomique — en améliorant la santé et les choix de la famille — ainsi qu'au niveau macroéconomique. Dans ce contexte, il y a lieu d'inclure ces programmes dans les thèmes des discussions de politique générale et de l'analyse sectorielle, afin de déterminer comment, le cas échéant, ils devraient être conçus et utilisés dans des circonstances spécifiques. En outre, ces études de cas posent la question de savoir s'il est souhaitable, dans certaines circonstances, de prêter pour des projets purement de population, plutôt qu'à des projets de santé ayant des volets de planning familial. Si elle avait adopté cette approche plus tôt et plus systématiquement, la Banque n'aurait pas rencontré autant d'opposition et de méfiance dans ces pays.

Kenya. Cette étude de cas montre bien combien il est utile — et nécessaire d'être patient et persévérant dans le domaine de la population. Malgré les efforts intenses déployés par les bailleurs de fonds, depuis la fin des années 60, pour convaincre les autorités de lancer un programme de grande envergure, ce n'est qu'en 1988–89 qu'on a commencé à voir baisser la fécondité.

En plus d'un appui à l'effort global de développement économique, qui comportait des fonds importants pour l'éducation, la contribution de la Banque a pris essentiellement deux formes. A partir de 1974, quatre projets ont été financés. Les deux premiers ont mis des fonds à la disposition du Ministère de la santé pour la création d'un réseau de centres ruraux de formation et de soins de santé; les volets de planning familial de ces projets laissaient à désirer et ont été largement ignorés pendant l'exécution. Durant cette période, le taux de croissance de la population a en fait augmenté. Les troisième et quatrième projets faisaient une plus grande place aux activités de population et de planning familial, mais ils ont été lancés trop tard (1988 et 1990) pour avoir influencé les tendances de la fécondité. La contribution de la Banque a prix une deuxième forme, à savoir son dialogue avec les pouvoirs publics, ses travaux sectoriels et les efforts qu'elle a faits pour influencer de diverses façons l'évolution du programme. C'est ainsi qu'elle a réussi à convaincre le Gouvernement de créer, en dehors du Ministère de la santé, un organisme de coordination interministériel pour les questions de population (condition à laquelle était assujetti le deuxième prêt d'ajustement structurel), puis de lui confier davantage de responsabilités; et elle s'est efforcée de persuader le Ministère de la santé de libéraliser les directives de distribution des contraceptifs, d'intégrer la PF aux activités traditionnelles du Ministère de la santé et d'offrir des services de stérilisation. Ces deux lignes d'ac-

4. Certaines ONG internationales ont cependant bénéficié d'appuis bilatéraux et multilatéraux, en particulier de l'USAID et du Fonds des Nations Unies pour les activités en matière de population (FNUAP).

5. Il convient de signaler à cet égard l'existence d'un très grand nombre d'avortements illicites dans ces pays. Voir Singh et Wolf, 1991.

tion ont été des éléments importants d'une stratégie globale qui comportait une assistance technique et une aide en nature d'autres bailleurs de fonds, et, plus important encore peut-être, des signaux explicites du Président du Kenya indiquant qu'il fallait prendre au sérieux le planning familial.

La Banque aurait-elle pu faire quelque chose pour accélérer ce processus? Si elle aurait pu faire beaucoup plus d'efforts pour mettre sur pied des composantes efficaces d'IEC, de vulgarisation, de suivi, d'évaluation et de recherche, la Banque s'est montrée assez résolue, face au Gouvernement, sur un grand nombre de ces questions et semble avoir tiré parti des occasions qui s'offraient à mesure qu'elles se présentaient. Dans ce cas, l'absence d'agents résidents affectés à ce secteur ne semble pas avoir été une grosse entrave vu l'existence d'amples ressources pour la supervision et les déplacements, et la contribution apportée par d'autres bailleurs de fonds qui disposaient eux, d'un personnel technique sur le terrain.

Le programme semble être plus ou moins sur la bonne voie pour le moment, et il faudrait continuer de le développer, tout en mettant beaucoup plus l'accent sur la qualité des services, la vulgarisation et les services d'IEC. Toutefois, même si l'on arrivait à combler totalement l'écart entre le nombre d'enfants idéal et le nombre d'enfants effectif par famille, l'indice synthétique de fécondité serait encore de 4 à 5 enfants, ce qui implique un taux de croissance de la population encore supérieur à 2 % par an. Entre 1984 et 1987, le nombre idéal d'enfants est tombé en moyenne de 5,8 à 4,4. Pour accélérer cette évolution, une stratégie axée sur l'offre ne suffit plus. Le rapport propose un certain nombre d'options, mais fait valoir que la recherche et les études pilotes sont extrêmement importantes dans ce cas, car on ne sait pas encore très bien comment on peut aider à réduire le nombre d'enfants idéal dans un système fortement nataliste.

Sénégal. A part un projet de santé rurale, conçu en 1982, qui consistait à financer des constructions et du matériel pour étendre les services de santé de base, la Banque, jusqu'à une date encore récente, s'est efforcée avant tout d'aider le Gouvernement à élaborer une politique générale en matière de population. Cette stratégie avait été recommandée par une étude sectorielle de 1985–86, qui avait conclu que l'USAID et le FNUAP faisaient déjà tout ce qui pouvait être fait utilement pour développer les services de PF. Pour mettre en oeuvre cette stratégie, la Banque a décidé, entre autres, de faire de l'élaboration de cette déclaration de politique de population l'une des conditions d'un prêt à l'ajustement structurel. Certains responsables gouvernementaux ont peut-être accédé à cette demande parce qu'elle paraissait assez anodine, mais cette déclaration et son processus d'élaboration ont fait boule de neige et entraîné de grands progrès, progrès qui auraient sinon été beaucoup plus lents, à cause de la stagnation sociale et économique observée ces dernières années. Cette stratégie pourrait être particulièrement importante en Afrique francophone à cause de son héritage colonial nataliste avec lequel il faut rompre explicitement et publiquement si l'on veut légitimiser les activités de planning familial.

La décision de la Banque de se concentrer sur l'élaboration d'une politique d'ensemble était probablement justifiée à l'époque car, contrairement aux autres bailleurs de fonds, elle n'avait pas le personnel de terrain voulu pour mettre à exécution des opérations plus complexes, mais elle avait accès aux plus hauts responsables du fait que son programme d'action était beaucoup plus vaste. Plus récemment, la Banque a décidé de jouer un rôle beaucoup plus dynamique en lançant un projet qui, entre autres, vise à offrir des services de planning familial et autres au plus bas échelon du système de soins de santé sénégalais. C'est là une entreprise risquée. L'USAID, par exemple, se contente d'agir au niveau juste au-dessus, car l'Etat a des moyens si limités pour administrer et fournir les services. Etant donné la nature urgente du problème, il est probable que ces risques valent la peine d'être pris et qu'on peut les contenir dans des limites acceptables en commençant à petite échelle et en élargissant les opérations lentement; ce type de projet requiert cependant une supervision beaucoup plus intense et plus étroite que celle qui caractérise normalement les projets de la Banque au Sénégal.

Problèmes clés à résoudre pour la Banque

L'expérience acquise ces 20 dernières années montre clairement que, même dans les pays pauvres qui n'ont pas encore fait beaucoup de progrès sur le plan social et économique, on peut amorcer une baisse de la fécondité avec un programme type de planning familial centré sur la distribution de moyens de contraception, de services et information connexes. Cette baisse interviendra plus rapidement si le programme fait une grande place à la vulgarisation et fournit des services de qualité adaptés aux besoins des clients. Cette stratégie exige un bon encadrement sur le terrain, une bonne formation et une bonne motivation — autant de conditions qui sont difficiles à réunir dans les zones rurales pauvres.

Toutefois, il ne semble pas, même avec le programme le mieux administré, qu'on puisse faire beaucoup plus que répondre aux besoins de ceux qui sont déjà prédisposés à accepter des services de planning familial[6]. Dans tous les cas étudiés, même si toutes ces personnes participaient à un

6. L'étude du cas du Bangladesh peut nous amener à modifier cette affirmation. Il est plausible que dans ce cas le succès des efforts d'IEC et l'effet de démonstration d'une prévalence croissante de la contraception aient contribué à réduire le nombre d'enfants idéal, malgré l'absence de progrès socioéconomiques.

programme de planning familial — ou même si l'on pouvait étendre à tous le pays les taux de prévalence de la contraception les plus élevés enregistrés dans les meilleurs programmes pilotes — il n'y a pas un seul pays parmi les huit, sauf peut-être les trois d'Amérique latine, où l'indice synthétique de fécondité tomberait à un niveau acceptable[7]. D'autres types d'interventions seront nécessaires si l'on veut aller plus loin. Des stratégies axées sur l'offre peuvent être suffisantes pour ramener de 6 à 4 l'indice synthétique de fécondité, mais, en l'absence de transformations socioéconomiques profondes, une stratégie différente sera probablement nécessaire pour le ramener de 4 à 2.

La Banque n'a pas su élaborer des programmes centrés sur cette question. Les efforts les plus importants qu'elle a faits dans ce sens ont consisté à promouvoir le développement social et économique général. Plus que tout autre facteur, c'est là probablement le moteur le plus puissant que nous connaissons pour réduire le nombre idéal d'enfants et encourager l'espacement des naissances. Mais ces efforts n'ont pas été entrepris dans la perspective des effets démographiques qu'ils pouvaient avoir. Si cela avait été fait — si la Banque avait cherché, en favorisant le développement, des moyens d'intervention sélectifs susceptibles de modifier les avantages et coûts implicites des familles nombreuses — elle aurait sans doute pu accomplir bien davantage. Il est bien connu, par exemple, que le fait d'instruire les femmes — ou le simple fait de les garder à l'école quelques années de plus — tend à reculer l'âge au mariage et à abaisser les taux de fécondité des couples en question. Il y a d'autres moyens d'intervention prometteurs, et notamment les programmes qui visent spécifiquement à accroître les chances de survie des enfants jusqu'à l'âge adulte, la création, pour les femmes, de possibilités d'emploi, entrant en concurrence avec le métier de mère (par exemple, un travail d'usine ou de bureau plutôt qu'un travail à la ferme) et l'amélioration des programmes de sécurité sociale pour que les adultes ressentent moins la nécessité d'une famille nombreuse pour avoir ce type de sécurité.

Des études antérieures du programme de la Banque dans le secteur de la population avait recommandé de mettre davantage l'accent sur ces facteurs liés à la demande, mais peu d'efforts ont été faits pour que cette recommandation débouche sur des programmes opérationnels. Plusieurs facteurs expliquent cette inaction : scepticisme quant à la nécessité d'interventions axées sur la demande; doutes sur ce qui pouvait être accompli; et compartimentalisation et inertie du personnel. Cette situation est peut-être également due au fait que la population est généralement traitée comme un secteur à part qui relève administrativement d'un service donné, ce qui libère implicitement les autres services sectoriels de cette responsabilité. Or la population n'est pas un secteur d'activité distinct, pas plus que le développement économique ou la réduction de la pauvreté. Dans ces trois cas, il s'agit plus d'objectifs stratégiques dont la responsabilité incombe à tous les secteurs.

Depuis 1987, on a assisté à plusieurs changements qui ont des répercussions positives sur la situation au sein de la Banque. L'intégration administrative de l'éducation, de la population, de la santé et de la nutrition a permis et encouragé une réflexion sur la façon dont chaque secteur pouvait concourir à la réalisation des objectifs des autres secteurs. Certaines initiatives, *Le rôle de la femme dans le développement* et *La survie de l'enfant*, focalisent actuellement l'attention sur deux des possibilités les plus importantes[8]. Plusieurs composantes prometteuses commencent à apparaître dans les projets d'éducation. Cependant, on pourrait et on devrait faire bien davantage. La Banque est exceptionnellement bien placée pour cela.

En plus d'indiquer la nécessité d'élargir le champ des activités de population, les études de cas proposent plusieurs améliorations qui peuvent être apportées dans les projets de population et les secteurs d'activité plus traditionnels. Les premiers projets tendaient à privilégier l'expansion des infrastructures matérielles aux dépens des éléments "non matériels", ces derniers étant censés être pris en charge par l'Etat ou par d'autres bailleurs de fonds. Cette hypothèse s'est avérée plus souvent fausse que correcte, et des mesures ont été prises pour rétablir l'équilibre dans chaque projet. D'après les études de cas, on serait encore loin du compte dans certains pays. Il convient de suivre de près la tendance des projets de population à prendre de l'expansion et à financer un volume croissant de charges récurrentes, afin de ne pas dépasser la capacité d'absorption ni les limites de viabilité à long terme. Pour des raisons connexes, il est nécessaire de se préoccuper davantage de la maîtrise des coûts et de l'efficience interne au sein même des projets et programmes de planning familial. Avant de s'engager massivement à financer la distribution des contraceptifs, il faudrait envisager de plus près la possibilité de financer, dans les grands pays, des moyens de production de contraceptifs. L'aptitude de la Banque et des pays à évaluer l'effi-

7. Dans certains de ces pays, il y a cependant des régions où la fécondité est proche du niveau de remplacement : Yogyakarta (2,1), Bali (2,5), Java-Est (2,6), Kerala, (2,2) et Tamil Nadu (2,6). Dans tous les cas, le développement social et économique et/ou la capacité administrative sont supérieurs à la moyenne nationale.

8. Une autre initiative récente — l'élaboration de projets intégrés de ressources humaines — vaut la peine d'être tentée, mais pourrait en fin de compte ne pas donner beaucoup de résultats. Le danger est que ces projets finissent par être une collection de composantes indépendantes qui sont administrativement très difficiles à administrer. Il serait peut-être plus pragmatique d'élaborer des projets séparés qui intégrent les préoccupations démographiques — par exemple, des projets d'éducation qui visent spécifiquement à scolariser les filles et à les garder à l'école plus longtemps, des projets industriels qui réservent des emplois spécifiques pour les femmes, etc.

cacité des projets et programmes est limitée, et elle le restera tant qu'ils négligeront d'inclure des activités de suivi et d'évaluation et d'établir des capacités de recherche.

Ces études de cas offrent plusieurs enseignements plus généraux. Toute intervention dans le secteur de la population exige de la patience, mais cette patience finit par être récompensée. Cette constatation doit influencer la façon dont les objectifs et les critères d'évaluation des activités de population sont fixés. Les activités hors projet — dialogue, études sectorielles, efforts tendant à définir des orientations, à améliorer l'organisation et à modifier la réglementation — sont très importantes. A certains stades, elles sont plus importantes que l'élaboration d'un projet. Ce type d'activités doit être apprécié à sa juste valeur et encouragé. Citons, par exemple, les efforts remarquables déployés par la Banque l'an passé pour instaurer un consensus en Afrique, lequel, soit dit en passant, a maintenant débouché sur des propositions de projets utiles. Le cas du Bangladesh est particulièrement important car il montre le mérite d'une programmation conjointe des prêts et des dons, et la façon d'opérer cette coordination. Toute ces remarques donnent à penser que le "secteur" de la population fait une utilisation plus intensive de personnel que la plupart des autres secteurs, ce dont il faut tenir compte au plan des ressources.

Enfin, que peut-on dire du niveau global des efforts faits par la Banque dans ce domaine, point sur lequel la Banque a été bien critiquée ces dernières années? Pour se faire une opinion sur ce point, il convient de se rappeler que la contribution financière est à elle seule un piètre indicateur du niveau d'effort, surtout dans le secteur de la population, et qu'on ne peut pas évaluer l'action de la Banque indépendamment de ce que font d'autres donateurs, qui eux disposent de fonds sous forme de dons.

Dans les pays retenus pour les études de cas, rien n'indique qu'un surcroît de ressources financières, pour le type de projets que la Banque finance actuellement dans ces pays, aurait fait une grande différence. Dans certains cas, des fonds supplémentaires auraient été utiles : pour accroître le temps de travail consacré aux fonctions de supervision et d'assistance technique; pour lancer un plus grand nombre d'activités hors projet (plus de d'études sectorielles, un plus gros effort de collaboration et de coordination avec les autres bailleurs de fonds, et un rôle plus dynamique dans certains pays); pour élargir les activités de population en dehors du secteur de la population. Des ressources supplémentaires seront également nécessaires pour développer les activités dans les pays où la Banque n'a pas actuellement de programme. Mais ces changements ne représenteraient qu'une réorientation et une expansion modestes d'un programme qui, dans l'ensemble, paraît être sur la bonne voie.

1. Introduction

This study assesses the role of the Bank in the population sector, by reviewing the specific experience in eight countries. In each case, the study poses the following three questions:

- What demographic and related socioeconomic changes have occurred since 1968, when the President of the Bank first announced that it would begin lending for population?
- What government policies affecting these trends were instituted?
- What role was played by the Bank vis-à-vis other population donors during this period?

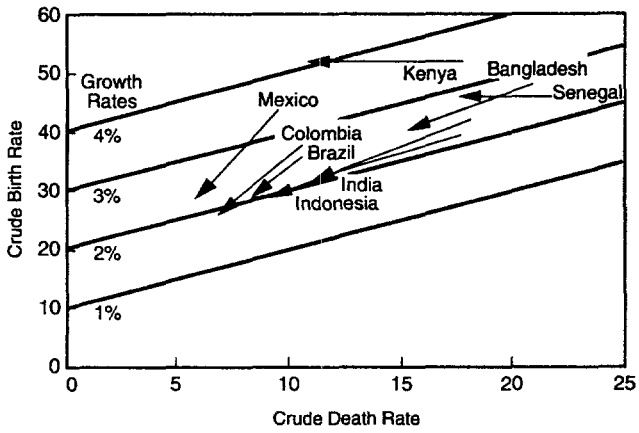
From these case studies, which for the most part take a historic approach to events, a number of cross-cutting issues are extracted for further discussion and suggestions are made for future activities.

The countries examined in this study—three in Asia, three in Latin America, and two in Africa—were selected for two reasons. First, all are countries that would benefit from programs to alter demographic trends. Second, they span the range of experience covered by most developing countries. In all these countries, maternal, infant, and child mortality rates are far above desirable levels for the majority of their populations. So too are population growth rates—even in Latin America, where they are still above two percent per annum. In all of them, high fertility rates are an important factor contributing to these demographic features. Table 1.1 in the statistical appendix provides comparative data on these and other critical indicators of general socioeconomic well-being and advancement for the study countries. Social and economic development may eventually ameliorate the problems of rapid population growth. However, only in Latin America is development likely to occur fast enough to achieve acceptable rates of improvement in the current demographic trends; and even here, there are large pockets of relative backwardness which will lag far behind unless assisted by special programs.

In other respects, the countries selected for this study are very dissimilar. They are at very different stages of social, economic, and demographic development. As Table 1.1 (see statistical appendix) indicates, their values for a variety of development indicators span the range experienced by developing countries as a whole. The range of values specifically for demographic indicators is more clearly seen in Figures 1.1 and 1.2 and warrants special comment. No country in this group of eight is at a stage prior to the beginning of a demographic transition, the point at which population growth rate is low because of high and roughly equal birth and death rates. Senegal and Kenya are clearly in the first stages of demographic transition, in which death rates are falling without commensurate declines in birth rates. The result, predictably, is high and rising population growth rates. In the other six countries, population growth rates are declining at different speeds, almost imperceptibly in the case of Bangladesh and at significant rates in the case of the three Latin American nations. All eight, however, remain far from the third stage reached by many OECD countries, in which birth and death rates are roughly equal at low levels of population growth.

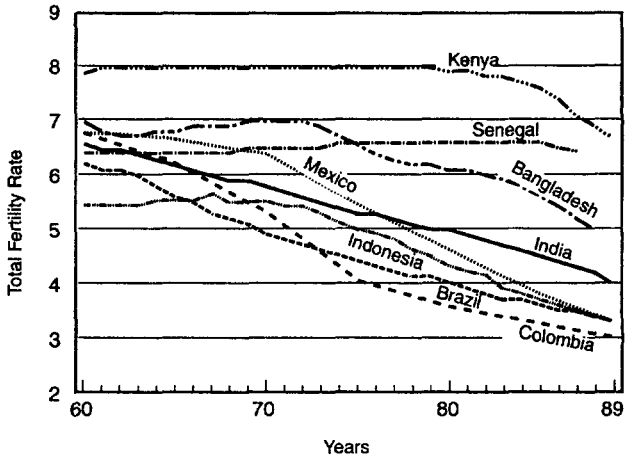
Second, their population programs differ greatly. Senegal's program is the least developed; Kenya's the next least-developed. The Asian countries all have large, well-established family planning programs in place. In Brazil and Colombia, these matters are more or less left to NGOs and para-public organizations, which operate quite sizeable and effective programs. In Mexico, family planning services are offered through both the Government social security system and its Ministry of Health. Third, these countries cover the range of Bank experience with population programs, from very heavy involvement in the case of Bangladesh, to almost no involvement in the three Latin American cases.

Figure 1.1: Case Study Countries, Birth, Death, and Population Growth Rates, 1970–87



Note: Growth rates are natural rates of increase, i.e., excluding migration.
Source: World Bank data.

Figure 1.2: Case Study Countries, Total Fertility Rates, 1960–89



Source: World Bank data.

Thus, these eight cases provide a good sample of experience from which to make generalizations. The following sections review these experiences one by one. This exercise is then used to answer more general questions about the Bank's role in this field. The case study approach allows one to observe and speak to a variety of other issues, for example, what program features commonly work. However, such issues are not discussed in as much depth as the topic warrants, because of the particular focus of this report.

2. *Indonesia*

Demographic Trends

Since 1970, Indonesia's fertility has fallen more rapidly than anyone expected at the time. This was because of its relatively low level of development, its cultural diversity, large areas of Muslim fundamentalism, and a legacy from before the "New Order" period of a bloated bureaucracy, political instability, and a poor health structure.

The total fertility rate, estimated at 5.5 for 1967–70, had fallen to 3.3 by 1984–87. This 40 percent decline, while not as large or as rapid as that in a few other Asian countries, is substantial in terms of the initial expectations. The decline is even more impressive when seen as 65 percent of the distance between the initial high-fertility level and the replacement level of 2.1.

The most important immediate cause of the fertility decline was an increase in the use of contraception by married couples to limit the number of children and to increase the spaced interval between births. In the 1960s, the contraceptive prevalence rate was probably less than 10 percent. By 1976, it had increased to 19 percent, and by 1987, it was 48 percent. Between 20 and 25 percent of the fertility decline was due to an increasing age at marriage. Most of the remainder is accounted for by increased use of contraception.

The significant increase in contraceptive prevalence reflected an increasing demand for small, planned families. Between 1976 and 1982, the mean desired number of children decreased from 4.6 to 3.2, and the proportion of women wanting no more children increased from 37 to 51 percent. By 1987, 42 percent of mothers with two children and 67 percent of those with three said that they didn't want any more children. Forty percent of all currently-married women of childbearing age in 1987 were not yet using contraception and either wanted no more children or wanted to postpone the next pregnancy for at least two years.

While Indonesia's fertility decline is impressive, its population is still growing rapidly—1.8–1.9 percent per annum. This is partly because mortality has fallen along with fertility and partly because it has a very young age distribution, a product of higher fertility rates in previous decades.

Social and Economic Changes

Among the three Asian countries reviewed, Indonesia is most clearly characterized by the kinds of developmental changes generally believed to be favorable to lower fertility rates. A major program for massive increases in educational levels has made primary education virtually universal, greatly increased both secondary and higher education, and produced greater equity for boys and girls. Educational achievement is related in Indonesia to wanting and having fewer children, greater knowledge of and greater use of contraception, and later marriage. There have also been major increases in mass media communications and government-organized information and education programs at the village level. Both the younger and older generations are increasingly linked to the worldwide communication system. The development of a denser and more extensive transportation network has increased the circulation of people, goods, and ideas. There has been an associated increase in the ownership and availability of consumer goods. There have also been improvements in the health and longevity of both children and adults. Undergirding all these changes is broad improvement in the economy and considerable decrease in poverty. Over the period 1965 to 1988, real GNP per capita is estimated have increased by a very healthy 4.3 percent per year.

Associated with social and economic changes have been fundamental changes in the outlook of the young adult population, making them more independent of familial direction. This is evident, for example, in later marriages, a sharp decline in arranged marriages, and increased influence of peer groups. All of these changes are in directions generally believed to be conducive to lower fertility.

One other aspect of Indonesian society pertinent to the success of its family planning program is its unusual capacity for communication to and from the local community level and for mobilizing local community involvement. This is a critical element for a successful family planning program.

These substantial social and economic changes contributed to the fertility decline in two important ways; by decreasing the demand for children and increasing the demand for contraception, and by greatly improving the general national infrastructure which facilitated the work of the national family planning program. In this development context, the National Family Planning Program (BKKBN) helped to legitimize small planned families and provided the contraceptive supplies and services to make that possible. There is little doubt that both the favorable development trends and the effective family planning program contributed to the fertility decline, although these influences cannot be separated and quantified.

Indonesia's Family Planning Program

The BKKBN has created a program that operates effectively at every level—the nation, the 27 provinces, the 301 districts, the sub-districts, and eventually, at the village and hamlet level. Through this hierarchy, it has succeeded in reaching the mass of married couples in the several hundred thousand hamlets below the village level. While activities outside Java are somewhat less intense, the Indonesian program comes closer than any other to achieving the goal of complete, country-wide, community-Board coverage. BKKBN, formally a coordinating rather than a line agency, works through such ministries as those for health, education, home affairs, information, religion, and the armed services. However, BKKBN also has important implementation capacities which enable it to carry out some important activities directly and to test, expand, and hasten new initiatives.

In summary, then, the success of the family planning program is attributable to:

1. The continuing strong government support from the President and through him, the whole administrative structure. Because of this, plus its effective leadership, BKKBN has successfully engaged support from many ministries and agencies, including those for health, education, religion, home, and defense.
2. An administrative structure that facilitates communication and mobilization of action at the grass-roots level for a wide range of development activities, including family planning. This system is unusually effective.[1]
3. Stable and effective leadership. The charismatic chairman of the BKKBN and most of his principal deputies have been in leadership positions for more than 15 years.
4. Significant social and economic development which has affected attitudes about marriage, family life, and reproduction; increased openness to new ideas; and created a transportation and communication infrastructure through which the program could function as it expanded throughout the Indonesian islands.[2]
5. Considerable financial and technical support from international and bilateral donors. This support has not subverted indigenous Indonesian direction of the program, in part because the government has paid an increasing share of program cost, reaching 70 percent by 1980. The BKKBN has been generally successful in gaining and coordinating donor assistance for its policies and it has worked closely with donors in developing new initiatives.
6. Considerable success in working with religious leaders. This has been facilitated by a tradition of working out problems through frequent conferences and discussions in which confrontation is avoided and accommodation and consensus are stressed. Muslim leaders were asked for advice and co-opted to a common enterprise. The effectiveness of this approach is evident in the relatively high acceptance rates, even in areas of Java known to be more orthodox in their Muslim identification.

The Indonesian program has been given a high ranking in the Mauldin-Lapham comparative ratings of family planning programs. Its performance was also very favorably assessed as a model for other agencies in the Bank's comprehensive report on management in Indonesia's development program, and in a book devoted to deriving les-

1. Three features help explain this effectiveness. First, there is considerable social pressure to make decisions by consensus and for individuals to abide by that consensus once reached. Second, everyone in the administrative hierarchy, including the village chieftain, is rated by how well he (and his constituency) achieve agreed-to targets. BKKBN has been successful in getting family planning targets accepted by top levels of the Government as one of the most important to achieve. Third, BKKBN has been successful in placing their representatives throughout the country and providing them with a degree of importance in the eyes of the villagers. Thus, after national targets are agreed to and disaggregated by region, the local BKKBN representative visits community leaders to discuss the extent to which the community can help in their achievement. Once fully discussed and agreed to, social pressure takes over to make individuals feel that it is unfair and socially irresponsible to have too large a family. These features, plus some program activities like the "safaris"—more intensive family planning campaigns that are held periodically—have led some observers to describe the program as coercive. To some extent, one's view of the situation depends on his or her cultural background. No hard evidence has been presented on this matter and BKKBN has never condoned coercive practices.

2. Some of this development resulted from special programs that have supplemented the impact of general economic development. Especially noteworthy is Indonesia's adult literacy and non-formal education program, which is assisted by the Bank. It is among the largest of its kind in the world.

sons from successful management development programs (Samuel Paul, 1982).

Of course, the program is not without its problems. BKKBN has become a large, complex bureaucracy with many of the problems typical of such organizations, including increasing difficulties in maintaining good internal communications and in reacting rapidly and innovatively to changing events. Its strong target-achievement orientation conflicts with equally strong desires to insist on accurate reporting, focus on quality, and promote voluntarism at the local level. Research and evaluation capacity remains inadequate. Uniformity of coverage could be improved. More immediate problems include the need to introduce cost recovery and increase private sector participation in order to compensate for a planned decline in USAID funding of contraceptive supplies (see below) and to improve coordination with the Ministry of Health as the demand for more clinical methods like NORPLANT increases.

However, none of these problems is of a character or degree of severity that threatens future progress. Given the program's strengths and momentum, plus prospects for continued social and economic development, it is highly probable that the contraceptive prevalence rate will continue to rise and the fertility rate will continue to decline during the next few years without any radical change in program directions. Whether the TFR will reach a replacement level of 2.1 in the near future without such a change is an open question, however.

World Bank Involvement

After the announcement of a national family planning program in 1968, the Bank initiated a series of discussions on population policy with government leaders, at least one of which involved a meeting between the President of Indonesia and the President of the Bank. In 1972, the first population project was approved. Three other projects followed, in 1977, 1980, and 1985. Together, these first four have resulted in Bank lending to this sector of US$122.4 million.[3] During the 1980s, these projects contributed about 10 percent of total program expenditures. The Government financed 70 percent—up from 40 percent in the early 1970s. Other donors, including NGOs, financed the remaining 20 percent.[4] A fifth project has just begun. This financial support was probably not of crucial budgetary significance for the program. Not only was the Government strongly committed to the program, but the amounts involved were small relative to the size of the development budget. However, the symbolic value of the Bank's lending and support has been of great importance in legitimizing the program for diverse political and religious groups in Indonesia, particularly in the program's formative years.

Nearly all the Bank lending was provided to BKKBN[5], and two-thirds of this to expand its physical plant and equipment. Approximately 40 percent was used to construct headquarters, warehouses, and training facilities for BKKBN, not only in Jakarta, but in the 27 provincial and 301 district capitals. Another 26 percent went for transport, IEC, and other equipment. The remaining third was used for production of materials and curricula for various programs, including sizeable population education and IEC programs, plus some support for research and evaluation, salaries, and consultants.

The buildings put in place are impressive—significantly better than other nearby government buildings, particularly in the countryside. Had Bank financing not been available, it is probable that the Government would have provided BKKBN with similar buildings, but they would have been built more slowly and been fewer, smaller, and more spartan. The impact of the Bank's inputs, therefore, was to speed up the expansion of the program and to help it achieve status in the eyes of the public and its own staff. Similar comments can be made about the transport and other equipment provided by the Bank loans. They allowed a more rapid deployment of more and better equipment than could otherwise have been afforded. These are not inconsequential achievements, particularly for a new program that must change social mores and overcome doubts to acquire a clientele.

The high-level dialogue that preceded the first of these projects, while not critical for the initiation of this long period of Bank involvement, was certainly useful. Given the high regard in which the Bank was held at the time, this dialogue may have assisted the Government in consolidating support for a forceful program in its early days. It certainly sent a strong message to the staff of both the Bank and the Government about the extent of support the Government could expect from the Bank, and this may have encouraged the country to proceed more rapidly and aggressively than it might otherwise have done.

Dialogue on a more technical and operational level, while it could have been very helpful—especially in the early years when the program was being designed—appears to have played only a minor role until lately. One way to judge this is in terms of sector and analytical work undertaken by the Bank to underpin such dialogue. The first major sector report on population and family planning ap-

3. Includes actual disbursements for the first three projects and the loan amount for the fourth.

4. These estimates are based on a comparison of figures from Repelita III, loan amounts for Population III and IV, and donor contributions for the period 1982-88 taken from *Global Population Assistance Report 1982-88*, UNFPA, New York, 1989.

5. The fourth project provided some support to a newly-created Ministry of Population and Environment.

peared only in 1980, when the third project was about to begin. The second, a review of trends in fertility and contraceptive prevalence, was issued in 1986, one year after the fourth project was initiated. Research and studies included within the population projects do not appear to have contributed much either. In at least two instances in which potentially important operations research studies were included to test out new ideas, the results were not very useful, in part because of inadequate collaboration with Indonesian counterparts in the initial stages. However, two quite recent reports—a study of needs and prospects for the family planning program in the 1990s and a much-needed financial and economic analysis of the population and health sector—are highly relevant to program needs and have influenced the design of the fifth population project, now under implementation.

In addition, of course, the Bank has contributed indirectly to the population program through its other loans to Indonesia. Population lending *per se* has constituted only 0.8 percent of US$14.8 billion lent to date. However, 10 percent has gone to the education sector, 1 percent to health, and the remainder to the major economic sectors—industry, agriculture, transport and communications, etc. While none of these loans was designed or justified in terms of its possible effects on fertility, they must have had a substantial impact on desired family size and the willingness to do something about it. They could, however, have had a larger impact if thought had been given to possible linkages with fertility in their design. This is especially true insofar as education and health projects are concerned. The same might also be true for projects involving communications and transportation. For example, more effort in the education sector might have been put into female education, and in the health sector, into maternal and child health care.

In contrast to the Bank's focus on plant and equipment, other donors have concentrated more on providing commodities and technical expertise that helped, for example, in designing training programs, and improving work routines and managerial system. These donors also financed pilot projects to test new initiatives aimed particularly at involving NGOs and local communitites. Often the Bank came along later to help scale up the more successful of these innovations to full operations. Thus, a *de facto* division of labor has developed in which the Bank has focused on program hardware and other donors, on software elements. The net result for the program has been a fairly well-balanced package of foreign assistance.

It is interesting to observe how these different approaches have been justified. USAID, for example, has become increasingly reluctant to finance construction in most countries on grounds that it requires mostly local-cost finance which governments should be able to finance themselves. On the other hand, USAID *has* been willing to fund recurrent costs (which often also have a low foreign exchange component) when it believed this was necessary for the success of the project. In contrast, the Bank has been willing to provide a larger fraction of local costs when there is a savings or a balance of payments gap which it believes a government is incapable of filling itself. However, the Bank has been reluctant to finance recurrent costs (unless they are incremental, and then only on a declining basis) on grounds that the project is not sustainable unless the government is willing and able to take over recurrent cost requirements by the time the project ends. The two agencies seem to have different views about what constitutes discipline and a show of commitment. A consequence of this difference is that USAID has become involved in program operations to a greater extent than has the Bank, and that may be the point to USAID's willingness to fund recurrent costs.

This situation has also resulted in the Bank being perceived as not providing intellectual leadership to the Indonesian program. This is in sharp contrast to its acknowledged, important intellectual leadership role in macroeconomic policy and some other sectors in Indonesia. While the Bank has population staff capable of playing this role, the implicit or explicit choice was to let other donors with competent resident staff lead the way in this sector.

There are three explanations for the emergence of this pattern. First, the GOI has preferred grants for software components and program operations and loans for capital components. Second, the operating style of various participating agencies has played a role. In contrast to USAID and UNFPA (the largest donors excluding the World Bank), the Bank typically delegates little decision-making authority to the field and has limited field representation. In this case, there was one senior specialist located in Jakarta for about six years during the 1970s. Since it operates at arm's length, Bank staff feel more comfortable with components like construction, which require few changes after the design stage has been completed, as opposed to components like training or IEC, in which learning by doing and adaptation during implementation are more important. Also, it is much easier to develop large projects by focusing on construction. Third, given the intellectual leadership displayed by BKKBN and several major donors, there has been less need for the Bank to become involved in technical policy issues. In the early years, Bank staff sometimes raised questions about the managerial capacity of BKKBN and its frequent reorganizations. Over time, however, this attitude has been replaced with statements of praise and confidence.

After a long period of poor Bank relations with other donors, the situation has greatly improved in recent years, as evident in cooperative funding of specific projects, regular exchanges of information, and cooperative evaluation of program components of mutual interest. Such cooperation

and an improved division of labor among donors would be fostered if reports on various donor activities, at least as they relate to the Bank's activities, were made a regular part of supervision, project completion, and audit reports.

What might the Bank have done better or differently to have increased its contribution in the population field in Indonesia? First, a representative for the Bank in the population field (and possibly also the health and education fields) might have been located in Jakarta for more of the period under review and given some latitude to make adjustments in project components as the need arose.

A case can still be made for locating someone in the field on a long-term basis. In the future, programmatic attention will increasingly focus on improving software components like outreach and IEC, cost recovery, and other financial issues—components not easily handled with an arms-length approach. However, it must be recognized that such a move would have been more productive if undertaken earlier. Now that BKKBN and its programs are well established, the need for more intimate and continuous contact by the Bank is less. Given BKKBN's present capacity to manage and innovate, if additional external financing is required, the Bank should consider program or sector loans. Especially in the case of Indonesia, these might require fewer rather than more inputs from Bank staff.

Second, the Bank might have considered funding recurrent costs at an earlier stage. Had it done so—and if the GOI been willing to accept loans for this purpose—its involvement in program and policy activities might have been more substantial. This issue also continues to have relevance for the future. On the one side, the need for funding contraceptive supplies and services is growing, in part because of successful expansion of the program in the past, and in part because of the need to continue increasing the contraceptive prevalence rate if the target of a replacement fertility rate of 2.1 is to be reached early next century. On the other, USAID and other donors have indicated their intention to scale down participation by 1995. BKKBN is trying to respond to these trends by promoting privatization of supply and greater cost recovery in public programs. The need for external funding will depend in large part on how successful these efforts are. Since they are not likely to be that successful in rural and more remote areas, where the bulk of non-users reside, there can be no doubt that financial requirements will increase. The numbers are not large and certainly smaller than the amounts that have been provided for construction and equipment in recent years, activities which can now be scaled back; but they involve recurrent costs rather than capital costs, for which—as indicated above—both the GOI and the Bank have trouble justifying the use of loan funds.

Third, the Bank might usefully have considered both a more integrated approach to population and health and more substantial strategic assistance to upgrade the health system as a whole. This would have served both health and population objectives. The Fifth Population Project, which includes substantial maternity and child health components and provides over a quarter of its funds to the Ministry of Health, is a promising beginning to correct this bias.

Fourth, the Bank could have done more to assist and encourage BKKBN in upgrading its research and evaluation work. BKKBN has been quite successful at innovating "from the driver's seat," even without many sound research studies that investigate the relationships between inputs and outputs to determine what works and what does not. However, this success may have been due in large part to the rapid social and economic development that took place during the last 20 years, plus the fact that fertility levels were coming down from very high levels. It may be much harder to bring the fertility rate down from its current level of 3.4 to a replacement level of 2.1, particularly if there is a slowdown in economic development during the next decade. The Bank could make a substantial contribution if it could assist the BKKBN in finding ways to upgrade its capacity to undertake research that might assist it as it enters these uncharted waters. Also, the very success of the Indonesian program deserves careful study to determine which of its elements might usefully be employed elsewhere.[6] In the process, the Bank would find itself involved in very challenging intellectual issues, a by-product of which would be a positive change in its image.

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6. For example, much of the success of this program has been attributed to the role of outreach and community institutions in achieving social and behavioral change. How this was achieved and how these community institutions were mobilized for this task is not well understood. Nor is it clear how they might be mobilized to tackle related problems like high maternal and perinatal mortality which require more clinically-based delivery of services.

3. *India*

Demographic and Socioeconomic Trends

Between 1970 and 1987, India's total fertility rate fell from about 6.0 to 4.1, a 32 percent decline. This represents roughly half the distance between the initial rate of 6.0 and the replacement level of 2.1[1]. The current level is roughly the same as the median for developing countries with populations of at least 45 million. Its decline has been considerably less than that of Indonesia, China, or Thailand, but somewhat greater than that of the Philippines, Bangladesh, and Pakistan. This rate of decline has been approximately matched by the decline in mortality rates. The result is that the population growth rate has remained at or slightly above 2 percent per year during the last three decades.

About a third of this decline can be attributed to an increase in the age of marriage, which is quite low in India compared to other Asian countries. Most of the remainder is attributable to a decline in marital fertility resulting from an increase in contraceptive use from 10 to 39 percent over this period. Nearly 90 percent of the supplies and services involved are provided by the Government's program.

Latent demand for contraception appears to have been substantial, even in 1970, before this major decline in fertility. This is reflected in national surveys of that time indicating that half the women of reproductive age wanted no more children and that 80 percent of this group were not using contraception. In other words, 40 percent of all women of reproductive age could be considered "in need" of contraception at that time. By 1980, the increase in contraceptive use had reduced this proportion in need to 18 percent. Between 1980 and 1988, this figure has remained roughly constant, suggesting that further increases in contraceptive use were offset by increases in the proportion of women wanting no more children. This is a notable achievement, but it would be incorrect to assume that there is little remaining unmet need. Indonesia had a comparable 18 percent figure in 1976 in the midst of a continuing increase in contraceptive prevalence, with growing numbers wanting no more children and using contraception. A further indication of latent demand is that by 1988, five out of six women in India , with at least three children wanted no more, and many of those already had more than they wanted. In addition, these figures do not reflect the latent demand for contraception for spacing purposes.

India has made steady but slow progress in improving general socioeconomic conditions. Real GNP per capita grew 1.8 percent per year during the 1965–88 period. The gross primary school enrollment rate for females increased from 56 to 67 percent during the 1970–85 period. Between 1971 and 1989, the infant mortality rate declined from 139 to 91 per 1,000 and literacy among wives increased from 17 to 39 percent. It is probably for this reason that the average desired family size has declined slowly, from 3.65 to 3.4 between 1980 and 1988. This is not much higher than estimates at about the same time for Indonesia (3.2), Mexico (3.0), and Colombia (3.1). However, further progress is likely to be limited without much greater social and economic progress. In particular, improvements in the education and status of women and in child health and longevity are urgently required, especially in India's northern states.

These national figures can be misleading, however, because of the extreme diversity of these indicators within the country. Fertility (and contraceptive prevalence) rates vary greatly among Indian states, from approximately 2.2 in Kerala and 2.6 in Tamil Nadu to between 4.7 to 5.3 in the four northern states of Uttar Pradesh, Madhya Pradesh, Rajasthan, and Bihar, which together constitute 40 percent of India's population. Anrudh Jain (1985) has explained these differences by differences in social development, as indexed by female illiteracy and infant mortality. These

1. These estimates come from Satia (1991). Using the UN estimate of a TFR of 5.7 for 1965-70 and the 4.2 figure for 1988 from the ORG study yields a 25 percent decline.

indices are substantially higher and development program performance has been generally weaker in these northern states.

The Indian Family Welfare Program

The Indian family planning program—renamed the Family Welfare Program in 1977 when MCH was incorporated into it—is the oldest and, with the possible exception of China's, the largest program in the world. Early years were characterized by large-scale IEC campaigns to spread contraceptive knowledge and gain acceptance for a small family as a norm. It was a time when red triangles (the program's symbol) and posters portraying a happy couple with two healthy children became ubiquitous. Those years of naive enthusiasm gave way to periods of frustration that sometimes resulted in coercive campaigns which created a political backlash and set the program back. All the while, however, the principal channel for delivering services was being expanded. Today, there is one primary health center (PHC) per 40,000 and one subcenter (SC) per 5,700 persons, operated by state Ministries of Health and Family Welfare, with budgets and guidance from the center. This is an impressive achievement in a country with a population of close to 850 million. When fully staffed, the PHCs are capable of providing comprehensive health and family planning (FP) services, including sterilizations and IUD insertions. They also support and supervise outreach services operated from subcenters. Services at these subcenters are supposed to be provided by one male and one female multi-purpose worker, who are responsible for rudimentary health, MCH, and FP outreach activities. However, only about half of the male workers are in place in the northern states. Other delivery mechanisms include intensive campaigns to enroll sterilization acceptors in rural areas twice per year and social marketing schemes to distribute condoms and pills. Funding for the program, amounting in 1987-88 to about 7.50 rupees (US$0.50) per capita, comes mainly from the center and constitutes 0.7 percent of the central budget. In addition, a number of public and private agencies—including the postal service, the defense establishment, the railways, and a number of large manufacturing enterprises—have quite active programs. NGOs are not a major force. The Family Planning Association of India, for example, the country's largest and oldest, provides services to about one percent of the population, largely in urban areas.

In addition to its overall impact, the program's major accomplishments include meeting the contraceptive needs of about two thirds of couples not desiring additional children, and making knowledge and general acceptance of family planning—that is, sterilization (see following paragraphs)—nearly universal. Despite these accomplishments, many knowledgeable observers judge the program's success to be modest. In part, this stems from the fact that the program set unrealistically ambitious goals for itself which it could not meet. In addition, many programs which started later than the Indian program have accomplished more, which has contributed to the perception of a comparative lack of achievement. However, these judgements also stem from several major problems with the program's design and operation.

Excessive focus on sterilization. Since the early 1970s, the Indian family planning program has focused on sterilization as the primary means to reduce fertility.[2] Despite rhetoric about a cafeteria approach, little has changed since that time other than a shift in focus from men to women. This emphasis can be seen in the following figures on the percentages of married couples of reproductive age using various types of contraception:[3]

Year	*Total*	*Sterilization*	*IUD*	*Pill*	*Condom*	*Natural Family Planning*
1970	14	6	1	0	3	4
1980	34	22	*	1	5	6
1988	45	31	2	1	5	5

Note: * = <0.5

This focus results from several factors. (1) Targets are set in terms of equivalents to sterilizations, for example, one sterilization being equal to three IUD acceptors, nine pill users, or 10 condom users over a year. In practical terms, a focus on sterilizations means fewer people to contact and motivate to reach a given target. Also, sterilizations require no re-motivation and supply and are easier for supervisors to monitor and verify. (2) Substantial 'compensation payments' are provided only for sterilizations. (Acceptors receive 100 rupees for a sterilization, but only 10 for an IUD insertion and nothing for other methods.) (3) Spacing methods are not readily and reliably available. The program still relies heavily on campaigns and camps for service delivery and neglects the type of regular contact, follow-up, and resupply arrangements required for spacing. Many multipurpose workers still have not been trained to insert IUDs. No regular outlet for condoms exists in a large number of villages—60 percent according to one study. Pills, introduced only recently, are widely considered unsafe and injectables and implants are not yet offered. (4) While

2. In 1965 and 1966, an effort was made to promote the IUD, but it ceased when medical complications began to be reported. In the view of many knowledgeable observers, this was a mistake which set the program back.

3. These figures are derived from ORG surveys. Government service statistics have very similar numbers for sterilizations but higher numbers for temporary methods, which knowledgeable observers believe to be inflated.

knowledge of sterilization is nearly universal—indeed, that is what the words "family planning" mean to many—almost half of women of childbearing age do not know about modern spacing methods.

The emphasis on sterilization has meant that a large fraction of the program's potential audience—younger couples who might be interested in spacing—are more or less ignored. In addition, because of its success in reaching high-parity couples interested in termination, the program is realizing diminishing returns. Indian women on average have their third child around age 30, so even if childbearing after age 30 were completely eliminated by sterilization, the TFR would not decline to replacement levels. India has demonstrated that it is possible to rely on sterilization to bring the TFR down from six to four, but its target of a replacement level of 2.1 will not be possible without placing much more reliance on temporary methods.[4]

Insufficient attention to program operations and quality in the interests of program expansion. This is a general point that may explain a number of program deficiencies, especially weak outreach and poor service quality. The focus of the program managers has been on increasing the inputs believed necessary to increase the contraception prevalence rate. Thus, a great deal of attention has been given to achieving specified norms for the distribution of clinics and staff, but much less attention has been paid to how the system operates. Health centers and subcenters have been constructed, but maintenance is a problem. Staff have been hired and trained, but on-the-job training, supervision, and the establishment of efficient work routines have been neglected. Also neglected are the reporting systems and operations research studies necessary to monitor, test, and make corrections in program procedures, as well as the great regional disparities in culture, level of development, and administrative capacities.

Several surveys have indicated that a large majority of married women have never been visited by a health or family planning worker. This is not surprising, given the large number of tasks and the caseload assigned to the multipurpose workers and the absence of rules for establishing priorities. An important suggestion made in a recent internal Bank report is that both FP and MCH outreach efforts should focus on women who are about to deliver or have recently delivered, since this is the group with the greatest need for both family planing and MCH services. Those who are visited or come into clinics often report that the quality of services is poor. In one study, a third of sterilization acceptors complained of post-operative complications and expressed dissatisfaction with follow-up services. Other studies report low utilization of available services and a preference for private services where available and affordable.

The specification of targets—in terms of numbers of sterilizations performed, IUDs inserted, and condoms distributed—without regard to local conditions and individual needs exacerbates these problems. Program managers should be held responsible for making available high-quality services, tailored to couples' needs as those needs change over their lifetimes. This requires, not rigid, uniform target-setting from afar, but multiple methods, multiple delivery channels, attention to delivering high-quality services, and some form of feedback and client participation.

Excessive centralization and single-channel delivery system. The near monopoly of the Departments of Family Welfare for delivery of services contributes to the above problems. The private sector, which currently provides two thirds of health services, should be enlisted to play a major role. Other government programs—for example the Integrated Child Development Services program which operates in 40 percent of the country's villages—should be involved. Social marketing and community-based distribution systems need substantial expansion and strengthening.

Neglect of factors that influence demand for contraception and small families. Despite rhetoric to the contrary, the Government has focused narrowly on family planning—the provision of supplies, services, and related information—as almost the sole means of reducing the population growth rate. No other agency outside the Ministry of Health and Family Welfare has been assigned any real responsibility for this goal. In particular, the Ministry of Education and its state counterparts have done little to focus on the special educational deficiencies of women, especially in the high-fertility states. Nor has the Government done much to involve NGOs and the private sector. The Planning Commission and cabinet committees are supposed to encourage and coordinate such agencies, but their efforts to date have been unimpressive. Even the Ministry of Health and Family Welfare has neglected programs in its own realm that are important for influencing effective demand, specifically the MCH program and spacing aspects of family planning. Both are needed to reduce infant and child mortality. It is difficult to believe that fertility rates can be reduced much further without resorting again to coercive measures, unless the probability of children surviving is substantially increased.

Defenders of the program argue that there were few effective alternatives to sterilization in the early 1970s. They

4. Anrudh Jain (1989) reported on three computer simulations that make the case very clearly. If sterilizations alone were used to achieve replacement fertility of 2.1 by the year 2020, 55 percent of couples in the 20-24 age bracket would have to be sterilized. If the method mix of 1980 were maintained, the figure would be reduced to 24 percent. If *all* methods were readily available, the figure might be reduced to 7 percent, though it might still have to be 25 percent for the 25-29 years age group. The latter figures may still be unacceptably high, implying that the goal may not feasible.

also maintain that the urgency of the population problem and the magnitude of the administrative problems in a country as large as India justified the use of special campaigns, an emphasis on numbers rather than quality, and the use of targets and incentives. They argue that the focus was on expanding supply rather than demand because of the presumption—which proved to be correct—that substantial latent demand was already present. Moreover, this approach has worked; at the least, it seems to have worked no worse than programs in other countries at similar socioeconomic levels and rates of progress.

The question is whether more could have been accomplished had these problems been resolved and whether this approach can continue to work in the future. In retrospect, the peaks in acceptor rates reached during special campaign years were surely not worth the public backlash, and the program neglect and falloff in acceptors that occurred in subsequent years. Surely, this approach, now fully institutionalized and difficult to change, will find it more and more difficult to make progress in the future. Its modest successes to date not withstanding, little has been done to anticipate the fact that its methods cannot continue working this well in the future.

The Bank's Role Prior to 1987–88

While the Bank's role has evolved over time, it can most easily be characterized by two time periods; that is, before 1987-88 and post-1988. During the first and longer of these (1972-88), the Bank provided a modest amount of financial support. For the most part, this assisted the Government in carrying out its preconceived plans, and it had little influence on the program's directions. This judgement is based on a review of the magnitude and timing of the funding, the nature of the projects and the way they were administered, the character of the dialogue and sector work involved, the role that the Bank played in other sectors, and the Bank's relations with other donors during this period.

Magnitudes and timing. Implementation of the first Bank-financed population project was initiated in 1972, long after India's approach to its population problems was firmly entrenched. Up to 1988, the Bank funded five projects involving US$245.7 million. While that constituted 28 percent of the Bank's population portfolio to that date, it was a small fraction—3.6 percent during the 1980-88 period—of total expenditures of India's Family Welfare Program. Donors as a whole contributed 12-14 percent of government expenditures, and the Bank provided about a fourth of this amount. The absence of Bank resources, therefore, would have made little difference to the program funding. However, the presence of these funds clearly indicated to both the Government and other donors the Bank's support for the general directions of this program.

In 1989 and 1990, the Bank provided two additional credits, of $124.6 million and $96.7 million, respectively. If this new and much higher level of lending continues, the picture of Bank participation will look quite different after a few years. As of now, however, even with these large credits added in, the Bank's contribution to the Indian program has not been greater than 4 percent of government expenditures.

Nature of the projects and their administration. The overall goal of the first five of these projects was to accelerate the expansion of the service delivery network for family planning and MCH in specific districts more rapidly than resources would permit the Government to do elsewhere. By concentrating resources in a few districts, the Bank hoped to have more influence, at least in these districts, than it could on a broader level, and then to use the experience gained there to influence the national program. The first project (1973-80) was considered experimental, designed to complete and test the Government's service delivery pattern and identify ways to strengthen it. It was implemented in six districts of Uttar Pradesh and five districts of Karnataka. The second (1980–88), third (1983–) and fourth (1985–) projects, termed area projects, were meant to implement a model plan or blueprint in selected districts of various states. The third and fourth projects also included some support for MIS, IEC, and training at the state level. The fifth project (1988-) provided support for the metropolitan areas of Bombay and Madras and one district in Tamil Nadu. No significant policy conditionality was attached to these projects.

Results from the first two of these projects—the only ones so far completed—suggest that they have had no differential impact on the program. In comparing both project and non-project districts, the overall character of the program was the same, contraceptive prevalence rates increased at roughly the same slow rates, and most indices of MCH performance (e.g., use of clinics, immunization rates) indicated no upward trend. Three factors seem most important in explaining this outcome:

- *Neglect of inputs other than infrastructure.* Between 40 and 60 percent of costs in the first four projects were expended on civil works. (In the fifth project, civil works constituted 11 percent of total costs.) If furniture and equipment are included, these figures rise to between 51 and 68 percent. While the emphasis on training, MIES, operations research, and IEC increased over time in part as a result of Bank pressure, the quality and effectiveness of these components were generally weak, depending more on the interest of the state and project unit concerned than on the Bank's presence. In general, issues of field-worker training, motivation, work program, performance

measurement, and feedback were not well-addressed.[5]

- *Insignificant differentiation between areas.* In formulating the area projects, it was anticipated that locally appropriate approaches would be developed and would serve to guide national program development. However, no conditionality was introduced into project documents that would require this to happen, and no plans were developed for this purpose.[6] In practice, the approach continued to be based on the uniform model plan[7], and the difference in the speed with which some districts achieved the model standards was not great enough to significantly affect the outcome.
- *The fact that project as well as non-project districts operated under the constraints of the overall program.* Many of these constraints were more binding than mere lack of physical inputs. Examples include excessive focus on sterilization, excessively large target populations and numbers of tasks per worker, a weak MCH program, continued neglect of other factors that could influence demand such as female education and employment opportunities, and weak institutional capacity (due, among other reasons, to frequent changes in top management, limited depth of managerial skills, and inadequate use of feedback, monitoring, evaluation and research). The first five Bank-funded projects did little to try to change these constraints.

Preliminary results from the other projects are mixed. Progress seems to be good in Kerala, West Bengal, and Madras, but disappointing in Karnataka and Bombay.

Dialogue and sector work. In the early 1970s, family planning was still a politically sensitive topic in India, with some arguing that it diverted attention and resources from development and the alleviation of inequalities—the fundamental cause of large families. The Bank, quite appropriately, played a low-key role, but it continued to play this role throughout the remainder of the 1970s and well into the 1980s, during a time when it would have been helpful to challenge the Government on issues being raised by program critics. One reason for this is that, since the Bank historically has played a reactive role in India, it would have been out of character to have played a different role in this sector. Another important reason, however, is that comprehensive sector work did not exist until very recently. The Bank sponsored a few studies (for example, some reviews of results from research and pilot experiments). It also included hortatory statements in Country Economic Memoranda (for example, about the negative consequences of rapid population growth, the need to strengthen service delivery, and the need to emphasize spacing methods and raise the age of marriage), and it periodically reviewed five-year plan strategies for the sector. However, these efforts were either too piecemeal or too general to be of operational use. How, for example, should the accountability system be altered in order to place less emphasis on sterilization, or work rules changed to ensure more effective outreach efforts? The Bank had no answers to such questions. The first significant break in this pattern occurred in 1989, with the publication of two papers that began to develop a strategic image of what was needed.[8] To be sure, over this whole period, the Government did nothing to encourage such efforts, but had a continuous stream of materials as useful as these two studies been produced, it would have been difficult to ignore them.

Modest Bank staff inputs. Considering the size and importance of this program, staff inputs were meager. From the early 1970s to the mid-1980s, the program operated with one full-time person in Washington, a series of consultants, and PHN staff brought in for short-term assignments. During the first half of this period, there was one person in the resident mission in New Delhi with other responsibilities as

5. *Training* improved over time, with an increasing emphasis being placed on in-service training. However, it is still largely oriented toward providing knowledge and some technical skills, as opposed to improving work routines and quality of services. The *MIES* developed in the first project and supported in all subsequent projects has resulted in some improvements in field-level reporting, but analysis and use of data gathered has been limited. While funds were included for *operations research* in all projects, output has been negligible. In the first project, these activities were derailed by the sterilization campaigns during the 1975-77 emergency period, and in subsequent projects, by the neglect of program managers who did not see their utility. Two population research and training centers were established by the first project, but took a long time to become operational. The fourth project sought to establish a State Institute of Health and Family Welfare, but plans have been scaled back because of the recurrent cost burden. The first project paid little attention to *demand generation* except for research to study the issue. Subsequent projects included significant *IEC* components which led to sizeable increases in the quantity and quality of such activities over time. However, the overall impact of these activities was constrained because they were implemented top-down, more as publicity and propaganda campaigns, and not backed by research on client groups; professional skills for effective IEC activities were limited; and program managers were not adequately convinced of the need for IEC.

6. State governments resisted the few efforts that were made—for example, to supply project areas with more transportation equipment—on grounds that this would involve unacceptable discrimination.

7. By the end of the second project, a few differences had emerged: the number of sub-centers, plus staff and equipment for them, increased a little more rapidly; the proportion of constructed versus rented facilities was greater; and IEC and management training inputs were somewhat greater. But there were no differences in other inputs such as medical supplies, multipurpose worker training, and field supervision, or in the effective availability of spacing methods.

8. "Improving Family Planning, Health and Nutrition Outreach in India: Experiences from some World Bank Assisted Programs" (World Bank Discussion Paper, 1989) and "Family Welfare Strategy in India: Changing the Signals" (Sector Review Paper, 1989). A third study, "Strengthening the Role of NGOs in the Health and Family Welfare Sector of India"(1989) was also helpful.

well. In the mid-1980s, a second senior staff member was added. Since the end of the 1970s until 1987, there was no one in Delhi working on population. Given these numbers and the level of Bank activity in other fields for which these staff were responsible, it is not surprising that little sector work was undertaken and that supervision was sorely neglected at times.

Assistance to other sectors and agencies. The Bank is the largest donor to India for economic development programs. While seventy percent of its lending has been provided to the energy and the agriculture and industry sectors, only 1.7 percent has been allocated to the population and health and nutrition sectors combined, and only 1.6 percent to the education sector (see Table 4.1 in statistical appendix). Except for a few urban development projects which included some assistance to the family welfare program, and the Tamil Nadu Nutrition Project, none of the non-population projects tried to take into account the demographic impact they might have had. This is especially telling in the education sector, where the only assistance provided prior to 1987 was for an agricultural education project that placed no special emphasis on women. Nor did the Bank attempt, until quite recently, to assist in the development of other channels for delivery of family planning services, supplies, and messages. This pattern was largely the result of the Indian Government's desires, but there is little evidence that the Bank tried to have it any other way.

Relations with other donors. While the Bank's inputs to the Indian population program were small, combined donor inputs were in the range of 12-14 percent of total outlays. As the largest of the donors during the 1980s, the Bank might have been expected to take the lead in developing a coordinated donor approach to program strategy issues. This never happened, nor did any significant amount of co-financing develop. This is due in large part to the Indian Government, which served as the donor coordinating agency and discouraged jointly-funded projects. In fact, the area projects approach effectively kept donors apart, with each one working in a different part of the country. While the Bank's relations with other donors were cordial, consultations were limited in large part to discussions by visiting Bank missions, because the Bank did not have a significant local presence for most of the period.

Developments since 1987–88

Since 1987, this picture has begun to change in promising ways. First, staff inputs (for the combined PHN-plus-education sector) have increased. From 1987 through 1989, four full-time senior staff worked on these sectors, one of whom was located in Delhi. In 1990, two additional senior persons were added. This may prove to be of only marginal direct benefit to the population sector because of the number of new, non-population projects that have come on stream since 1987. Nevertheless, a number of these projects are relevant for population.[9] In addition, as noted above, a number of strategy papers and high-quality studies began to be produced. Finally, the central Government—as well as the Bank—have become disappointed with progress and appear more willing to consider alternative approaches and to substantially increase expenditure levels.[10] These last two factors have resulted in a more substantial dialogue between the Government and the Bank. This, in turn, has led to some changes in the nature of subsequent projects.

The sixth (1989–) and seventh (1990–) projects differ from their predecessors in important ways: they are considerably larger, both in terms of funds and the number of states covered; they operate at the state rather than the district level; their stated goal is to improve priority program components such as development of human resource management skills and training, rather than expansion of the delivery system; they include support for NGOs and for social marketing; and they include significant operations research components.[11] In addition, the third, fourth, and fifth projects were restructured in 1990 to include some of these new features.[12]

While these are very hopeful signs which indicate a more pro-active role on the part of the Bank, two notes of caution are in order. First, although some key deficiencies of the present approach are now fairly well accepted by central program managers,[13] they have not been translated into practical, "implementable" proposals for their correction. For example, the appraisal documents for these new projects recognize the need to emphasize spacing and methods other than sterilization, but present no concrete plans to attack key issues—such as work routines, target-

9. The Integrated Child Development Services, a second Tamil Nadu nutrition project, a vocational training project, two technical education projects, and a proposed basic education project are all cases in point. The vocational training and technical education projects include components designed to increase access for women to modern industrial training, and a major emphasis of the basic education project is to enroll female children and keep them in school for a longer period.

10. India's Draft Eighth Five-Year Plan (1990-95) allocates US$2.7 billion to the family welfare program, a substantial increase over the Seventh Plan, and the Bank has indicated its desire to increase its commitments to roughly 10 percent of this amount. An additional factor may be the deterioration in India's macro-economic situation in recent years, which has resulted in signals to sector ministries to do what they can to maximize resource transfers.

11. In fact, both projects include specific agreements that project states will release designated blocks from existing family planning targets for research purposes.

12. This restructuring occurred mainly because of slow disbursements related (mainly) to exchange rate changes. However, advantage was taken of this situation to include additional areas and programs, including social marketing of contraceptives, NGO activities, and strengthening of implementation and monitoring capability at the ministry level.

13. Though perhaps not the local program managers, many of whom appear to feel that the program is on the right track, but only suffers from shortages of resources and skilled personnel.

ing, monitoring, and accountability—that have kept the program focused on sterilization. All of these remain to be worked out during implementation. These projects provide the resources necessary to do things differently in a number of respects, but do not mandate specific changes. Accordingly, much will depend on how much advantage program managers take of the opportunities offered to them and how persuasive the Bank can be in arguing for the changes it deems necessary.

Second, as Table 3.3 indicates, the sixth and seventh projects have allocated roughly the same proportions of total project costs to construction and to equipment as was the case in the first four projects. While this does not necessarily mean that expansion rather than human resource development remains the priority, it does mean that special care will have to be taken to ensure that these financial allocations do not drive the time allocation of staff and judgements about implementation progress as they have in the past.

The Child Survival and Safe Motherhood Project (1991–) appears to have applied these lessons. More attention is paid to requirements for implementation. For example, it includes functional guidelines for changes in work routines for field workers, field-level coordination with the Integrated Child Development Service Project, field-level reporting, and community participation—a first for this series of projects. Moreover, it contains hardly any funds for civil works, the understanding being that adequate funds for this purpose are included in the sixth and seventh projects. On the other hand, it is weak on details about the family planning components (included here under the safe motherhood portion of the project). While this is understandable, given the focus of this project, special care will have to be taken to ensure that this component is not overlooked in the midst of these laudable efforts to improve the long-neglected health aspects of the Family Welfare Program.

The next step is to translate these good intentions into field-level results. On the Bank's side, this will require more intensive and continuous attention to supervision by staff conversant in the substantive issues than has been the case in the past. This will be especially important for the Child Survival Project, which is national in scope.

4. Bangladesh

Demographic and Socioeconomic Trends

The decline of the total fertility rate in Bangladesh from 7 to 4.9 and the increase in contraceptive prevalence from 3 to 35 percent since 1970 was unexpected by most observers. Bangladesh is one of the poorest countries in the world. Illiteracy is very high, especially for females. It is a patriarchal society in which most women are in purdah, their status is low, and they are dependent on their fathers, brothers, and sons. The density of population on available land is the highest in the world in this agricultural economy and environmental risks, especially flooding, are serious. Families and individuals face many risks for which relatives, especially adult sons, are the only available insurance.

This is a complex of conditions generally considered to be classic determinants of high desired and actual fertility. These conditions led many competent observers[1] as recently as the last decade to believe that in Bangladesh there could not be a significant demand for family planning services and lower fertility before substantial structural changes occurred. Indeed, they remain a basis for the plausible idea that further gains will be difficult and that a plateau will be reached in fertility levels long before the recent decline brings fertility to replacement levels.

The significant increase in contraceptive practice and the fertility decline in Bangladesh have been associated with an extensive family planning program and considerable donor commitment. However, before concluding that the family planning program accounts for these trends, three competing interpretations must be considered. First, this trend in fertility might be explained by factors unrelated to increased use of modern contraception being promoted by the program. Second, improvements in health conditions and mortality may have changed the climate for fertility regulation. Third, social and economic changes unrelated to the family welfare program might explain the increased use of contraceptives.

Can the fertility decline be explained by factors unrelated to contraception? Studies of changes in all the proximate determinants of fertility (e.g., marriage age and duration, postpartum infecundity, contraceptive use and abortion) suggest that the most important factor by a large margin is increased use of contraception, accounting for 80 percent of the decline. The only other factor of significance is the change in marriage patterns, which accounts for most of the remainder.[2]

Can this fertility decline be attributed to improvements in health conditions or declines in mortality? While there have been slow declines in mortality during the first half of this century and somewhat more rapid declines in infant and child mortality in recent years, mortality remains very high: infant mortality, about 12 percent; child mortality to age five, about 20 percent; maternal mortality, 70 times Western levels; and a life expectancy of only 51 years. The risks of losing children, husbands, and sons is still very high.

Can the decline be attributed to social and economic changes unrelated to the program? Little evidence of this can be found in published indicators of such change. Since 1970, GNP per capita has changed very little and remains one of the lowest in the world, unemployment and landlessness remain high, and illiteracy among adult women, while it has fallen modestly, remains above two-thirds. The Government has not developed social security programs

1. See, for example, Demeny (1975); and Arthur and McNicoll (1978).

2. The change in marriage patterns is mainly an increase in the age of marriage. Duration of marriage has lengthened, partially offsetting the age effect. The only other change of significance has been a decline in postpartum infecundity, which has had a positive effect on fertility. Changes in the extent of abortion are not known.

that would substitute for the family and children as safeguards against the many continuing hazards of life. Most of the country's 66,000 villages remain inaccessible by road, and river transport is inadequate even during flooding season.

There is, of course, the possibility that unrecorded changes have taken place. Some sociologists and anthropologists report that villagers appear more prosperous than 20 years ago; others, however, have reported greater impoverishment. The Food for Work program has opened up additional employment opportunities for women. Also, surveys report increasing numbers of persons who indicate that they cannot afford to marry as early or have as many children as they would like.[3] However, these changes are small relative to the magnitude of changes that appear to have occurred in other countries with similar demographic changes.

Apparently, then, it is possible for fertility to decline and contraceptive use to increase without much change in those social, economic, and health variables generally believed to be crucial pre-conditions for demographic change. This makes Bangladesh an especially important case to study in view of the great interest in whether similar demographic changes are possible in many other poor countries in which there is no obvious sign of the onset of fertility decline.

One interpretation is that there has been a significant latent demand for family limitation for some time despite adverse socioeconomic conditions. Cleland and Wilson (1987) argue that this is the case in many pre-transition societies and that such demand becomes manifest when ideas about the legitimacy and efficacy of birth control are widely diffused.

In 1975, the mean desired number of children in Bangladesh was about four—identical to that in Taiwan in 1965 when it was well launched on its precipitous fertility decline. This number decreased to 2.9 in 1989—the level for Taiwan, China in 1976 when its fertility rate was 2.7. In successive surveys, a substantial number of Bangladeshi women not using contraception have said that they wanted no more children—one indicator of demand. Until recently, however, these data, indicating considerable demand, have been discounted as polite statements of what many respondents thought the interviewers wanted to hear.

After the fact, it now seems plausible that pre-existing latent demand was crystallized by the family planning program, which provided information, legitimation, and contraceptive supplies and services. Although the family planning program began with (and continues to have) many serious problems, it can nevertheless be credited with building a system which made possible these changes in contraceptive use and fertility.

The Bangladesh Family Planning Program

This program had to operate in an extremely difficult environment. (1) As indicated above, the program has received no assistance from improvements in social and economic conditions, which still seem to favor large families. (2) The physical environment makes implementation of all programs in the countryside very difficult. The seasonal flooding that occurs over vast areas of the countryside greatly complicates logistics and communications on a regular basis, and natural disasters result in periodic shifts in priority away from longer-term programs like family planning and education. (3) The administrative structure and operating style of the Government is highly centralized and hierarchical, better suited for developing plans, issuing orders, and dealing with foreign agencies like the World Bank than for obtaining feedback, working collaboratively with field workers and clients, and obtaining the cooperation of agencies over which it has no direct control—conditions that seem to be necessary for an effective family planning program. (4) Managerial talent with an innovative, problem-solving bent—especially important in a program where the best practice is not well defined—is generally very scarce in Bangladesh, and especially scarce in the population program because of all the more immediate competing demands elsewhere in the country. (5) This limited managerial talent found itself inundated by demands from all quarters, from the central political authorities who insisted on quick results and from a multitude of foreign aid donors—multilateral, bilateral, and private—all eager to help but all with different motivations, procedures, and philosophies.

In addition, the sense of urgency that surrounded the beginning of the program in 1971 resulted in the premature initiation of a large, complex program without a testing of strategies or a gradual scaling-up, thereby locking in place problems that persist to this day. The history of the first IDA-assisted population project in Bangladesh is indicative. Although it was designed by a small working group from the Planning Commission and the Bank that had little knowledge of field conditions and operational realities, political and administrative pressures in the country resulted in an atmosphere in which anything short of a comprehensive and ambitious program was unthinkable. The result was a large, complex, unwieldy project and administrative structure. At the outset, consideration was given to a vari-

3. Armindo Miranda from the Chr. Michelsen Institute in Norway has put forward an interesting hypothesis to explain the increasing age of marriage. Since the 1960s, the dowry required to marry off a daughter has increased dramatically, a phenomenon he explains by a bulge in births after World War II currently reaching marriage age, which temporarily increases the supply of eligible women more than eligible men (because men marry at much later ages than women). It is not clear what effect this phenomenon has on marital fertility rates.

ety of strategies, including an independent family planning outreach program, an integrated program of basic health and family planning services, and a set of special development programs aimed at generating demand for family planning services. In the end, it was decided to try all three strategies simultaneously. A categorical family planning program was established in the population wing of the Ministry of Health, and this operated fairly independently of the rest of the Ministry. A maternal and child health (MCH) program which incorporates family planning as one of its components was also established in the Ministry of Health. Programs for demand generation were established in other ministries in the fields of education, agriculture, rural development, labor, women's affairs, and communications. All told, eight ministries were involved. Funds were provided to purchase civil works, equipment, technical assistance, fellowships and training, contraceptives, salaries, and other operating costs for these programs. An inter-ministerial coordinating body, established without a secretariat, never operated very well. The next two projects, each one double the size of the previous one, continued the rapid expansion of this elaborate system.

The result was a series of projects which continuously threatened to overwhelm the carrying capacity of the Government and a program with several serious, unresolved problems. Perhaps the most important is the failure to integrate the health and family planning programs at intermediate levels between the center and the local community, a factor contributing to inadequate quality of care and a cause of serious friction between the separate cadres. Compounding this problem is the fact that most health workers tend to be men and most family planning workers women. Also important, the program continues to be based on rigid, uniform standards, irrespective of local conditions, and unrealistically high targets and workloads for outreach workers, which also adversely affect service quality and morale.

Despite these problems, the program has a number of important achievements to its credit:

- MCH clinics have been constructed, equipped, and staffed in 2,716 of the 4,325 unions (the basic local unit of Government). These union-level clinics provide non-surgical contraceptives and primary care for side effects plus some basic maternal and child health services. Many of these primary centers are in extremely poor shape, however, because of lack of maintenance.
- Tubectomy and vasectomy services are available in every district and subdistrict hospital at no cost to the patient. Such services are also available from NGOs operating in most district headquarters and large towns.
- There are now 23,500 female outreach workers deployed to deliver family planning services to couples in their homes. Surveys indicate that about 40 percent of women of childbearing years have been visited by female village workers at least once quarterly. These workers also deliver immunization and other simple health services to households, contributing to the credibility of the family planning messages. This is a two-edged sword, however, since these activities sometimes crowd out the time that is supposed to be devoted to family planning.
- Mass-media campaigns, along with the information activities of the clinics and outreach workers, has succeeded in making knowledge about contraception almost universal in this largely illiterate society. According to survey research, about 6 percent of all married women had heard about contraception in the mid-1960s. By 1969, this had increased to 52 percent, although few women knew where to obtain services. By 1983, 99 percent knew of at least one method. Today, most women know about several modern methods, where to obtain them, and their costs.
- Non-clinical distribution channels are beginning to be effectively used. By 1989, almost 40 percent of couples practicing contraception were using condoms and pills supplied by pharmacies and other commercial outlets through a very successful social marketing project.
- By 1990, 120 NGOs were collaborating with the Government program in providing contraceptive services, estimated to reach as many as 20 percent of the contraceptive users. They have now been authorized to receive foreign aid funds for this activity.

The Foreign Assistance Community and the Bank

How was it possible in this environment to accomplish this much? Seven factors seem to have been critical.

Government commitment and interest in assistance. First and foremost, the determination of the government to solve the country's population problem—to proceed publicly and rapidly despite the political risks involved, to allocate a sizeable portion of its limited budget[4] and managerial talent to this program, and to request and utilize foreign assistance and advice—was crucial. This is probably the most

4. From fiscal year 1974/5 (when separate accounts for family planning and health began to be maintained) to 1986/7, almost 6 percent of the development budget and 5 percent of the revenue budget were devoted to family planning programs and another 3.5-4.0 percent was devoted to health. The figures for family planning are high by world standards. Indonesia, for example, has devoted about 1 percent of its budget to population and family planning. Per capita expenditures have been rising; in 1987/8, the figure for both population and health was $1.60, an increase of perhaps 50 percent in real terms over what it was a decade earlier, but still quite modest by most standards. (Based on personal communication from Charles Griffin, University of Oregon, who has recently completed a study of population funding in Bangladesh for The World Bank.)

important factor explaining why more progress has been made in Bangladesh than in Pakistan.

The magnitude of the foreign assistance made available to Bangladesh has also been critical. Between 1982 and 1988, Bangladesh has received nearly US$43 million per year for its population programs, sufficient to finance about two-thirds of its expenditures on these programs. Two-thirds of this external assistance has come from bilateral donors, 18 percent from multilateral donors, and 15 percent from NGOs. The Bank's contribution has been made through three IDA credits, approved in 1975, 1979, and 1986. The first of these projects cost almost US$46 million, of which IDA and co-financiers contributed more than US$40 million. Each subsequent project was at least double its predecessor in size. The Fourth Project, scheduled to begin in 1992, is estimated to cost $600 million, three-fourths of which is likely to be contributed by IDA and co-financiers. While considerable waste must have been involved in attempting to move as rapidly as these figures imply, these projects helped to promote a degree of progress that otherwise would have been impossible without such extensive aid.

The character of the foreign assistance. In contrast to the typical Bank-funded population projects, two-thirds of the external funding for these projects came from co-financiers on a grant basis. One consequence has been that a larger fraction of foreign assistance has been provided for software components (technical assistance, fellowships and training, and operating costs) than is typical. Table 4 provides an indication of this, at least for the Bank projects. Another and perhaps more important consequence has been the flexibility that these grant funds have provided to project managers to get the job done. Examples of how this worked and the importance of this element are given below.

The Bank's pro-active role. With the encouragement of the Government, the Bank has played a very active role in all phases of these projects—design, fund-raising, donor coordination, implementation, and evaluation—far more active than is typical in Bank projects. This special role was made possible by the assignment of more staff than is normally allowed, both in the field and in headquarters, to work exclusively on the Bangladesh population program. Supervision was not intermittent, as is typically the case. The additional staff, in turn, was made possible by the availability of grant funds that paid for these inputs. Initially, one person was assigned to the field mission, but, as the projects have grown in size, this staff has grown until, today, there are four persons in Dhaka and four in Washington working on various aspects, including handling the complex accounting arrangements for the co-financiers and assisting the Government in the development of Five-Year Plans for the sector. The impact of this involvement has been enhanced by the synchronization of several cycles, the project development, the development of Five-Year Plans, and cycles of organizational changes. The coincidence of these cycles placed the Bank in a unique position to collaborate in the policy development process.

It is significant that in this case the Bank found no difficulty getting involved in broader policy issues without resorting to sector or program loans. The most important reasons why this occurred are that the Government wanted it that way and that, with donor assistance, the Bank was able to respond with heavy staff inputs and dynamic leadership on the ground. The synchronization of project and Five-Year Plan development cycles was also helpful. The form that the loans took was probably unimportant.

Collaboration amongst donors has been substantial. The first project included seven co-financiers who provided funds for a project designed in large part by the Bank and the Government. This arrangement continued in the second and third projects but with increasing donor participation. It has now reached the stage in which it is more accurate to describe the fourth loan as a consortium, rather than a Bank, loan. Only two major donors, USAID and UNFPA, remain outside this consortium, but both attend major meetings sponsored by the consortium and have even participated in the design of the fourth project. This collaboration has been important, not only for the additional resources that it mobilized, but also because the consortium members have proved to be an effective voice insisting on more attention being paid to quality of services provided (as opposed to simple expansion of the delivery system).

Mechanisms for innovation and flexible problem solving. Mechanisms have been established to encourage innovative activities and help solve unanticipated problems that threaten progress. In the second project, an "Innovative Projects Fund" was established to cover research needs not anticipated at the time of appraisal. Research on such issues as contraceptive acceptability and compensation to sterilization clients and tests of innovative approaches applied by NGOs have been funded in this way. The fund is financed by IDA and the cofinanciers, administered by IDA, and supervised by an expert committee of Bangladeshi policymakers. The third project established a "Management Development Unit," funded by co-financiers, to resolve internal communications problems and serve as a management consulting team reporting to senior MOH officers. Much of their activity has involved the vetting of directives before they are issued and the provision of feedback on their implementation. The fourth project envisions the development of a Health Economics and Financing Group in the Ministry of Health and Family Welfare, responsible for economic and financial analysis on which to base financial planning and policy formulation.

Use of pilot project findings. Before the favorable national trends in Bangladesh were established, a pilot project in the

Matlab area demonstrated that the significant latent demand measured there was real and that a high-quality service program adapted to the local cultural situation could have significant effects. This project (Phillips, 1987), mainly supported by USAID with technical support from the Population Council, succeeded in bringing contraceptive prevalence up to more than 50 percent from initially very low levels, in an area not substantially better off than the rest of Bangladesh in social, economic, and health terms. It had at least two very important effects in Bangladesh. First, the demonstration that such a success was possible greatly strengthened the morale and commitment of Bangladeshis and donors alike. Secondly, the programmatic lessons of this carefully designed and monitored project influenced the development of the Bangladesh program in a number of important ways. To cite only one important example, the Matlab findings indicating that the program needed to increase greatly the density of field-staff deployment influenced the important decision of the GOB to increase considerably the field staff a few years ago. The Matlab experience is being studied by scholars and program leaders all over the world for its possible relevance in other places, especially those with what appear to be unfavorable social, economic, and cultural circumstances.

Thus, the foreign aid community has found a variety of ways to expand the (initially) very limited absorptive capacity of the Government for undertaking work in the population field. Within this community, the Bank played a leading and catalytic role. No other agency—neither the Government nor any other donor—was in a position to play this role. Had the Bank not done so, the confusion, waste, and bottlenecks involved would have resulted in substantially fewer funds mobilized for this sector and substantially less progress.

Several Bank staff members provided dynamic and skilled leadership, willing to take risks and to cope with inevitable resistance from Bangladesh and Bank bureaucratic structures to achieve flexibility and unconventional procedures. Key members of the Bank staff found innovative ways to get things done and to work them through the Bank system. The Bank can be credited with eventually accommodating itself to such different procedures.

Implications and Lessons

Questions have been raised about whether the progress made to date can continue much longer without significant social and economic change or a radical change in program direction to compensate for lack of such change. There are several reasons to believe that diminishing returns from the present approach have not yet set in, and that further increases in infrastructure and outreach, plus improvements in program quality along lines already tested in pilot projects, could result in further increases in contraceptive prevalence. These include the following:

- Latent demand, reflected as unmet need in a variety of surveys, continues to be substantial. Such indicators have proved to have considerable validity in Bangladesh.
- Recent national surveys also indicate that 60 percent of women of childbearing age have not been contacted by a family planning worker in the previous quarter. Part of the reason for this is that more than one-third of unions (local government units) still do not have clinics around which program activity is typically organized. These clinics are planned for construction and operation within the decade.
- More limited surveys have indicated that there is an inverse correlation between distance to clinics and extent of outreach activity on the one hand, and the contraceptive prevalence rate on the other. Where density of service points is high, as it is in special pilot project areas like Matlab and some sites covered by NGO activities, prevalence rates above 50 percent have been achieved. Simply increasing clinic density further would increase contraceptive prevalence.
- In addition to increasing the density of service points and frequency of contacts, additional increments of prevalence should be possible from improvements in the quality of services along lines that have already proved successful in some locations: better training and increased mobility of workers, more effective supervision, and decentralization to achieve more flexible local programming. Substantial improvements in efficiency and outreach intensity could be realized by improving coordination of NGO field programs with government outreach efforts and better delineating their roles. Further improvements in efficiency will be realized when male workers of the health wing retire in the 1990s and are replaced by multi-purpose female health and family planning workers. Especially important would be reduction in the workload of outreach workers by focusing on women who are pregnant or have recently delivered, the group most interested in—and in need of—MCH care at any point in time.

It is difficult to predict how much increase in contraceptive prevalence is likely as a consequence of these quantitative and qualitative improvements. However, even if it increased from its current level of 35 to close to the 50 percent level obtained in Matlab (very unlikely on a national scale) the total fertility rate would be about 3.7, still well above the replacement level of 2.1.

To achieve prevalence rates required for replacement-level fertility, new approaches that go beyond these supply-

side initiatives and increase the level of demand are likely to be needed. These probably will require basic structural changes involving such matters as the education, status, and employment of women, infant and child mortality, and improved economic conditions. Given the intractability of these problems and how little is known about the speed and extent to which demand might respond to these changes, plus uncertainties about the limits of the supply-side approach, prudence strongly suggests that both approaches be pursued vigorously and simultaneously. To date, only the supply-side approach has been forcefully pursued.[5]

The most important lesson to glean from the Bangladesh experience is that a supply-oriented approach can increase contraceptive practice and decrease fertility significantly, even in exceptionally unfavorable social, economic, and institutional circumstances, providing there is sufficient latent demand. A key element seems to be trained and well-supervised workers who visit rural households on a regular basis and offer a range of reliable family planning services.

A second lesson of importance is that developing a successful supply-side approach in such inhospitable settings is a complex, difficult, and time-consuming process involving considerable risk of strategic error. This has a number of implications for new programs and first population projects. Such projects must be carefully tailored to specific local circumstances; they cannot be packaged and transferred to new settings, as a first power project might be. The preparation period is therefore likely to be longer, perhaps involving pilot studies and certainly involving more intensive staff and technical assistance inputs than the Bank usually supplies. In such settings, there is much to be said for "starting small" and scaling up only after learning from successes and failures. It helps considerably to have staff in the field with access to grant funds and authority to use them in reasonably flexible ways.

Such situations are not ideal for application of the traditional Bank approach to lending, involving large projects, loans, standardized procedures, arms-length involvement in preparation, and intermittent supervision. Ways around these problems were found in the Bangladesh case in part by using the flexibility provided by other donors. There may be ways other than those used in Bangladesh to achieve the flexibility and the intimate knowledge of the situation required. However, a sufficient number of well-qualified personnel concentrating on the country, both in Washington and in the field, seems essential. If such approaches are not feasible for the Bank in other settings, the Bank should consider allowing or encouraging donors with grant funds and flexible procedures to take the lead in the early phases of program development, only coming in with large, traditional projects when the program begins to take shape. This may mean playing more of a supportive than a leadership role in the early stages. The alternative, of course, is to find ways to change Bank procedures with respect to population projects.

The Bangladesh experience illuminates both the positive and negative consequences of very large projects which press hard against the absorptive capacity limits of an administrative body. On the positive side, there can be no doubt that these limits gave way more rapidly and led to more progress than had they not been breached. Such an approach is most useful when one is confident of the directions in which a program is to move. If this confidence is missing, it is more appropriate to scale up in a more orderly fashion from smaller projects and pilot studies. Failure to do so in the Bangladesh case led to considerable waste and the institutionalization of some prematurely-made decisions which have proved difficult to change. Nevertheless, the Bangladesh experience has been a considerable success in terms of what was expected in its early phases. Under such difficult circumstances and operating in uncharted waters, waste and false starts may have been inevitable.

Before drawing implications for other countries and for the future of the Bangladesh program, it is important to try to understand the origin of the demand which prior theory and experience in such unfavorable situations suggested would not be present. One explanation, already noted, is that a significant latent demand for smaller numbers of children has always existed even in pretransition societies, and that it becomes manifest when ideas about the legitimacy and efficacy of birth control are diffused (Cleland and Wilson, 1987) and contraceptives made easily available and affordable.

This latent demand involves more than a few isolated individuals who deviate from the norm; it involves more than a third of the population. Where could it have come from? Perhaps, for these persons, traditional values have been eroded not by progress but by its opposite: their increasing economic deprivation, a result of three decades of deterioration in the rural economy which may have made many parents believe that children can no longer be counted on for support in sickness or old age. Under conditions of extreme deprivation, they must know that they themselves cannot be counted on to support parents and relatives. At the same time, modern communications are continuing to provide pictures from around the world of families leading a good life with fewer children. This too may be altering fertility desires (Freedman, Khoo, and Su-

5. Some recent encouraging efforts on the demand side should be noted, however. The General Education Project calls for efforts to recruit female teachers and enroll more girls in primary school; a Female Secondary School Assistance Project is being developed to provide stipends for girls from rural areas; a non-formal education project has been proposed; and an Intersectoral Population Activities Program to involve other ministries and agencies is being developed.

praptilah, 1981; and Freedman and Freedman, 1986). The presumption is that demand for contraceptives and fertility reduction may increase because of the combination of Malthusian pressures and new ideas affecting aspirations.

Finally, to some extent, a strong supply-oriented program may itself generate new demand. This possibility is based on the view that structural factors are less important than group norms and behavior which slowly change as the program becomes more visible and as leaders and pacesetters themselves become acceptors.

In view of the importance of the Bangladesh experience for other pre-transition countries, this case should be thoroughly studied to develop a more definitive explanation of what has happened so far and to monitor future events. While it seems likely that the downward trend in fertility will continue for some time without structural changes, it is an open question when, if at all, a plateau will be reached. If and when it does occur, the program will have to change in radically different ways to continue progress. Some contingency planning to anticipate this day would be prudent.

5. *Brazil, Colombia, Mexico*

Demographic Trends, Development, and the Role of Government

Brazil, Colombia, and Mexico have experienced substantial fertility declines (29-45 percent) since 1970, comparable to or somewhat greater than the declines in India, Indonesia, and Bangladesh (Table 1.1 in statistical appendix). When measured as a proportion of the distance between the beginning fertility levels and the replacement level of 2.1, the fertility declines are an impressive 51-79 percent. Their contraceptive prevalence rates of 53-66 percent are higher than those of the three Asian countries previously discussed. As compared with the Asian countries, contraceptive prevalence in the Latin American countries accounts for more and nuptiality for less of the fertility decline. While data are not very reliable, it appears that illegal abortion may count for 25 percent of overall fertility control in Latin America.

The significant increases in contraceptive prevalence in the three Latin American countries are behavioral evidence of a demand for family limitation. There is further evidence of this in the low reported desired number of children, with means of 2.8 to 3.1. There is a striking convergence of these rates with those for the three Asian countries (2.9 to 3.4).[1] This was unexpected in view of large differences between the two groups in socioeconomic levels and in the character of their family planning programs. However, the proportion of women wanting no more children in the three Latin American countries (64-69 percent) is considerably higher than that in the three Asian countries (50-58 percent).

These fertility declines have taken place against backgrounds of substantial socioeconomic changes that were conducive to small-family values and to new attitudes about the use of contraception. Among these changes are increased female education and labor force participation, rapid urbanization, and the spread of consumerism and exposure to the mass media. Also contributing was change in the economic climate. During the period of rapid growth in the 1960s and 1970s, many urban consumers formed expectations about improved living standards, only to confront much harsher economic realities during the 1980s. The pace of fertility decline may have accelerated because families adjusted to the economic squeeze by deciding to postpone or stop having more children. Another factor that could be significant is the effectiveness of the IEC approaches used in Latin America, in which FP advocates have used radio spots, rock videos, soap operas, and comic books to deliver their messages.

The three Latin American countries clearly rank higher than the three Asian countries and Kenya on a broad range of development indicators (Table 1.1). These include much higher GNP per capita, higher life expectancy, lower infant mortality, and much lower illiteracy. Nevertheless, fertility levels for Brazil and Mexico are somewhat higher than those for Indonesia, and Colombia's is only marginally lower. India's fertility rate is only marginally higher than Mexico's. Thus, while the higher development levels in Latin America are consistent with their falling fertility, the actual fertility levels attained do not put them in a different class from the three Asian countries studied, despite their much lower development levels. Whether the stronger and much earlier family planning programs in the three Asian countries explain this anomaly is a question that is discussed later.

While all three countries had increased contraceptive prevalence and declining fertility, these outcomes were reached via quite different policies and organization of services. Until the mid-1970s, Brazil had a pro-natalist policy. After that, its *laissez-faire* stance opened the way to consid-

1. The 3.4 figure for India is obtained by adding the mean number of additional children desired to the number of living children. This is biased upward, because some respondents already had more children than they wanted.

erable activity by NGOs, particularly BEMFAM, the Brazilian IPPF affiliate, which was active in public education to popularize and legitimize family planning, and in the provision of some services; in the latter, going so far as setting up community-based distribution programs at the invitation of some states. The contraceptive pill was mainly provided by private pharmacies whose prices were very low because of price controls on pharmaceuticals, and because local producers paid no royalties and had to compete with free pills from NGOs. Sterilization, the most common method, was provided about equally by private and Government agencies. The Government played an important, but passive, role in the large increase in female sterilization, both in government and private facilities, because the Social Security Health system paid for Caesarian deliveries which provided an opportunity for a tubal ligation as a side arrangement, for an additional payment. Thus, while Brazil has had no formal policy to increase access to family planning services, the combination of strong NGO activities, low-cost commercial supplies, and indirect subsidies for sterilizations resulted in the highest prevalence rate among the three countries. It is plausible that this rate would have been even higher and fertility lower if there had been a well-organized national family planning program. This would have increased prevalence, especially in the poorer regions and strata of the population where prevalence rates are lower.

In Colombia, NGOs have been the principal provider of FP services and supplies. The dominant role has been played by PROFAMILIA[2], that country's IPPF affiliate. PROFAMILIA established a network of family planning clinics, conducted information and education campaigns, and launched male and female sterilization programs during the 1970s, and remains the main provider of sterilization services. Though drugstores are the main source of pills in Colombia, PROFAMILIA helped to keep pill prices down by buying them in bulk and re-selling them to pharmacies. It was also a pioneer in organizing outreach service programs for rural areas and in social marketing efforts.

In contrast, the Government until recently has played a distinctly secondary role. While it announced a national policy to slow population growth as early as 1969, its efforts were sporadic during the 1970s. Since 1981, the Ministry of Health has developed a program to improve maternal and child health services, which includes family planning. After initial outside donor support by UNFPA, it has also had support from the World Bank since 1985 for services in poor areas.

Family planning and fertility decline in Mexico lagged considerably behind the trends in Colombia and Brazil, despite the fact that social and economic progress in the 1960s and 1970s was substantially ahead of these countries. UN estimates place the TFR in Mexico at 6.4 as late as 1970–75, when Brazil was at 4.7 and Colombia at 4.8. Mexico's fertility fell precipitously after 1970-1975 (to an estimated 4.9 in 1975–80 and 4.2 by 1980–85). Contraceptive prevalence increased from 12 percent in 1973 to 38 percent in 1979, and to 53 percent by 1987. The onset of this rapid rise in contraceptive use and the associated decline in fertility coincided with the inauguration of a substantial national family planning program.

After a long period of pro-natalist policy, the Mexican Government moved in the early 1970s to adopt a policy to slow population growth and make family planning available through its social security system and the Ministry of Health. Most of the increase in contraceptive prevalence since the 1970s is attributable to these programs. Thus, the most likely explanation for Mexico's different experience is that latent demand built up during the 1960s and 1970s but did not become effective until government policy changed and availability of supplies and services and information increased.

NGOs have played an important role in Mexico in such activities as training, mobilization of support by physicians, and work with special groups such as teenagers and underserved poor groups. However, in terms of direct service provision, they have been much less important than their counterparts in Colombia and Brazil, where the direct government role is much less.

It is likely that three sets of interacting factors jointly explain the experience of these three countries: (1) modernizing forces associated with the socioeconomic changes previously described; (2) the impact of improvements in the supply of FP services and supplies on demand, either by increasing consciousness about being able to exercise fertility control or by transforming latent demand into actual demand, as availability and access to low cost contraceptives increased; and (3) economic setbacks amid rising expectations. The timing of demographic change in Mexico—little change at first despite socioeconomic improvements, and rapid changes after the introduction of the national program—suggests that factors on the supply side are especially salient.

External Assistance and the Role of the Bank

In contrast to other regions, external assistance provided only a small part of the costs of family planning in Latin America and, of that, close to three-fourths was provided by private (NGO) rather than multilateral or bilateral agencies. Nevertheless, these inputs played a critical role in the expansion of services by enabling providers to deliver ser-

2. Plus its predecessor, ASCOFAME, which focused on training and public education, paving the way for later provision of supplies and services.

vices at a lower cost, helping them to legitimize and popularize FP and providing them with training. USAID, for example, channeled most of its support to local NGOs, directly and indirectly (through its contributions to international NGOs) and played a major role in supplying them with low-cost contraceptives. A large share of UNFPA funds, which went to the governments involved, were used for non-FP activities such as policy development, research, and training.

A review of the possible avenues through which the World Bank might have contributed to fertility declines suggests that its influence was minimal.

- *Policy dialogue.* While the Bank made a limited contribution to the policy changes that occurred in Mexico (see below) population policy was either not significant or too sensitive to deal with in Brazil and Colombia.
- *Sectoral research and analysis.* Some useful contributions were made in the human resource area generally, but very little focused directly on population or family planning prior to 1989. An exception was a 1974 sector report on population, health, and nutrition in Brazil.
- *Projects.* Family planning was included as components of MCH in health projects in Colombia and Brazil, but little was done to implement these subcomponents. A loan for population activities was prepared for signature in Mexico, but withdrawn when a new government came to power and decided to use grant funds from NGOs (some supported by USAID) for the same purpose. In general, health lending in many Latin American countries has been limited by governments' reluctance to borrow hard currency for social sectors.
- *Other lending.* Lending to other sectors which can have indirect effects on fertility—for example, education, transport, and communications—was undertaken, but not with demographic considerations in mind.

Three factors appear to explain the Bank's limited impact:

- *Political sensitivity.* Particularly during the 1970s, when the direction of policies and programs was being shaped, Bank management was perceived in Latin America to be outspoken about the need to reduce population growth rates, a rationale for family planning programs that was unacceptable in these countries. This made it difficult for Bank staff to broach the subject with these governments. In contrast, USAID, which also started with a hard-sell approach, changed tactics and began working with NGOs, thereby avoiding confrontation with the governments while still channeling significant support to these countries.
- *Timing.* By the time Bank policy changed to permit lending directly for health (which offers another avenue for the Bank to approach FP), contraceptive prevalence was already comparatively high and the structure of service delivery well established.
- *Importance of private and para-public providers.* The most effective actors in the population field—NGOs in Brazil and Colombia and the social security system in Mexico—are not institutions with which the Bank typically works directly. Given the attitude of the governments, it was not possible to work indirectly with these organizations as the Bank did in Kenya and elsewhere.

The Bank's current approach in Latin America is to focus on reproductive health and safe motherhood—not the benefits of reducing population growth rates—as rationales for family planning. While some Latin Americans believe the ulterior motive remains population control, this approach does in fact speak to the main needs for family planning, given the present demographic situation of these countries.[3] Fertility rates have come down and contraceptive prevalence rates increased to the point at which one can foresee significant declines in population growth rates as the age structure evens itself out over time. To force this process to occur more rapidly would be unwarranted and politically unwise. However, important issues of equity, quality, and effectiveness in the utilization of resources for family planning still remain. Many of these problems are subsets of issues that the Bank is already dealing with in its work on health services in general. It therefore seems appropriate and opportune to bring family planning into these discussions, and into project lending focused on the health sector.

The cases of these three countries demonstrate the importance for the Bank of supporting its population work with a rationale acceptable to all parties: government, Bank management, and Bank operating staff. In these three cases, Bank management was perceived by government officials as holding an unacceptable view, and Bank staff were caught in between. While the staff backed away from the population control issue, it continued to be hampered by the perception within the Bank as well as within these countries that they were out of step with what the Bank is really about in its population work—in other words, that population control is really the Bank's strategic objective. If the Bank wants to work in countries that do not accept this rationale, as well as in countries that do, it will have to base its population program on a broader and more flexible set of principles.

In establishing such a set of principles, one could begin with the recognition that the Bank's overall objective is to promote sustainable improvements in living standards,

3. Graphic evidence of one of these needs was presented in a recent article indicating the high incidence of illegal induced abortions in some of these countries. See Singh and Wolf (1991).

and that family planning programs influence variables related to this objective on two levels. At the micro-level, they can improve family health and enlarge the range of control individuals have over their lives. At the macro-level, they can have major demographic, and therefore economic, impacts. Such programs are therefore appropriate topics for policy dialogue and sector analysis in order to develop tactical judgements about how, if at all, they should be developed and used in specific contexts. It is likely that most such discussions would conclude that FP programs are appropriate for their micro-impacts in nearly all circumstances, and for their macro-impacts in cases where population growth rates are "too high". But judgements can differ considerably about what constitutes "too high" a growth rate.

6. Kenya

Demographic Developments and Principal Determinants

During the last 20 years, Kenya has had one of the highest total fertility rates in the world. These high rates coincide with very large desired family size which in turn is plausibly explained by a strongly entrenched and distinctively African family system. Most observers have therefore held out little hope that family planning programs would succeed. This view is corroborated by observers.

> "There is little reason to expect the demand for children [in Kenya] to decline in the absence of any change in economic, social, or cultural conditions, since it is solidly founded on African institutions" (Frank 1987, p. 197).
>
> "Marriage in Kenya was traditionally, and in considerable measure remains, a form of contractual quid pro quo between two lineages, not a direct commitment between husbands and wives.... The lineage, as well as the husbands and wives, have interests favoring high fertility.... These obstacles to change may erode, but only as the family system itself is modified...." (Frank and McNicoll, 1987, pp. 209-243 ff).

Other scholars have written in a similar vein about other countries in sub-Saharan Africa, as well as Kenya (see, for example, Dow and Werner, 1983, Kamuzora, 1989, and most recently Caldwell and Caldwell, 1990).

In addition, until very recently, Kenya's family planning program was considered to be quite weak. Although its population and family planning policy was established in 1967—the first in sub-Saharan Africa—availability of services and supplies of modern contraceptives grew very slowly. This slow growth resulted from an early decision to provide FP services through the MCH program. This was the responsibility of the MOH, which at the time gave priority to rural health, not FP. The first 10–15 years were devoted to creating the basic MCH network of facilities and staff. Primary health centers were scattered throughout the countryside to provide MCH/FP services for those who desired them. It was essentially a passive, clinic-based system operated by medical personnel. Efforts to create an outreach program did not get very far. Logistics, IEC, research, and evaluation components of the program were weak and often neglected. In 1982, an umbrella organization, the National Council on Population and Development (NCPD), was created with responsibilities for promotion, information, education, and communication programs (IEC), relations with foreign donor agencies, and coordination of the FP activities of NGOs, but this too got off to a very slow start. Lapham and Mauldin, in their 1984 study which provided comparative ratings of family planning programs, ranked the Kenyan program in both 1972 and 1982 as "weak," its lowest category (although its ranking was higher than other sub-Saharan countries). As late as 1987, Frank and McNicoll described the program as a "conspicuous failure" whose impact was "thus far negligible."[1] (Frank and McNicoll 1987, p. 209).

Because of such views, the results of the 1989 Kenya Demographic Health Survey (KDHS, 1989) were unexpected by most observers. According to this survey, the total fertility rate was 6.7 in 1989, down by 13 percent from the 1984 estimate of 7.7 and by 16 percent from the 1977–78 figure of 7.9. This decline is probably real, given its remarkable consistency with other indicators. During this 1984–87 period, the contraceptive prevalence rate increased from 17 to

1. In fairness, it should be noted that they did call attention to the potential for improvement. Following their detailed analysis of barriers to fertility decline, they wrote: "Notwithstanding these caveats, an increasing recourse to fertility regulation in Kenya is not an implausible finding.... Even within the more traditional family pattern... some changes in reproductive behavior can be expected from increasing exposure to urban... lifestyles and more intense competition for higher education and modern-sector employment, especially given the difficult economic circumstances of the last decade." (p. 240).

27 percent, most of this because of increased use of modern methods; the proportion of women indicating in surveys that they want no more children increased from 41 to 50 percent; the mean desired number of children declined (for husbands as well as wives) from 5.8 to 4.4; and the percent of women pregnant at the time of the survey declined from 11 to 8.9. Moreover, 11 percent of women with a birth in the last 12 months were willing to say that they did not want to have the last child when it was conceived, an extraordinary finding by African standards. All these indicators began to move in the directions noted during the 1977/78-to-1984 period, but so slowly—the TFR, for example, only declined from 7.9 to 7.7—that they were discounted by most observers. By now, however, the magnitudes and rates of change are such that they can no longer be ignored.

Of the total decline in fertility, from 7.9 to 6.7, about half appears to have resulted from an increase in the age of marriage. The other half was probably due to an increase in use of contraception. Both factors have had to be strong enough to offset decreases in breastfeeding and postpartum abstinence which by themselves would have increased fertility. It is not known whether any changes occurred in abortion rates.

What explains this turnaround? While no in-depth studies have yet been undertaken, six factors operating in combination appear to be the most important.

1. *Education attainment and costs.* The demand for education as a means to social and economic advancement has been strong in Kenya since colonial days. After independence in 1963, the Government quickly announced a policy of universal, free, primary education and embarked on a massive school expansion program. During most of the 1970s, education expenditures were about 7 percent of GDP, a larger percentage on a sustained basis than nearly any other country in the world, and much larger than that of other countries in this study, which ranged from 2.5 to 3.5 percent. The result has been a dramatic improvement in educational attainment from the very low base existing at the time of independence. Most significant, a substantial fraction of women have now become literate and have completed six years of schooling (which many studies indicate to be the threshold for maximum effect on fertility).[2] This achievement has come at increasing cost to individual families. While there are no primary enrollment fees, villagers are typically responsible for constructing and maintaining the school building and must bear the cost of textbooks, supplies, and uniforms, which can be substantial, especially for poor families. These characteristics—high demand, increasing costs, and significant improvements in educational attainment—appear to have interacted in the way theory says they should, to change parents' attitudes about the benefits and costs of children and make them want to substitute quality for quantity.
2. *Improvements in health.* The Government, plus the NGO community, has also invested heavily in health services since independence—almost 4 percent of GDP during the 1970s. The result has been that, between 1970 and today, life expectancy has increased from 46 to 58 years and infant mortality has decreased from over 100 to about 70[3]. This factor also is likely to have had its expected effect of reducing the number of children parents need to ensure the survival of the desired number and reinforcing the growing concern with quality over quantity.
3. *Increases in female labor force participation.* While a large fraction of Kenyan women have typically been recorded as participating in the labor force—in our sample, only Senegal has a higher fraction—the character of this employment seems to be changing. An increasing number are becoming involved in new occupations or in more modern versions of traditional occupations such as farming and trading, which in general are more competitive with childbearing. This change undoubtedly has been associated with improved female education levels and improved status generally.
4. *Declining size of landholdings.* Concerns about the growing density of population on arable land—a small portion of Kenya's vast open spaces—have been voiced since before independence. During the last two decades, it has reached a point where farm families themselves can see the connection between the number of children they have and the size of plots they can pass on to them.
5. *Improvements in supplies and services.* Although modern contraceptives were relatively abundant in the 1970s, their effective availability was limited because of restrictive guidelines for their use in government health clinics, the small number of supply points, lack of training, and lack of interest on the part of the health staff. By the mid-to-late 1980s, restrictions on to whom and how contraceptives could be offered were relaxed, the density of supply points had increased, and a wider variety of delivery channels—government, NGOs, and commer-

2. Female enrollment in primary education, which was roughly in the same range as that in Senegal, Bangladesh, and India in 1970, is now substantially higher than in those countries. Secondary enrollment of females, which was similar to that of Senegal and Bangladesh in 1970, is substantially above those countries today, though still below that of India; and the female literacy rate was recorded at 50 percent in 1985, placing it substantially above that of Senegal, Bangladesh, and India in that year.

3. This last figure is substantially lower than those observed in Senegal, Bangladesh, and India, comparable to that of Indonesia, and not much above that of Brazil.

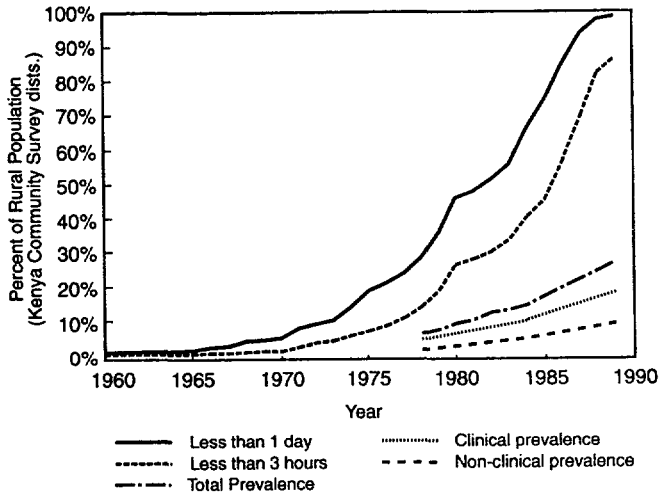
cial—had developed. NGOs, for example, with USAID support, initiated large-scale outreach programs (social marketing and community-based distribution schemes) during this period, which the previous health center-based program lacked. Perhaps most important, as indicated below, signals were changed in ways that made health center staff give higher priority to the provision of services.

The dramatic increase in supply points and its correlation with increases in contraceptive prevalence is graphically illustrated in Figure 6.1. It shows that, despite an anti-natalist policy since Independence, contraceptive services were not available to a large proportion of the rural population until the mid-1980s. In 1970, less than 10 percent of this population was within one day's travel to a delivery site. By 1980, this figure had risen to 40 percent, and by 1985, to more than 75 percent. By the end of that decade, almost 90 percent of the rural population was within three hours of such services. Most of this increase occurred because of growth in the number of government clinics, with a sizeable minority receiving supplies from field educators and family planning distributors. The increase in use of clinical and non-clinical methods, as revealed by a series of sample surveys, is also depicted for three points in time.

6. *National leadership.* While President Kenyatta was not very interested in the population program, President Moi has gone out of his way to promote it. This has legitimized the program and a smaller family norm and has prodded government officials—for example, district commissioners and village chiefs, who have the power to allocate funds for construction and to assist NGOs with transport, petrol, meeting rooms, and the like—to give the program more priority. The President's leadership also led to an open debate on the population problem, the outcome of which was greater public support and consensus.[4]

At least two other factors may be playing significant roles. First, the country has been especially open to the influences of Western lifestyles and attitudes about family size. The Government has allowed markets to operate relatively freely and has encouraged private entrepreneurship, both foreign and local. This policy—in direct contrast to that of most of its neighbors—plus a relatively stable government and strong economy has resulted in an influx of foreign aid donors, private investors, and tourists which in turn has exposed the population to a materialistic, Western lifestyle at the same time as it has increased opportunities with which to pursue it. In the process, the perceived value of children and large families may have declined more rapidly than in other African countries with similar traditional values. Second, fertility control for spacing has been accepted in Africa for generations. This may help explain why acceptance of contraception for limiting family size proceeded rapidly in Kenya once attitudes towards large families changed.

Figure 6.1: Family Planning Accessibility and Prevalence in Kenya: Travel Time, by Year Facility Started



Source: Hammerslough, 1991.

Foreign Assistance and the Role of the Bank

What role has the Bank played in this process? First, the Bank, along with other donors, has encouraged and financially supported the Government's economic policies; in particular, its heavy emphasis on education and health. Since 1970, the Bank has provided loans and credits to Kenya of more than US$2.6 billion, of which 4 percent went to the education sector. This percentage is close to average for Bank lending in Sub-Saharan Africa, but larger than that found in Bank lending programs elsewhere. Financial assistance to other sectors—transport and communications, for example, which has amounted to 20 percent—may have helped the program by providing needed infrastructure. However, there has not been—at least up to about 1989—any conscious attempt to slant these lending programs in ways that would maximize their fertility impact. (An example would be specifically encouraging enrollment of wom-

4. Starting in 1984, NCPD hosted two national and a series of district-level population conferences that have proved to be very useful. The first conference, for example, which was co-chaired by the Vice President and the Minister of Health and attended by all Cabinet members, led to a series of debates that were continued in the press. One such debate over the use of Depoprovera led to a technical defense of its use by the Director of Medical Services, which was reported in the press and may have been associated with a significant increase in demand that occurred shortly thereafter.

en or introducing population education programs into the curricula.)

Second, the Bank, along with other donors, has provided a significant portion—perhaps 70-80 percent—of the funds spent by the Government on its population and MCH programs. According to the UNFPA (1989), during the 1982–89 period, Kenya received more than US$8 million per year for its population program. In per capita terms (because of the small size of its population), this is one of the largest amounts in the world.[5] Bilateral agencies provided 54 percent; multilateral agencies (including the World Bank), 10 percent; and private organizations, 36 percent of this amount. The Bank's contribution, in the form of four credits for projects initiated in 1974, 1982, 1988, and 1990, has amounted to US$82.2 million.

Bank involvement started in the fall of 1969, shortly after establishment of the Population Projects Department within the Bank's Central Projects Staff. This was a time when the new and relatively inexperienced staff was under substantial pressure to produce a "bankable project," particularly in Sub-Saharan Africa. On the basis of a five-year health plan prepared largely by expatriate advisors, the Government, after considerable internal debate and discussions with donors, decided that its primary interest was rural health and that it would consider FP only as a part of the MCH program. Accordingly, it proposed a project focusing on construction of rural health facilities and training schools. The rationale was that, since FP was to be delivered through the MCH program, the establishment of a network of delivery points and training for that program was the first priority. While WHO supported that position, UNFPA and USAID objected on grounds that this strategy would have little or no impact on the population growth rate during its lifetime. The Bank decided to support the Government's position and went forward with the appraisal without the involvement of these other agencies. The consequence was a project that was 89 percent civil works, 9 percent furniture and equipment, and 2 percent technical assistance, including fellowships and training. Nearly all of this was provided to the MOH, where commitment to family planning was weak. Little thought and fewer resources were devoted to the problem of what to do about demand or what to do about the very small gap between actual and desired family size. This was essentially a supply-side, clinic-based program that was unlikely to receive many requests for service.

Quantitatively, the project achieved most of its construction and training targets. However, organizational support for effective integration of FP and MCH activities was never forthcoming. The National Family Welfare Center, established by the project to plan and support the activities of the new MCH/FP program, was never provided with the staff required for the purpose. As a consequence of this and other factors, little progress was made in implementing other components such as IEC, research, and evaluation, and the impetus for a new category of health worker—family health field educators, who might have served as the nucleus for an outreach program—was dissipated and eventually died. In the end, there was really nothing in this project directly related to family planning, other than the agreement that when MCH services eventually came on stream, they would include a FP component.

Also, no progress was made toward achieving the stated goals of the project—goals which must have appeared naive and unrealistic to many observers, even at that time. These were: (1) to reduce the population growth rate from 3.3 to 3 percent and (2) improve the health of mothers and children. By the time the project ended, the population growth rate had in fact increased to 3.9 percent. The implicit presumption was that construction and training would quickly lead to effective operations and the latter would quickly lead to reductions in fertility and improvements in health. Under the circumstances of the time, it was a considerable achievement to have successfully completed the construction and training program. Had project goals been specified in terms of future expansion of the system, with the explicit understanding that this would be an important first step on a long and difficult path, perhaps the disillusionment that followed the end of this project could have been avoided.

Considerable analysis and soul-searching went on before the second project was sent to the Board. The general consensus was that four factors stood in the way of progress: lack of commitment at senior levels in Government; weak organizational support provided by MOH; lack of effort in dealing with continuing high levels of demand for children; and excessive focus on investment in building health infrastructure, as opposed to providing FP services through existing health centers and the substantial NGO service network.

The second project continued support for expansion of the MOH health delivery system. However, in order to correct these earlier problems, two new elements were added: support for the newly-established NCPD and for the development of an IEC program by that agency. It was later amended to use surplus funds to finance development of surgical facilities for sterilization. Efforts beyond IEC to promote demand for smaller families and FP were not believed to be politically feasible at the time. This project (completed in December, 1990), like the first, was successful insofar as its construction and training components were

5. However, this figure probably includes substantial funds for MCH and other health programs. This is certainly the case insofar as the Bank loans are concerned.

concerned, but made only halting progress with respect to its IEC and other components.

By 1988, when the third population project was approved, further expansion of the health delivery system no longer appeared necessary, the political climate for family planning had substantially improved, and signs of increased demand were becoming apparent. The designers of this project appear to have taken advantage of these changes by focusing on three areas: strengthening of NCPD (construction of headquarters and district office buildings, staff training, and MIS and research and evaluation activities), the establishment of a multisectoral IEC program (funds for IEC activities in other agencies, as well as NCPD), and support for NGOs to enhance their IEC and service delivery activities. The only funds made available to the MOH were for the conversion of its Health Education Unit into a Media Production Centre to produce IEC materials for all users. The fourth project, initiated just two years later because of a critical shortfall in the availability of funds from other donors for purchase of contraceptives, is basically an amendment or add-on to the third population project.

In addition to these projects, the Bank involved itself in policy dialogue, sector work, and efforts to influence the evolution of the program in a variety of ways. In the early days, these efforts were mostly aimed at raising the sense of urgency with which the GOK approached its population problems. The general economic reviews produced by the Bank in 1969 and 1979 included sections on the negative consequences for economic growth of rapid population growth and increasing population density on arable land. So too did the *Population Sector Review* of 1974 and the Economic Report of 1980, entitled *Population and Development in Kenya*, a particularly good analytical document. In addition, senior Bank officials from the President on down lost few opportunities to raise the issue with their counterparts. In the words of more than one observer, the Bank made a significant nuisance of itself during this period.

There was, however, very little if any dialogue about program content before 1980. The first significant intervention on that level involved support for the establishment of NCPD. This came, among other ways, in the form of a condition for release of the second tranche of the Second Structural Adjustment Loan. This loan became effective August 27, 1982, the same day the second population project was signed. It is not clear whether such pressure was necessary to ensure the establishment of this organization, since it was proposed and supported by important elements within the Government. Its creation, however, was opposed by the MOH, and as a consequence, dialogue on other matters of program content with the MOH remained negligible for several more years.

The Bank was also influential in the Government's decisions to expand the role of NCPD, from one focusing strictly on IEC to one coordinating all agencies involved in population work—donors, NGOs, other ministries, and District Population and Family Planning Committees—and becoming the principal executing agency for the third and fourth population projects. This agency has had significant teething problems and has grown only slowly in effectiveness. After a short residence in the Office of the Vice President, it was moved to the Ministry of Home Affairs, from which position it had difficulty promoting the involvement of other ministries and retaining good staff. Its IEC and promotional activities remain timid and it has not assumed a strong leadership role in coordinating donors and NGOs or pressing other ministries to become involved in the population program. It has, however, sponsored a very useful series of conferences (see footnote 4) and developed a population policy statement enacted by Parliament. The judgement is still to be made, therefore, on whether it was a good idea to have promoted the development of this new organization, rather than continuing to influence the MOH to move more forcefully into the population field.

Other program interventions included successful efforts to persuade the MOH to liberalize guidelines for providing contraceptives, to integrate FP into the mainstream of MOH activities, and to offer sterilization services. The Bank also played a critical role in the financing of contraceptives when funding was reduced by other donors. This was done despite restrictive guidelines about funding recurrent costs, by arguing that these expenditures are equivalent to investments in creating demand for a product which will eventually be purchased without subsidies. Finally, the Bank played a significant role in encouraging the GOK to make greater use of NGOs in the FP program, in part by earmarking project funds to NCPD for their use.[6]

It is interesting to note that nearly all these interventions were undertaken by staff stationed at headquarters, albeit with rather liberal budgets for supervision and travel.[7] It is not clear how much more might have been accomplished had staff been stationed in the field. Matters might have otherwise progressed more quickly. It is also interesting to note that funding of NGOs, contraceptives, and other recurrent costs was accomplished in Kenya at a time when it was commonly believed that it was difficult if not impossible for the Bank to do so elsewhere.

6. Interestingly, one commentator pointed out that since the Government has traditionally provided funds to NGOs to help finance their health activities and, in contrast to many other governments, has been willing to borrow at least on IDA terms for this purpose, it was not very difficult to make the case for extension to family planning.

7. Before the appraisal of the third project, the Bank appointed a doctor to serve in Nairobi, but with responsibilities for all of East and South Africa.

Implications and Lessons

This case provides a good illustration of the virtue of patience and perseverance in the population field. It has taken 20 years to reach the takeoff stage in Kenya; it could well take that long in other countries in the early stages of the demographic transition. As such, it should provide a good antidote to two self-defeating tendencies: to expect too much too quickly and, when disillusionment sets in, to expect that nothing will work. It also suggests that some rethinking about the way project goals and targets are specified and evaluated is in order in the population field.

Could anything have been done to speed up the process? Probably not too much. While each of the Bank projects included co-financiers, cooperation with other donors left much to be desired at times. Significantly, more efforts could have been made to correct program weaknesses—especially in IEC, outreach, monitoring, evaluation, and research--and to attempt in other ways to influence demand for smaller families. Better donor coordination on these and related issues would have helped. The Bank pressed the Government fairly strongly on many of these issues—perhaps too strongly at times—and seems to have taken advantage of opportunities to progress as they emerged. As an example, it actively encouraged and funded NGO activities, especially in areas in which the Government seemed unwilling or unable to act. Attempts to proceed more rapidly might have been counter-productive. As indicated above, the evidence with which to judge whether support for the development of NCPD was a wise move on the whole is still inadequate.

Regarding the future, is the program now finally on the right track? There is good reason to believe that progress can continue for some time longer without significant changes in policy directions. According to a 1989 survey of married women of childbearing age, 32 percent indicated that they wanted no more children but were not using contraception. An additional 28 percent wanted to postpone the next birth by at least two years, even though they were not using contraception. Thus, 60 percent of these women can be classified as in need of family planning, a potentially very large market for services. Most of this "need," however, will not manifest itself spontaneously. For some time to come, free and convenient access to high quality services and supplies, plus considerable encouragement, will be required to affect actions. Thus, while fundamental policy changes are not required in the near future, funding must continue to expand, quality of services must improve, and most important, promotional efforts like IEC and outreach—very weak aspects of the Government program so far—must be significantly improved.

However, given existing family size preferences, even if the gap between desired and actual family size were totally closed, the TFR would decline only to the range of 4-5 children per family. This implies a population growth rate still substantially above 2 percent per year. To reduce the TFR further will require continued changes in social and economic conditions of the type that have led to the decline so far, and/or selective interventions into those conditions to encourage changes in desired family size norms that are out of phase with normal development processes. Promising possibilities include programs aimed to improve the legal, economic, and educational status of women, induce more rapid declines in infant and child mortality rates, and improve old-age security options.

Considerable ignorance remains, however, about what has induced the initial changes in reproductive behavior, let alone what might be accomplished by deliberate policy changes. It is plausible that the pro-natalist family system with the high value it places on large families has been weakened by the social, economic, and policy changes that have taken place, but this is only conjecture. We do not know which components have been the most significant and how amenable they are to being influenced by policy. A significant research effort to improve understanding of what has happened so far, plus pilot projects to try out alternative interventions for the future are urgently needed if one is to be ready for the time when diminishing returns to the present approach set in. Trying to understand the basis for the incipient changes in Kenya (as well as in Botswana and Zimbabwe) may help in developing programs for other Sub-Saharan countries where change is not yet under way.

7. Senegal

Senegal was selected for case study review because it is illustrative of a number of small Sub-Saharan countries with high fertility in which there is little indication of a significant demand for family planning, relatively slow progress in social and economic development, and only recent beginnings of official support for organized family planning services. It is also a country in which the Bank has had some influence on developing a policy favorable to family planning.

Demographic and Socioeconomic Trends

On the basis of its 1986 Demographic and Health Survey, Senegal's total fertility rate for 1983–86 was estimated to be 6.37. This represents a decline from an estimated 7.55 for the 4-7 year period preceding the survey and from 7.1 in the 1976 survey. Part of the decline in general fertility is due to a rising age at marriage.

Whether the estimated trend represents a real decline in marital fertility is an open question. It is likely that part of the decline is attributable to a displacement of births backward in time from recent to earlier periods. In any case, there is little evidence of an increase in contraceptive prevalence that could have produced a decline in marital fertility. The proportion of couples using modern contraception increased only slightly, from 0.6 percent in 1978 to 2.4 in 1986. While an additional 7.4 percent were using traditional methods, this mainly involved prolonged postpartum abstinence, which has been common for many years.

While Senegalese women still want large numbers of children, there are some small signs of change. The mean desired number of children did decline from 8.8 in a 1978 survey to 7.2 in 1986. Further, in 1986, 19 percent of the women in marital unions were fertile, wanted no more children, and were not using contraception. An additional 26 percent wanted to postpone a birth for at least two years. However, the idea that spacing births is desirable is not new. It is a traditional value. Further, 85 percent of those who said that they wanted no more children were concentrated among women who already had five or more children, with 73 percent having six or more.

There has been a significant increase in knowledge about contraception. In 1978, only 23 percent of women had heard of a modern contraceptive. By 1986, this percentage had increased to 69, although there is some evidence that the knowledge is superficial. This increase is probably the result of the considerable coverage of the mass media in Senegal and the frequent interaction between urban and rural populations in this small country.

Given current socioeconomic levels and trends, reproductive behavior is unlikely to change very rapidly in Senegal. Per capita gross national product in 1988 dollars was $650. While similar figures are recorded for the Philippines, Zimbabwe, and Egypt, Senegal appears much poorer. Its per capita GNP declined 0.8 percent per year between 1965 and 1988, in contrast to the modest growth experienced by these other countries. Obstacles to economic growth are substantial. The country has few natural resources. In particular, rainfall is unreliable, only 20 percent of the land is arable (and nearly all of that is in use), and deforestation and desertification are palpable threats. Infrastructure is poor and less-than-optimal use is being made of these limited resources because of misguided economic policies.

Educational levels are still low in Senegal, although improving slowly. In 1986, the DHS found that 77 percent of women of childbearing years had no formal education, 14 percent had attended primary school, and only 9 percent had attended secondary school. These educational attainment levels are considerably below those of Botswana, Kenya, and Zimbabwe, the three Sub-Saharan countries with significant declines in marital fertility and increases in contraceptive prevalence. Infant and child mortality rates have also improved, but remain substantially higher than those in these three countries.

While 40 percent of Senegal's population lives in urban areas, the difference in modern contraceptive prevalence rates is not great—6.7 percent in urban and 0.3 percent in rural areas. The rate of urbanization is modest by African standards—4 percent compared to over 8 percent in Kenya and Botswana and over 6 percent in Nigeria and Zimbabwe. These figures do not provide a very substantial basis for the diffusion of new types of reproductive behavior.

Life is especially hard for Senegalese women. Strong traditional forces channel women into agriculture and/or selling in the informal sector, where they put in long hours. For the most part, they are illiterate and uneducated. Islamic traditions pose further restrictions on women, granting them status and security based on the number of children they have, limiting wives' inheritance to one-eighth of their husbands' estate, and forbidding them employment in certain jobs. In its recent draft document outlining plans for a National Program in Family Planning, the Government outlined the socio-cultural constraints it perceives as affecting the provision of family planning services in Senegal. These factors include pro-natalist traditions; fatalistic attitudes and the view that children are the gift of God; false rumors about family planning, which build upon irrational fears; and a tradition of males disassociating themselves from contraceptive use decisions.

There are a few positive signs. The concept of deliberately limiting births for spacing purposes is widely accepted and Islamic leaders have been playing a neutral or modestly supportive role. However, these seem weak influences compared to the many pro-natalist cultural and socioeconomic factors in operation.

Population Policies and Family Planning Programs

This pro-natalist heritage was reinforced by the French colonial administration which made sale and distribution of modern contraceptives illegal, a prohibition that ceased to be enforced in the 1970s and was repealed in 1980. A turning point was Senegal's first-ever census, in 1976, which indicated a population size and growth rate much larger than expected. These results led President Senghor to warn of serious difficulties in providing basic services if the population growth rate were not curtailed. In 1978, the Government created the *Direction de la Condition feminine* and assigned it "tutelle" (responsibility) for family planning. In 1979, the National Population Commission (CONAPOP) was established to coordinate various ministries' activities with respect to demographic issues. However, it has never developed into an effective organization despite substantial donor efforts.[1] Turf battles ensued between Condition Feminine and the Ministry of Health after the latter was made the executing agency for a USAID-funded Family Health Project. Eventually, Condition Feminine, which later became the Ministry of Social Development (MSD), was assigned responsibility for family planning IEC and the MOH responsibility for clinical services. In 1990, the MSD was dissolved and the MOH, was assigned sole responsibility for all aspects of the program.

After the legalization of contraceptives in 1980, USAID and UNFPA negotiated for family health projects to include family planning. While these initiatives encountered opposition and bureaucratic obstacles, they have gradually increased their service points and the range of information, training, and service activities. Following an earlier, partially successful project, USAID designed a follow-through project to its initial family health project. This, too, encountered opposition and implementation problems. However, with patience, compromises were worked out. This second USAID project has enabled the Government and several noes to make some progress, although not to meet initial goals. While the proportion of all eligible women being served is still quite small, infrastructure has been created to encourage and accommodate additional use. This is especially notable in the government sector, where there was essentially no service 10 years ago.

During the latter half of the 1980s, CONAPOP'S secretariat, the Directorate of Human Resources in the Ministry of Planning, undertook a process of discussion and consensus-building which culminated in the publication of a national population policy in 1988. The preparation of this policy statement, long overdue and much needed, was instigated and actively supported by the World Bank. This statement was followed by a more operational document entitled the Population Action and Investment Plan (PAIP), officially adopted by CONAPOP in February, 1991. A major recommendation of the PAIP was that the Government establish within the MOH a National Program in Family Planning (NPFP), which was done in April, 1991.[2] These actions appear to have legitimized open support for family planning among Government officials. Together with the slow development of a family planning service delivery system, they provide the basis for a moderate degree of optimism about future developments.

The formation of a program in the Senegalese context is very significant. Prior to the establishment of the NPFP, all population activities were in the form of "projects," signify-

1. CONAPOP consists of representatives from various ministries, with the Directorate of Human Resources in the Ministry of Plan serving as its secretariat. Its most significant action has been to agree on a population policy paper prepared by the Directorate.

2. It is interesting to contrast these events with those in Kenya. There, the policy statement was drafted first and the process of consensus-building around it took place thereafter. We are not in a position to say which process is better or more efficient; both appear to have worked. It does mean, however, that Senegal is not as far behind Kenya as the difference in dates of their policy statements might suggest.

ing an entity created by a donor which begins and ends with outside funding. The word "program" implies acceptance of the activity within the Senegalese system, and while the funding for the program might still come from projects funded by donors, the sense of ownership has shifted from one that is external to internal.

Foreign Assistance and World Bank Involvement

Since independence in 1960, Senegal has received large amounts of donor assistance. As of 1987, the per capita amount of foreign aid was about US$80, almost double that of other Sahelian countries. About 40 percent of this aid comes from France and 8.5 percent from the World Bank. During the period 1960–87, the Bank committed approximately $800 million to Senegal through 61 loans, 80 percent of which was on IDA terms. Most of these commitments were allocated to transportation, industry, and tourism. Lending to education constituted only one percent of the total, probably because this has been a focus of French assistance. After a number of years of disappointing results, in part because of poor economic policies, the Bank began to focus on structural adjustment loans. Since 1985, these loans have amounted to 40 percent of total lending.

So far, the Bank has had one project in the PHN area, a rural health project signed in 1982 which focused on the provision of buildings and equipment for expansion of basic health services. This project called for the provision of FP along with MCH services in health clinics, and a standard package of equipment for this purpose was provided. However, this stipulation was ignored in the training program and not mentioned in either the supervision reports or the PCR. Failure to implement this element, as well as most other software components of this project, is attributable to lack of interest, insufficient budgetary allocations by the Minister of Finance, rivalry and turf battles between the Ministry of Health and what later became the Ministry of Social Development, and poor relations between the Minister of Health and the Bank at that time.

Of relevance here is the possibility that the Bank's operating style may also have played a role. The FP provision was not a part of the original Government submission, but was introduced at the behest of Bank staff on the basis of correspondence and discussions during brief visits. It was *not* developed in a collegial, problem-solving atmosphere which might have led the Government to assume ownership of the idea. The Bank also did less than it could have during implementation to follow up and encourage the Government to proceed with this and other software elements. It is interesting to contrast this experience with that of USAID, which had similar problems with its first family health project. In this case, however, USAID's field staff spent many months mediating differences between the two rival ministries and eventually got them to agree to a separate project management unit with representatives from both ministries. The result was that the project did proceed to implementation. This same field staff continued on an almost daily basis to follow up during implementation, to good effect.

In 1985–86, the Bank undertook a general population sector review which concluded that USAID and UNFPA were doing as much as could usefully be done at the time in the FP field. It recommended that the Bank, instead of trying to supplement these activities (as it tried to do in the rural health project), concentrate instead on helping the Government develop a comprehensive population policy. This recommendation was accepted and eventually implemented by making the development of such a policy statement a condition for release of the second tranche of the third structural adjustment loan. While news of this approach provoked statements of resentment in other African countries, no significant negative reactions appear to have developed in Senegal. The Government did at first express skepticism because it did not understand the process, purpose, and content of such a statement. However, these doubts were overcome during the course of discussions, and the Government, utilizing a Special Project Preparation Facility grant and a multi-sectoral team, produced the statement, which eventually was published in 1988.

Subsequent events have proven that the policy and the World Bank's role in its development have been welcomed by Senegal. This document and the process of consensus-building that led up to it appear to have allowed and encouraged activities in this field that were more difficult to initiate before. As indicated above, it provided the impetus necessary for the Government to give family planning the status of a program and created a framework under which the many donors wishing to fund discrete population projects may now do so in a more coordinated and rational manner. Another consequence has been the development of a Human Resources Project for Senegal, approved by the Board in April, 1991. A condition of negotiation was liberalization of restrictions on provision of FP services. As a result, nurses can now provide all services except sterilization and traditional birth attendants can distribute pills. These are radical changes from earlier, when only doctors could provide such services. A condition of approval was official adoption of the NPFP. In addition to expansion of MCH and FP services, a few demand-side steps have been added: an IEC program focused on youth, a WID component which includes a functional literacy campaign, and research into legal issues like polygamy and personal taxation. More central issues of female education have been left to a proposed education project.

Did the Bank make the right decision in the 1980s to leave assistance for FP up to USAID and UNFPA and encourage policy development instead? Probably yes, on two grounds. First, much of the early effort to establish FP activities required intimate contact and flexibility, which could be undertaken effectively by these agencies' field staff, but not by the Bank from Washington. Second, the Bank, with its broad policy agenda and access to senior policy circles, was in a good position to discuss and encourage the development of a population policy. Thus, a good *de facto* division of labor appears to have developed between the various donors in this field during this period.

In the last few years, this division of labor has been changed by the more pro-active role played by the Bank in developing the Human Resources Development (HRD) Project. Some donors have raised questions about the appropriateness of encouraging the Government to borrow for activities which other donors could fund on a grant basis. Others have raised questions about whether this project, added on top of ongoing and planned USAID and UNFPA projects, will exceed the absorptive capacity limits of the Government. The project aims to extend family planning and other services to the 600 health posts, the lowest level in Senegal's health delivery system. While agreeing on the importance of this extension at some point, critics point out that to date, USAID has restricted itself to operating at the next highest level, which consists of 44 health centers, because of concerns that it is already straining the Government's capacity to adequately supervise and provide supporting infrastructure, transportation, and IEC services.

The Bank's position is that it wishes to take advantage of the Government's current willingness to extend services to the periphery; that the urgency of the problem warrants taking more risks than is implied in USAID's approach; that it is not displacing grant funds, since other donors do not appear willing at present to operate at this level; and that the risks involved can be minimized by starting on a small scale and slowly escalating.

Without an intimate knowledge of field conditions, a judgement cannot be made with confidence between these two positions. Two things are clear, however. First, while it is true that an incremental approach to implementation would reduce risks, this approach requires a different style of operations than is typical for the Bank. It requires much more intimate contact with day-to-day field operations, much more technical support, and much greater willingness to make significant mid-course corrections.

Second, if one looks strictly at Senegal's demographic and socioeconomic characteristics, it must be concluded that the prognosis is for slow and reluctant progress in reducing fertility rates in this country. It may be that latent demand exists, as appears to be the case in Bangladesh and Kenya. For some reason, however, this is not being picked up in surveys, so that positive steps on the policy and service delivery side will quickly begin affecting prevalence. Much will depend on whether the momentum on policy of recent months is sustained, and more important, how well these policy decisions are implemented. So far, there has been little public support by high-level government officials, an element that seems to have been crucial in Kenya. In addition, the Government's implementation capacity seems very limited. The HRD project provides a good opportunity to continue progress, but it is a complex, multisectoral project that would be difficult to implement in any country.

Both points strongly suggest that the Bank consider ways to more intensively and intimately assist the Government to implement this project than its typical supervision procedures allow. If the urgency of the problem warrants taking additional risks in this case, it also warrants a more intensive effort to ensure a successful outcome.

8. *Major Issues for the World Bank*

Neglect of Population Issues in Non-Population Sectors

While there is evidence that family planning programs can contribute to fertility decline even where development levels are low, there is no question that development, especially in such sectors as education and health, has a facilitating effect in reducing the demand for children and increasing the demand for family planning services. Other aspects of development supported by the Bank (e.g., transportation, communications, and electric power) are also important because they increase the circulation of information and new ideas and because they improve the capacity of the family planning program to organize, provide services, and spread its message.

For example, there is evidence that in Indonesia a set of dynamic social and economic programs supported strongly by the Bank had a profound effect on the aspirations of young persons for themselves and their children. These in turn led to later age of marriage, a shift in desire for quality over quantity of offspring, and a greater interest in family planning. The Bank could have done more to encourage progress in Indonesia's lagging health sector. This is, somewhat belatedly, a major thrust of the fifth Indonesia population loan, which was just inaugurated.

The Bank could also have done more in both India and Bangladesh to encourage greater investments in female education and in maternal and child health services, where low levels and slow rates of improvement are inhibiting progress with family planning programs and threatening future progress. Here too, recent initiatives are encouraging.

Kenya is another case in which rapid progress in the education and health sectors, strongly supported by the Bank, contributed to the recent, unexpected increase in family planning practice and fertility decline. Much less development progress in Senegal undoubtedly is a barrier to fertility decline there.

Typically, the Bank's major investments in a broad range of development sectors are made and justified without reference to population issues. Had these issues been taken into account, their impact on demographic developments could have been greater. This is certainly the case in education and health, where there is good evidence that special emphases on female education and on maternal and child health services have strong demographic effects. It is likely to be the case in a number of other sectors, for example, in the transport and communications sector, where a greater focus on opening up isolated areas to external influences could be helpful; in agricultural and industrial projects that could be designed to increase the number of jobs available to women; and in projects and programs concerned with social security, which might build incentives for smaller families into the rate and benefit schedules.

Recommendations for such selective interventions in the development process on behalf of population have been made by every external advisory group to review the Bank's population activities since its inception. Their neglect is probably due to a combination of factors: skepticism about the argument for selective interventions, doubts about what can be done, failure to establish significant research programs to overcome these doubts,[1] and staff specialization and compartmentalization.[2] Underlying many of these factors may be the fact that population is treated by the Bank as a sector, with responsibility for it assigned to a specific administrative unit. Implicitly, this leaves other sectoral units free from any responsibility. However, population is not a sector any more than economic development

1. For example, by setting up pilot projects to test the effects of different interventions.

2. Even within the population sector, there is compartmentalization. Most staff assigned to this field are either demographers, family planning specialists, or generalists responsible for loan processing. Social scientists concerned with how development variables influence—and might be modified to influence—fertility decisions are rare.

or poverty alleviation. All three are more in the nature of strategic objectives that should be the responsibility of all sectors.

A step in the right direction was taken in 1980 when the Bank officially started lending for health and established a department whose aim was to integrate population, health, and nutrition. The situation improved further after the 1987 reorganization with the inclusion of education in a newly-established sector called Population and Human Resources.[3] A more important step was the establishment of the *Women in Development* and *Safe Motherhood* programs which come closer to doing much of what is required to influence desired family size without special pleading as is necessary in other fields. Promising initiatives can be found in an increasing number of projects,[4] but considerably more can and should be done in a variety of fields.

Everything is in place for the Bank to move more forcefully and imaginatively in this direction. Health and education projects should be asked to routinely include components likely to have an influence on age of marriage and desired number of children. Projects in other fields should be asked to routinely consider locational and gender issues in their design. Pilot projects would help speed the accumulation of experience about what works. Economic and sector reports should be required to routinely consider possible demographic impacts of policy developments, just as they are asked to consider environmental and poverty impacts. Efforts in these directions would be encouraged by assigning responsibility for promoting, monitoring, and exchanging information on these initiatives to a specific office.[5]

Dialogue, Policy Promotion, and Sector Work

The Bank is uniquely qualified among donors to encourage political commitment through a continuing dialogue on population issues with top government leaders. Its frequent contact with such leaders about the overall lending program and about macro-economic issues, plus the high regard placed on its analysis of economic issues, ensures that this is the case. The Bank appears to have had a significant supporting influence in the development of national population policies in Indonesia, Kenya, Senegal, and Bangladesh. It has had little influence in India, where a strong anti-natalist population policy was already in place, and in some Latin American and Middle Eastern countries, where ideological or religious opposition to such policies are still strong.

As illustrated in the case of Senegal and Kenya, the Bank can sometimes go beyond discussion by making development of a policy statement a lending condition. In both cases, the Bank undertook this approach in conjunction with encouragement of an important group within the government, which felt it could benefit from external support. However, such situations are likely to be rare. Moreover, as the recent efforts at population consensus-building in Africa demonstrate, it is possible to get governments to develop population policy statements that are based on the felt needs of their populations without using lending conditionality.

In Latin America, Bank representatives have been reluctant to stress these issues because of concerns that it might jeopardize their influence in other areas. There, progress has been made in recent years by emphasizing the incorporation of family planning services into the MCH aspects of health projects without explicit demographic justification. This is a desirable approach where necessary, although Bank staff should continue explaining the economic and social value of slower population growth at every appropriate opportunity.

Generally, however, there has been increasing acceptance of the Bank's efforts to promote the idea that policies to reduce excessively rapid population growth are an important part of an effective development program. At a minimum, it has served to encourage and legitimize the worldwide movement to increase government support for explicit anti-natalist policies and family planning programs.

On the other hand, the Bank does not appear to have a comparative advantage over other donors when it comes to influencing the development of programs to implement national policies. In part, this results from the generally lower staff inputs in the field compared to other donors. It also results from a failure at times to undertake the quantity and character of sector work in this field that would give Bank staff convincing arguments for alternative approaches.

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3. A logical extension of these attempts to integrate various social sectors through administrative re-grouping is attempts to develop "human resource projects". The danger, however, is that such projects will be "Christmas trees:", collections of unintegrated projects in various social sectors which would make their implementation extremely difficult. A more practical approach is to introduce population concerns into all relevant social sector projects. For example, all education projects should attempt to increase proportion and duration of female enrollment, consider changes in curricula that might encourage acceptance of a small family norm and promote MCH, consider ways that teachers might be involved in family planning and MCH outreach with parents of their pupils, etc.

4. Some of these developments may occur as a natural result of expansion of capacity. In education, for example, the first priority is generally to expand the number of spaces without regard to gender. Even if boys fill the spaces first, after a point, further expansion will automatically focus on girls. In labor markets, once unemployment falls to a certain level, the number of jobs available to women will naturally increase. Such mechanisms cannot be relied upon as policy measures, however, because of equity considerations and the slow rate at which they operate.

5. The WID Office is one possibility, but its mandate would have to be broadened to include efforts to alter the perceived benefits and costs of children. The overlap with its current functions is sizeable, but leaves out a number of promising possibilities.

Consider, for example, what appears to be a central element in all successful programs; that is, programs founded on community-based outreach (as opposed to programs that are primarily clinic-based). The establishment of such programs requires an administrative structure that facilitates two-way communication and mobilizes actions initiated at the village level—a very difficult task requiring intimate knowledge of local conditions and personalities. Amongst our sample, only the Indonesia program has developed a truly effective system of this type, and it did so, not by creating a new administrative structure, but by making imaginative use of the existing structure. While it is difficult for donors to influence such a process, USAID was able to do so using a high-caliber group of resident representatives and consultants. The Bank helped in important ways to implement the program after the ideas were developed and tested by others. In India, neither agency has been very successful in influencing the program, in large part because the Government has resisted such advice. However, considering the level and location of staffing and the absence of significant and relevant sector work prior to 1988, it must also be said that, in this instance, the Bank did not try very hard.

The Bangladesh case is something of an exception. Here, the Bank has played a leading role in helping develop details of the program. The difference is largely accounted for by the fact that the Government encouraged the Bank to play this role; the Bank devoted unusually intensive staffing to this program, both in Washington and in the field; and other donors provided funds for this purpose.

The Bank could have had more influence on both general and operational policy through its sector reports, which are respected for their generally high quality. Prior to the creation of the PHN Department in 1979, relatively little population sector work was done, perhaps because of the primary pressure to develop loan volume and because the Population Projects Department was out of the Bank mainstream. During the 1980s, the volume of sector work has grown to the point where there is now in many countries—Indonesia and India are cases in point—a reasonably solid basis on which to make policy recommendations and develop new projects. This trend needs to be encouraged and increasingly focused on technical and operational issues in which the Bank has less strength.

The Bank's capacity for providing assistance at a more detailed operational level—and hence its influence—would also have been greater had a larger share of the time of technically competent population and health staff been devoted to supervision and field operations . In some cases, it would also have helped if more of these staff had been located in the field.[6]

6. In fact, field representation has increased during the last two years, a welcome development which should be monitored to determine whether the expected benefits from this placement do in fact occur.

Project-related Issues

Linkages to health and emphasis on hardware. Nearly all Bank-funded projects with the word "population" in their titles include sizeable health components. More than two-thirds of all projects with the word "health" in their titles include population or family planning activities, and nearly all of these projects include sizeable hardware (construction, furniture, and equipment) expenditures. Indeed, in the four case study countries with at least two population loans, the average proportion allocated to such "hardware" elements ranged between 60 and 70 percent. With the exception of the Indonesia projects, most of this was for expansion of the health infrastructure. Contrary to expectations, there is no clear trend toward lower percentages of hardware in these countries, except in the case of Bangladesh (see Table 3.3 in statistical appendix).

There are three main reasons for these characteristics. First, it is often determined that the best way to deliver family planning services is through the health system, which in many countries has had to be expanded before it can serve this purpose. This determination, while usually correct, needs to be qualified, as suggested later in this chapter. Second, pure population programs consist mostly of software activities, requiring technical inputs and donor field presence rather than capital investments. If packaged by themselves, these projects would tend to be small; too small, in fact, to have much policy leverage. Third, within the donor community, the Bank has specialized in providing construction for sectors like population and health. This represents a *de facto* division of labor with other donors, who are unwilling to provide bricks and mortar. Construction is also an activity that can utilize Bank experience in other sectors and requires less continuing local field representation.

Support for such hardware elements is especially important in the early years of a program, when infrastructure for the delivery system needs to be established. However, it is based on the implicit assumption that other necessary components will be provided by the government or other donors. In Sub-Saharan Africa, where many new population loans are now being made, this assumption is not justified; projects need to provide the whole package of required inputs for satisfactory completion and operation if they are to succeed. Also, there is a tendency in some countries to continue providing building funds for a somewhat longer period than is justified, with the relative neglect of software components. Indonesia and India may be cases in point, although this is an arguable issue.

These characteristics—the tendency to package population and health components in one project and the focus on hardware support—have all too frequently resulted in family planning components of these combined projects being

given low priority. This lack of clear priority appears both in the project design stage, where programmatic detail about service provision and demand creation is often limited, and in supervision, where sizeable disbursements remain one of the main indicators of satisfactory implementation.

Since free-standing population projects without significant health components are the exception and likely to remain so, special attention must be devoted to insuring that the technical design and implementation of the population components are given the priority they require. This may require some change in evaluation criteria, a topic addressed in the last section of this chapter.

Tendency for project size to grow and to fund an increasing share of recurrent costs. In earlier years, population projects (and PHN projects generally) grew in size, largely because of increases in expenditures on hardware. In later years, the share accounted for by hardware has stabilized and in some cases declined. However, projects have continued to grow in size because of increased funding of recurrent costs. These trends can be seen in Table 3.3, but become more evident when proposed projects, are taken into account. The most dramatic example of this is the Bangladesh projects, which have more than doubled in size (in terms of funding levels) every five years, mainly because additional slices of recurrent program costs have been financed by each subsequent project.

These trends are occurring for a number of reasons: growth in capacity to effectively administer larger programs; growth in demand for contraceptive supplies and services; concern that other sources of external assistance will not fill the gap; and a lowering of the barriers against recurrent cost financing in fields in which they can be justified as developmental or capital expenditures. They raise three potentially serious concerns.

- The rapidity of the increase, at least in the case of Bangladesh, raises questions about whether the absorptive capacity limits of the governments in this instance are being overwhelmed. Signs of waste and inefficiency noted in field visits suggest that this may be the case.
- Population project documents seldom portray any serious concern about cost-effectiveness or efficiency. This is quite different from education project documents, for example, where issues of internal and external efficiency are more commonly discussed.
- Increasing recurrent cost funding, no matter how justified on developmental grounds, still raises serious concerns about longer-run financial sustainability of these programs. Most project documents in this field also lack a serious consideration of this issue and what to do about it.

These three concerns will surface as major issues if the trends to increase project size and recurrent cost financing continue. It would be wise to deal with them in detail in future project documents.

Neglect of monitoring, evaluation, and research components. One of the frustrating aspects of this study has been our inability to determine more clearly whether population projects are having the desired impact or not. This inability is due precisely to the neglect of monitoring, evaluation, and research components in these projects. While a monitoring and evaluation component is required in all projects, they are typically not developed in advance and are generally neglected during supervision. However, without baseline and control group data (acquisition of which should really start before project implementation), proper assessment is impossible.

While it is obviously very difficult to separate out the impact of a given project from all the other factors influencing the situation, at a minimum, an assessment can be made of the proximate effects of individual components. For example, it may never be possible to know what the impact of an IEC program is on desired family size. However, a great deal can be inferred about its usefulness simply by knowing how many times a given message was transmitted, what the size and character of the audience was, and what the audience thought of the message. Even these simple indicators, however, are not routinely gathered and assessed.

Part of the problem is the absence of adequate capacity for undertaking such work. Such capacity needs to be local and to be independent of the principal implementing agencies with respect to both the government and the donor. While some improvements have occurred during the last 15 years, this capacity remains inadequate in all the case study countries.[7] An elementary indication is the inadequate system for measuring presumed program impact on contraceptive prevalence and fertility change. This is being remedied mainly, but only partially, through sample surveys; usually conducted by outside agencies.[8] At present, however, none of the countries systematically studies contraceptive acceptability, continuation rates, or side effects with adequate samples. Nor are there adequate studies of the impact of IEC efforts in any of the case study countries. While there is a large volume of so-called operations research, its quality is often dubious. Judging from results, the efforts that the Bank and other donors have expended to assist in the development of such capacity has been inadequate.

7. Such capacity is best developed in India. There, the problem is more that such capacity has not been effectively tapped and utilized, especially at the state level where implementation occurs.

8. These *ad hoc* surveys provide adequate measurements at the national or regional level at periodic intervals, but do not provide reasonable estimates for local areas necessary to manage the program.

Another part of the problem is lack of effective demand for the output of such efforts. It does not matter enough what an evaluation study concludes or whether the monitoring and evaluation component is satisfactorily implemented to pay close attention to these issues. The situation would improve if the Board required that evaluations of past efforts be used to explain and justify projects proposed to it.[9] It would also help if senior management were to make it clear that a proposed project has not been properly designed—and therefore is not ready for Board presentation—until it includes a convincing plan for establishing a monitoring and evaluation capacity and then for utilizing that capacity to answer questions about the project.

A larger role in commissioning research from local institutions and providing them with assistance in designing and undertaking the work would also help. There are a variety of questions of broad—as well as more narrow—relevance that could usefully be studied. In Bangladesh and Kenya, what accounts for the initial success of the program despite unfavorable cultural, social, and economic conditions? If the answer is something like latent demand, where does it come from and how can it be stimulated? Is this a case in which supply creates its own demand or will supply-oriented programs run into diminishing returns, as we suspect, long before a satisfactory fertility rate has been achieved? Can a similar phenomenon be counted on to start the fertility transition in Senegal? Would a pilot project similar to Matlab be useful there to demonstrate the existence of latent demand, and what it takes to reach it? In the past, such efforts have been insufficient to generate much interest in the monitoring, evaluation, and research components.

Lack of funding of contraceptive production facilities. If the rise in demand for contraceptives is creating a financial problem that donors should consider filling, the scope for development of local production facilities should also be increasing. To date, the Bank has funded only one such facility, a plant constructed in Indonesia in 1978–79. What has inhibited more activity in this field? For a time, concerns that demand was insufficient for a plant of an economic scale may have explained lack of interest. In the larger countries however—Indonesia, India, Bangladesh, Brazil, and Mexico—this can no longer be the case.

Interviews within the Bank suggest the following reasons. Industry staff are not interested because the projects would be too small and because, at least in poorer countries, production would have to be subsidized or purchased by a donor. Governments are not interested so long as they are obtaining free supplies from donors. In addition, donors prefer to provide commodities, or tied grants to purchase them, rather than provide (untied) grants to governments to purchase the output of domestic plants. Population staff in the Bank have also not been interested because of the availability of free supplies. However, if the Bank is increasingly being called upon to fund the purchase of contraceptive supplies in hard currency, these positions should be reconsidered.

Such a reconsideration is occurring in the Bangladesh program, where the Bank has agreed to fund the building of a contraceptive production facility and provide a loan to the Government for the purchase of its output if a good feasibility study for such an operation can be developed. The UNFPA is assisting in the attempt to produce such a study. Similar explorations should occur elsewhere.

Project staffing requirements. These case studies suggest that population projects, if undertaken properly, are more staff-intensive than projects in most other sectors. Proper design requires attention to processes and procedures that can be taken a bit more for granted in many other fields. Supervision invariably involves considerable technical assistance working with field-level problems—a time-consuming task if done correctly. Given this, one should expect to find that staff coefficients devoted to these projects are greater than for other sectors.

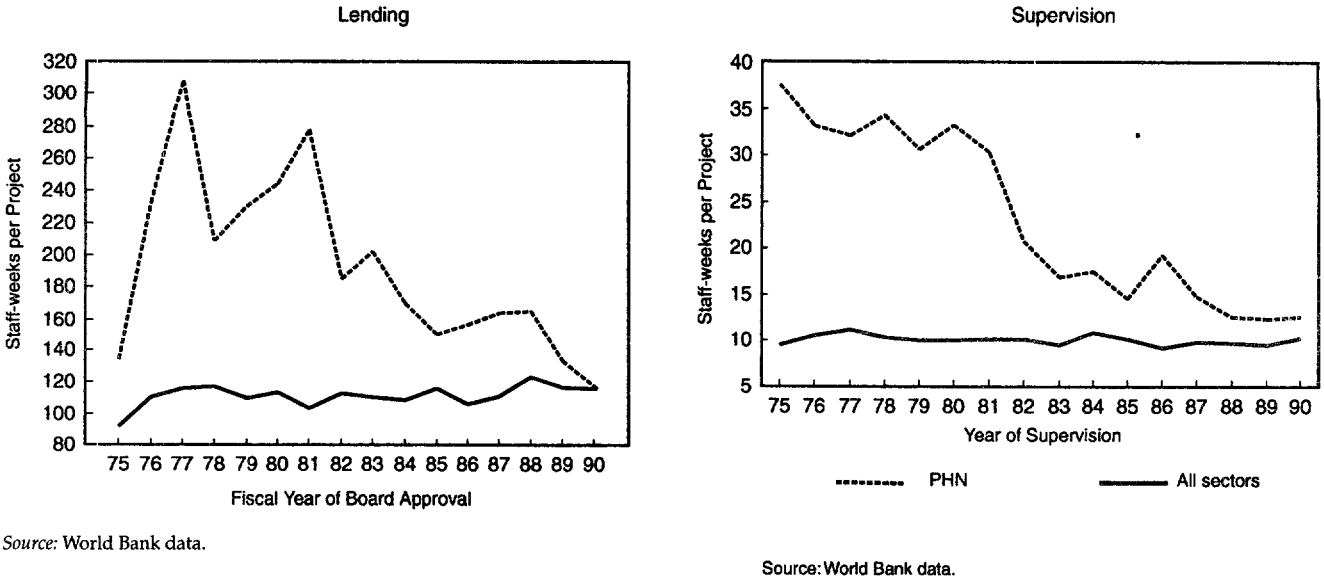
However, as Figure 8.1 (which covers all PHN projects) demonstrates, this was the case in the early years, but over time, these coefficients have declined to the point at which they are now no different from the Bank average. It is not surprising that these coefficients have declined from the early, formative days of this program, but it is surprising they have fallen all the way to the Bank average. If the picture emerging from these case studies is correct, this suggests that population (and health and nutrition) projects are being forced to fit into a Procrustean bed determined by the needs of other sectors. The consequence must be poorer-quality projects and weaker implementation than could (and should) be the case.

The high staff coefficients of earlier years resulted from the earmarking of staff time specifically for population-related activities.[10] This approach may no longer be appropriate in a more decentralized Bank. Nor would it be appropriate to mandate specific coefficients for these projects, since their requirements differ greatly. At a minimum, however, managers should understand that this sector is likely to require higher coefficients and be willing to provide them when a good case can be made.

9. Virtually any probing question would require a review of past experience. For example: why do you believe this project will take five years when the last two took seven; what evidence do you have the proposed IEC approach will work; why are you not proposing to focus on on-the-job training in this project when the Audit considered it an error of omission in the previous project?

10. It may also have been the result of the small size of the program and its lack of integration with related sectors which resulted in staff inputs being used less efficiently than is possible today. More recent declines may be the result of growth in lending proceeding ahead of recruitment.

Figure 8.1: Staff-Weeks per Project, PHN vs. All Sectors



Source: World Bank data.

Source: World Bank data.

Donor Coordination and Involvement of Non-Governmental Agencies

The division of labor that implicitly or explicitly develops between the agencies assisting a given country is an important determinant of the effectiveness of the assistance program in this field. The case studies demonstrate that a well-rounded assistance package should include software and technical assistance as well as hardware, grants as well as loans, detailed knowledge of local conditions, intimate daily contact with counterparts, inputs into a variety of sectors, and periodic access to high-level decision-makers. No donor is in a position to provide all these elements; indeed, some may be best provided by NGOs. This is why the mechanisms that have evolved for donor coordination and involvement of NGOs in Bangladesh are so attractive. Indeed, the next step in this evolution may be the development of projects that are thought of as consortium projects, not Bank or UNFPA projects.[11] This might be a useful direction in which to move in a number of African countries where a wide variety of inputs is needed and the governments are not in a position to provide effective leadership for the donor community.

Country Organization of Population and Family Planning Activities

In the 1960s, conventional wisdom argued that family planning services should be delivered through their own vertical program because they would get lost if they also became just one more component of primary health care or of a MCH program, and because ministries of health were generally weak agencies. Conventional wisdom today is nearly the reverse. The current thinking is that family planning should be integrated and delivered with MCH services, for the following reasons. (1) Family planning is less likely to get lost in an MCH program today because it is far better accepted as a legitimate intervention for both health and demographic reasons. (2) The time in a woman's life when MCH is most pertinent is also the time when adoption or resumption of contraceptive use is highly relevant. (3) Reducing child mortality is a facilitating condition for decreasing the demand for more children; similarly, increased spacing between children is a facilitating condition for improving maternal and child health. (4) Good quality family planning services require medical backup and supervision. (5) Many countries which will not accept donor support for what they perceive to be population control programs will accept support for family health and welfare programs with family planning components.

In all the case study countries, the Bank could do more to foster stronger MCH services, both for health and for family planning purposes. Fortunately, the Bank is now moving in this direction. The recently approved fifth population loan in Indonesia, the Child Survival and Safe Motherhood Project in India, and the Fourth Population and Health Project in Bangladesh are cases in point. In Africa, seven countries have initiated joint population/health loans in recent years. Additional countries in both Latin America and Africa have family planning components in MCH programs supported by loans to the health sector.

11. There will, of course, still be the need for one agency to take the lead, but it need not be the largest contributor.

While it is clear that health ministries have an important role to play in delivering family planning and MCH services, there are a number of reasons for not giving them sole or even principal responsibility for either family planning or for other aspects of what should constitute a full-blown population program. (1) Exclusive focus on the link between MCH and FP will inevitably neglect young couples and men. (2) Ministries of health are generally among the weaker ministries. Moreover, they are often led by members of the medical profession who are more interested in curative than in preventive care or public health programs. (3) As a consequence, unless special care is taken, this approach tends to lead to neglect of other delivery channels, for example, NGOs, private medical facilities, pharmacies, social marketing arrangements, and family planning programs in (or which might be developed in) other agencies, such as the military and large corporations. (4) For similar reasons, IEC programs run through ministries of health are often weak. (5) When structured this way, other ministries—for example, education, information, planning, agriculture, and religion—tend not to participate in the program. All five of these problems have arisen in both India and Bangladesh, where the ministries of health and family welfare have primary responsibility for their population programs.

The effort to correct these shortcomings has sometimes led the Bank and other donors to support the establishment of high-level governmental coordinating and facilitating agencies along the lines of the highly successful BKKBN in Indonesia. Unfortunately, this is the only truly successful example of such an agency. It has worked there because of strong support from central authorities, astute and charismatic leadership, and highly competent management—conditions that are infrequently found together. In the end, decisions about administrative arrangements for various aspects of a country's population program will have to be based on the special circumstances of individual countries.

Need for a Long-run Programmatic Approach

Kenya exemplifies the value of patient building of consensus, information, and infrastructure over almost 20 years before significant reproductive change becomes evident. A privately-run pilot project (Chogoria) in Kenya, which demonstrated the presence of latent demand and the fact that it can be turned into active demand by a good service system, shows what can be done in the interim to determine whether one is on the right track.

Several implications for the Bank and other donors follow from this point. (1) If best judgement about a country is that it will take (for example) 20 years of effort before significant fertility reductions and health improvements can be observed, the Bank should think in terms of a *program* for the country, and budget and plan accordingly. (2) If during that period it is reasonable to have, for example, four projects, these should be thought of as necessary steps along the way whose goals and monitorable targets are specified in terms of these steps, and not exclusively (as so often has been the case in the past) in terms of the long-run objectives of the program.[12] To do otherwise encourages frustration and disillusionment when in fact considerable progress is being made. (3) The program will undoubtedly require more than these projects alone to succeed, and the Bank may have to consider assisting the government with some of these elements. Such elements may include sector work, pilot projects and research, training programs, and funding of recurrent cost items such as contraceptives that do not fit neatly into the time frame and scope of these projects. (4) Progress toward achieving the program goals probably has to be monitored in different ways from progress in achieving the goals of individual projects. Special provision should be made for this.

The Extent and Allocation of Bank Resources

Since 1980, 1 percent of the Bank's loan portfolio has been devoted to population projects (defined as projects with population in their title)[13]. This amount constitutes about 10 percent of the funds provided by bilateral, multilateral, and private donors to the developing world for population activities. Four countries (India, Indonesia, Bangladesh, and Kenya) have received 79 percent of these funds. Only 10 countries, constituting 32 percent of the developing world's population, have had two or more Bank-assisted population projects. In 1988, the Bank was financing ongoing projects in 17 countries. In contrast, UNFPA and USAID are active in a much larger group of countries. In 1988, the UNFPA had activities or projects that provided more than US$1.0 million dollars per year to each of 31 countries, and USAID had the same in 39 countries.

These data have led Bank critics to argue that the Bank has devoted too little effort to this field. Projections of resource requirements based on numbers of couples projected to be using contraceptives in the future have been used to argue that the Bank needs to do much more in the fu-

12. In countries just beginning to build a population program, a necessary first step is to create a delivery system and the institutional capacity to operate it. This in itself is likely to be sufficiently difficult and time-consuming such that several projects could usefully be devoted to this exclusively. The Bank has helped effectively with the physical aspects of delivery systems, but has not been so effective with institutional aspects. (In earlier projects, the Bank sometimes obscured the situation by stating project objectives in terms of fertility reduction, the implicit assumption being that everything else was in place or would be put in place by others.)

13. This percentage is understated to the extent that population components of health projects are left out, but it is overstated to the extent that health components of population projects are not excluded.

ture.[14] On the basis of the case studies and general information about Bank population activities in other countries, can these judgements be supported?

Before answering this question, it is important to note that the Bank's role cannot be adequately judged by considering the extent of funding it has provided, at least not in the aggregate. There are cases in which the Bank has had significant influence without providing funds directly for population (Senegal). There are also cases in which the Bank has had little influence despite having invested considerable sums of money (India). Money is an especially misleading indicator in the early stages of program development. This aspect is relevant to many cases in Africa, for example.[15] A better proxy, at least for level of effort, is staff inputs, though this, too, is not a good indicator of influence. The best approach is to derive judgements from reviews of individual country experiences, as this study tries to do. Strictly speaking, however, the insights obtained thereby are limited to the case studies selected.

Moreover, the adequacy of the Bank's role cannot be assessed independently of what other donors are doing. The real question is whether the total contribution of all donors is adequate. In addition, Bank funds are in the form of loans or credits for which there is a limited market, whereas nearly all of other donors' funds are in the form of grants, often for program activities as distinct from projects, for which demand is much greater.

Within case study countries, we have found no evidence that progress has been constrained by lack of external funds for family planning programs *per se*. Additional Bank assistance in this field would not have been useful. It would instead have overwhelmed these countries' already hard-pressed absorptive capacity. If any additional external funds at all were needed, the most useful would have been grant funds, which could have been used flexibly, as was the case in Bangladesh. Nor is there evidence that constraints on progress resulted from lack of local funds or operating budgets, largely because donors generally provided funds for these purposes when serious shortages emerged. This could become a problem in the future, however, if donors do not continue filling what may be a growing gap between resource needs and governments' ability to fund.

Additional funds could have been—and could still be—used by these countries for demand-creating activities in non-population sectors. Also, there is some evidence that additional staff inputs, both at headquarters and in the field, could have been usefully employed in several of the case study countries. Such inputs would have allowed and encouraged more effective supervision and the development of more sector and analytical work. However, there is a limit on the extent to which external staff and technical assistants can substitute for local capacity, especially where governments are unwilling or unable to move faster.

Of greater importance than increased funding in countries with existing Bank-supported projects is a shift in the composition of activities, away from large-scale construction projects and towards a more programmatic approach that includes the help of sectors in addition to population and health. It would also be useful to consider shifting the composition of Bank and other donor funds between countries, as recommended in the recent PHR paper. This would serve to concentrate Bank financing on better-established programs and grant funds on programs in their formative stages.

If there is any scope for expanding the Bank's population and related health programs, it is to countries without currently active Bank-supported population projects. While not all these countries need Bank inputs, either because they do not have a population problem or because other donors are providing adequate inputs, there is surely scope for useful expansion. However, to make this case adequately requires an assessment of needs that lies beyond the scope of this study.

Thus, while expansion of funding for hardware in countries in which the Bank has been active for many years is no longer needed—and in some cases, should be reduced—additional funds are needed in three areas: quite possibly for new countries; definitely for expansion of population-related activities in non-population sectors; and for relevant software elements of population and population-related projects. These changes would require some net increases in funding, though probably not as sizeable as critics might like. Of greater significance, they imply some changes in direction which could substantially improve the effectiveness of the Bank's efforts in this field.

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14. The Population Crisis Committee argues (in *The World Bank's Role in Global Population Efforts: An Agenda for Effective Action, 1989)* that Bank activities in the population field have been constrained by a variety of factors. It recommends changing these so that the Bank can increase its level of lending from the 1989-90 average of $200-225 million to $1 billion a year. At this point, it would be contributing 13% of estimated global needs of $7.5 billion a year. The U.S. Senate Committee on Appropriations (*Report 101-519*, October 10, 1990, p. 47) expressed concern last year about the "minor role" the Bank has played in international family planning assistance and asserted that, "It is incumbent on the World Bank, with its enormous resources, to make this a first priority, in dollars, as well as rhetoric." A PHR paper dated March 8, 1991, *Strengthening the Bank's Population Work in the Nineties*, argues that because of successful efforts to increase demand and because of stagnation and planned declines in levels of bilateral assistance (especially USAID's planned reduction in contraceptive funding), "the Bank will have to play a larger role in both mobilizing additional grant fund and in direct financing than it has in the past." (p. 17).

15. An especially good example is the African population initiative, a low-budget but staff- intensive activity that has been highly successful in breaking the logjam of inertia and resistance to population activities in Africa, and which now seems to be resulting in proposals for projects—for other donors, as well as for the Bank.

Implications for Evaluating and Staffing Bank Population Activities

This review suggests that the population field is unique in a number of respects. A larger-than-usual proportion of non-project activities, some of which may be at least as important as individual projects, seem to be required. Such activities include advocacy efforts (such as the African Population Agenda Initiative), technical assistance for policy development, analysis of current population issues; and active cooperation with other donors. Within population projects, software components are often more important in reaching program goals than they are in other sectors. Such activities and components are time- consuming and staff-intensive, but do not require large financial resources. Furthermore, population activities and projects tend to involve longer lead times and looser connections between initial inputs and ultimate impacts than do projects in other sectors. This is a sector that is still in its formative stages, where experimentation and the search for new approaches remains especially important. While it is convenient to refer to the broad range of population activities as a sector, it is also true that selective interventions from non-population sectors could be equally important at times in the achievement of population goals.

These characteristics have a number of implications for evaluation. The typical approach is to focus on projects rather than non-project activities; to ask whether the project did what the SAR and President's Report said it would do; and within projects, to focus on the more expensive and quantifiable inputs. While this is important for accountability purposes, it leads to an excessive focus on projects, on inputs rather than outputs, and more important, on the specific inputs included in the project, rather than on whatever is needed to advance the sector goals.

It is especially important in the population sector to correct these biases. In evaluating population projects, more weight should be given to proximate output measures, focusing on those believed to be the most important for achieving the sector goals—even if the associated inputs do not require the most resources. In evaluating Bank efforts in a given country, more attention should be paid to non-project activities and efforts in other sectors. In evaluating Bank efforts not specifically related to a given country, more weight should be given to the appropriateness of the content, relative to needs and what other donors are doing, than to the extent of the resource transfer. Overall, more attention needs to be devoted to possible errors of omission—what could have been done that would have made a larger difference—than to errors of commission.

These characteristics also have implications for staffing, most of which have been pointed out in different contexts above. If the Bank wishes to improve its effectiveness in this area, it must allow and encourage the use of more technical staff for both non-project and project work and should consider locating more of this staff in the field in special circumstances. This is especially important in countries without adequate indigenous capacity or which are lacking assistance from other donors. That the Bank has done as well as it has so far is a tribute to extra efforts expended by a small core of dedicated staff—not a situation that should be relied on for the long run, regular operation of an important program.

Statistical Appendix

Table 1.1: Demographic and Socioeconomic Indicators, Selected Countries and Years

A. Basic Indicators

	Population	GNP per Capita		Life Expectancy at Birth	Illiteracy Rate Adult Female	Mortality per 1000		Urban Population
	Mid-1988 (mil.)	1988 (US$)	1965–88 (% per yr)	1988	1985	Under 5 1985	Maternal* 1985	% 1985
Indonesia	174.8	440	4.3	61	35	128.3	8.0	22.2
India	815.6	340	1.8	58	71	76.2	5.0	23.4
Bangladesh	108.9	170	0.4	51	78	175.7	6.0	10.4
Brazil	144.4	2160	3.6	65	24	127.3	1.5	67.5
Colombia	31.7	1180	2.4	68	13	112.9	1.3	64.2
Mexico	83.7	1760	2.3	69	12	59.3	0.9	66.4
Kenya	22.4	370	1.9	59	51	47.4	5.1	16.1
Senegal	7.0	650	-0.8	48	81	98.1	5.3	34.9

B. Time Series

	1960	1965	1970	1975	1980	1985	1988	1989
Total Fertility Rate								
Indonesia	5.4	5.5	5.5	5.0	4.3	3.7		
India	6.6	6.2	5.8	5.3	5.0	4.6		4.0
Bangladesh	7.0	6.8	7.2	6.6	6.1	5.7	5.0	4.9
Brazil	6.2	5.6	4.9	4.4	4.0	3.6		3.3
Colombia	6.8	6.3	5.3	4.0	3.5	3.3		3.0
Mexico	6.8	6.7	6.5	5.5	4.5	3.8		3.4
Kenya	7.9	8.0	8.0	8.0	7.9	7.6		6.7
Senegal	6.4	6.4	6.5	6.6	6.6	6.6		
Female Population Using Contraceptives (%)								
Indonesia				11.0		48.0		
India			10.0	19.0	22.0		39.0	
Bangladesh			3.0	7.7	12.0	25.0		32.0
Brazil			32.0		56.0	66.0		39.0
Colombia			33.0		49.0	65.0		
Mexico			12.0			53.0		
Kenya			1.0	7.0	7.0			27.0
Senegal				0.5		2.4		8.0
Infant (0-1) Mortality Rate (per 1000)								
Indonesia	137.8	127.6	118.0	108.6	99.0	80.6		
India	163.4	149.8	139.0	129.6	114.0	103.4		93.0
Bangladesh	154.8	144.0	140.0	138.2	131.6	122.6	118.0	
Brazil	114.2	103.6	94.6	83.8	74.2	66.2		
Colombia	103.0	96.0	79.2	66.1	58.2	48.9		
Mexico	90.8	81.8	73.0	63.6	55.8	49.4		
Kenya	122.8	112.0	102.0	92.0	83.2	75.2		
Senegal	179.2	171.2	164.4	157.2	146.8	133.6		

Table 1.1 *(continued)*

B. Time Series

	1960	1965	1970	1975	1980	1985	1988	1989
Crude Birth Rate (per 1000)								
Indonesia	43.9	42.7	41.9	38.4	34.5	30.5		
India	47.6	44.8	37.8	36.0	33.7	32.0		30.5
Bangladesh	46.7	47.2	48.1	47.7	45.8	42.3	40.0	
Brazil	42.6	38.7	34.8	32.7	31.2	29.3		
Colombia	46.8	44.7	36.9	31.3	29.7	26.9		
Mexico	45.7	44.9	43.4	37.7	32.8	29.9		
Kenya	52.8	52.4	52.6	53.3	53.8	52.8		
Senegal	47.4	46.9	46.6	46.4	46.1	45.7		
Crude Death Rate (per 1000)								
Indonesia	22.6	20.2	18.1	15.4	12.1	9.8		
India	23.5	20.3	16.5	15.1	12.6	11.2		10.2
Bangladesh	22.4	21.4	20.9	19.7	18.1	16.2		
Brazil	12.8	11.4	10.2	9.2	8.6	8.1		
Colombia	16.1	14.0	10.5	9.0	8.0	7.1		
Mexico	12.0	10.6	9.4	7.9	6.7	6.0		
Kenya	22.2	20.1	18.1	16.2	14.4	12.1		
Senegal	24.1	22.8	21.7	20.8	19.8	18.4		
Population Growth Rate (%)								
Indonesia		2.2	2.4	2.3	2.2	2.0		1.9
India		2.3	2.1	2.1	2.1	2.1		2.0
Bangladesh		2.6	2.7	2.7	2.8	2.6		2.5
Brazil		2.8	2.5	2.4	2.3	2.1		2.0
Colombia		3.3	2.4	1.9	1.9	1.9		1.8
Mexico		3.2	3.3	3.0	2.4	2.2		2.1
Kenya		3.2	3.4	3.7	3.9	4.1		4.1
Senegal		2.4	2.3	2.5	2.8	2.8		2.9
Physicians per 10,000 Population								
Indonesia			0.37	0.37				
India			2.05	2.04	3.71			
Bangladesh			1.18		1.18	1.49		
Brazil			4.93	6.25				
Colombia			4.45					
Mexico			6.44	6.67				
Kenya			1.25	1.27		0.99		
Senegal			0.60	0.60				
Hospital Beds per 10,000 Population								
Indonesia			6.55	8.18		5.51		
India			6.04	5.88	7.70	7.69		
Bangladesh			1.55		2.11	2.78		
Brazil			36.97	49.99				
Colombia			22.25		17.18			
Mexico			11.86	12.51				
Kenya			12.64	12.50		16.67		
Senegal			12.23	12.50				

Table 1.1 *(continued)*

	B. Time Series							
	1960	*1965*	*1970*	*1975*	*1980*	*1985*	*1988*	*1989*
Health Expenditures (as % of GDP)								
Indonesia					1.4			
India				2.3	1.9	2.0		
Bangladesh						1.8		
Brazil				3.8	4.2			
Colombia				4.1	4.2			
Mexico				2.9	2.9			
Kenya				3.7	1.4	0.2		
Senegal					1.7	1.6		
Education Expenditures (as % of GDP)								
Indonesia					2.3			
India				2.6	2.8	2.8		
Bangladesh						1.1		
Brazil				2.6	3.6			
Colombia				6.4	3.0			
Mexico				2.7	2.9			
Kenya				7.4	6.9	1.2		
Senegal					2.8	0.3		
Gross Enrollment Ratio, Primary, Female								
Indonesia			73.0	78.0	100.0	115.0		
India			56.0	62.0	67.0			
Bangladesh			35.0	51.0	46.0	50.0		
Brazil				87.0	97.0			
Colombia			110.0	120.0	130.0	119.0		
Mexico			101.0	106.0	119.0	114.0		
Kenya			48.0	87.0	104.0	91.0		
Senegal			32.0	34.0	36.0	45.0		
Gross Enrollment Ratio, Secondary, Female								
Indonesia			11.0	15.0	23.0			
India			15.0	16.0	22.0			
Bangladesh			3.0	11.0	9.0	10.0		
Brazil			26.0	28.0	36.0	40.6		
Colombia			24.0	39.0	45.0	51.0		
Mexico			17.0	28.0	45.0	54.0		
Kenya			5.0	9.0	15.0	15.0		
Senegal			6.0		7.0	9.0		
Female Labor Participation Rate								
Indonesia			22.7	22.8	23.2	23.8	24.3	24.4
India			24.8	23.2	21.7	21.0	20.5	20.4
Bangladesh			3.4	3.5	3.7	4.0	4.3	4.4
Brazil			14.3	16.9	19.6	19.9	20.0	20.0
Colombia			12.7	13.3	13.9	14.3	14.4	14.4
Mexico			10.1	13.5	17.3	17.9	18.4	18.6
Kenya			36.9	36.0	35.1	33.2	31.7	31.3
Senegal			39.0	38.5	38.1	35.9	34.1	33.7

Sources: World Bank data modified by information from country sources where available.

Table 2.1: Donor Expenditures for Population Programs in Selected Countries, 1982–89

Country	*1982*	*1983*	*1984*	*1985*	*1986*	*1987*	*1988*	*1989*	*Average*
Indonesia (US$ 1000)	27,307	15,515	15,450	8,526	18,894	23,803	7,792	13632	16,365
Bilateral (%)	80	67	64	18	68	47	23	74	55
Multilateral (%)	10	15	15	48	11	13	6	0	15
Private (%)	10	18	21	34	21	40	71	26	30
India (US$ 1000)	20,113	43,704	45,575	43,062	23,415	23,159	22,365	32,401	31,724
Bilateral (%)	30	60	39	61	36	53	19	52	44
Multilateral (%)	47	31	51	28	40	31	50	31	39
Private (%)	23	9	10	11	24	16	31	18	18
Bangladesh (US$ 1000)	36,148	35,168	40,166	51,518	43,311	46,302	56,176	49,923	44,839
Bilateral (%)	80	75	76	80	72	66	67	78	74
Multilateral (%)	12	12	13	8	7	5	5	9	9
Private (%)	8	13	11	12	21	29	28	13	17
Brazil (US$ 1000)	6,987	4,644	7,379	7,199	7,666	6,728	15,770	11,973	8,543
Bilateral (%)	5	0	0	0	0	3	0	6	2
Multilateral (%)	4	4	5	28	100	1	39	26	26
Private (%)	91	96	95	72	0	96	61	68	72
Colombia (US$ 1000)	5,854	3,835	4,564	4,367	3,571	3,502	7,687	6,498	4,985
Bilateral (%)	0	0	2	3	14	24	20	2	8
Multilateral (%)	10	33	25	28	10	6	5	17	17
Private(%)	90	67	72	70	76	70	75	81	75
Mexico (US$ 1000)	11,168	4,520	8,058	9,551	5,555	6,502	11,100	10,629	8,385
Bilateral (%)	NA	1	3	9	0	3	5	13	4
Multilateral (%)	15	39	34	32	18	15	21	17	24
Private (%)	85	60	63	60	82	82	74	70	72
Kenya (US$ 1000)	6,957	5,675	7,662	9,059	4,908	9,536	18,554	20,277	10,329
Bilateral (%)	68	60	67	68	33	39	35	56	53
Multilateral (%)	8	8	4	5	15	11	13	16	10
Private (%)	23	33	29	26	52	50	52	27	37
Senegal (US$ 1000)	729	968	2,045	11,142	3,274	6,752	2,350	4,284	3,943
Bilateral (%)	0	0	33	85	54	66	14	70	40
Multilateral (%)	67	65	38	8	14	9	23	4	29
Private (%)	33	35	29	7	32	25	63	25	31

Note: Figures are based on commitments. The result is that they shift considerably in years when large commitments are made, for example, in 1986, when the Bank's third population loan was committed to Bangladesh.

Source: UNFPA, *Global Population Assistance Report 1982-1989*, New York City

Table 3.1: Summary Data for Population and Population-Related Projects in Case Study Countries, FY70–FY90

Country/Project Name	Approval Year	Completion Year	Bank Funding	Terms (IBRD/ IDA)	Total Project Cost (US$m)	Financing Plan[1] (%)			Type of Report[2]	Project Ratings[3]		
						Bank	Co-Financing	Local		Overall	Sustainability	Institutional Development
Indonesia												
Population	FY72	FY80	13.2	IDA	33.0	40.0	40.0	20.0	AUDIT	S		
Second Population	FY77	FY82	24.5	IBRD	60.0	40.8		59.2	AUDIT	S		
Third Population	FY80	FY85	35.0	IBRD	72.6	48.2		51.8	PCR	S		
Fourth Population	FY85		46.0	IBRD	94.4	48.7		51.3				
FP & Safe Motherhood Project	FY91		104.0	IBRD	148.4	70.0		30.0				
India												
Population	FY72	FY80	21.2	IDA	31.8	66.7	33.3		AUDIT	S		
Second Population	FY80	FY89	46.0	IDA	96.0	47.9		52.1	AUDIT	U		
Third Population	FY84		70.0	IDA	123.5	56.7		43.3				
West Bengal 4th Population	FY86		51.5	IDA	89.0	57.9		42.1				
Fifth (Bombay & Madras) Population	FY88		57.0	IDA	78.2	72.8		27.2				
Sixth Population	FY89		124.6	IBRD	182.0	68.5		31.5				
Population VII	FY90		96.7	IDA	141.5	68.3		31.7				
Bangladesh												
Population	FY75	FY83	15.0	IDA	45.7	32.8	55.5	11.6	AUDIT	U		
Population & Family Health	FY79	FY87	32.0	IDA	110.0	29.1	60.9	10.0	PCR	S	Likely	Partial
Third Population & Family Health	FY86		78.0	IDA	213.9	36.5	46.5	17.0				
Fourth Population & Health	FY91		180.0	IDA	601.4	29.9	42.7	27.4				
Kenya												
Population	FY74	FY80	12.0	IDA	15.4	78.0		22.0	AUDIT	S		
Integrated Rural Health & FP	FY82		23.0	IDA	61.1	37.7	40.6	21.7				
Third Population	FY88		12.2	IDA	28.3	43.1	47.3	9.5				
Population IV	FY90		35.0	IDA	41.3	84.7	5.3	9.9				

1. The following co-financing agencies participated in the above projects: Bangladesh I - ADAB, CIDA, Germany, NORAD, SIDA & the United Kingdom; Bangladesh II - ADAB, CIDA, Germany, the Netherlands, NORAD, SIDA & the United Kingdom; Bangladesh III - ADAB, CIDA, Germany, the Netherlands, NORAD & the United Kingdom; India I - SIDA; Indonesia I - UNFPA; Kenya II - DANIDA, Germany, NORAD, SIDA, UNFPA & USAID; KENYA III - NORAD & the United Kingdom; Kenya IV - USAID.

2. All completed projects have PCRs, but not all completed projects have Audits.

3. The project ratings are drawn from Audits, where available; otherwise they are drawn from the PCR.

S = Satisfactory; U = Unsatisfactory

Table 3.2: Project Costs by Component in Population and Population-Related Projects for Case Study Countries

Project	*Supply of Services*[1] *(percent)*	*Demand Generation and IEC (percent)*	*Manpower Development (percent)*	*Institutional Development (percent)*	*Project Admin. and Preparation (percent)*	*Not Allocated (percent)*	*Total Project Costs (US$mil)*	*Foreign Exchange Component (percent)*
Indonesia								
Population	30.1	14.9	23.0	12.2	1.6	18.2	33.00	38.8
Second Population	35.9	15.6	33.6	14.9	—	0.0	44.30	18.3
Third Population	26.2	21.9	24.0	28.0	—	0.0	72.60	25.1
Fourth Population	37.4	20.0	13.1	11.8	—	17.7	94.40	43.9
India								
Population	79.3	—	—	4.2	0.5	16.0	31.80	5.0
Second Population	64.5	6.3	5.3	0.8	1.3	21.9	96.00	17.9
Third Population	65.3	5.2	—	2.2	6.2	21.2	123.50	10.0
West Bengal 4th Population	53.9	5.6	10.6	1.3	4.7	23.9	89.90	8.0
Fifth (Bombay & Madras) Population	58.9	—	4.2	14.2	—	22.8	78.21	5.4
Sixth Population	27.3	0.0	9.7	37.0	—	25.9	182.00	7.2
Population VII	33.9	24.1	28.1	10.4	—	3.5	141.5	7.9
Bangladesh								
Population	6.0	12.7	39.1	3.9	0.6	37.7	45.70	52.6
Population & Family Health	65.6	10.5	20.8	1.9	1.2	0.0	110.00	33.1
Third Population & Family Health	81.7	4.2	—	1.3	0.8	12.0	213.85	31.5
Kenya								
Population	70.0	0.0	23.1	—	0.1	6.8	15.37	31.9
Integrated Rural Health & FP	40.6	19.8	16.8	—	—	22.8	61.05	35.2
Third Population	60.1	8.6	0.0	14.7	—	16.5	28.34	32.5
Population IV	43.5	17.8	0.6	27.6	—	10.5	41.27	62.3

1. The supply of services includes the provision of health and family planning services (which all projects provided), as well as nutrition activities (provided in India I and Indonesia IV), and disease control or sanitation activities (provided in India III and India IV).

Table 3.3: Appraisal Project Costs and Bank Financing, by Category of Expenditure, for Population Projects in Case Study Countries

Project	*Total Project Cost (US$m)*	*Civil Works (%)*	*Furniture Equipment (%)*	*TA & Training (%)*	*Operating Costs (%)*	*Special Activities (%)*	*Allocated (%)*	*Bank Financing (US$m)*	*Civil Works (%)*	*Furniture Equipment (%)*	*TA and Training (%)*	*Operating Costs (%)*	*Special Activities (%)*	*Unallocated (%)*
Indonesia														
Population	33.00	27.6	14.8	16.7	22.7	0.0	18.2	13.20	34.5	18.6	20.8	9.1	0.0	17.0
Second Population	60.00	16.7	10.5	8.7	38.0	0.0	26.2	24.50	31.4	30.2	24.9	0.0	0.0	13.5
Third Population	72.60	46.4	9.9	15.4	0.3	0.0	28.0	35.00	48.0	18.3	25.1	0.0	0.0	8.6
Fourth Population	94.40	28.3	39.6	32.1	—	0.0	0.0	46.00	50.4	23.9	25.7	0.0	0.0	0.0
India														
Population	31.80	39.6	14.7	8.4	14.6	6.5	16.1	21.20	39.6	14.7	8.4	14.6	6.5	16.1
Second Population	96.00	31.4	8.5	0.0	36.7	1.6	21.9	46.00	37.0	11.7	0.0	42.6	2.2	6.5
Third Population	123.50	43.6	11.9	0.0	23.2	0.0	21.2	70.00	57.1	18.6	0.0	18.6	0.0	5.7
West Bengal 4th Population	89.00	44.3	6.9	0.0	24.7	0.0	24.2	51.50	58.1	8.3	0.0	22.3	0.0	11.3
Fifth (Bombay & Madras) Population	78.21	10.8	25.2	6.1	57.9	0.0	0.0	56.96	12.6	25.6	8.3	53.4	0.0	0.0
Sixth Population	182.00	42.8	21.2	11.8	24.2	0.0	0.0	124.60	46.9	23.2	12.9	17.0	0.0	0.0
Population VII	141.50	37.3	16.7	26.0	11.0	9.0	0.0	96.68	42.2	17.1	23.5	9.2	7.9	0.0
Bangladesh														
Population	45.71	30.2	13.6	1.5	16.1	0.8	37.8	15.00	27.9	17.6	2.9	12.2	2.0	37.5
Population & Family Health	110.00	42.1	15.1	2.0	22.1	1.8	16.8	31.99	58.1	17.2	0.3	2.3	4.6	17.5
Third Population & Family Health	213.85	21.1	28.0	9.4	24.1	17.4	0.0	78.00	52.8	40.1	0.7	0.0	6.4	0.0
Kenya														
Population	15.38	89.3	8.9	1.8	—	0.0	0.0	12.00	66.7	5.4	1.7	0.0	0.0	26.3
Integrated Rural Health & FP	61.05	30.2	20.5	1.5	17.6	20.9	9.3	23.00	25.8	12.7	2.7	35.4	20.9	2.5
Third Population	28.30	19.8	20.5	24.7	18.7	0.0	16.3	12.20	20.5	34.4	30.3	0.0	0.0	14.8
Population IV	41.30	21.5	42.6	19.1	6.1	0.0	10.7	35.00	22.6	45.7	20.3	0.0	0.0	11.4

Table 4.1: Bank Lending by Sector, Case Study Countries, 1970–90

	1970–79		1980–90		1970–90	
	US$million	Percent	US$million	Percent	US$million	Percent
Indonesia						
Education	186	6	1,349	11	1,536	10
Pop., Health & Nutrition	51	2	224	2	275	2
(Population)	(38)	(1)	(81)	(1)	(119)	(1)
Agriculture & Rural Dev.	1,087	34	2,706	22	3,793	24
Industry	247	8	237	2	483	3
Energy & Power	632	20	2,758	22	3,390	22
Telecommunications	13	0	365	3	377	2
Transportation	519	16	1,470	12	1,989	13
Urban Dev., Water, Sewage	182	6	1,115	9	1,297	8
Other[1]	267	8	2,190	18	2,457	16
Total	3183	100	12,413	100	15,596	100
India						
Education	12	0	540	2	552	2
Pop., Health & Nutrition	21	0	573	2	594	2
(Population)	(21)	(0.3)	(349)	(1)	(416)	(1)
Agriculture & Rural Dev.	2,385	33	6,915	27	9,300	28
Industry	693	10	2,745	11	3,438	10
Energy & Power	1,397	19	9,153	35	10,550	32
Telecommunications	358	5	659	3	1,017	3
Transportation	593	8	1,925	7	2,518	8
Urban Dev., Water, Sewage	548	8	1,804	7	2,352	7
Other[1]	1,240	17	1,565	0	2,805	8
Total	7,247	100	25,879	100	33,126	100
Bangladesh						
Education	58	9	333	12	391	12
Pop., Health & Nutrition	47	7	78	3	125	4
(Population)	(47)	(7)	(78)	(3)	(125)	(4)
Agriculture & Rural Dev.	246	39	770	28	1,016	30
Industry	62	10	84	3	146	4
Energy & Power	28	4	901	33	929	28
Telecommunications	20	3	35	1	55	2
Transportation	125	20	424	16	549	16
Urban Dev., Water, Sewage	42	7	98	4	140	4
Total	628	100	2,723	100	3,351	100
Brazil						
Education	64	2	239	2	302	2
Pop., Health & Nutrition	19	0	605	5	624	4
(Population)	0	(0)	(71)	(1)	(71)	(0.4)
Agriculture & Rural Dev.	589	15	4,591	34	5,180	30
Industry	776	20	562	4	1338	8
Energy & Power	859	22	2640	20	3499	20
Transportation	970	24	1,567	12	2,537	15
Urban Dev., Water, Sewage	574	14	2,158	16	2,732	16
Other[1]	110	3	1,011	8	1,121	6
Total	3,961	100	13,372	100	17,333	100

Table 4.1 *(continued)*

	1970–79		1980–90		1970–90	
	US$million	*Percent*	*US$million*	*Percent*	*US$million*	*Percent*
Colombia						
Education	28	2	115	3	143	2
Pop., Health & Nutrition	25	2	61	1	86	1
Agriculture & Rural Dev.	208	13	670	16	878	15
Industry	0	0	90	2	90	2
Energy & Power	440	27	1,656	39	2,096	35
Telecommunications	90	5	44	1	134	2
Transportation	208	13	602	14	810	14
Urban Dev., Water, Sewage	258	16	362	8	619	10
Other[1]	384	23	692	16	1,076	18
Total	1,640	100	4,290	100	5,930	100
Mexico						
Education	0	0	251	2	251	1
Pop., Health & Nutrition	0	0	0	0	0	0
Agriculture & Rural Dev.	1,297	44	2,941	21	4,238	25
Industry	295	10	713	5	1,008	6
Energy & Power	250	8	910	6	1,160	7
Transportation	452	15	1,327	9	1,779	10
Urban Dev., Water, Sewage	147	5	1,859	13	2,005	12
Other[1]	521	18	6,301	44	6,822	40
Total	2961	100	14,302	100	17,263	100
Kenya						
Education	39	4	78	5	117	4
Pop., Health & Nutrition	12	1	70	4	82	3
(Population)	(12)	(1)	(70)	(4)	(82)	(3)
Agriculture & Rural Dev.	298	30	346	21	643	24
Industry	0	0	166	10	166	6
Energy & Power	115	12	216	13	331	13
Telecommunications	34	3	77	5	111	4
Transportation	244	25	176	11	420	16
Urban Dev., Water, Sewage	159	16	100	6	259	10
Other[1]	92	9	415	25	507	19
Total	993	100	1,644	100	2,637	100
Senegal						
Education	1	0	8	2	8	1
Pop., Health & Nutrition	1	0	41	10	41	7
(Population)	(0)	(0)	(15)	(4)	(15)	(2)
Agriculture & Rural Dev.	68	35	146	35	214	35
Energy & Power	38	20	10	2	48	8
Telecommunications	0	0	15	4	15	2
Transportation	6	3	22	5	28	5
Urban Dev., Water, Sewage	68	35	86	20	155	25
Other[1]	11	5	96	23	107	17
Total	193	100	423	100	616	100

[1] Public sector management, development finance companies, non-project lending, technical assistance and unallocated.

Table 5.1: Civil Works, Furniture, and Equipment in Bank Population Projects, Appraisal Estimates

	Percent of Total			*Percent Excluding Unallocated*		
Project	*Civil Works*	*Furniture & Equipment*	*Total*	*Civil Works*	*Furniture & Equipment*	*Total*
Indonesia						
Population	33.7	18.1	51.9	41.6	22.4	63.9
Second Population	22.6	14.2	36.8	36.3	34.9	71.2
Third Population	64.4	13.8	78.2	52.5	20.0	72.5
Fourth Population	28.3	39.6	67.9	50.4	23.9	74.3
India						
Population	47.2	17.5	64.8	47.2	17.5	64.8
Second Population	40.1	10.9	51.1	39.5	12.6	52.1
Third Population	55.4	15.1	70.5	60.6	19.7	80.3
West Bengal 4th Population	58.4	9.0	67.4	65.4	9.4	74.8
Fifth (Bombay & Madras) Population	10.8	25.2	36.0	12.6	25.6	38.2
Sixth Population	42.8	21.2	64.0	46.9	23.2	70.1
Population VII	37.3	16.7	54.0	42.2	17.1	59.3
Bangladesh						
Population	48.6	21.8	70.4	44.6	28.1	72.7
Population & Family Health	50.7	18.2	68.8	70.5	20.8	91.3
Third Population & Family Health	21.1	28.0	49.1	52.8	40.1	92.8
Kenya						
Population	89.3	8.9	98.2	90.4	7.3	97.7
Integrated Rural Health & FP	33.2	22.6	55.9	26.5	13.1	39.5
Third Population	23.6	24.5	48.1	24.0	40.4	64.4
Population IV	24.1	47.7	71.8	25.5	51.6	77.1

Table 6.1: Commitments for International Population Assistance by World Bank and Other Donors, 1952–89
(millions of current and 1985 US dollars)

	1952–59	*1960–69*	*1970–79*	*1980–84*	*1985–89*	*Total*
World Bank						
Current $	—	—	196.6	270.7	413.8	881.1
1985 $	—	—	273.4	263.8	323.2	860.4
Other Donors						
Current $	6.7	305.5	2517.3	2156.0	2935.1	7920.6
1985 $	23.1	954.7	4146.0	2108.7	2341.4	9573.9
Total						
Current $	6.7	305.5	2713.9	2426.7	3348.9	8801.7
1985 $	23.1	954.7	4419.4	2372.5	2664.6	10434.3
World Bank as % of Total						
Current $	—	—	7.2	11.2	12.4	10.0
1985 $	—	—	6.2	11.1	12.1	8.2

Source: Table 1 in United Nations Population Fund, *Global Population Assistance Report, 1982-89*. New York: United Nations Population Fund, 1991.

References

References

Arthur, W. B. and G. McNicoll. 1978. "An Analytical Survey of Population and Development in Bangladesh." *Population and Development Review* 4(1): 23-80.

Caldwell, John C. and Pat Caldwell. 1990. "High Fertility in Sub-Saharan Africa." *Scientific American*, May 1990, pp. 118–125.

Cleland, J. and C. Wilson. 1987. "Demand Theories of the Fertility Transition: An Iconoclastic View." *Population Studies* 41(1): 5-30.

Demeny, P. 1975. "Observations on Population Policy and Population Program in Bangladesh." *Population and Development Review* 1(2): 307-321.

Dow, Thomas E. and Linda Werner. 1982. "Modern Transitional and Traditional and Contraceptive Patterns among Kenyan Women." *Studies in Family Planning* 13(1): 12-23.

Frank, Odile. 1987. "The Demand for Fertility Control in Sub-Saharan Africa." *Studies in Family Planning* 18(4): 181–201.

Frank, Odile and G. McNicoll. 1987. "An Interpretation of Fertility and Population Policy in Kenya." *Population and Development Review* 13(2): 209-243.

Freedman, R. and D. Freedman. 1986. "Adding Demand-Side Variables to Study the Intersection between Demand and Supply in Bangladesh." *PHN Technical Note* 86-28, World Bank, Population, Health and Nutrition Department, Washington, D.C.

Freedman R., S. E. Khoo, and B. Supraptilah. 1981. "Use of Modern Contraceptives in Indonesia: A Challenge to the Conventional Wisdom." *International Family Planning Perspectives* 7(1): 3-15.

Hammerslough, Charles R. 1992. "Proximity to Contraceptive Services and Fertility Transition in Rural Kenya." *International Family Planning Perspectives* 18(2).

Jain, Anrudh. 1985. "The Impact of Development and Population Policies on Fertility in India." *Studies in Family Planning* 16(4): 181-198.

Kamuzora, C. L. 1987. "Survival Strategy: The Historical and Economic Roots of an African High Fertility Culture." In Etienne Van de Walle and J.A. Ebigbola, eds., *The Cultural Roots of African Fertility Regimes.* Proceedings of the conference, University of Pennsylvania, February-March, 1987.

Kenya, National Council for Population and Development and Ministry of Home Affairs and National Heritage. *Demographic and Health Survey, 1989.* Nairobi.

Mauldin, W. Parker and Robert Lapham. 1984. "Family Planning Program Effort and Birthrate Decline in Developing Countries." *International Family Planning Perspectives* 10(4): 109-118.

Paul, Samuel. 1982. *Managing Development Programs: The Lessons of Success.* Boulder, Colorado: Westview Press.

Phillips, J. F. 1987. "Translating Pilot Project Success into National Policy Development: Two Projects in Bangladesh."
Asia-Pacific Population Journal 2(4): 3-28.

Population Crisis Committee. 1989. *The World Bank's Role in Global Population Efforts: An Agenda for Effective Action.* Washington, D. C.

Sinding, Steven W. 1991. *Strengthening the Bank's Population Work in the Nineties.* Policy Research Working Paper No. 802. World Bank, Population and Human Resources Department, Washington, D.C.

Singh, Susheela, and Deirda Wolf. 1991. "Estimating Abortion Levels in Brazil, Colombia, Peru." *International Family Planning Perspectives,* 17(1): 8-13.

UNFPA. 1979. *Report of Kenya Needs Assessment Mission.* New York.

———. 1989. *Global Population Assistance Report 1982–1988.* New York.

U.S. Congress. Senate. 1990. Committee on Appropriations *Report No. 101-519.* Washington, D.C.

World Bank. 1980. *Population and Development in Kenya.* Washington, D.C.

———. 1990. *World Development Report, 1990.* Oxford: Oxford University Press.

Annex 1
The World Bank and Bangladesh's Population Program

Executive Summary

Introduction

Population policies and programs have been a central priority of the Government of Bangladesh (GOB) since Independence in 1971. This report examines recent demographic changes in Bangladesh with particular attention to the role of population programs and policies, and the contribution of the World Bank to this effort. The Bank has supported three population projects over the 1973 to 1990 period. A fourth Bank project is currently under preparation. Although the strategies pursued by the Bangladesh program have been the subject of considerable debate, there is now incontrovertible evidence that contraceptive use has increased, that fertility has begun to decline, and that Bank financed elements of the Bangladesh population program have contributed to the observed trend. Lessons from the Bank's success in Bangladesh are relevant to population lending in unfavorable institutional settings elsewhere.

The Social and Demographic Context

Since 1970, contraceptive use has increased from 3 to 32 percent, and the total fertility rate has declined from over 7 to about 5.

While a quantitative assessment is not possible, findings from recent surveys suggest that the family planning program has played an important role.

- Most of the contraceptive methods bring used are the modern, effective methods provided by program sources. Government service agencies, private voluntary agencies, and the social marketing project supply over 90 percent of the commodities in use.
- The timing of increases in prevalence correspond to the timing of service intensification. This is particularly evident for sterilization, which was not widely practiced until after 1988, when services were made widely available. Improvements in IUD services had a similar impact on use.
- Differentials in contraception use between educated and uneducated, poor and prosperous, and older versus younger women are all narrowing, suggesting that the program is reaching disadvantaged and more difficult-to-reach groups.
- Contraceptive use correlates with availability of services and outreach activities: with distance between workers' and clients' homes, with frequency of contacts, and with the range and quality of services provided. Where good services and information are routinely available, prevalence has reached 30 percent—and in special circumstances 50 percent—even in the absence of concomitant changes in social and economic conditions.

These findings should not be interpreted as meaning that social and economic change is not also important, but only that significant progress on the demographic front — while more difficult — can still be made, even in the absence of such changes. Latent demand for contraceptives appears to be substantial, despite pervasive traditionalism and adversity.

Some social and economic changes that contribute to increasing demand for contraceptives and for smaller families have undoubtedly occurred. During the last two decades, the probability that a child will die before reaching age 5 has decreased from 25 percent to 20 percent. Since 1974, female literacy has increased from about 13% to 23%; GNP per capita has inched up at an annual average rate of 0.4 percent; and subtle changes in women's status and the perceived value of children are likely to have occurred. But the pace and level of these changes are hardly sufficient to explain the observed changes in reproductive behavior.

The most important characteristic of demand for contraception in Bangladesh is its tendency to remain latent in the

absence of effective support, encouragement, and services. In rural Bangladesh, women are restricted by the customs of *purda* to remain close to their homes, to subordinate personal preferences to familial interests, and to defer to their husbands in all aspects of personal decision-making. These features prevent women from acting on their own. Even in these circumstances, outreach efforts by supportive family planning workers can have a pronounced demographic effect.

Despite evidence that program efforts are reducing fertility, the achievement of a replacement level of approximately 2.1 is not possible in the near future using only supply-side approaches. Even in special pilot project areas under near-optimal conditions where the contraceptive prevalence rate has reached 55 percent, couples continue to desire at least two sons and a daughter. In the absence of very significant social and economic change, existing strategies and resources are insufficient to achieve what appears to be the Government's goal.

The Bangladesh Program

The crisis mentality of the period immediately after Independence resulted in the expansion of the modest family planning program that existed during the Pakistan era without testing or careful phasing-in of its various elements. In the process, several bureaucratic legacies from the Pakistan and even from the British era became institutionalized. One of these legacies is a bureaucratic culture favoring a centralized, top-down approach — features that are not conducive to implementing multi-sectoral programs which by their nature have to be managed at the community level. Another was continuation of a separation between population and health activities. While a categorical family planning program was constituted as a wing of the health ministry and labeled as "integrated" by virtue of its location, integration has occurred to some extent only at the top of the hierarchy in the Ministry of Health and Family Welfare, and in principle, at the bottom — where village level health and family planning workers are told to work as a team. At all levels in between, no integration has occurred.

The first of these legacies has resulted in a mechanistic management style. Rigid, centrally-imposed targets are viewed by senior program managers as critical to maintaining minimal performance standards. Demographic projections are converted into contraceptive use objectives, and national-level goals are parcelled out to workers uniformly, without regard to their past performance, current work prospects, or to local conditions and needs. Unrealistically high targets, prepared in this fashion, undermine morale. A closely-related problem is the tendency to focus objectives on targeted outputs rather than client needs.

The structural bifurcation of the population and health programs has had detrimental operational consequences. The family planning effort inadequately addresses health issues. Health services tend to omit family planning. Interdivisional conflict is rampant and field operations are inefficient. Problems are most evident at the periphery, where integration, from the client's perspective, presumably matters the most.

Other problems with the program include:

- *Lapses in service quality.* In the absence of comprehensive operational planning, large numbers of field workers were rapidly recruited and posted, facilities were constructed, and services were implemented. Implementation preceded the development of training and supervisory systems. Service quality suffered as a consequence.
- *Poor service utilization rates.* Caseloads at rural health and family planning clinics are low. Studies have shown that poor utilization is related to poor service quality and inadequate supply and logistics.
- *Problems in the utilization of non-governmental agencies (NGOs).* In recent years, NGOs have proliferated. There is a need to coordinate public and private sector effort at the periphery, without stifling initiative.
- *Weak interministerial coordination.* There are few interministerial or multi-sectoral activities (apart from the work of a few NGOs). Resources are provided to eight line ministries whose activities are supposed to be coordinated by the National Population Control Council (NPCC), but that organization lacks a secretariat.
- *Inadequate concern about finances and internal efficiency.* Perhaps because of the crisis mentality that has pervaded much of the life of this program, cost recovery or long-term financial planning for sustainability have not been central preoccupations. External inputs, however, cannot continue doubling every five years. Increasingly, further expansion must rely on improvements in efficiency, a neglected issue.

Although these operational constraints persist, criticism of the program in Bangladesh must now be reappraised in light of the recent evidence of fertility decline. Key elements of the Bangladesh strategy that appear to have contributed to the success achieved to date are the following:

- *Communication.* Owing to extensive publicity, program outreach, and mass communication, knowledge of contraception is virtually universal.
- *Outreach.* A cadre of approximately 19,500 female workers has been hired, trained, and equipped to deliver family planning services to couples in their homes.
- *Clinical back-up.* A system of maternal and child health (MCH) clinics now blankets the country and provides

primary care facilities for intrauterine device insertion, side effects treatment, and basic family planning ancillary health care. By 1989, 2,716 of the 4,325 unions had clinics constructed and equipped to provide services. By the end of 1995, all unions will be equipped with MCH clinics.

- *Accessible non-clinical supply sources.* Nearly all pharmaceutical outlets in Bangladesh are supplied with low-cost, subsidized contraceptives. By 1989, about 40 percent of the couples practicing contraception in Bangladesh were using condoms and pills supplied through subsidized commercial sales.
- *Surgical contraception.* Sterilization services are provided at no cost to patients in every subdistrict hospital in Bangladesh.
- *Ancillary health services.* Efforts to extend child immunization services to rural households have been linked to family planning outreach activities. Successful health outreach services have contributed to the credibility of family planning.
- *Services provided by NGOs.* Originally organized as a public sector program, the population program in Bangladesh is increasingly a collaborative effort involving NGOs. Approximately 120 private voluntary organizations are involved in the program, providing services to 40 percent of the couples practicing a method.
- *Implementation-based planning.* Early negotiations between the Bank and the Government of Bangladesh were Bank-directed and largely external to the GOB. With each successive project, however, leadership has shifted to the Government. Moreover, the planners have become increasingly pragmatic. Priorities for operational change are set on the basis of informed trial and experience rather than by administrative fiat. This has become particularly evident in the planning of the Fourth Project, which involved GOB-led work conferences, field investigations, and technical reports.

The Role of the World Bank

The comparative advantage of the Bank as a donor in the population field is its capacity to marshall resources for large-scale infrastructure projects. In Bangladesh, this strength has been complemented by two additional elements: an institutional development perspective involving software and technical assistance that has been crucial to the success of the more traditional hardware components, and an extensive consultation system involving all major parties—donors, the Government, and the Bank, plus a number of NGOs and advisors—that has permitted this community to adapt strategies to needs as they unfold. This approach requires more Bank staff inputs in both the field and in headquarters than has been typical of its population projects. Fortunately, these inputs have been made available to this program, thanks in large part to mobilization of donor resources for this purpose.

Thus, the Bank's success in the Bangladesh population sector derives, not only from its capacity to marshall resources, but also from its successful coordination and leadership. These achievements, however, derive less from established mechanisms of the Bank than from a serendipitous combination of co-financing mechanisms that have allowed Bank staff to circumvent customary norms and procedures. Five key elements are involved:

- *Lending.* Foreign financing accounted for 46 percent of total program costs during the 1975-80 period and 67 percent during the 1984-88 period. The World Bank has been a major actor in this effort, contributing between 10 and 15 percent of the total. Most of these funds have been used for construction and equipment that cannot be funded from other sources. Since 1975, there have been three population projects, and negotiations for a fourth have been completed.
- *Co-financing.* In addition to its own resources, the Bank has helped mobilize grant funds from other donors. Two-thirds of the foreign assistance provided by Bank projects has come from co-financiers. The consequence has been a larger fraction of project funding for software components and a greater degree of flexibility to make mid-course corrections than is typical in Bank projects.
- *Coordination.* This arrangement—lending in combination with grants—involves such a large fraction of total external resources that donors not formally involved find it necessary to coordinate their activities with those of the Bank in order to be effective. For this reason, the negotiations for a new Bank project in Bangladesh have major policy significance for the country, affecting the strategies of the national program and all foreign donors, whether co-financiers or not. Over time formal procedures for consultation have evolved which appear now to be working well.
- *Operational leadership.* With the encouragement of the GOB, Bank staff have played a lead role, not only in donor coordination and mobilization of grant resources for the program, but also in program planning and foreign aid and administration. In so doing, the Bank has made possible the effective administration of a much larger program than the GOB could have administered on its own. To play this role effectively, greater staff resources — both in Dhaka and Washington — have had to be devoted to these projects. This has been made possible by funding for this purpose from co-financiers.
- *Innovation and financial flexibility.* The flexibility and innovative character of the program has been enhanced, not only by resident technical assistance, but by an "Innova-

tive Project Fund" established by grants from co-financiers and headed by a steering committee of local experts. This fund has been used for critically-needed research on service quality, contraception innovations, and other issues not anticipated in original Bank agreements.

Implications for Bank Operations in Similarly-Constrained Settings

Elements of the Bank's Bangladesh experience that hold promise for application in other cases where the institutional setting is constrained in similar ways include the following:

- *Phased implementation.* Early Bank efforts in Bangladesh were inordinately complex. The national program was financed before fundamental structural problems in the program were resolved. Premature implementation of the first project on a large scale institutionalized organizational problems that subsequent projects have attempted to solve. By starting on a smaller scale and more simply, such problems would have been reduced and the second project would have found it easier to apply the lessons learned from the first.
- *The role of pilots.* While numerous pilot studies of individual components were specified in appraisals, they accomplished much less than they might have because of flawed research design and implementation. For maximum benefits, pilots should try out the whole proposed project design in one or two districts prior to finalizing the design. That would mean, for example, that a pilot trial of the fifth project should be included in the fourth project. In countries just starting with a series of Bank projects, it might mean that the first project itself should be a pilot for the second.
- *Flexibility.* In settings where demand is fragile and administrative capacity limited, donors must take a more pro-active role and be prepared to engage in strategic planning to solve problems as they arise. Mechanisms in the Bangladesh projects that provided the Bank staff with such flexibility merit review for application elsewhere.
- *Intensive staff inputs.* The success of Bank efforts in Bangladesh relate directly to heavy staff inputs and dynamic leadership on the ground. Arms-length project design and negotiation and intermittent supervision would not have worked in this case. The same principle will apply in any setting where institutional capacities are weak.
- *Co-financing, donor coordination, and the phased use of grant and loan funds.* The capacity to program a package of loan and grant funds has been extremely useful in Bangladesh. Where the need for population assistance coincides with limited capacity to develop a project, consideration should be given to forming a consortium even before lending begins. Grants could be used to initiate activities on a pilot basis, fund resident staff, and create a framework for later appraisal. The program would then be scaled up and involve increasing components for IDA lending. Established Bank lending procedures and project cycles would thus be invoked after a project was developed and tested. As a program matures, loans would play a larger role and grants would be phased out.

More generally, the Bangladesh case demonstrates the need for the Bank to adjust its operating style to the setting. Weak indigenous capacity for management, technical leadership, and coordination require correspondingly creative donor mechanisms for supervision, technical support, and interagency liaison. While the Bank could have provided more advisory inputs on the technical level, the character of its operations in other respects is laudatory and resulted in the mobilization of grant funds — especially successful in Bangladesh — that would not otherwise have occurred.

1. Introduction

In the chronicle of concerns about development constraints in Bangladesh, progress achieved in the population sector has received less attention than its due. Surveys conducted over the past two decades show that contraceptive use prevalence has increased from 3 to 32 percent, and suggest that the total fertility rate has declined from over 7 to about 5. [1]Child mortality has also declined, particularly among infants. Changes are modest in comparison to demographic trends observed elsewhere in Asia, but surprising in light of arguments that have been marshalled to explain why Bangladesh fertility and mortality rates are high and constrained to remain so. Bangladesh thus represents a demographic anomaly. Recent trends are inconsistent with conventional theory on how demographic change relates to societal conditions.

This report examines the contribution of the World Bank to the Bangladesh population program, a program that has had extensive support from the World Bank since Independence. Negotiations for the first project commenced in 1972, at a time when population lending was new to the Bank. This project, planned by a small technical staff in the Planning Commission and in the Bank, set the stage for a pattern of active involvement and leadership that has characterized the Bank's role to date. Since then, two additional projects have been implemented and a fourth is about to begin. Each has been timed to coincide with five-year plans commencing in 1975 and extending through 1994.

The First Population Project was prepared before an international consensus had emerged on directions for population policy that are appropriate for settings such as Bangladesh. Some analysts advocated family planning services as the central thrust of population policy, arguing that survey responses evinced substantial unmet demand for contraception. Others argued that supply-side strategies were unlikely to succeed unless there were prior changes in underlying economic and social determinants of reproductive motives.[2] Amid considerable controversy, without first resolving critical issues in the debate, a large and complex program was launched throughout the country. Constraints, difficulties, and skepticism about prospects for success, so prominent in the literature about Bangladesh at the time of its Independence, must now be reassessed in light of evidence that fertility has begun to decline.

The critical contribution of the Bank to the Bangladesh population program derives from the timing, co-financing and donor coordination mechanisms, scale, and complexity of the four population projects.

Projects are timed to coincide with the planning cycle of the GOB. Planning cycles, in turn, correspond to cycles of organizational change. The coincidence of project planning with national program planning places the Bank in a unique position to collaborate in the policy development process, and to collaborate with the Government in planning at a time when the GOB traditionally reviews programs and undertakes new commitments.

The first Bangladesh population project was the first Bank project in the social sectors to be "co-financed," an arrangement whereby donor grant funds are administered by the Bank. Australia, Canada, the Federal Republic of Germany (FRG), the Netherlands, Norway, Sweden, and the United Kingdom contributed to the First and Second Projects. Sweden withdrew from the Third Project but may rejoin the Fourth Project. Japan has joined the Fourth Project.[3]

1. In 1989, two national sample surveys were conducted that produced nearly identical estimates of contraceptive prevalence (Huq and Cleland, 1990, and Mitra, 1989). The Fourth Five Year Plan uses a figure of 35 percent. It should be noted that traditional methods are included in these estimates.

2. See for example, Demeny 1975.

3. In this report, "co-financiers" refers to formal participants in the projects and "donor consortium" refers to co-financiers and other donors participating in the project preparatory and monitoring process.

Because the combined resources of the project co-financiers are so large, and coordination among major donors is vital to the program, the entire consortium of population donors participates in strategic Bank project meetings, including donors not formally involved in project funding.[4] Meetings address a range of issues and needs extending far beyond the scope of lending, to include such diverse issues as research, technical assistance requirements, service quality, logistics, and the like. Mechanisms for the Bangladesh World Bank Projects thus extend well beyond the traditional role of the Bank in lending, to include the administration of foreign aid, the coordination of donors, and technical assistance.

Taken together, the four projects comprise the largest single source of external support to the Bangladesh population program in the post-Independence era. Table 1 at the end of this case study presents appraisal data for the three Bangladesh population projects and preliminary budget data for the Fourth Project.[5] The most striking feature is the approximate doubling in size of each successive project. About half of these funds were allocated to hardware (civil works and equipment) and about half to software (training, staff salaries, and special activities), of which salaries were by far the largest component. The First Project allocated 37.8 percent to contingencies, reflecting the uncertainty and institutional constraints prevailing in the immediate post-independence period. Capacities to absorb funds and implement programs improved with time, disbursement levels increased, and the unallocated component declined to 16.8 percent in the Second Project and to zero in the Third and Fourth Projects.[6]

The bottom row of Table 1 shows the percentage distribution of sources of funding. As can be seen, the Government has progressively increased its share, from 10-12 percent in the first two projects to 28 percent in the fourth. However, the budgetary increase, from US$5.3 million to US$214 million in the third, and US$165 million in the fourth, is considerably less than these figures imply, because the growth in salary contributions from the Third to the Fourth Projects reflects inclusion of encadred health service staff rather than an incremental commitment of resources.[7]

In contrast to other programs, the share of external funds contributed by co-financiers has been consistently greater than that of IDA. Over the four projects, this share has varied from 56 to 63 percent.

The allocation of funding from loans versus grants has changed with time. As Table 1 shows, the proportionate distribution of project resources was similar for IDA and grant components. By the Second Project, however, IDA funding was concentrated on hardware, while grant support was directed to software components. By the Third Project, construction was entirely IDA funded and salary support was entirely grant-supported. This pattern continued into the Fourth Project.

As the program expanded and prevalence increased, the component of the program devoted to contraceptive commodities, related pharmaceuticals, and basic equipment increased dramatically, from $6.2 million in the First Project, to $59.9 million in the Third Project. By the Fourth Project, commodity and equipment costs were the largest component of overall project costs. This growing commitment to commodity support was borne by the co-financiers.

The achievements of these three projects, and plans for the fourth may contribute insights into World Bank deliberations on strategies appropriate for traditional societies where demographic changes are not expected to spontaneously arise. The sheer size of the Bank's commitment to the Bangladesh population program heightens the need to derive lessons from this experience.

While the declines in fertility and mortality that Bangladesh has experienced so far do not represent a demographic transformation of the country, they are substantial when weighed in light of social and economic barriers to the modernization of reproductive behavior in Bangladesh. More important, operational features of the Bank's Bangladesh projects may be relevant to lending strategies elsewhere. References to the economic, social, and demographic problems of the world's least developed countries often focus on the Bangladesh case. Of the world's 20 poorest countries, it is the most populous and the largest recipient of foreign assistance. Given the extensive investment in the Bangladesh population program, and emerging evidence of success, it is appropriate to review the role of the Bangladesh family planning program

4. These include: United States Agency for International Development (USAID), one of the largest bilateral donors, but not a co-financier; the Asian Development Bank (ADP), which is increasingly active in population lending and relates its programs to components of the program that are also IDA-funded; the United Nations agencies, which are implementing some components of the project; and the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF), and the World Health Organization (WHO,) which administer technical assistance contracts for the Bank.

5. The budget for the Fourth Bangladesh Population and Family Health Project has not been finalized. A pre-appraisal budget of $571.4 million has been proposed, and will not change appreciably.

6. Problems with the capacity of the program to absorb funds continued into the Third Project owing to a variety of administrative problems. Disbursement involves a myriad of steps and procedures, complex and archaic accounting mechanisms, and frequent procedural lapses. Resident Mission in Bangladesh (RMB) support to the Project often takes the form of monitoring the flow of funds, resolving delays, and arranging for disbursement.

7. See Karim et al. 1985. The actual contribution of the Government of Bangladesh to population, including contributions external to projects, is not documented. Also, there is no single source of information about total sectoral budgets, including external resources, other than projects of the Bank. For this reason, there is considerable confusion about the actual costs of the Bangladesh population program. (People's Republic of Bangladesh 1985.)

in recent demographic developments, take stock of continuing difficulties and constraints, and assess implications of the Bangladesh experience for programs elsewhere.

This report examines evidence as to whether the overall strategy has been sound—first, by reviewing demographic trends for evidence that intended outcomes were achieved and by reviewing the congruence of societal conditions with programmatic aims. Next, the report examines the implementation of the projects in terms of the appropriateness of the Bank's mechanisms and the congruence of project plans with Bangladesh's institutional capacities. The institutional style of the Bank and its relationship to the donor community are reviewed for lessons from this experience for population sector lending in other, similarly constrained institutional contexts. The report concludes with recommendations for Bank operations that emerge from the Bangladesh experience.

2. *The Demographic Situation in Bangladesh*

Until recently, the broad outlines of demographic dynamics in Bangladesh were typical of South Asia in general. Mortality and fertility were extremely high until, with the introduction of basic preventive health measures, mortality declined and rapid population growth ensued. Although fertility rates declined in South India and Sri Lanka in the 1960s and 1970s, rates in North India, Pakistan, Nepal and Bangladesh were uniformly high. Fertility changes in Bangladesh in the 1980s have introduced a new element of diversity into the demography of South Asia.

Mortality in Bangladesh declined gradually during the first half of the century and rapidly in the 1950s and 1960s. Progress was interrupted by the 1969-70 liberation war and famine in 1974-75. A breakdown in public sector organizational problems in the immediate post-independence period disrupted health services and delayed the introduction of child survival programs. By the late 1970s, however, economic conditions began to improve, the political climate stabilized, and mortality declines that had been interrupted since the late 1960s resumed.

While the progress in mortality reduction achieved in the 1980s is significant, as yet there is no convincing evidence that rural Bangladeshis perceive the survival prospects of today's children as markedly improved. Infant mortality ranged between 130 to 160 in the 1950s and 1960s, and remained above 120 in the 1980s. In the 1960s, roughly one quarter of all children died in childhood versus one in five by the 1980s. Modest changes of this magnitude are unlikely to have altered parental perceptions of child survival or to have induced recent changes in reproductive behavior.[8] Life expectancy remains low in Bangladesh—54 and 49 years among males and females, respectively.[9]

For the historical period for which reliable records are available, fertility has been extremely high in Bengal.[10] Although seasonality is pronounced, annual total fertility rates remained above 7.0 for the first seven decades of this century.[11] Fertility decline is thus a relatively recent phenomenon, probably commencing in the late 1970s, and gradually accelerating in the 1980s.

The relative role of proximate determinants of this trend has been examined in the course of several national surveys over the past 20 years and summarized in two recent GOB-sponsored studies.[12] Survey results corresponding to the earliest and latest estimates from this series of studies are presented in Table 2 at the end of this case study. The

8. At least one study has shown that parents perceive survival prospects of children as improving, but this finding may relate more to special health services in the study area than to the national situation (Nag and Duza 1988). When birth rates decline, villagers are aware that fewer children are dying and attribute this to better health, even if mortality rates are unchanged. Perceptions of mortality and their influence on reproductive aspirations merit further research in Bangladesh.

9. That female life expectancy is lower than male life expectancy is due to several factors. For reasons that are not well understood, infectious disease morbidity is generally higher among women than men. Maternal mortality, at about 6 per thousand live births, is 70 times rates reported from developed countries. Most important, female child mortality rates are substantially higher than corresponding rates for males, a relationship that is apparently related to traditional male gender preferences and to selective neglect of girls in the allocation of familial resources. (United Nations Economic and Social Commission for Asia and the Pacific 1981.) As a consequence, female life expectancy in Bangladesh is one of the lowest in Asia (D'Souza and Chen 1980).

10. UNESCAP 1981 and 1984.

11. Long-term fertility trends are reviewed in the report of the Committee on Population and Demography, National Academy of Sciences (1981). An overview of natural fertility dynamics in rural Bangladesh appears in Menken and Phillips 1990.

12. An overview of these surveys appears in Duza 1990a and fertility trends are analyzed in Kabir and Rob 1990. The most recent survey, published after the Kabir and Rob review, is a study of the Bangladesh National Institute for Population Research and Training (Huq and Cleland 1990).

table employs the method proposed by Bongaarts (1978) to decompose fertility into proximate determinants.[13]

As Table 2 shows, an increase in the age of marriage has reduced fertility among very young women. The fertility-reducing effects of this trend have been offset somewhat by declining rates of widowhood and increased rates of remarriage among divorced women. Nuptiality changes have thus reduced fertility, but changes are offsetting and the overall effects are modest (C_m declined from .92 to .86). Nuptiality changes account for a decline of .3 births in the TFR over the 1975-89 period.

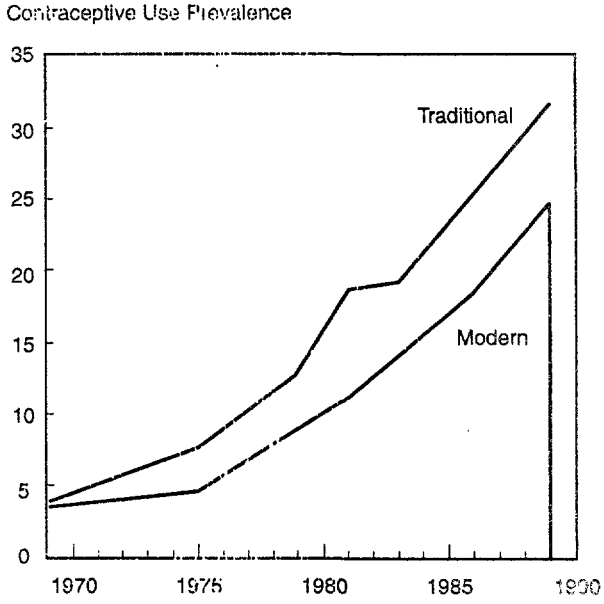
Various estimates of the fertility-reducing effects of abortion have been marred by estimation problems, incomplete data, and other difficulties. Some analysts estimate that about 17 percent of all pregnancies end in abortion. A rough estimate of the fertility effect of abortion can be obtained by comparing direct estimates of the 1975 Bangladesh Fertility Survey (BFS) fertility (TFR=6.7) with Bongaarts estimates implied by a null effect of abortion (TFR=7.2), for which the value of C_a (abortion) is .93. Roughly comparable estimates emerge from special studies of abortion in Bangladesh. For lack of data on this issue, C_a in Table 2 is assumed to be constant.

Prolonged post-partum infecundity that arises from prolonged breastfeeding is the most important fertility-inhibiting variable among the proximate fertility determinants in Bangladesh.[14] In some settings, the modernization of reproductive behavior has lead to reduced breastfeeding and shorter durations of post-partum amenorrhea. Although various studies of reproductive behavior have shown that breastfeeding durations have remained stable over the last 15 years and exceed 28 months on the average in both urban and rural areas, lactational protection may have diminished, as suggested by comparisons of 1975 and 1989 surveys showing a decline in the length of postpartum amenorrhea from 18 to 12 months. A trend toward less intense breastfeeding could explain this, partially offsetting the fertility-depressing effects of contraception. The C_i index in Table 2 is based on estimated rather than reported duration, since recall of amenorrhea durations may be subject to bias. In fact, it seems possible that the role of abortion has increased (implying a C_a decline) and post-partum infecundity has decreased (implying a C_i increase). Effects are likely to be offsetting, with lactation continuing to represent a major fertility depressant.[15]

Estimates from six national surveys show a consistent increase in use of contraception, beginning at very low levels in the post-Independence period, and continuously increasing to nearly a third of all couples by 1989 (Figure 2.1).[16] Most of this increase has been in use of modern methods. According to the 1989 Bangladesh Fertility Survey (BFS), 10 percent of all couples have accepted sterilization, a figure representing about one fourth of all modern contraception users.

Fertility aspirations have declined, possibly helping to increase contraceptive practice. The mean desired family size declined from four children in 1975 to 2.9 in 1989. Even more telling is the fall, from 28 to 9 percent, in the proportion of women giving non-numerical, fatalistic responses to the question on desired fertility. Several special studies, where services are intensely purveyed, suggest that prevalence rates exceeding 50 percent may be achieved if existing demand is met.[17] The relative slopes of trends in contraceptive prevalence have been estimated in a recent United Nations-sponsored review of the demographic situation in South Asia and are reproduced in Figure 2.2 below. If current trends continue, prevalence will reach 50 percent by the year 2000, a level that will surpass prevalence in the large states of North India and substantially exceed prevalence in Pakistan and Nepal.[18]

Figure 2.1: Trends in Contraceptive Prevalence Among Currently Married Women in Bangladesh, 1969-89



13. Empirical investigation has shown that virtually all areal variance in total fertility rates can be explained by variance in the fertility-reducing effects of contraception, exposure to intercourse, abortion, and post-partum infecundity (Bongaarts and Potter 1983). Bongaarts developed indices for the proportionate reduction in fertility that can be attributed to each of these factors. In the Bongaarts model, the total fertility rate is given by the product of the total fecundity rate and four indices: contraception (C_c), marriage (C_m), abortion (C_a), post partum infecundity (C_i). Following his framework, these indices have been computed for Bangladesh and reported in Table 2.

14. Huffman et al. 1980.

15. Huq and Cleland 1990.

16. See Mitra 1986; Mitra and Kamal 1985; and Mitra 1989.

17. See Koenig et al. 1987; Phillips et al. 1988.

18. Mauldin 1990.

Figure 2.2: Contraceptive Prevalence, South Asia, 1970–2000

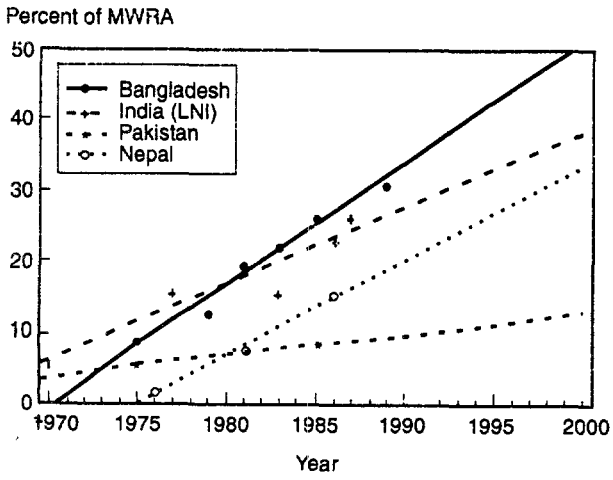


Table 2 shows the demographic implications of increased contraceptive use in Bangladesh.[19] Prevalence increased from 7.7 in 1975 to 31.4 in 1989. Because the efficiency of contraception also improved, owing to the increasing proportion of all users who are sterilized or using an intra-uterine device, contraceptive effectiveness increased. Taken together, the increases in prevalence and efficiency reduce C_c from .93 to .71. This implies that the predominant factor in the Bangladesh fertility decline has been contraception: Of the TFR decline of about 1.8 births over the 1975 to 1989 period, 1.5 births are attributable to increased practice of contraception and 0.3 births are attributable to nuptiality changes. Thus, to understand fertility changes in Bangladesh requires an explanation of trends in contraceptive use.

Although contraception is the predominant factor in the Bangladesh fertility decline, prevalence rates of 50 by the year 2000 would achieve a fertility decline falling far above the current target of a net reproduction rate (NRR) of 1. Moreover, there is reason to doubt that the slope of the Figure 1 trend will be accelerated in the future.[20] Caution is suggested by the experience of special projects in Bangladesh. No intensive service research project has produced levels of prevalence commensurate with the requirements of replacement fertility. Producing replacement fertility requires a prevalence rate of 70 percent—a level of contraceptive use as yet unsubstantiated by demographic or operations research. Known strategies can reduce total fertility to about 4, but most couples continue to desire two sons and a daughter. It is not clear whether future declines in reproductive aspirations are in the offing or whether such changes are even required to sustain further increases in contraceptive use.[21] The dynamics of contraceptive use thus merit careful field study and continuous review. That current programs are succeeding does not ensure that future aims will be attained with existing strategies and known resources.

Successive Bank projects have aimed to foster increases in contraceptive use and reduce fertility. The precise impact of strategies will never be known. Although targets have been overly ambitious, demographic trends are proceeding in the desired direction and contraception has been the leading cause. This lends support to the view that the program has had a role in the coincidence of the observed trend with the intensification of services, and evidence that most users depend upon program sources for supplies. Demographic research thus lends support to the view that the broad thrust of the Bank's strategy in Bangladesh has been sound.

19. Ministry of Health and Population Control 1979; Huq and Cleland 1990. A second national contraceptive survey in 1989 produced similar results (Mitra 1989).

20. See for example, Khuda and Howlader 1985.

21. In East Asia, contraceptive use continued to increase even in the absence of prior changes in reproductive aspirations (See for example, Chang et al. 1987).

3. The Environmental, Social, and Economic Context

The January 1990, population of Bangladesh was estimated to be 113 million, growing at a rate of 2.3 percent. Dispersed in an area of only 144 thousand square kilometers, the Bangladesh population is 90 percent rural. Its density, 819 per square kilometer, is the highest of any country in the world. Arable land is only a tenth of a hectare per capita and over a half of it is under water during the monsoon season. Under even the most optimistic assumptions of dramatic fertility decline, Bangladesh will have a population exceeding 400 million in the next century. It is difficult to construct a scenario of economic development or population redistribution that can sustain this anticipated population growth.

A Diffuse Society

Much has been written about the societal ramifications of poverty, risk, and adversity in Bangladesh, and how traditional social institutions perpetuate high fertility.[22] Skepticism about the role of family planning programs, and the approach used by the Bank in its population lending, is grounded in research showing that Bangladesh is an inauspicious setting for family planning programs.[23] Extreme poverty, traditionalism, and environmental adversity are rooted in constraints to increasing agricultural productivity, enhancing women's status, improving health conditions, and reducing fertility. To some observers, economic and social problems attest to the need for an effective family planning program in Bangladesh. To others, such problems explain why family planning programs have not worked as well as their proponents had hoped. There is general agreement, however, that population dynamics and societal well-being are inextricably linked in Bangladesh, and that reducing rates of population growth represents a critical policy issue, since reproductive change is unlikely to occur spontaneously.

Of the Bangladeshi social characteristics with ramifications for organizing human services, the most striking is the "diffuse social structure" of rural Bangladesh—a characteristic of social organization that affects capacities to structure formal organizations that deliver effective community- based services. Located on small clusters of artificially-elevated land, household groupings are fragmented into isolated groupings known as *Baris. Baris* lack clear leadership and traditional linkages between *baris* are fragmented and diffuse. As a consequence, village government does not exist, . This lack of structure permeates all social systems in Bangladesh.[24] Models for community-based service systems that have been developed effectively in East Asia do not transfer well to Bangladesh.

There is little doubt that the geography of East Bengal has historically impeded efforts to impose external rule and severely constrained contemporary efforts to develop participatory social programs at the periphery. Without village leadership to relate to, development efforts tend to be externally imposed and artificially contrived, lacking an indigenous organizational base with links to the political system or the bureaucracy. Although community-based programs often succeed on a small scale when charismatic leaders can exercise influence, they fail when activities are extended to scale.

22. See Cain 1981 and 1983. See also the critical commentary on this perspective by Robinson (1986) and Cain's reply (1986). According to Robinson, the climate of risk may not have the constraining effects posited by Cain.

23. See for example, Demeny 1975.

24. See Arthur and McNicoll 1978.

Weak traditional village organizational structures may explain why rural life is so rife with conflict, and why security concerns are so salient to rural Bangladeshi families. As one study has noted:

> "Economic power, physical power, and prestige are all to a large extent convertible into each other, for example, by using wealth to bribe the police or by using force to extract money or steal land. However, few power-holders specialize in all these simultaneously; rather they maximize the benefits of their special skills and opportunities, and have close ties with others who have different abilities."
>
> *Bangladesh Rural Advancement Committee, 1983*

Thus, to advance in status or acquire wealth, the villager must form alliances, join networks, and cement lateral relationships among peers either to foster individual gain at the expense of others, or to protect vital interests from change of any kind.

Patronage is also important in the allocation of resources and insurance against risk. Although patronage has been traditionally defined by land tenure relationships, the village patronage system may be changing with the increasing displacement of peasants from land. Landlessness is not only becoming more common, but trading, petty business, and other non-agricultural sources of income are becoming increasingly important components of the village economy, and increasingly important sources of economic mobility and patronage. Although land retains its value as the ultimate source of security, patronage and networks built around trade relations are increasingly important sources of prestige, influence, and political power.[25]

The diffuse social order profoundly affects the organizing capabilities of formal bureaucracies in Bangladesh. Formal organizational structures embrace the strict application of bureaucratic rules, encouraging hierarchical thinking, mechanistic management, and inaction. Informal bureaucratic culture introduces dynamic components, directed however, at survival, not performance. Lateral networks are formed, dissolved, and reformed for personal gain, with lines of accountability to peers and patrons in a manner that insulates individuals from the influence of formal organizational structure. The pursuit of personal gain blends formal organizational contacts with extra-organizational networks and alliances. Individual prerogatives condition the setting of goals, the perception of achievement, and the allocation of resources. Formal organization, like the village social order, is typically diffuse.

The fragmentation of formal organizations is compounded by strong cultural values supporting the pursuit and protection of personal status. Status defines access to resources and the parameters of personal influence over the use of resources; it is defined less by organizational rules than by patronage and the power of lateral networks. Status therefore becomes a necessary obsession: every nuance of title, formality, and activity is mediated by its pursuit; and yet, status is never entirely secure, always vulnerable to encroachment by rival networks or patrons. Personal gain, like advancement in the village, is viewed as a zero sum game—the good things in life are limited, and gainers represent a threat to those left behind.[26] The diffuse society, pervasive poverty, and the concept of limited good undermine organizational capabilities.

Low Levels of Educational Attainment

Just as illiteracy and conservatism impede social change, limited educational opportunities hamper the process of organizational development or renewal. Educational standards are low, and staff capabilities to train cadres of sympathetic and creative village workers are limited in every sense: both trainers and trainees have limited competence. Deficiencies at senior levels sustain technical deficiencies so that the obstacles to staff development are substantial, pervasive, and synergistic.

Moreover, the traditional values of villagers are shared, as well, by organizational personnel whose perception of the world and their job is unenlightened by exposure to a modern economy, to a strong educational system, or to outside ideas. Workers thus share the conservatism of society at large: women are expected to attend to their household duties, and are reluctant to leave their village. Not surprisingly, female domiciliary workers tend to work near their homes, if at all. Exchanges between clients and service providers are consequently infrequent, and the quality and quantity of outreach activity is impaired. Male workers are reluctant to deal with family planning; justifiably perhaps, because men cannot readily talk with women, and most certainly cannot discuss something as sensitive as family planning.

Low Levels of Development

Although per capita income in Bangladesh is among the lowest of any country in the world, painfully little progress has been registered in improving the economic status of the rural poor over the past three decades. Wage labor is pursued by increasing numbers of rural Bangladeshis, but real wages have declined.[27] Educational levels, while already low, have not improved, and literacy among women — at

25. See for example, Khan 1977.

26. See for example, Foster 1967.

27. See World Bank 1981.

20 percent — is the lowest in Asia and substantially below literacy levels for men.

Under the difficult economic conditions confronting the typical Bangladeshi family, children have economic value, not only for their productive activities in the household economy, but also for their insurance value to parents. Sons are thus valuable to parents, and strong gender preferences are consistently reflected in survey data.[28]

Status of Women

The life cycle of women is a sequence of dependencies on men: father, husband, and sons. Dowries absolve fathers of future obligations to daughters; but with marriage, women's economic and social roles are circumscribed by the traditions of purdah. Maternal dependency on sons is common, owing to large spousal age differentials and high mortality, and the absence of extra-familial sources of security to disadvantaged women. A woman facing adversity lacks a broader collective to turn to, in part because poverty is so pervasive, and in part because social structure mitigates against the distribution of risk. Lateral kinship links are weak, so that protection from adversity derives from vertical lineages, particularly sons. In the absence of social security, a family without sons is vulnerable to encroachment on vital interests.

Economic Deterioration

The deterioration of the rural economy over recent decades has undermined the capacity of the public sector to develop and sustain service programs. As their real wages have declined, civil servants have spent more and more time in supplemental activities such as trading, farming, and commerce during normal work time. The situation has progressed to the point where these supplemental activities often provide more income than the civil service job itself. The result is weakening supervision and motivation at all levels, down to and including outreach workers.[29]

At the same time, social institutions, grounded in the dominant economic role of agriculture, have been altered by the decline of land ownership. Systems of patriarchy and power, grounded in traditional land tenurial relationships, have been uprooted as the proportion of landed households has declined. The traditional elite retain much of their influence, but traders, middlemen, and non-traditional entrepreneurs have become increasingly important actors in the rural economy. This trend is complicating economic roles even for the subsistence farmer, who must pursue any opportunity for wage labor or petty trading, even if the gains are modest.[30]

Strong patronage systems and networks formed around economic activities insulate personnel from pressures to perform their organizational duties. In any case, supervisors also have goals external to organizational objectives, so that applying sanctions is rarely considered, and in any case, would be ineffectual. Control mechanisms are therefore virtually nonexistent in public sector organizations because organizational duties threaten vital personal interests. Hiring, training, and supervising a work force must confront an increasingly unfavorable climate for motivating workers to work and disciplining those who do not.

Environmental constraints. The environmental setting poses obvious challenges to social outreach programs that depend heavily on organized activity at the periphery. Most of the country's 66,000 villages are inaccessible by road. Although river transport is extensive, scheduled launch transport that could be used for field management is virtually nonexistent. Diffuse management systems, seemingly lacking in basic control mechanisms, performance standards, or rigor, undoubtedly reflect fundamental ecological constraints to effective communication.

The Demographic Role of a Supply-side Approach in Bangladesh

Given the comprehensive system of constraints on the family planning program in Bangladesh, powerful arguments have been marshalled to explain its difficulties. Social, economic, and institutional conditions consistently mitigate against success. Although survey data from the 1960s and 1970s suggested a considerable gap between reproductive intentions and fertility regulation behavior, the demographic relevance of family planning services was much debated until projects subjected perspectives in the debate to formal tests in field experiments.[31] Although much debated in the past, there is now little reason to

28. See Cain et al. 1979; Cain 1981, 1983, and 1986.

29. See Koenig and Simmons 1989.

30. While economic conditions in rural areas have not improved, these changes have been in some sense modernizing —forcing men to travel for trading, inducing families to diversify their economic pursuits, enhancing the value of education, while undermining the traditional economic functions of the extended family and kindred relationships. (See Khan 1977.) Some social theorists have hypothesized that growing poverty can lead to the modernization of reproductive behavior (e.g., Freedman et al. 1981). This issue has not been investigated in Bangladesh, and merits investigation, however.

31. Several projects have had careful research and monitoring, and at least one study has incorporated an experimental design and demographic monitoring. See the reviews by Chowdhury and Huda 1990; Alauddin and Khan 1983; Choudhuri and Akhter 1990; Phillips 1987. Studies suggest that simple distribution of contraception fails, however, because many couples are ambivalent about contraception, and a support system is required that addresses a range of family planning needs (Rahman et al. 1980).

doubt that there is substantial demand for family planning. Supply-side approaches can have net demographic effects in rural Bangladesh.[32]

First, there is substantial demand for family planning in rural Bangladesh that remains latent in the absence of an effective supply of contraceptive services. When localities are isolated from information and services, the prevalence of contraceptive use remains low. If services are delivered to couples in their homes, *baris*, or hamlets, contraceptive use rapidly increases. This suggests that women demand family planning, but lack sufficient resources, motivation, or social support to act on these desires. Pervasive ambivalence about contraception, reluctance to contracept, and social pressures mitigate against the success of family planning. But when convenient contraceptive services are offered to rural women, a third to a half of all couples will use a method.

Second, there is no single "best design" for a family planning program in Bangladesh. Some successful projects have used an integrated approach emphasizing health services, while others have emphasized the provision of contraception. Still others have worked through development programs, with family planning consigned to an ancillary service role. Some successful projects function as women's programs. Organizational philosophies and designs of successful projects thus differ.

Third, although there is no single best design, there are common elements of successful projects:[33]

- Frequent contact between outreach workers and clients increases contraceptive use. Establishing this requires a management system that is oriented to the need of rural women for regular encounters with service providers. Workers need to understand basic technical tasks, have basic management information, supervisory support, and reliable logistics.
- The quality of services matters. In Bangladesh, the availability of follow-up, multiple methods, and ancillary health services provided by trained and caring workers are elements of successful family planning services. Although acceptor targets are emphasized by the national service system, targets do not seem to matter if workers are supported and supervised.
- Establishing a strong supervisory system has been a priority of every successful project. Supervision systems differ, but all successful projects have clear lines of authority delegated to supervisors, decentralized personnel decision-making, systems for management control, and salaries commensurate with the task.
- Adapting strategies and organizational designs to social conditions contributes to success. Traditional gender roles require women to remain close to home and to retain familial duties, even if they are hired into full-time jobs. Men will travel in their work roles, but other economic roles compete for their time. A few full-time and well-paid male workers are more effective than a large male staff; a large part-time female work force is more effective than a small staff of full-time female workers. Sociologically appropriate designs for supervision, management control, and information are suggested by the successful management systems of small-scale projects.
- All successful projects have mechanisms for local flexibility and resource allocation. Staffing patterns reflect task requirements. Replicating the success of special projects in the public sector will require meaningful decentralization. Special projects have well- developed capacities to adapt strategies to local conditions and needs.

The themes of effective outreach, service quality, strong supervision, and decentralization recur in case studies of success in Bangladesh. The demographic significance of these elements of success has been demonstrated in carefully controlled studies, lending support to the view that program activities have contributed to contraceptive trends.

Conclusion

Conventional interpretations of the determinants of fertility decline center on the role of economic and social betterment in reshaping reproductive aspirations. Little that has occurred in Bangladesh leads one to conclude that such improvements are occurring. No analyst of the institutional context has concluded that economic conditions are improving rapidly in ways that are favorable to the modernization of reproductive behavior. Yet fertility has begun to decline.

The critical characteristic of Bangladesh society that explains this apparent anomaly is the phenomenon that is termed "latent demand." Powerful traditional forces continue to structure high fertility. Other emerging forces produce counteracting effects, even though these trends are not appropriately characterized as development. Since women are isolated, impoverished, and confined, changes in demand have emerged without affecting contraceptive behavior. The determinants of these changes are not well understood, but relate to the declining economic value of children with secular changes in the rural economy, the pressures on families to seek wage income, pressures that counteract traditional restrictions on the role of women, and other factors.

32. See for example, Phillips et al. 1982 and 1988.

33. See for example, Nag 1990; Nag and Duza 1988; Alauddin and Khan 1983.

Family planning program communication activities undoubtedly nurture emerging demand, but outreach services have had the most important effects. If trained and well-supervised workers visit rural households on a regular basis, and offer a range of family planning services, contraceptive use increases and fertility declines. Even when such services are readily available, however, demand is fragile, and the need for intensive outreach and ancillary health services continues to be acute. As adoption rates increase, contraceptive failure rates and discontinuation rates increase as well. Turbulent use dynamics betray an underlying ambivalence about contraception that is sustained by social conditions, even as reproductive behavior is modernizing.

Under these circumstances, the basic thrust of the Bank's strategy in Bangladesh—to support the provision of convenient contraceptive care to the rural poor—has been sound. There is substantial demand for family planning, despite all of the constraints that have been noted. There is a need to assign priority to meeting that demand by intensifying outreach and improving service intensity and quality. Even without a favorable climate, much has been achieved with supply-side approaches, and more can be achieved in the future. Field research suggests that an optimal supply system produces a prevalence rate of about 50 percent. Even with an imperfect system in place, however, a substantial demand for services has been met, contraceptive use has increased, and fertility has declined.

4. The National Family Planning Program

If family planning program effort is traced to its origins in the Pakistan era, the Bangladesh program is one of the oldest programs of its kind in the world. Numerous reviews, appraisals, and consultant missions have examined the structure of the Bangladesh population program, its field operations, and the effectiveness of various operational components.[34]

Although management reviews aim to diagnose operational problems and recommend changes, Bank assessments have had considerably more impact on program design than studies sponsored by the GOB directly or by other donors, because Bank assessments often correspond to project appraisals. This chapter reviews the institutional context of the Bank's population projects in Bangladesh, the history of the program, and its major institutional achievements.

The Institutional Context

The Colonial Legacy

British India established traditions of administration and governance that affect the bureaucratic culture of contemporary GOB programs. The colonial civil service, oriented toward revenue collection and maintaining public order, instituted narrow spans of authority, top-down decision-making, and extreme centralization. Positions in the British civil service were reserved for a select few and located at the district level, effectively insulating the routine activities of the bureaucracy from village life. A position in the public service was prestigious; salaries were high in comparison to wage income outside the public sector.

In the post-colonial era, the role of the civil service changed dramatically. The mandate of the civil service was extended to include village-based programs, and its size was greatly expanded in health, development, agriculture, and other sectors. Although sustained by post-colonial regimes, bureaucratic traditions developed during the Raj were inappropriate for social action programs requiring outreach, decentralization, and flexibility. Family planning programs, in particular, require active organizations at the periphery— village-based services that influence reproductive behavior of couples through the provision of information and contraceptive care. The dysfunctional preoccupation with demographic goals, targets, administrative orders, and rigid rules, so often noted in analyses of the Bangladesh program, have historic roots that are not readily dislodged with exhortations for change. Programs are consequently overly-centralized, decision-making tends to be autocratic, and operational planning is based upon fiat rather than trial and learning.[35] Sectoral ministries lack mechanisms for interagency coordination, so there is little capacity to implement multi-sectoral programs or initiatives involving the private sector. Structural change is promulgated without attending to the operational implications of orders.

In the population sector, weak administrative capacities have led to logisticical and distribution problems that

34. Among the more comprehensive reviews are the studies by Chauls et al. 1984; P and M Consultants 1977; and Korten 1975. The Bank's population projects and certain internal Bank evaluations have addressed organizational structure and impact. GOB commissioned management studies more typically focus on the effectiveness of component strategies (e.g., Mahbud et al. 1990).

35. Some analysts have attributed considerable significance to the role of research in fostering program innovation in East Asia. Conversely, failure to apply research to policy deliberations has detracted from the success of South Asian programs.

artificially constrain the availability of supplies. Supervision is weak, outreach is sporadic, and other organizational problems artificially restrict access to methods. Priorities and programs are shifted centrally without adequate attention to operational planning and capacities to actually implement activities in the field. In its brief history, emphasis in the population program has been shifted from population control, to population welfare, and then to MCH-based integrated services. In the First and Second Five Year Plans, five reorganizations were ordered. While these shifts led to new components, procedures, and implementing mechanisms, the intended changes in structure, coordination, and organizational design have not been undertaken as planned, creating structural confusion.

In the face of such constraints, the Bank has had a unique role to play. Its projects and mechanisms can foster major change in the way the program is structured and the manner in which it is implemented—changes that responsible Government officers sometimes seek to undertake, but are powerless to pursue without the institutional backing of the Bank.

Legacies of the Pakistan Period

The predominant thrust of population policy in Bangladesh has been clinical family planning services augmented with village outreach and mass communication activities—a policy focus developed in the Pakistan era in three phases: 1) A private, non-governmental agency phase (1953-59) was implemented by the Family Planning Association of Pakistan, but subsidized by government clinical services in large towns. This program failed to have demographic effects, but its pilot projects and training programs developed experience in family planning that was applied to subsequent efforts. 2) An integrated health service phase (1960-65) established the Government as a primary service provider, and created, for the first time, an outreach program. This phase also failed because the staff was poorly trained, services were narrowly focused on family planning to the exclusion of health, and resources were inadequate. 3) An intensive family planning service phase was launched in 1965. Clinical services, communication programs, and outreach were expanded and intensified. An autonomous Family Planning Board was created as an agency that was independent of sectoral ministries, including the Ministry of Health. Although intended to accelerate program effort, the program achieved little more than promoting public awareness of population issues and increasing basic knowledge of contraception.[36]

Although the Pakistan program developed models for clinical services, communication, and outreach, elements of the Pakistan legacy weakened family planning effort in the Bangladesh era:

- *The quality of services was poor, undermining the credibility of family planning.* Incentives for clients, pressures on staff, and rapid expansion of the program resulted in poor training and lapses in service quality. Rumors and problems with the intrauterine device were particularly damaging.[37]
- *Fissures between health and population specialists arose when family planning was placed in a separate organization.* Originally intended to enhance the prestige of population, and avoid associating family planning with the organizational weaknesses of the Ministry of Health, the decision failed to achieve its operational aims. Organizational rivalries launched at that time have never been effectively resolved.
- *Dysfunctional organizational traditions continued in the Bangladesh period.* Structural arrangements established in the Pakistan program have been reorganized in several subsequent plans of the GOB, but certain elements of the Pakistan program remain. First, the program is predominantly a public sector effort. Although private agency contributions are growing in importance, this is a relatively recent development. Second, policies and priorities are centrally planned for the country as a whole, and units responsible for operational planning are isolated from units charged with implementation. Large-scale change is ordered without information flowing upward from the field. Unanticipated problems arise, because decisions are centralized, and there is little capacity to adjust strategies to local needs. Third, major changes in the program's focus, content, and structure are promulgated without field trial or phased implementation. In the view of some respected observers, this represents the most serious single deficiency of the Bangladesh program.[38]
- *Political support was not translated into political action.* As the East Asian experience demonstrates, lethargy in the civil service can be overcome if political support is strong and if commitment at the top translates into coordinated action at various levels of government. Ever since Independence, and even before in the Pakistan era, national leaders have provided strong support to the

36. A useful review of the history of family planning efforts in East Pakistan and its impact on the Bangladesh program appears in Duza 1985. Early concerns about the consequences of rapid population growth are summarized in an influential article by Khan (1973).

37. The program had no demographic impact but did have some effect on contraceptive knowledge, although it is unclear whether stated knowledge in surveys corresponded to well defined understanding of how contraception is practiced (Sirageldin et al. 1975).

38. See for example, Freedman 1987. Various units were established for research, such as the East Pakistan Research and Evaluation Centre, the Central Evaluation Unity, and the Academy for Rural Development at Comilla. Nonetheless, research was viewed as a means of assessing impact rather than a resource for guiding operational planning. The important rural experiments of the Comilla academy had no appreciable effect on policy.

national family planning program. Presidential speeches to the parliament, cabinet, and the public have extended clear support to the program, and this has undoubtedly provided impetus to activities on the ground. What has been missing, however, is a politically-supported chain of command that reaches from the President's office to the village to provide a backbone for multi-sectoral programs that are otherwise spread over several ministries. Key actors in the program lack mechanisms for marshalling political leadership for village-based development activities that villagers relate to as a group. Strong support at the top has yet to be translated into a grass roots movement with links to national parties, development programs, or local government. Centralized multi-sectoral programs that fail to empower local development are unlikely to establish the links between population and development that are used to justify their existence as World Bank population project-funded initiatives.[39]

The Immediate Post-war Context

Preparation of the First Five Year Plan was initiated shortly after cessation of the war with Pakistan and in the midst of a famine. A major international relief action was underway, and an atmosphere of crisis permeated all national planning and donor negotiations at that time. The devastation from this war was particularly debilitating to the health and social service sectors of the Government. The bureaucracy had collapsed, universities and training institutes were decimated, and many of the critically-needed health facilities were destroyed. Basic communication was disrupted, further straining capacities to organize effective Government. The nation's only political party was new to the task of governing, and its extensive grass roots organization was oriented more to the war effort than to development. Mechanisms for coordinating complex tasks at the periphery—where family planning services would have their effects—simply did not exist. Nevertheless, a sense of urgency prevailed, leading to deliberations on creating and financing a large and complex program.[40]

Much debated at the time was the future role of staff from the Pakistan program. Senior planners pressed for fundamental strategic and organizational change, arguing that past efforts had failed and the revolutionary regime had a mandate to start afresh. Senior civil servants, with considerable support from the donor community, argued that the urgency of the situation required rapid implementation of the existing program. The latter view prevailed, with the result that workers from the old program were kept on and the organizational culture in which they worked survived.

The First Three Five-year Plans and the World Bank

By financing a large, complex multi-sectoral and centrally-planned program in the First Project, the Bank could be faulted for subsidizing a program that would most certainly be difficult for the new Government to implement. But it is appropriate to weigh such criticism in light of prevailing opinion in the early 1970s and the context in which negotiations were undertaken. Because Bangladesh was viewed as a crisis zone, most external observers and Government planners believed that there was no time for a phased-in approach. Anything less than a comprehensive and ambitious program was unthinkable in light of the obvious urgency attached to the program. Many competing strategies were debated at the time—family planning outreach versus health integrated with family planning versus demand-generating development approaches. In the view of government planners and their colleagues at the Bank, the most cautious approach under the circumstances was to try all three strategies simultaneously: (1) categorical family planning administered by a population wing of the health ministry, (2) integrated health and family planning services in maternal and child health program, and (3) multi-sectoral programs for demand generation in the fields of education, agriculture, rural development, labor, and communication. Funds were channeled to various ministries for population activities, although budgets were never functionally integrated. Creating village-based multi-sectoral development and health activities would have required careful field trial, extensive institutional development, a phased-in approach permitting lessons to be learned and problems to be solved at each stage, and meaningful decentralization to the sub-district level and below. A decade or more would have been required, beginning with a small, highly focused program in a few localities and gradual expansion of program coverage and scope with time.

The First Five-year Plan

GOB interest in population planning was manifest in its First Five-year Plan (1973-78), and the new Government took several actions to establish a program even before the First Plan was developed. A policy conference in 1972[41] led

39. An insightful critique of the Bangladesh multi-sectoral strategy appears in Demeny 1975.

40. An influential conference in the immediate post-Independence period focused on projections and consequences issues (Bangladesh, People's Republic of, 1972). Although drastic action was called for, there was little attention to what that entailed in practical operational terms. Discussion was dominated by debate on alternative administrative structure of the program and whether family planning should be integrated into health, rather than on designs for field trials that would resolve controversy.

41. See Bangladesh, People's Republic of, 1972.

to a decision to place population within the health ministry under an arrangement termed "functional integration." This policy disbanded the discredited Pakistan Family Planning Board by creating a population wing of the health ministry and consolidating activities in a directorate of the population wing. In practice, functional integration has meant separating health and family planning into separate and distinct structures, but placing the two structures under a single minister.

Although there have been shifts in focus, the Bangladesh program has retained the basic structure established in the First Five-year Plan.[42] The Family Planning Directorate is divided into five sub-units responsible for administration, training, communication, planning, and service delivery. The sub-directorate for service delivery has a chain of command extending to the periphery.

The organizational structure. The most serious structural problem associated with the program relates to the integration of health with family planning and the respective roles, responsibilities, and authority of officers in delineated wings of the Ministry of Health and Family Welfare (MOHFW).[43] The organizational structure of the Bangladesh health and population program is complex, although the fundamental structural characteristic is its delineation of health and family planning into separate, vertical wings, joined at the top by the Office of the Secretary, MOHFW, and at the bottom, by multi-purpose village workers, but bifurcated at levels in between extending from units in Dhaka, to districts,[44] sub-districts,[45] unions[46] and wards.[47]

Efforts to streamline this structure have been characterized as "integration." In fact, considerable overlap in health and family planning functions exists, since maternal and child health services are delivered in the family planning wing, and family planning medical officers are assigned on deputation from the health wing. Various attempts to create a unified chain of command have failed, not because health and family planning are separate, but because staff in the two wings have concerns about their relative bureaucratic rank, tenure, and authority.[48]

The dysfunctional structure has origins that can be traced to policies of the Pakistan era, and even earlier to a bureaucratic culture extending into the Raj. The present administrative reality, however, is that lines of authority are confused, supervision is weak, and morale is low. Official exhortations to correct operational problems have had little impact on underlying systemic problems.

The First Population Project. The First Bangladesh Project established the Bank as the most influential donor in the population sector in Bangladesh. Innovative procedures and mechanisms were outside of the mold of Bank lending operations in other sectors and atypical of the Bank's approach to population lending elsewhere. Various precedents set in the First Project continue to guide strategic plans of the Bank in Bangladesh.

Large-scale projects. The First Project budget was $47.5 million, nearly two thirds of which derived from grants from Canada, Sweden, Germany, Australia, Great Britain, Norway, and the Netherlands. The large scale of the project set a pattern for lending that continues, since nearly all aspects of the population plans of Bangladesh have been at least partially funded under Bank projects. Unlike Bank commitments elsewhere, the First Project focused on software. Eight ministries were involved, covering aspects as diverse as communication, clinical services, education, women's affairs, mothers' clubs, rural cooperatives, agricultural extension, and other issues.

At least some of the pressure for a large-scale project in Bangladesh relates to "lending pressure" from within the Bank, deriving from its traditional focus on large loans for development infrastructure. More important, however, were antecedent events setting the context for the loan, discussed above. A Bangladesh economic crisis led to a foreign exchange crisis, reinforcing interest at the Bank in large infrastructure projects. Institutional interests aside, there was clearly a need for infrastructure: hospitals were in disrepair or destroyed by the war, convenient clinical facilities did not exist, and training centers were inadequate. Although criticized at times for a "bricks-and-mortar" bias, the Bank identified priority issues in its commitment to hardware, and balanced that commitment with co-financed support to software.

Complexity. Eight sectoral ministries were to implement components of the program, officially described as "multisectoral." Components were specified for women's programs, mothers' clubs, agricultural outreach, community programs, communication and broadcasting, and other activities collectively designed to foster demand for

42. There are no mechanisms for coordinating the work of NGOs.

43. Choudhuri and Akhter 1990.

44. Districts or "zillas" are 64 geographic units grouped into four regional divisions. Divisions have little administrative authority, and divisional directorates are located in Dhaka. In each district there are separate offices for the Civil Surgeon, responsible for the health wing, and the Deputy Director for Family Planning, responsible for population activities. Each district has about 6 subdistricts.

45. The subdistrict is the basic unit of civil administration for the police, various development activities, and the civil service administration. The population of subdistricts typically range between 200,000 and 300,000.

46. There are typically about 10 unions in an upazilla, each with an elected council.

47. There are three wards to each union, and each ward has a uniform staffing pattern for family planning workers. The Health Division also has staff posted at this level, but different areal units are delineated, "mouza." Work areas and worker density differ for the divisions. Nonetheless, central orders have been issued for workers at this level to operate as a team.

48. BRAC 1990.

contraception and enhance the availability of services. Opinions vary as to whether activity at the periphery actually represented a multi-sectoral approach, or is more appropriately characterized as a complex, interagency family planning service system. Most consistent with the concept of "multi-sectoral approaches" is the work of a few private voluntary agencies that combine family planning with village development activities. These are activities external to the official program, however, and have yet to constitute a substantial proportion of the overall volume of services in Bangladesh. The Bangladesh approach to multi-sectoral population activities differs substantially from the design of such approaches in East Asia, where development components are closely linked with family planning service components, and entire multi-sectoral systems are coordinated by a single agency. Multi-sectoral coordination has been weak in Bangladesh for a variety of reasons:

- *Weak coordinating mechanisms.* The NPCC was charged with the task of coordinating the program, but it lacked a secretariat,[49] and its principal contribution was to legitimize policy rather than to coordinate operations. Lacking a secretariat and clear lines of authority over sectoral ministries, the NPCC has never functioned effectively as a coordination agency.[50] Its first policy declaration, in 1976, nonetheless legitimated the broad outlines of policy action. A consequence of the weak coordinating role of the NPCC is that each "multi-sectoral" scheme is administered by a separate ministry. In theory, these efforts created a multi-sectoral program, but from the perspective of Bangladeshi villagers, little about this program was likely to be perceived as a package, since activities were parcelled out to eight different ministries, each with serious implementation problems of their own.
- *Weak research and evaluation.* Despite difficulties in achieving coordination, there have been several First Project pilot efforts of sectoral ministries that may have had some impact, although evidence of this is anecdotal. There has been little systematic accumulation of knowledge about what works and what does not.
- *Premature expansion.* Pilots involving community development, women's cooperatives, mothers' clubs, and vocational training programs were specified in the First Plan and were expanded over subsequent plans with funding from the Bank. Scaling-up was considered desirable because multi-sectoral activities generated political support for the program in several ministries. Whether the approaches used were sufficiently efficient or effective to justify their institutionalization was never seriously appraised.
- *Operational optimism.* Beginning with the First Project, there has been a tendency for appraisals and project agreements to overestimate the capacity of the GOB to implement stated operational goals. According to the First Project audit, implementation was delayed considerably, even for components as straightforward as construction:

1. "Disbursements lagged substantially behind schedule, and by December, 1979, the first closing date, only 35 percent of the total amount had been disbursed. The total amount was disbursed three and one half years later. Start up project activities were delayed by over a year by delays in declaring the credit effective, and further delayed in formalizing donor commitments. The construction component was further delayed due to technical, organizational, procedural, and contractual problems. Once completed, many difficulties were encountered in making the facilities operational, largely due to design and quality control deficiencies. Nearly all the sites visited by the audit mission required major repairs and maintenance, while much of the equipment provided under the project was either not installed or not functional at the time." (World Bank, 1986)
2. Difficulties of the First Project reflect a pattern of project execution. Ambitious goals are set, implementation lags, problem- solving follows, and remedial steps are undertaken that eventually move the program forward.
3. Operational optimism derives, in part, from the tendency of the Bangladesh Government to set unrealistic demographic objectives and assume implementation capacity is adequate to achieve them. A series of such targeting exercises has been undertaken, each in turn providing guidelines for a forthcoming plan and responding to the failure of previous targets to achieve stated aims. Demographic goals are converted into contraceptive use targets, under an assumed method mix.[51] This target is compared to current prevalence, and objectives are developed for the national program and divided by cadre so that each individual worker has a monthly performance goal for new acceptors of various contraceptive methods. This scheme for converting

49. The NPC has been renamed the National Population Control Council (NPCC).

50. Analysts of the role of multisectoral programs note that it is difficult to make any definitive statement about their impact (Duza et al. 1989). Some evaluation studies show that prevalence in special project areas is higher than national level prevalence rates, but since comparison areas are lacking, and areal variance in prevalence is pronounced, no conclusion can be reached regarding the efficacy of various schemes. The role of multisectoral programs nonetheless enhances the standing of the MOHFP vis a vis the ministries that it funds to carry out these activities. Even though the MOHFP has little coordinating authority to exercise over this activity, it strongly supports the multisectoral components of the program.

51. See procedures proposed by Bongaarts and Stover (1986).

demographic objectives into task objectives has been associated with serious dysfunctions:

First, national-level demographic targets are unrealistic. The First Five-year Plan specified cautious demographic targets, but when their implications for future growth was cause for alarm, they were revised in 1976. Working from the premise that sustaining population growth below the level of 120 million in the year 2000 was a matter of economic necessity, it was concluded that replacement fertility was required by 1985, implying a decline in the crude birth rate from 40 to 17 in nine years—an unprecedented change in reproductive behavior with no empirical justification. Successive plans have noted the "failure" of the previous plan, and a new set of ambitious and unattainable goals. While targets have been revised, operational implications are not thoroughly examined.[52]

Second, performance targets for workers are inflexible and unrealistic. If prevalence in a locality is low, targets can be readily met. As prevalence increases, however, meeting fixed targets is increasingly difficult. The introduction of new, reversible-method programs is often resisted, because workers believe that successful introduction of methods other than sterilization will undermine opportunities to meet sterilization targets. Rather than motivating workers, targets are detrimental to morale.

Third, targets lead to inappropriate emphasis on methods rather than client needs. In an ideal program, couples select methods from a range of available options. Targets can lead to efforts to recruit acceptors of particular methods rather than to care for their clients' more general contraceptive needs. This may have led to undue emphasis on sterilization, and a neglect of spacing as an element in contraceptive care.

- *Operational leadership.* The Bank was the first major donor to assist the Bangladesh program. A pattern of leadership and assertiveness was established in the First Project that continues to date. Procedures were developed for contracting the construction of clinics, supplying clinics with equipment and drugs, training workers, setting goals, and monitoring performance. Basic subsystems developed in the First Project continue to the present. Numerous other examples of operational developments can be cited, each supported by the resident mission or Bank consultants to the project. Most important among the various new initiatives were commitments to establish service outreach and hire women to provide village services aimed at increasing program coverage.

A focus on the periphery.[53] The First Plan established a pattern for activities at the periphery that is still being developed. The "union" is the primary level of government in Bangladesh, typically comprising from 15 to 20 villages and a population of 20-25,000. A key component of the First Plan was a pilot of the construction of union-level clinics for basic maternal and child health services. Each team of field workers is led by a male supervisor at the union level. Until 1985, each supervisor had three female outreach workers for village outreach activities.[54] Clinics are staffed by a male medical assistant and a female paramedic, responsible for health and family planning, respectively.

The Second Five-year Plan proposed little in the population sector that was fundamentally new. Rather, the Bank's Second Project aimed to consolidate progress, expand program coverage, and sustain key initiatives of the First Project—the construction of health and training facilities, the training of technical staff, and the expansion and refinement of communication activities.

Despite its rather modest operational goals, the Second Plan called for an astonishingly ambitious target of replacement fertility in five years. Targets were revised again in 1982, setting a pattern that continues: an order is issued declaring an ambitious target, followed by a new order revising it when evidence indicates that it cannot be attained.

In the course of the First and Second Five-year Plans, there were five reorganization orders addressed to implementing integration. All were met with opposition from the staff of the health ministry. None of them addressed the fundamental problems of a bifurcated structure, and disintegration was institutionalized in the process.

The Bank's Second Project continued to support salaries and software components of the program, and greatly expanded the construction program for rural clinics. The total budget was US$110 million, of which construction was roughly half of the estimated cost. Of the US$10 million, US$32 million was financed by IDA, and the remainder was co-financed. Since the IDA funding was structured as the resource of last resort—to be used only if grant funds could not be absorbed — the Bank's primary role in Bangladesh Project II was to administer foreign aid for the consortium.

The Third Plan represented a further expansion of the initiatives launched during the previous decade. It called for a near-doubling of female village workers and continued construction programs of previous plans. Targets were revised again, to reflect the goal of replacement fertility by the year 2000.

52. See Khuda and Howlader 1985.

53. The need for this focus has been reviewed by Heaver (1988).

54. Unfortunately, this design has separated field teams from the clinical program. Current plans call for expanding the paramedical team, and assigning field supervisory duties to them. In the Third Plan, nearly 10,000 additional female village workers were hired, increasing the union level field staff to 5 per supervisor.

In response to concerns about the state of child health, new goals were spelled out for maternal and child health activities. Female outreach workers, previously restricted to family planning duties, were given duties in disease control, immunization, and ante-natal care. Apart from the added emphasis on health, there were initiatives designed to improve management and management information, NGO utilization, and research coordination.

Apart from these new components, the most salient feature of the Third Project was its emphasis on sustaining initiatives from the First and Second Projects. The total cost was US$213.8 million, of which US$78.0 million was IDA funding, US$21.8 GOB counterpart funding, and US$114.0 million was grant funding from Australia, Canada, Germany, the Netherlands, Norway, and the United Kingdom. In budgetary terms, each successive project doubled the budget of the preceding project.

The Current Program: The Fourth Five-year Plan and the Forthcoming Fourth Population Project

The Bangladesh program has been beset with operational deficiencies that are noted in numerous reports[55] and World Bank appraisals for the first three projects. The Third and Fourth Projects address key problems:

- *Bureaucratic triage.* A possible solution to the structural problems of the health ministry is simply to allow dysfunctional cadres to retire over time without replacement. In keeping with this strategy, retiring male field workers in the health division will be replaced with women who will be trained to provide both health and family planning care. As these new workers are phased in and the previous cadres retire, prospects for meaningful integration of family planning with primary health care will improve.
- *Improving training and continuing education.* In past projects, training has been limited to service providers, and until recently, mid-level administrators and political leaders were not provided with basic training. Efforts to improve training are incorporated in the Fourth Five-Year Plan. Management training continues to be weak, but systematic efforts to diagnose management problems and take corrective action are the focus of forthcoming training plans.
- *Expanding coverage and outreach.* Female outreach workers were first hired in the course of the First Project, and their numbers were increased from 13,500 to 23,500 in the Third Project. To further increase coverage, a new cadre of volunteer workers is proposed.
- *The coordination of non-governmental organizations.* Restrictions on the role of NGOs have been relaxed in recent years, and NGOs have rapidly proliferated. There is now a recognized need for mechanisms to coordinate public and private sector effort at the periphery, without stifling initiative or re-imposing operational constraints.
- *The pace of implementation.* The implementation of the program is weakened by operational deficiencies in its strategic planning system and management sub-systems for supervision, training, personnel management, logistics, and MIS. Performance targets continue to be unrealistic, inflexible, and dysfunctional. Rewards for achievement are lacking; sanctions for poor performance are rarely imposed.

Various initiatives are proposed in the Fourth Project to improve managerial capacities, both centrally and in the field. Most important among them are efforts to improve supervision and strengthen management information capabilities. Specifics are not yet developed, but mechanisms for field diagnosis of problems and communication of operational deficiencies to senior officers were initiated in the Third Project, and will be refined and developed in the Fourth.

The Elements of Program Success in Bangladesh

As yet, the precise mechanisms through which program activities translate into reproductive change are incompletely understood, but it seems likely that at least six of the elements of the Bangladesh strategy have been crucial to the success achieved to date:[56]

Communication

Owing to extensive publicity, program outreach, and mass communication, knowledge of contraception is virtually universal. Young women learn of contraception before marriage. Family planning is openly discussed in the public media, undermining traditional conservatism about inter-personal communication on this issue. According to survey research, about 6 percent of all married women had heard about contraception prior to the Pakistan Third Plan in the mid-1960s. By 1969, this had increased to 52 percent, although few women knew where to obtain services. By the end of the 1970s, 94.8 percent of all women knew of at least one method;[57] by 1983, 98.6 percent knew of at least one method.[58] Most women know about several modern methods, where to obtain them, and what costs are involved.

55. See for example, Duza et al. 1989.

56. See Robinson 1985.

57. National Institute of Population Research and Training, Government of Bangladesh 1981.

58. Mitra and Kamal 1985.

Outreach

A cadre of approximately 19,500 female workers has been hired, trained, and equipped to deliver family planning services to couples in their homes. To address the social isolation of village women, outreach workers are instructed to visit households and provide women with basic family planning services in their homes. Although problems have been noted with this outreach system,[59] survey responses suggest that 40 percent of all rural women are visited by female village workers at least once quarterly.[60] Contraceptive use correlates with distance from a worker's home to a client's home, with the frequency of encounters with workers, and with the range of services that workers can provide.[61] Various studies suggest efforts to make services accessible in Bangladesh are critically important to the impact of the program. Because of the social restrictions that *purdah* imposes on rural women, most women are not free to travel to fixed service points, even for primary health care. In the absence of outreach, demand for family planning can be substantial, and contraceptive use minimal, even if clinical services are readily available. For this reason, outreach has played a particularly crucial role in the Bangladesh family planning program.

Clinical Back-up

Maternal and child health clinics now blanket the country and serve as primary care facilities for intrauterine device insertion, side effects treatment, and basic family planning ancillary health care. Basic ambulatory services are also offered. Staffed by a female paramedic and a medical assistant, clinics are now located in 2,716 of the 4,325 unions[62] in Bangladesh. If the conservation goals of the Fourth Population Project are met, more than half of all couples will live within five miles of a clinic by 1995. At each clinic, long-acting contraceptives are offered and ancillary health care is provided at no cost. Although there are extensive operational deficiencies of the clinical program, and considerable room for improvement in the quality of care,[63] there is little doubt that the clinical system has contributed to the increase in contraceptive use. Owing to the large number of clinics, even with low case loads averaging about 30 clients a day, the volume of care is substantial. By 1989, 2,716 of the 4,325 unions had clinics constructed and equipped to provide services. By the end of 1995, all unions will be equipped with MCH clinics.

Accessible Non-clinical Supply Sources

Nearly all pharmaceutical outlets in Bangladesh are supplied with low- cost, subsidized contraceptives. Contraceptives are widely advertised and conveniently available at low cost in every locality of Bangladesh. Recent decisions to encourage private voluntary agencies to expand services in rural areas have increased service accessibility. By 1989, about 40 percent of the couples practicing contraception in Bangladesh were using condoms and pills supplied through subsidized commercial sales (Mitra and Associates 1990). The success of subsidized commercial sales of contraceptives is due to the efforts of a privately-owned and USAID-subsidized "Social Marketing Project" (SMP). While not involved directly, the SMP has enjoyed full encouragement and support from the GOB for licensing, importation, and other legal needs. This collaborative effort of the GOB with the SMP is the most successful project of its kind in the world.

Surgical Contraception

Sterilization services are offered in every subdistrict hospital in Bangladesh by medical officers trained to provide vasectomies and tubectomies to clients free of charge.[64]

Ancillary Health Services

Efforts to extend child immunization services to rural households have been linked to family planning outreach activities. Successful health outreach services have contributed to the credibility of family planning. Clinical support for family planning is offered by paramedics who also provide basic maternal and child heath services. Much needs to be done to improve the quality of such services. Nonetheless, basic health care facilities for women and children are closely linked to the availability of family planning.

59. See BRAC 1990.

60. By 1983, about a third of the contraceptive pills and condoms in use were provided by outreach workers (Mitra and Kamal 1985). By 1989 the role of outreach had increased considerably: of the supplies that women discussed with interviewers, 42, 20, and 28 percent of the pills, injectables, and condoms currently used were provided by female outreach workers (Huq and Cleland 1990).

61. Assessment of social and programmatic determinants of areal variance in contraceptive use has shown that the quality and intensity of outreach is a key determinant of contraceptive use. (See Rahman 1984 and 1986; Phillips et al. 1986.)

62. A union is a unit of local government with an elected council serving a population of 20,000 to 30,000 people.

63. For example, regulations stipulate that paramedics reside in the clinics they serve —a regulation that is often broken owing to security concerns or supervisory lapses (Mahbud et al. 1990). There is considerable need to improve paramedical training and medical back-up, logistics support, and supervision (see BRAC 1990).

64. Field workers are given monthly targets for recruiting sterilization clients. Whether targets for specific methods are helpful or detrimental is the subject of considerable debate (see Huq and Ahmad 1989). There is little doubt, however, that priority is placed on long acting contraception.

NGO Services

Originally organized as a public sector program, the population program in Bangladesh is increasingly a collaborative effort involving NGOs. By 1990, 120 NGOs were involved in providing family planning services. Although estimates are undoubtedly subject to error, it is estimated that approximately 20 percent of all modern method users are supplied by NGOs.[65] The proliferation of NGOs, and services provided by them, has been facilitated by the decision to permit NGOs to provide services in rural areas, and to receive foreign aid funds for such activities.

Conclusion

It was against a background of considerable institutional weakness that the First Population Project was launched in Bangladesh. The economy was in disarray, disrupting operations in the civil service, and capacities to mobilize political support for the program at the periphery were weak. The most basic technical tasks to be performed by the new Bangladesh family planning program faced formidable organizational constraints—services were in demand by individual couples, but social support for contraception was weak at best. Implementing a service system was further impaired by weak administrative capacities in the public sector. Social and bureaucratic forces undermine mechanisms for insuring that something would actually be done to offer the services that national leaders were promoting.

In light of these constraints, it seems surprising, in retrospect, that the Bank would devise an ambitious and complex, multi-sectoral population project. Population Project I was an exceedingly high-risk venture, developed by a small group of planners in Dhaka and counterparts in Washington in a matter of a few months. The institutions supported in the project provided the terms of reference for all subsequent Bank assistance to Bangladesh in the population sector.

Even more surprising than the ambitiousness of the strategy pursued is the fact that it seems to have worked, despite severe societal and institutional constraints. The outreach component, in particular, has fulfilled a critical need. Clinical services are also important, however, particularly for sterilization and the IUD.

Despite considerable operational difficulty in implementing the Bangladesh projects, project size has been increasing rapidly—in part because the volume of services provided has been expanding, but in part because each new project sustains previous components as new commitments are added. A critical issue for the future will be the sustainability of co-financier participation, expansion of GOB funding, and cost recovery. Attention in the past has focused on the question of whether family planning can succeed in Bangladesh and strategies for implementing a large-scale program that reaches every town and hamlet. In the future, deliberations will shift to strategies for improving program efficiency and operational effectiveness.

65. USAID 1990. At present, USAID is the only donor assisting NGOs in family planning in Bangladesh.

5. *The Bangladesh Population Projects and the Bank's Institutional Style*

The GOB depends heavily on external assistance to its population program. Of the resources committed to the population sector in the 1975-80 period, 46 percent was foreign-financed. By the 1984-88 period, this had increased to 67 percent, a level of dependence that is likely to persist in the coming decade. The World Bank has been a major actor in this effort. Originally involved in global population programs in the early 1970s, the Bank's commitment to the Bangladesh population program commenced soon after negotiations were launched in 1972—a time when population lending was new to the Bank and an emerging priority issue.

Lending Mechanisms

The Bank's lending mechanisms, which were developed for large-scale loans for infrastructure, employ procedures and staffing patterns that are better-suited to hardware and capital-intensive lending programs than to software-intensive, grant-supported projects in population.[66] Nonetheless, mechanisms of the Bangladesh projects address key limitations of Bank procedures through collaboration with donors, and mechanisms that provide the Bangladesh Government and donors alike with key advantages.

Co-financing

Of the funds committed to Bangladesh projects, over 60 percent have been grant funds from Australia, Britain, Canada, Germany, Norway, and the Netherlands. Sweden participated in the First and Second Projects; Japan may join the Fourth. From its inception, this arrangement has posed administrative challenges related to the diversity of donor mechanisms, priorities, and commitments to be accommodated. Each co-financier, in turn, administers a bilateral aid program in Bangladesh, and some of this assistance is in the population and health sector. In addition to the co-financiers, USAID has a program in population and health, with annual budgets of approximately US$25 million. UNFPA also has a major program, although the level of assistance is somewhat less than the USAID commitment. Major support for child health programs is rendered by UNICEF. Although UNFPA and USAID are not formal parties to lending agreements, they participate in the project development and assessment process. ADB, WHO, and most small foundations active in the population field have projects or activities in Bangladesh. ADB in particular must liaise closely with the Bank because it has a program of lending for infrastructure in health that augments existing Bank programs. Not surprisingly, the diversity of donors with disparate interests and philosophies has posed diplomatic and administrative challenges for the Bank. At issue has been a dispute between donors over priorities for child health components of the Third Project. Structural problems in the MOHFW exacerbate such problems, because responding to external pressure faces fundamental operational obstacles.

The administrative mechanisms associated with co-financing are complex, involving accounts in Washington, revolving accounts in Dhaka, and mechanisms for monitoring the flow of resources from various sources to the

66. See for example, Crane and Finkle 1981; Wolfson 1983.

relevant sub-component of the project that a particular donor is funding. This machinery alone requires extensive administrative support, although staff costs required for administrative operations are covered by the short-term interest that accrues on funds awaiting disbursement. Apart from minor disruptions unrelated to the Bank, the administrative support of the consortium arrangement works remarkably well. In the view of some senior GOB officers, this administrative capacity of the Bank is vital to the program at its current stage of development. The role that has evolved for the Bank in the population sector is somewhat atypical of its role in other development sectors, as described below:

The Bank as a Coordinating Agency

The co-financing arrangement for the Bangladesh projects represents a critically-needed coordination mechanism. Although participating donors strongly support the Bangladesh program individually, serious inefficiencies would arise if each were separately negotiating bilateral projects with the GOB. It is clear that no alternative to the Bank's mechanism for donor coordination is acceptable to the GOB at this time. Senior GOB officers welcome the role of the Bank as a coordinator and view alternative mechanisms as unwieldy at best, and quite possibly, threatening to the resource needs of the program. The Bank, as a lending agency, is viewed less as a donor than as a collaborating agency. The notion that any donor could somehow replace the Bank as a coordinator of donors is unacceptable, since donor coordination could evolve into a mechanism for external direction and control of the program. This is a reasonable concern given the fact that nearly all resources for the program derive from external assistance. The Bank's style of relating to the GOB as a borrower makes its role as a donor coordinator acceptable as a neutral partner in decision-making. If the Bank did not exercise a coordinating role, some other less effective and less acceptable mechanism would emerge.

Initiative for Improving Donor Coordination

With the growing complexity of projects, there has been increasing attention to improving coordination.

Liaison in Dhaka. Project consultants and technical advisors are contributed to the project by co-financiers. Advisors develop a role within project subcomponents, but do not always have direct links to the RMB. At times, dialogue between RMB staff and GOB officers does not adequately address technical issues. Mechanisms have improved in recent years, however, owing to the increased frequency of technical meetings and exchanges. Advisors assigned to a project component typically have broader interest in policy issues, however, and welcome efforts from the Bank to keep them informed about the broad range of exchanges between the RMB and the Government. Useful and comprehensive *aides memoires* accompany each Bank mission to Dhaka, and these are now shared more widely than has been the case in the past. *Aides memoires* are also prepared for each meeting between the RMB staff and GOB officers, but circulation is apparently internal to the Bank. Without further encumbering communication tasks, there could be greater information sharing.[67] Such mechanisms should be viewed in the manner of fine tuning an arrangement that is already functioning, however. In the absence of the Bank and its consortium arrangements, communication among donors would be fragmentary at best.[68]

Liaison mechanisms of the Fourth Project. In the Fourth Project, innovative liaison mechanisms have been developed that have improved coordination, without the consortium as a pressure group. In addition to the regular exchanges that occur between GOB officers and the resident mission staff, there are donor consortium meetings in Dhaka involving resident cofinancier officers. The most important improvement in this process has involved Bank assistance to GOB-sponsored work conferences and planning sessions addressed to strategic planning and donor coordination. Building on these local working sessions, there have been meetings in Europe, sponsored by the Bank, and attended by representatives of the Government, the co-financiers, and the Bank. Bank-sponsored meetings involve information exchange on progress, plans, and coordination issues. All such mechanisms are in addition to the routine supervision and appraisal missions of the Bank, and most participants agree that this has improved the technical content of projects and collegiality among participating agencies.

Mechanisms for Enhancing Project Flexibility

Resident Mission Staff

The combination of the resident mission presence and the co-financier resources has given the Bank an element of flexibility in Bangladesh that it lacks elsewhere. The following examples of the role of the Bank in this context are instructive:

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67. Caution must be exercised, however, lest the sharing of information undermine the climate of trust and collegiality between the Bank and the GOB. A monthly liaison note, circulated for discussion, might improve donor communication.

68. Somewhat surprisingly, the home offices of donor agencies often fail to communicate decisions to their Dhaka counterparts. Lines of communication flow from Washington to various home offices of the cofinanciers, where the follow-up of information can sometimes stop. Similar mechanisms could be developed for dissemination of information in Dhaka.

The compensation controversy. The policy of compensating clients and referral agents for sterilization has always been controversial. Intended as a means of covering costs, payment of any kind could become an incentive. Although such disbursements were not funded by the Bank, publicity about ethical issues threatened European and North American donor commitment to the Bangladesh program. Although Government officers were aware of the controversy, they had no appraisal of the extent to which controversy threatened long-term donor relations. Using the "innovative project mechanism" and co-financier funding, a comprehensive study was commissioned that resolved major controversies and led to needed procedural change. The diplomatic role of the Bank staff was critical to this initiative: the diplomatic role of the RMB clarified the need for a study; liaison with the donor community from Washington translated political pressure on an emotional issue into an objective scientific inquiry; and the study results preserved the fabric of donor support and introduced appropriate changes in the program.[69]

The quality of surgical contraception. In the 1980s, a series of carefully-conducted studies showed that the rates of sterilization-related complications and deaths were unacceptably high. Responding to the urgent need to re-train surgical staff, revise procedures, and monitor change required recruitment of an expert team of surgeons, logistical support, and a sustained regimen of technical assistance. Because the Bank's staff could respond to these needs, technical improvements were instituted, and epidemiological surveillance was undertaken demonstrating a marked reduction in morbidity and the elimination of excess mortality.[70]

The health and family welfare centres. Convenient clinical referral points have been critical to family planning programs around the world. The First Population Project provided for pilot construction of rural clinics, but no mechanism for its expansion when the pilot succeeded and the need for clinics was demonstrated. In the course of the project, however, Bangladesh devalued its currency, creating a situation whereby agreements and priorities could be re-examined. Funds for the construction of 80 clinics were identified in the course of negotiations—funds that would otherwise have been lost to the project. Because resident staff in Dhaka were aware of needs and opportunities, and could undertake sustained negotiations, resources committed to the project could be efficiently utilized.

In numerous cases, conditions changed and initial project agreements were insufficient for emerging circumstances. Critically-needed shifts in construction programs, training, service quality, logistics, and other elements of the program were undertaken in the course of the first two projects. Where institutional capacities are weak, the role of resident technical support is critical.

A support team in Washington. Just as the resident mission presence has enabled the Bank to respond to changing needs, a project team in Washington has provided backstopping. In the view of senior officers in the GOB, the role of the Bank in coordinating the donor consortium has maintained a vitally-needed grant component of the project. Without the consortium providing grants, IDA funding could be controversial in the Finance Ministry and the scale of operations would have to be greatly reduced. The Bank's role in coordinating this arrangement depends upon a small team in Washington. In the view of some co-financier representatives, this team has sustained donor support for Bangladesh activities at times when funding could have lapsed.

Several examples can be cited of how critical events required donor liaison, consultants, or backstopping. Seemingly routine administrative operations have required support. In one such example, the flow of funds from Canada for salaries, commodities, and other critical components of the Third Project was interrupted by cash flow problems in Ottawa. However, accounts in Washington are managed so that advances paid by one donor can cover such cash flow needs. By agreement with the various donors concerned, resources continued to flow to Bangladesh without interruption.

The innovative projects fund and the role of research. While the first project contained a sizeable research component, many unanticipated needs and ideas for new approaches arose during implementation. This led program designers to search for a more flexible mechanism to provide finances for these purposes. The Innovative Projects Fund was the response. Funded by IDA and administered by a committee of Bangladeshi policymakers and population experts, in conjunction with IDA, it has been used to support — among other things — trials of innovative delivery systems, acceptability of new contraceptives, the evaluation of the effectiveness of a sterilization compensation scheme, and other innovative work of NGOs that held promise for the national program. It has recently also been used to fund part of the census.

In recent years, the fund has not always been fully utilized and some projects would have benefitted from more thorough preparation. Somewhat closer supervision could take care of this problem. It remains a very valuable tool for the program.

The contribution of co-financing to improving managerial capacities in the GOB. Key program management dysfunctions, we have said, derive from organizational traditions that are difficult to dislodge. Central among them is the ten-

69. See Cleland and Mauldin 1990 and the studies on which their assessment was based (Kamal et al. 1988; Khuda et al. 1988; Huq and Ahmad 1989).

70. See Khan and Mia 1984.

dency of senior administrative officers to issue directives without information on the operational implications of the order or feedback on its implementation. The Bank's Third Project incorporated a mechanism aimed at resolving internal communication problems in the MOHFW. The "Management Development Unit" is funded by co-financiers, but functions as a management consulting team reporting to senior officers of the Ministry. At the request of the GOB, its management support functions are being expanded in the Fourth Project.

Ultimately, the problems that the Bank faces in coordinating donors relate to problems that the Bangladesh Government must eventually solve, since donor consortium and coordination mechanisms are intrinsically GOB responsibilities. In recognition of this need, important mechanisms of the Fourth Project aim to develop GOB planning, donor coordination, and implementation capacities. At least one project cycle will be required before such mechanisms are fully developed, but most important among them is a Project Finance Cell responsible for monitoring the flow of resources and the disposition of accounts.[71] Improving accounting operations will address donor concerns about accountability to their governments for grant resources committed to the GOB through the Bank project mechanism. The relative advantage of joining the consortium versus administering projects relates directly to the capacity of the Bank to insure that implementation proceeds as planned and resources are committed efficiently.

Project Preparation Cycles

The long project planning cycle and the complexity of project components has led to various problems. Projects are enormously important to the program, setting in motion changes that can have major programmatic effects over a five-year period and obstructing opportunities for change in the interim. Once the process of project formulation begins, there is considerable pressure on the GOB to specify components. This can lead to resistance at the Bank to any change that would slow down the project cycle. Once an arrangement is reached, it is followed by five years of inflexibility in the GOB until the cycle is repeated. Given the complexity of the project and its co-financing, opening the process to participation of all donors and agencies can be fatal to closing an agreement. For this reason, projects have been developed in Washington and modified in the appraisal process. This essential procedural strategy is criticized because projects prepared in this fashion are removed from reality, over-designed, and impervious to change.

In the Fourth Project preparation, steps have been taken to resolve this problem by sponsoring work conferences, revising pre-appraisal drafts in response to conference outcomes, and vetoing preliminary plans to donors and the GOB well in advance of the formal Bank appraisal. Although this process has been labor-intensive, it has been characterized as a breakthrough in donor coordination, greatly strengthening GOB participation in project preparation and enhancing donor interest in funding project components.

A strength of the Bank operation in Bangladesh is the extent to which its representatives are viewed by GOB officers as trusted colleagues in the project development and implementation process. There is continuous and frequent dialogue between the RMB and MOHFW officers. Strong rapport and mutual trust between resident Bank officers and GOB counterparts has been critical to the preparation of the four population projects. Given the two-year project development cycle of the Bank and the complexity of the projects, close working relationships are essential. Any contentious issue, whether large or small, can retard the process of project development and jeopardize the flow of critically- needed resources. Bank officers are pressed to maintain the pace of project development, and GOB officers share their concern that lapses in the preparation of projects can produce major disruptions. Thus, there are powerful pressures on Bank staff and their GOB counterparts to work closely together as members of a common team. There is little doubt that this effective partnership has marshalled resources for the Bangladesh program that it would not otherwise command.

While this critically-important role of the Bank is acknowledged by co-financier representatives, the closeness of the collaboration is criticized by some as unbalanced and disproportionate to the actual diplomatic requirements of the project development task. Co-financiers feel excluded from this dialogue, and unaware of critical exchanges until it is too late in the project cycle to contribute substantively to what is going on. To the credit of the RMB, much has been done to improve donor communication. Meetings of the donor consortium are more frequent now than in past project development cycles. Nevertheless, while communi-

71. Much remains to be done in developing this unit. Basic modern management methods are yet to be developed, however, so that donors rely on the Bank rather than the Government for basic information on the disposition of resources. Spread sheets, computerized accounting MIS, and other management tools, so widely used in businesses in Bangladesh, should be instituted in the Project Finance Cell. Not only would this improve financial control and rates of disbursement, but the donor coordinating capacities of the GOB would be enhanced.

cation has undoubtedly improved, co-financier criticism of the Bank communication style in Dhaka persists.

The Continuing Operational Problems of Bank Projects

The Scale of Operations

Because of the demographic circumstances of Bangladesh and its recent history of war and calamity, its population program was viewed as an emergency action at the time of its creation. The language of crisis and the logic of impatience pervade the early planning literature of the Bangladesh program. Bank officers, in response to the Planning Commission requests, opted for a large, centrally-planned program. There was no blueprint for action in such situations—no success stories to build on, no consensus in the policy literature to guide strategic planning. Owing to the climate of crisis, there was pressure on the Bank to undertake something large and complex and to include nearly anything that could plausibly be argued to have potential. A multi-sectoral program was designed that was integrated with health and categorical family planning, both supply-oriented and demand generation-oriented, focused on hardware as well as software—as if no focus in fact was required because everything that was needed would be tried. There was remarkably little deliberation about what was unknown—how best to provide services, whether services under any conceivable scheme would work, how to structure tasks at the periphery, and how to organize a bureaucracy to ensure that tasks were actually implemented.

There was little deliberation, however, about what was unknown: about how best to provide services, whether services under any conceivable scheme would work, how to structure tasks at the periphery, and how to organize a bureaucracy to ensure that tasks were actually implemented. Nor was a well-articulated strategy adopted to overcome such knowledge gaps, for example, by starting small, scaling up, and revising plans on the basis of lessons learned. Such a cautious, phased-in approach had no constituency in Bangladesh and little in the Bank or amongst other donors. The style of project development and negotiation was simple: a few able and energetic senior staff from the Planning Commission interacted with a few like-minded colleagues from the Bank and developed a program to serve 64,000 villages. Donors were eager to contribute. The political chemistry was right for bold action. Trial, experimentation, phased development of focused initiatives—the elements of sound strategic planning—were not part of this chemistry. While more technical inputs and feedback from the field have gone into the designing of later projects, much in this culture of urgency remains. Project size has at least doubled every five years, constantly threatening to overwhelm implementation capacity, with little thought being given to internal efficiency or long-run financial sustainability.

Operational Mechanisms

Apart from the scale issue, there are continuing criticisms of Bank mechanisms and suggestions for operational improvements.

Technical leadership. The recent reorganization of the Bank reduced the concentration of population expertise in the Population, Health and Nutrition Division and increased the technical population staff in operating divisions. Reorganization had no effect on resident mission staffing, and has not contributed needed additional staff expertise to population and health project planning for Bangladesh. In the view of some external observers, reorganization may have even weakened technical support for the population projects somewhat. What is needed, in this view, is a team of officers such as the present support team for Bangladesh, who are knowledgeable about population issues and programs and available to work full-time on the project, dealing with administrative problems that inevitably arise in coordinating a large and complex undertaking in a weak institutional setting. Demographic research expertise is a less pressing need than the program monitoring and supervising roles of administrators with expertise in population project management. When specific demographic analyses are required, it is important to have technical staff to turn to, but these skills are best acquired from a research team that is specialized substantively in population studies rather than regionally specialized in operational units. But it had no effect on resident mission staffing or the Bank's contribution to planning of population and health projects at the technical level. In addition to the team of officers working on administrative problems and overall planning—absolutely necessary in this weak institutional setting—more technical inputs, best acquired from a research team specializing on this country rather than being regionally oriented, would have been very useful.

The greatest need is for expertise that can help resolve strategic planning issues in Bangladesh, reviewing the relative merits of competing options for improving program performance, and guiding the design of a project based on what has worked or not worked in previous projects. Dealing with complex issues in interagency coordination requires close collaboration with institutions affected and a continuous presence in Dhaka. For reorganization to make a difference to population lending, resources would need to be committed to fielding a larger operations staff, including administrative and technical assistance personnel. Technical assistance, pilot testing, and feasibility research would need to be expanded. As things stand now, field staff is

bogged down with administrative tasks and has little time for technical issues of strategic planning. Such issues are addressed by other donors and their consultants,[72] but few of the co-financiers believe this is an adequate substitute for Bank inputs.

The role of co-financed advisory support. When institutional support to a large and complex program is an issue, a technical assistance approach is required. This in turn requires a resident team of experts—something co-financiers are providing through their bilateral aid programs. As the number of technical staff grows, and their cohesion as a group grows, they have become critical of the Bank for doing less than they believe is needed to provide coordination and leadership in articulating problems as they see them to the GOB and seeking satisfactory resolutions.[73] Advisors typically have an office in their counterpart institution, but maintain close links with their respective embassies and donor representatives. Their technical contribution is much needed, but their link to the mechanisms of the Bank's projects could be strengthened. There is need for improved technical coordination among advisors, possibly involving contiguous office space at the RMB or at least a framework for technical meetings and exchange. Informal exchanges that occur between advisors and the RMB could be structured into a more formal mechanism for technical backstopping. This would obviate the need for increasing Bank staff while creating greater cohesion between co-financier advisors and RMB. To avoid the potential pitfall of creating an isolated pressure group, liaison mechanisms should include GOB technical counterparts.[74]

Costs and efficiency. Even more fundamental problems for the consortium mechanism may emerge in the coming decade. With the dramatic increase in the size of successive project budgets, there is growing concern that the Bank's approach is tantamount to an uncritical underwriting of the Bangladesh public sector. Just as there is a need to scale up what works, there is a need to phase out what does not. Evidence that workers are not performing or that clinics are underutilized is a growing source of concern. Even the success of the program is, in some sense, a source of concern. The successful expansion of services has accelerated the cost of commodities, drugs, and other recurring costs.[75]

The role of research in strategic planning. Until recently, the role of research in strategic planning has been informal, and much of what researchers do has had little effect on the design of five-year plans or Bank projects. Informal effects derive from the impact of small-scale studies on official opinion of what works. In recognition of the need to enhance the role of research, recent work seminars focus on policy planning and research issues simultaneously. The Fourth Project incorporates mechanisms for translating research into action and formalizes innovations of the Third Project.[76]

Research activities and findings are nonetheless diffuse and difficult to digest. Although problem-solving studies are extremely useful, linking decision-making mechanisms to experimental studies might contribute the Appraisal Process for the Fifth Project.[77]

This would involve:

- confronting each project with a set of critical operations to be resolved (implementing integration, improving supervision, coordinating outreach with NGOs, improving service quality, etc.);
- designating a district where these problems are to be resolved, tested, and researched;
- requiring that each project prepare Fifth Five-year Plan recommendations in time for the appraisal;
- allowing each project to work with separate resources and institutions; but
- specifying a coordination and steering committee mechanism.

A common framework, developed in this fashion, would greatly facilitate the utilization of research by creating a family of studies dealing with common and difficult-to-resolve systemic issues.

72. USAID, for example, has a staff of 20 and a sizeable budget for consultants for a much smaller and more focused project.

73. The contrasting institutional roles of lending and donor agencies may account for some of this criticism. Because lending involves resources that are owned by the borrower, accountability for the pace of implementation is less strictly enforced by Bank officers than is the case for grant officers awarding foreign aid (See, for example, Wolfson, 1983; Crane and Finkle, 1981). Cofinancing involves the diplomatically challenging task of merging project monitoring organizational cultures of the Bank and the cofinanciers. Perhaps reflecting the complexity of this task, representatives from the resident missions of cofinanciers express concern that they cannot account to their home offices for the state of implementation of project components that they are paying for, and cannot count on the RMB to press the GOB to implement activities on schedule.

74. At present, liaison involves RMB staff and senior officers who simply do not have time for more meetings of the sort proposed. A technical counterpart is a high ranking officer involved in implementation of a project component. These are formally designated directors of subcomponents of the Project.

75. The Fourth Project calls for studies of cost recovery for the first time, plus increased participation of the GOB in covering recurring costs from the revenue budget.

76. See for example, MOHFP 1989a and 1989b. These reports and proceedings of work conferences illustrate the increasingly sophisticated participation and planning role of the MOHFP in Bank projects. (Duza 1990a and 1990b.) See also, case studies by Yunus et al. 1984; and Koblinsky et al. 1989, addressed to the need to translate research into strategies for the Third Project.

77. These include the German Technical Cooperation Project in Munshiganj Division, projects of the International Centre for Diarrhoeal Disease Research in Matlab, the MCH-FP Extension Project, special studies of the Bangladesh Rural Action Committee, the Pathfinder Fund, and possibly others.

Prospects for Replicating the Bangladesh Approach in Other Population Projects

The flexibility that derives from co-financing has led to extensive staff inputs and adaptive planning. Numerous examples of crises could be cited that could have threatened Bank population projects. Staffing and flexible funding arrangements permitted Bank officers in the field and in Washington to deal with problems in ways that sustained implementation and improved project performance. Such problems are not unique to Bangladesh. Success in many countries where lending is under consideration will depend upon intensive staff inputs, creative financing arrangements, and extensive institutional development.

At present, a Bank officer responding to the need for technical support, donor liaison, or adaptive project planning and implementation will find little institutional support from the Bank itself for these activities. Incentives, as defined by routine performance evaluation criteria, encourage staff to minimize supervisory inputs, to de-emphasize liaison, and to structure agreements so that little administrative support will be required for their effective execution. Effectiveness of a loan, in turn, is judged more by the volume of lending and gross indicators of impact than by evidence that institutional capacities are being developed. That things were somewhat different in the Bangladesh program is a tribute to the specific task managers involved and to donors willing to provide grant funds for the purpose. Short of a very substantial change in the Bank's operational culture, these two conditions would have to be met in other countries to generate similar results.

6. Conclusions and Recommendations

Developing and expanding family planning services has been the principal thrust of the Bank's support to the population program in Bangladesh. Despite considerable initial controversy about the wisdom of supply-side priorities in such settings, there is now clear evidence that the program has worked. Much needs to be done to clarify the role of programs and policies vis-à-vis the role of societal and economic trends, but there is strong evidence from special projects to suggest that contraceptive services are critical to crystallizing and sustaining the modernization of reproductive behavior in Bangladesh. Prevalence has been increasing, particularly for sterilization, and fertility has begun to decline. This suggests that the overall approach to population assistance that has been used in Bangladesh, emphasizing supply-side strategies, is sound and merits consideration even in settings where social and economic conditions are unfavorable to family planning programs.

Developing a successful supply-side strategy is a complex undertaking, particularly in settings where family planning is neither widely practiced nor obviously in demand. In such settings, there is considerable risk of strategic error. Starting initiatives on a small scale, learning from success, and scaling-up reduces the risk of failure. Large-scale central planning, so endemic to Bank initiatives in this sector, can underwrite premature bureaucracies and institutionalize the elements of failure. While much about the Bangladesh program can be characterized as a success, dysfunctional elements have been externally funded that are now extremely difficult to disband.

Where programs are new, early projects define the terms of reference for all projects that follow. Bureaucratic machinery is subject to formal rules and procedures that the Bank and other donors cannot change. Because of the bureaucratic momentum that a first project establishes, there should be special mechanisms associated with them—particularly, if the Bank is planning a lead role in establishing a program, as it did in the case of Bangladesh. First projects in population should have an unusually intensive staffing commitment for the project preparation period. Consideration should be given to establishing mechanisms for pre-project technical assistance and pilot studies, not governed by the Bank's project cycle, but instead designed to inform the project planning process. First projects should be small, with an emphasis on phasing in regions or activities, in ways that inform the generation of subsequent projects. First projects should have high supervision ratios, and a strong emphasis on donor coordination. Since *lending* is not required for preliminary pilot activities, first projects should be financed largely, if not entirely, by grants. Loan components should be small and software-oriented.

The Bank has been a major factor in the development of the Bangladesh program. As the largest single donor and leader of the consortium, its missions and resident staff continue to exert major influence over operational policies and programs of other donors. This role is welcomed by GOB officials, who view the Bank's role as indispensable in mobilizing resources, providing smaller donors with a method of participating, and reducing administrative pressures on them.

The decision to post resident staff to Dhaka has been critical to the success of the Bank's efforts in Bangladesh. In comparison to other sectors, or to Bank population projects elsewhere, staff time assigned to the Bangladesh projects is unusually high. In the view of donors and GOB officers, however, this arrangement has been crucial to marshalling the resources that were required to develop the program.

In retrospect, decisions to develop a large, multi-sectoral program in the First Population Project were premature. In the absence of capacities to coordinate such a program centrally, or mechanisms to implement complex programs at the village level, the First Project should have been more focused with subsequent projects designed to scale up or phase in what was learned at earlier stages. Consideration could still be given to targeting the development of the

Fifth Project in one or two focal districts as a component of the Fourth Project. When bureaucratic capacities are weak, a phased-in approach is probably more workable than the project planning and implementation approach of the Bank.

While much has been done to improve mechanisms for project planning, there is continuing criticism of the Bank's tendency to centrally plan activities for large bureaucracies before there is adequate knowledge about what works and how to implement it. The dysfunctional structure and staffing pattern of the MOHFW that was created in the First Population Project continues to absorb considerable resources in the forthcoming project. Changes that are suggested by field research could improve efficiency and performance, but much of what is needed is neither politically nor operationally feasible.

There is a need for mechanisms that are external to project and lending cycles. Population assistance is needed most in doubly constrained settings such as Bangladesh; where societal constraints hamper demand for contraception and institutional constraints limit capacities to organize effective systems of supply. Much has been learned in the Bangladesh case that should guide lending in such situations:

- Pilots should be external to the lending cycle, but targeted on preparing the material for an initial appraisal mission.
- Developing a program in constrained settings involves heavy Bank staff inputs. Where institutional capacities are weak, flexibility and leadership is required. The past success in Bangladesh relates directly to heavy Bank staff inputs and dynamic leadership on the ground.
- Flexibility is critical to success. There are numerous examples of how Bank officers, working in Dhaka and in Washington with flexible resources and mechanisms, solved major problems that would otherwise have jeopardized project performance.
- A coordinated consortium approach can be useful to all parties concerned. Operational advantages of the Bank are combined with advantages of bilateral aid. Where there is a need for population assistance, combined with a limited capacity to develop a project, and an interest in Bank funding, consideration should be given to mechanisms for forming a consortium even before lending begins. In such settings, grants would initiate activity on a pilot basis, fund resident advisory assistance, and create a framework for an assessment mission. This arrangement would recognize the comparative advantages of different donor mechanisms at different stages in a program's development. Initial efforts should focus on small-scale trials and grants rather than loans. Institutionalizing a program should involve gradual scaling up, using pilot projects to identify components for IDA lending. Established Bank lending procedures and project cycles would be invoked after a project was developed and tested.

The Bangladesh program, and the Bank's contribution to this effort, have long been the subject of considerable discussion and debate. Much has been said about how conditions constrain demand for contraception and how institutional weaknesses constrain efforts to develop systems for the effective supply of family planning services. Criticism and skepticism about the role of the program in Bangladesh can now be confronted with the demographic reality that fertility has begun to decline. For all of its complexity and difficulties, the Bank's efforts in Bangladesh must now be labeled a success. Mitigating against this success has been the tendency of projects to go to scale before strategic planning is complete and operational implications are resolved. But outweighing these limitations, and contributing significantly to success, are a set of mechanisms providing the Bank and the GOB expertise, flexibility, and leadership that have extended the role of the Bank beyond its traditional focus on lending into the domains of donor coordination and institutional development.

Table 1: Bangladesh World Bank Population and Family Health Project, Appraisal Budgets, by Component and Financing Source, 1975–94

Component	*Population Project I*				*Population Project II*				*Population Project III*				*Population Project IV*[d]				
	IDA Loan	*Cofinanced Grants*	*GOB Counterpart Funds*	*Total*	*IDA Loan*	*Cofinanced Grants*	*GOB Counterpart Funds*	*Total*	*IDA Loan*	*Cofinanced Grants*	*GOB Counterpart Funds*	*Total*	*IDA Loan*	*Cofinanced Grants*	*GOB Counterpart Funds*	*Total*	*Total*
Civil works	4.18	7.27	2.37	13.82	18.60	24.62	3.14	46.36	41.15	0.00	3.32	45.07	64.2	19.7	8.2	92.1	197.35
(percent)	(27.8)	(28.6)	(44.6)	(30.2)	(58.1)	(36.7)	(28.5)	(41.1)	(52.8)	(0.0)	(10.8)	(21.1)	(35.7)	(7.7)	(5.0)	(15.4)	(20.35)
Equipment/ Supplies	6.64	3.35	0.21	6.20	5.50	7.82	3.30	16.62	31.26	23.03	5.58	59.87	26.8	17.8	15.1	59.7	142.39
(percent)	(17.6)	(13.2)	(3.9)	(13.6)	(17.2)	(11.7)	(30.0)	(15.1)	(40.1)	(23.2)	(15.3)	(28.0)	(14.9)	(7.0)	(9.2)	(10.0)	(14.69)
Training	0.43	0.27	0.00	0.70	0.10	1.78	0.37	2.25	0.58	18.55	1.02	20.15	37.7	40.4	1.5	79.6	102.70
(percent)	(2.9)	(1.1)	(0.0)	(1.5)	(0.3)	(2.7)	(3.4)	(2.0)	(0.7)	(18.7)	(2.8)	(9.4)	(20.9)	(15.8)	(0.9)	(13.3)	(10.59)
Salaries[a]	1.83	5.52	0.02	7.37	0.73	21.05	2.50	24.28	0.00	35.86	15.71	51.57	5.5	32.3	134.1	171.9	255.12
(percent)	(12.2)	(21.7)	(0.4)	(16.1)	(2.3)	(31.4)	(22.7)	(22.1)	(0.0)	(36.1)	(43.1)	(24.1)	(3.1)	(12.7)	(81.3)	(28.7)	(26.31)
Special Activities[b]	0.30	0.05	0.00	0.35	1.46	0.54	0.00	2.00	5.01	21.96	10.22	37.19	45.8	144.8	6.1	196.7	236.24
(percent)	(2.0)	(0.2)	(0.0)	(0.8)	(4.6)	(0.8)	(0.0)	(1.8)	(6.4)	(22.1)	(28.0)	(17.4)	(25.4)	(56.8)	(3.7)	(32.8)	(24.36)
Unallocated[c]	5.62	8.93	2.72	17.27	5.6	11.20	1.69	18.49	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	35.76
(percent)	(37.5)	(35.2)	(51.1)	(37.8)	(17.3)	(16.7)	(15.4)	(16.8)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(3.7)
Total	15.00	25.39	5.32	45.71	31.99	67.01	11.00	110.00	78.00	99.40	36.45	213.85	180.0	255.0	165.0	600.00	969.56
(percent)	(100.0)	(100.0)	(100.0)	(100.0)	(100.0)	(100.0)	(100.0)	(100.0)	(100.0)	(100.0)	(100.0)	(100.0)	(100.0)	(100.0)	(100.0)	(100.0)	(100.0)
Percent of Total	(32.81)	(55.55)	(11.64)	(100.0)	(29.08)	(60.92)	(10.0)	(100.0)	(36.47)	(46.48)	(17.05)	(100.0)	(30.0)	(42.5)	(27.5)	(100.0)	

a. Public sector salaries and related operating costs.
b. Research, innovative activities, and special NGO projects (including salaries).
c. Physical and price contingencies unallocated at appraisal, but consigned to specific components during implementation.
d. Budget at preappraisal (subject to modification).

Table 2: Estimates of the Proximate Determinants of Fertility in the Bangladesh Fertility Surveys of 1975 and 1989

Fertility Component		*Survey Year*	
		1975[a]	*1989*[b]
Total Fecundity (TF)		15.3	15.3
Contraceptive Prevalanece (u)		7.7	31.4
Contraceptive Effectiveness (e)		0.779	0.849
Lactational Infecundity (i)		17.5	16.6[c]
Bongaarts indices:			
Marriage	$[C]_m$	0.92	0.86
Abortion	$[C]_a$	0.93[d]	0.93[d]
Postpartum Infecundity	$[C]_i$	0.56	0.57[c]
Contraception	$[C]_c$	0.93	0.71
Total Fertility Rate (TFR)		6.7	4.9

a. Ministry of Health and Population Control Bangladesh Fertility Survey 1979; Kabir and Rob 1990
b. Huq and Cleland 1990.
c. Assuming estimated rather than observed durations of amenorrhea.
d. Indirect estimate based on 1975 Bangladesh Fertility Survey data.

References

Alauddin, Md. and Y. Khan 1983. "A Study of Five NGOs in Population Activities in Bangladesh," University of Dhaka, Institute of Social Welfare and Research, Dhaka (mimeographed).

Arthur, B.and G. McNicoll 1978. "An Analytical Survey of Population and Development in Bangladesh." *Population and Development Review* 4(1): 23-80.

Bangladesh, People's Republic of. 1972. "Proceedings of the National Seminar on Family Planning," Ministry of Health and Population Control, Dhaka.

———. 1979. *Bangladesh Fertility Survey: First Country Report - 1978, World Fertility Survey.* Ministry of Health and Population Control, Dhaka.

———. 1985. Government budget documents. External Resources Division, Ministry of Finance. Dhaka (unpublished).

———. 1989a. *Status Report on Bangladesh Third Population and Health Project.* Ministry of Health and Family Welfare, Planning Section, Family Planning Wing, Management Information Unit, Dhaka (unpublished).

———. 1989b. *Proposed Programme for the Health and Family Planning Sector in the Fourth Five Year Plan, 1990-95.* Ministry of Health and Family Welfare, Dhaka.

Bangladesh, Rural Advancement Committee. 1983. *The Net: Power Structure in Ten Villages,* Dhaka: BRAC Printers

———. 1990. "A Tale of Two Wings: Health and Family Planning Programmes in an Upazilla in Northern Bangladesh," Research and Evaluation Division, Bangladesh Rural Advancement Committee, Dhaka (unpublished).

Bongaarts, J. 1978. "A Framework for Analyzing the Proximate Determinants of Fertility."*Population and Development Review* 4(1): 105-132.

——— and R. Potter. 1983. *Fertility, Biology, and Behavior: An Analysis of the Proximate Determinants.* New York: Academic Press.

——— and J. Stover. 1986. *The Population Council Target Setting Model: A User's Manual.* Working Paper No. 130. The Population Council, Center for Policy Studies, New York.

Cain, M. 1981. "Risk and Insurance: Perspectives on Fertility and Agrarian Change in Rural India and Bangladesh. "*Population and Development Review* 7(3): 435-474.

———. 1983. "Fertility as an Adjustment to Risk." *Population and Development Review* 9(4): 688-702.

———. 1986. "Risk and Fertility: Reply to Robinson." *Population Studies* 40(2): 299-304.

———. S. R. Khanam, and S. Nahar 1979. "Class, Patriarchy, and Women's Work in Bangladesh." *Population and Development Review* 5(3): 405-438.

Chang, M-C., R. Freedman, and T-H. Sun. 1987. "Trends in Fertility, Family Size Preferences, and Family Planning Practice: Taiwan, 1961-85," *Studies in Family Planning,* 18(6)1: 320-337.

Chauls, D., B. Ryder, and W. Zaman. 1984. "An Assessment of Management of the Bangladesh Population Program." Management Sciences for Health, Boston, Massachusetts (unpublished report, January 1984).

Choudhuri, S. R. and H. H. Akhter. 1990. "Supply Aspects of Meeting Demand for Family Planning." In M.B. Duza, ed., *South Asia Study of Population Policy and Programmes: Bangladesh.* United Nations Population Fund, Dhaka.

Chowdhury, A. M. R. and K. S. Huda. 1990. "Lessons from Successful Experiences," In M. B. Duza, ed., *South Asia Study of Population Policy and Programmes: Bangladesh.* United Nations Population Fund, Dhaka.

Cleland, J. and C. Wilson. 1987. "Demand Theories of the Fertility Transition: An Iconoclastic View." *Population Studies* 41(1): 5-30.

——— and W. P. Mauldin. 1990. *The Promotion of Family Planning by Financial Payments: The Case of Bangladesh,* Research Division Working Paper No. 13. The Population Council, New York.

Committee on Population and Demography. 1981. *Estimation of Recent Trends in Fertility and Mortality in Bangladesh,* National Academy of Sciences Report No. 5. Washington, D.C.: National Academy Press.

Crane, B. B. and J. L. Finkle. 1981. "Organizational Impediments to Development Assistance: The World Bank's Population Program." *World Politics,* 33(4): 516-553.

Demeny, P. 1975. "Observations on Population Policy and Population Program in Bangladesh." *Population and Development Review* 1(2): 307-322.

D'Souza, S. and L. Chen. 1980. "Sex Differentials in Mortality in Rural Bangladesh."*Population and Development Review* 6(2): 257-270.

Duza, M. B. 1985. "Fertility Regulation in Bangladesh: Policy Evolution and Execution,"Cairo Demographic Centre Working Paper No. 10. Cairo Demographic Centre, Cairo (unpublished).

———. 1990a. "Overview of Findings." In M.B. Duza, ed., *South Asia Study of Population Policy and Programmes: Bangladesh,* United Nations Population Fund, Dhaka.

———. 1990b. "Government of Bangladesh-Donor Pre-appraisal Workshop on the Fourth Health and Family Welfare Project, 1991-1995: Report on Key Issues and Recommendations Emerging from the Workshop." Ministry of Health and Family Welfare Dhaka (unpublished).

——— et al. 1989. "Family Planning Programme Performance in Bangladesh and Strategies for Improvement: Report of the Task Force," Ministry of Health and Family Welfare, Dhaka (unpublished).

Foster, G. M. 1967. "Peasant Society and the Image of Limited Good." In J.M. Potter, M. N. Diaz, and G. M. Foster, eds., *Peasant Society.* Boston: Little Brown, and Company.

Freedman, R. 1987. "The Contribution of Social Science Research to Population Policy and Family Planning Program Effectiveness." *Studies in Family Planning* 18(2): 57-82.

———, Siew-Ean Khoo, and B. Supraptilah. 1981. "Contraceptive Use in Indonesia: A Challenge to Conventional Wisdom."*International Family Planning Perspectives* 7(1):3-15.

Heaver, Richard, 1988. *Reaching People at the Periphery: Can the World Bank's Population, Health, and Nutrition Operations do Better?* Working Paper WPS81. Population and Human Resources Department, The World Bank, Washington, D.C.

Huffman, S. L., A. K. M. A. Chowdhury, J. Chakraborty, and N. K. Simpson. 1980. "Breastfeeding Patterns in Rural Bangladesh." *American Journal of Clinical Nutrition* 33: 144-154.

Huq, Md.Najmul and S. Ahmad. 1989. *Study of Compensation Payments and Family Planning in Bangladesh: A Synthesis.* National Institute of Population Research and Training, Dhaka.

Kabir, M. and A. K. Ubaidur Rob. 1990. "Fertility and its Proximate Determinants."In M.B. Duza, ed., *South Asia Study of Population Policy and Programmes: Bangladesh.* United Nations Population Fund, Dhaka.

Kamal, G. M., A. U. Ahmed, and M. Khan. 1988. *Clinic-based Survey of Sterilization Clients.* National Institute for Population Research and Training, Dhaka.

Karim, Md. A., M. A. Rashid, M. M. Abdullah, and S. Khatun. 1985. *A Study of the Status of Foreign Assistance to Bangladesh Population Control Programme, 1973-1982.* Population Control Wing, Planning Cell, Ministry of Health and Population Control, Government of the People's Republic of Bangladesh. Dhaka.

Khan, A. R. 1977. "Poverty and Landlessness in Rural Bangladesh." ILO Report No. 9, International Labour Organization, Geneva.

——— and A. Mia, eds., 1984. *Contraceptive Practice in Bangladesh: Safety Issues,* PIACT, Dhaka.

Khan, M. R. 1973. "Bangladesh Population During the First Five Year Plan, Period 1973-78: An Estimate."*The Bangladesh Economic Review* 1(2): 186-198.

Khuda, Barkat-e- and S. R. Howlader. 1985. "Population Policy under the Third Five Year Plan of Bangladesh: How Realistic?" Paper presented at the biennial conference of the Bangladesh Economics Association at Jahangirnagar University, Savar (December 17-20).

———, R. Hasan, and S. N. Mitra 1988. *Follow-up Survey of Tubectomy and Matched Cases,* National Institute for Population Research and Training, Dhaka.

Koblinsky, M. A., S. J. G. Brechin, S. D. Clark, and M. Y. Hasan. 1989. "Helping Managers to Manage: Work Schedules of Field Workers in Rural Bangladesh." *Studies in Family Planning* 20(4): 225-234.

Koenig, M. A., J. F. Phillips, and R. Simmons. 1987. "Family Size Preferences and Contraceptive Use in Matlab, Bangladesh: 1975-1984." *Studies in Family Planning* 18(3): 117-127.

——— and R. Simmons. 1989. "Constraints on Supply and Demand for Family Planning: Evidence from Rural Bangladesh." Paper presented at the IUSSP Seminar on the Role of Family Planning Programmes as a Fertility Determinant, Tunis.

Korten, David C. 1975. "Organization and Management of the Division of Population Control and Family Planning."The Ford Foundation, Dhaka (unpublished).

Mahbud, M. A., A. T. P. L. Abeykoon, A. K. M. Ahmed-ul-Ghani, A. Z. M. Mahbudur Rahman, and Md. Abdur Rab. 1990. "An Impact Evaluation of the Union Health and Family Welfare Centres." PDEU Report No. 54, Population Development and Evaluation Unit, Planning Commission, Government of the People's Republic of Bangladesh, Dhaka (unpublished).

Mauldin, W. P. 1990. "Summary Comments in the July 18-19, 1990 Workshop." South Asia, Study of Population Policies and Programmes, sponsored by UNFPA, (unpublished).

Menken, J. and J. F. Phillips. 1990. "Population Change in a Rural Area of Bangladesh: 1967-1987."*The Annals of the American Academy of Political and Social Science* 510: 87-101.

Mitra, S.N. 1986. "The Bangladesh Contraceptive Prevalence Survey, 1985: Preliminary Tabulations."Mitra and Associates, Dhaka (unpublished notes).

———. 1989. "The Bangladesh Contraceptive Prevalence Survey, 1989: Preliminary Results." Mitra and Associates, Dhaka.

——— and G. M. Kamal. 1985. *Bangladesh Contraceptive Prevalence Survey - 1983.* A final report submitted to the Ministry of Health and Population Control, People's Republic of Bangladesh. Mitra and Associates, Dhaka.

Nag, M. 1990. "Family Planning Success Stories in Bangladesh and India." Paper prepared for the World Bank on family planning program effectiveness. The Population Council, New York (preliminary draft, restricted).

——— and M. B. Duza. 1988. "High Contraceptive Prevalence in an Unfavorable Social Setting: A Qualitative Case Study in Matlab, Bangladesh." A report submitted to the Swedish Institute of Development Studies, New York, The Population Council, (unpublished).

National Institute of Population Research and Training. 1981. *Bangladesh Contraceptive Prevalence Survey - 1979.* Ministry of Health and Population Control, People's Republic of Bangladesh, Dhaka.

Phillips, J. F. 1987. "Translating Pilot Project Success into National Policy Development: Two Projects in Bangladesh." *Asia-Pacific Population Journal* 2(2): 3-28.

———, W. S. Stinson, S. Bhatia, M. Rahman, and J. Chakraborty. 1982. "The Demographic Impact of the Family Planning Health Services Project in Matlab, Bangladesh," *Studies in Family Planning,* 13(5): 131-140.

———, M. B. Hossain, R. Simmons, and M. A. Koenig. 1986. "Worker-Client Exchanges and the Dynamics of Contraceptive Use in Rural Bangladesh." Paper presented at the annual meeting of the Population Association of America, San Francisco.

———, R. Simmons, M. A. Koenig, and J. Chakraborty. 1988. "The Determinants of Reproductive Change in a Traditional Society: Evidence from Matlab, Bangladesh." *Studies in Family Planning* 19(6): 313-334.

P and M Consultants. 1977. "Management Study." Report of a group of consultants to the Ministry of Health and Population Control, People's Republic of Bangladesh. Dhaka (unpublished).

Rahman, M. 1984. "Determinants of Areal Variation in Contraceptive Practice in Bangladesh."A thesis presented for the degree of Doctor of Philosophy at the Research School of Social Sciences, The Australian National University, Canberra.

———. 1986. *Tradition, Development, and the Individual,* Asian Population Change Series No. 1. Australian National University, Department of Demography, Canberra.

———, W. H. Mosley, A. R. Khan, A. I. Chowdhury, and J. Chakraborty. 1980. "Contraceptive Distribution in Bangladesh: Some Lessons Learned." *Studies in Family Planning* 11: 191-201.

Robinson, W. 1985. "Some Reflections on Recent Attacks on the Population Programme in Bangladesh." Population Issues Research Center, Institute for Policy Research and Evaluation, The Pennsylvania State University, State College, Pennsylvania (unpublished).

———. 1986. "High Fertility as Risk Insurance." *Population Studies* 40(2): 289-298.

Sirageldin, I., M. Hossain, and M. Cain. 1975. "Family Planning in Bangladesh: An Empirical Investigation." *The Bangladesh Development Studies* 3(1): 15-24.

United Nations Economic and Social Commission for Asia and the Pacific. 1981. *Population of Bangladesh,* Country Monograph No. 8. Bangkok,

———. 1984. "Study of Levels and Trends of Fertility in Bangladesh Using the Census Data." Asian Population Studies Series No. 62-J, Bangkok.

United States Agency for International Development. 1990. *USAID Population and Health Assistance Briefing Paper.* Office of Health and Population, Dhaka.

Wolfson, M. 1983. *Profiles in Population Assistance: A Comparative Review of the Principal Donor Agencies,* OECD, Paris.

World Bank. 1975a. *The Population Program of the Government of Bangladesh: A Sector Review,* World Bank, Population and Nutrition Projects Department, Washington, D.C.

Yunus, M., J. F. Phillips, M. Koblinsky, and R. Simmons. 1984. "Strategies for Implementing Change in a Rural Health and Family Planning Programme in Bangladesh." Paper presented at the annual meeting of the National Council for International Health, Washington, D.C.

Annex 2
The World Bank and Indonesia's Population Program

Executive Summary

Introduction

In the 20 years since 1970, Indonesia's fertility rates have fallen by 40 percent, mainly as a result of the increasing use of contraception. The Indonesian family planning program (BKKBN) has been immediately responsible for the increasing use of contraception by providing information, contraceptive supplies, and services. It has legitimated the concept of family planning in the thinking of Indonesians through a remarkable, pervasive, community-based program. As one of the international donors that has given the program financial support and technical assistance, the World Bank has played a significant, although limited, role in these developments. Support by the Bank and other donors also has helped to legitimize the family planning program which has been somewhat controversial, especially in its earlier years. The Bank has also had an effect on population trends through its major support of Indonesia's broad-based development program.

Causes of Indonesia's Fertility Decline

Indonesia's total fertility rate declined from about 5.5 to 3.3 between 1967-70 and 1984-87. An increase in the age at marriage accounted for part of the decline, but the main cause was a substantial increase in the use of contraception by couples of childbearing age, from less than 10 percent in the 1960s to 48 percent by 1987. The other factors which potentially might have affected the decline—abortion, divorce, fecundity, delayed marriage-consummation, breastfeeding—appear in combination not to have had much effect on fertility.

Substantial social and economic change associated with Indonesia's considerable development contributed to the fertility decline in two important ways: (a) by decreasing the demand for children and increasing the demand for contraception and (b) by greatly improving the general national infrastructure which facilitated the work of the national family planning program. In this developmental context, the BKKBN helped to legitimize small planned families and provided the contraceptive supplies and services to make that possible. There is little doubt that both the favorable developmental trends and the effective family planning program contributed to the fertility decline, although this cannot be quantified.

Indonesia's Family Planning Program

The BKKBN has created a program which operates effectively at every level—the nation, the 27 provinces, the 301 districts, the subdistricts, and eventually at the village and hamlet level. Through this hierarchy, it has succeeded in reaching the mass of married couples in the several hundred thousand hamlets below the village level. BKKBN, formally a coordinating agency rather than a line agency, works through such such ministries as those for health, education, home affairs, information, rligion, and the armed services. However, BKKBN also has important implementation capacities which enable it to carry out directly some important activities and o test, expand, and hasten new initiatives. While many family planning programs espouse the goal of country-wide, community-based activities, Indonesia is one of only a few developing countries in which this is a reality.

The success of the family planning program is attributable to:

1. The continuing strong political support of President Suharto and, through him, of the whole political-administrative system.
2. An administrative structure which facilitates communication and mobilization of action at the grass-roots level for a wide range of development activities, including

family planning. This system is unusually effective for a developing country.

3. Stable and effective leadership. The charismatic chairman of the BKKBN and most of his principal deputies have been in leadership positions for more than 15 years.
4. Significant social and economic development, which has affected attitudes about marriage, family life, and reproduction; increased openness to new ideas; and created a transportation and communication infrastructure through which the program could function as it expanded throughout the Indonesian islands.
5. Considerable financial and technical support from international and bilateral donors. This support does not subvert indigenous Indonesian direction of the program, in part because the Indonesians themselves have paid an increasing share of program cost, reaching 70 percent by 1980. The BKKBN has been generally successful in gaining and coordinating donor assistance for its policies, in contrast to the domination by donor direction characteristic of some other countries. It has worked closely with donors in developing new initiatives.

The Contribution of the World Bank to Indonesia's Family Planning Program

The World Bank has contributed to the success of the program in a number of ways:

1. Through population-policy dialogues with top government leaders, to whom its broad lending program in other sectors has given it continuing access. Its general prestige, arising from support for the whole range of development activities, has given legitimation to the population sector.
2. Through loans for basic program infrastructure: buildings, equipment, and vehicles. Two-thirds of Bank loan money was for this purpose. This is regarded as the Bank's distinctive and principal contribution to program operations. The buildings provided the physical base for the program as it expanded throughout the islands. The Bank provided headquarters and supply warehouses, not only in Jakarta and the 27 provincial capitals, but also in the 301 district capitals. They also provided a network of important training facilities. As the major provider of vehicles, the Bank made possible the mobility essential for field services, supplies, training, IEC work, and administration.
3. Through specific operational program components: training, population education, a hospital post-partum program, research and evaluation, and information-education-communication (IEC). Most of these "software" components have made some contribution to the program, but these generally have not been of central importance to the program's success. While the Bank has given only limited support to routine field service operations, it did provide important initial support for salaries when field workers were first employed to extend the outreach of health clinics. The Bank generally has not played a leading role among donors in such software aspects of program operations.
4. Through support for Indonesia's general development effort. More indirect, but possibly as important as direct program support, has been the Bank's large-scale support (15 billion dollars in the last 20 years) for Indonesia's development efforts in education, health, transportation and communications, electrification, agriculture, and other support for the economy. Development in these other sectors is changing Indonesian society in ways which probably affect the population's interest in smaller families and family planning.

The distinctive characteristics of the Bank's population work in Indonesia has resulted in a *de facto* division of labor with such other donors as USAID, UNFPA, and UNICEF in support of the BKKBN. The Bank has specialized in providing essential "hardware" infrastructure: buildings and their furnishings, equipment, and vehicles. Two-thirds of the Bank loans have been for this purpose.

Even during the first project, when there was more emphasis than later on software and program operations, 53 percent of the credit went for buildings, vehicles, and equipment. Part of the explanation for the Bank's emphasis on hardware was that the Indonesians (like other borrowers) preferred grants rather than loans for software components. Loans were more acceptable for capital costs and other hardware.

Especially after the first few years, new ideas for the program operations generally were developed and tested by BKKBN in collaboration with donors other than the Bank. The Bank then sometimes provided the resources for large-scale extension of such already-tested program initiatives. It has been perceived as—and indeed was—the major provider of the physical infrastructure of the buildings and the vehicles needed for program activities as they expanded throughout the islands.

The fact that, in the software area, the Bank played the less glamorous role of complementary extension of the ideas developed by the BKKBN and other donors is not necessarily to the Bank's discredit. It can be seen as a realistic recognition of the most effective division of labor, given the local staff and *modus operandi* of the various organizations in Indonesia.

The program emphases of the Bank were determined in part by its operating style and experience. The components of the Bank's four five-year projects have been de-

veloped over a period of several years by missions recurrently visiting Indonesia. Because the projects are financed by loans rather than grants, their development always involves the planning agency (BAPPENAS) as well as the BKKBN. This further complicates project development and implementation.

Unlike the other major donors, the Bank has not had a significant resident field staff for population, except for limited periods. Traveling Bank missions from Washington, however qualified, could not have the knowledge of Indonesia or the personal day-to-day relations with BKKBN staff necessary for cooperatively developing and testing ideas in a very dynamic program. In contrast, USAID, in addition to a resident staff of three population officers, has had many resident expatriate and Indonesian consultants working day-to-day with the BKKBN in operations research and in other ways. The Bank has fielded such resident staff or consultants only in a very limited way.

Once developed, the Bank's project components have been difficult to change, largely because such decisions had to be referred to Washington. In addition, because the projects were financed as loans rather than grants, time-consuming approvals were required from the Indonesian government. By contrast, USAID reviewed and revised its program annually and had the capacity to authorize new expenditures locally on short notice.

In the "soft"aspects of social sectors, such as population and health, flexibility is necessary both to adjust projects to changing conditions and to seize opportunities to test new initiatives. The difficulty of programming such activities five years in advance is less relevant for hardware components. Further, the Bank has had successful experience with hardware components for many sectors and countries.

The Bank's undoubted capacity for analytical sector work was rarely applied to population in Indonesia during the Bank's early projects. Even when such reports were later done, they do not appear to have affected the design or implementation of the Bank's first four loan projects very much. In at least two instances in which Bank projects included potentially important operations research projects to test new ideas, the results were not very useful, in part because of inadequate collaboration with Indonesians in the initial design. However, two recent reports are highly relevant to programmatic needs and are likely to influence the fifth population loan, now being negotiated. One deals with the prospects for the program in the 1990s. The other is a much-needed economic analysis of the program.

The net result of the Bank's distinctive operating style has been that, for most of the past 20 years, it has been perceived by the Indonesians and other donors as well qualified to provide essential hardware infrastructure and to support the large-scale extension of ideas tested and developed by the BKKBN working with other donors. The Bank is not perceived as having provided intellectual leadership. Bank staff have not played an important role in helping the BKKBN to develop the major ideas guiding the program after the first few years. Such a view of the Bank's role in population is in sharp contrast to its acknowledged important intellectual leadership role in Indonesia's general development program and in macro-economic policy for Indonesia. The Bank has population staff capable of exercising such leadership, but, at least in Indonesia, the implicit or explicit choice was to let other donors who had competent resident staff lead the way in policy for software operations.

While the perceptions about the Bank's role in population appear to be generally correct, they do not give the Bank sufficient credit for its more limited but useful support of specific project components such as training, population education, and IEC activities. Indonesian officials cite as an example of unusual Bank "flexibility,"its support for field salaries of the newly recruited field workers when there was no other support for this crucial first extension of services away from limited fixed clinic sites.

The Bank staff was concerned about the management capability of the BKKBN, especially during its first decade. However, the third loan period Bank reports complimented the BKKBN on improved management and claimed some credit for it. Even then, however, the Bank was concerned about too frequent administrative reorganizations. BKKBN management no doubt has improved, and the Bank and other donors may have contributed to the improvement. However, the BKKBN deserves most of the credit for creating an indigenous management style and structure which has been effective for many years, as judged by its results in the field. As for reorganizations, these seem to have been necessary adjustments for a dynamic program, responding to new ideas and to the problems of extension to the outer islands.

The criticisms of BKKBN management generally turn out to refer to meeting dissonant administrative requirements of the Bank and other very bureaucratic Indonesian agencies. Criticisms have been less directed to management of the program in the field. For some time, the BKKBN has been generally regarded by both Indonesian and expatriate observers as considerably better managed than other Indonesian human resource agencies or than other family planning programs in the region.

The Bank's major contribution to the success of the general Indonesian development program was not designed to meet population policy objectives. However, it had this effect. The major social and economic changes associated with the development program are generally believed to lead to lower fertility. For example, there have been significant improvements in education, a sector in which the Bank has been active and one with recognized links to lower fertility. The Bank has had a much smaller role in the health

sector, in which Indonesia lags. The health system is important for population, because it is a major factor in the delivery of family planning services and because of its effect on reproductive motivation. The Bank might have done more in this sector, both from a welfare and a population perspective.

The Bank's Relation to Other Donors

The Bank's relations to the other donors were not very good for many years. When interviewed in the late 1970s, the other donors characterized visiting Bank missions as arrogant and poorly informed. A recurrent complaint was that Bank missions asked for information and reports but did not reciprocate. Happily, when interviewed in 1990, donor representatives unanimously reported a complete change to relationships of reciprocity and trust in recent years. Further, there was appreciation of joint or coordinated activity. Such coordinated activities may be of increasing importance as the financial needs of the program expand with growing numbers of both actual and potential contraceptive users.

A Larger Perspective

The contributions of both the primary actor, the BKKBN, and the supporting donors is best understood in larger perspective. The BKKBN is responsible for the supply aspects of most of the rise in contraceptive prevalence, which in turn accounts for most of the fertility decline. However, the BKKBN properly defines itself as an integral part of Indonesia's comprehensive development program. The substantial social and economic changes associated with that development program probably help to account for a substantial rise in age at marriage, which in turn accounts for perhaps 20-25 percent of the fertility decline. Beyond that, these social changes have helped to produce changes in family life and in reproductive values, which affect the demand for contraception and, thus, facilitate the work of the BKKBN. It does not denigrate the remarkable success of the BKKBN to put it in this broader context. Similarly, the role of the donors, including the Bank, is placed in proper perspective if it is described as facilitating but not directing the work of the distinctively Indonesian BKKBN.

In this broader perspective, the contribution of the World Bank has three aspects. First, the loans in the population sector have strengthened the program in specific ways, especially in providing buildings and vehicles, but much less so in software components. Secondly, the much larger portfolio of Bank loans for other development sectors has contributed to social changes, which tend to change the desired number of children and the demand for family planning services. Finally, the Bank's important role in Indonesia's general development program has increased its credibility in supporting the population program and in its continuing policy dialogue with the highest levels of Indonesian leadership.

While primary credit for achievements belongs to the Indonesians, the Bank and other donors have made significant contributions. Because of its operating style, the Bank's role in assisting program operations has been mainly in providing hardware and in implementing software projects developed by others. The division of labor between the Bank and other donors in the past was reasonable and worked rather well in terms of results. However, if the Bank is to play a larger role in software projects, it would need to change its style of work. The decision not to have a resident staff for most of the period probably has limited the scope and effectiveness of the Bank's contribution to the operational program.

Lessons

What might the Bank have done differently or better that could have increased its contribution to the population program?

- Especially in the first decade, a resident Bank presence in the population field might have speeded up implementation, made the Bank more flexible, and allowed it to contribute more to program development and software components.
- The Bank could have been more sensitive and cooperative in its relations with other donors. While relations have improved over time, even today more regular reporting of the division of labor with other donors could still be helpful part of project completion reports, audits, and other documents as a basis for evaluating and directing Bank activity.
- Earlier and stronger initiatives in the health sector would have been useful.
- More generally, Indonesia would have been a good place to have tested strategies for intersectoral linkages between population and other sectors, for example education, female employment and, of course, health. The opportunity still exists.
- Indonesia's truly successful outreach and community-based program needs far more study than it has so far gotten to identify the factors associated with that success that might be transferable.

Issues for the Future

Indonesia faces major challenges if it is to reach its goal of reducing its total fertility rate from 3.4 to the replacement level of 2.1. The much larger number of contraceptive users

needed to reach the low fertility targets will require large increases in program expenditures, with the amount depending on how rapidly the BKKBN succeeds in its program for much greater privatization of contraceptive supply and greater cost recovery in public services. Such major changes raise issues of reorganization of the program, shifts to more permanent methods of contraception, and more reliance on self-motivation of contraceptive users.

USAID, the other major source of external funds, plans to scale down its participation greatly by 1995. The future role of the Bank depends on the extent to which it would continue what it has done in the past and the extent to which it might assume some of the financial and programmatic contributions that have been carried by USAID.

Further, the way the Bank structures its assistance will depend on its assessment of the extent to which BKKBN can manage its own program with continuing financial aid, but with less detailed project development and monitoring by the Bank. If the Bank is to take on more software components, it should consider a resident population staff in Indonesia, unless it decides the BKKBN no longer needs the resident staff support it has received from USAID.

Indonesia's broad development program, with continued Bank support, should facilitate continuing social and economic change, which in turn will facilitate the continuing success of the family planning program and fertility decline. Such indirect support through other sectors strongly complements but is no substitute for strong support for the BKKBN. The Indonesian population program has had a significant effect going beyond the facilitating indirect effects of progress in other sectors. The Bank can substantially increase its support for the population sector without significantly increasing its total Indonesian loan portfolio.

1. Introduction

Population policy has been an important element in Indonesia's development program almost from the beginning of its New Order government under the leadership of President Suharto (1966). At that time, Indonesia's population of 107 million was growing at the rapid rate of 2.35 percent[1] per annum. Indonesian leaders developed a vigorous family planning program because they believed that rapid population growth would impede their plans for social and economic development and that the lower fertility required to reduce population growth would also improve family welfare. It is significant that Professor Widjojo, an important leader of Indonesia's development program, was the author of the seminal work on Indonesia's population.[2]

As a result of its development and population programs, Indonesia's fertility rates have declined substantially in the last 20 years. A case study of this significant fertility decline offers an opportunity to evaluate the role of the World Bank in this historic event. The remarkable Indonesian family planning program (BKKBN) is generally believed to be responsible for much of Indonesia's fertility decline, because of its role in increasing the use of contraception. It is plausible that the World Bank may have contributed to this result by providing funds for the family planning program through loans, through technical assistance, and by its dialogue with Indonesian leaders about population policy and related development issues.

The Bank may also have had an effect on fertility and other demographic variables through its lending for projects in other sectors. In the 20 years under review there has been considerable social and economic development, as well as a mortality decline in Indonesia. Bank loans and projects in education, health, transportation and communication, and more generally for economic development, may have contributed to social and economic changes, which in turn could lead to a decrease in the number of children desired, an increased demand for controlled fertility, and a fertility decline. The effects of the family planning program and other basic social and economic changes could have had synergistic effects.

The Indonesian case, unlike that of some other countries, is one in which the Bank's activity in the population and other development sectors might have had an influence. There is something important to be explained, because contraceptive use did increase and fertility did decline. The causes of these changes are in the interactive influence of the family planning program and general social and economic development. The Bank's influence could be either direct, through its support for the BKKBN, or more indirect, through its support of the general development program. Changes in other such demographic factors as age at marriage could affect fertility independently of any direct program effort, but possibly as a result of social and economic change.

A precise evaluation of the Bank's role is not possible because of the complexity of the forces at work: changing marital and reproductive values and behavior under the influence of a complex and dynamic family planning program as well as social and economic development in a culturally and economically diverse country. Further, the Bank was only one of several major donors with diverse but overlapping programs. Neither the Bank's nor other donor interventions were made or could have been made in terms of an experimental design through which cause and

1. United Nations, Department of International Economic and Social Affairs, *World Population Prospects, 1988*, Population Studies No. 106, (New York: United Nations, 1989). Since Indonesia, like most developing countries, does not have vital statistics adequate to the purpose, such demographic statistics as birth rates, death rates, rates of natural increase, total fertility rates, and life expectancy are necessarily estimates from census and sample surveys. The word "about" or "approximately" should be understood as preceding all such cited numbers. However, it is believed that the demographic data and trends cited are correct in the general order of magnitude.

2. N. Widjojo, *Population Trends in Indonesia* (Ithaca, New York: Cornell University Press, 1970).

effect could be neatly assessed. The best that can be done is to assess what are plausible or probable influences of the program and the Bank.

This paper proceeds by first describing the fertility decline and its immediate demographic causes. Then, the role of the family planning program and of other social forces in producing these changes is discussed. Only then is it meaningful to discuss the role of the Bank, vis-à-vis other donors, in the achievements of the family planning program.

2. Indonesia's Declining Fertility and its Immediate Causes

Since 1970, Indonesia's fertility has fallen more rapidly than anyone had expected at the time, in view of its relatively low level of development, cultural diversity, large areas of Muslim fundamentalism, and a legacy from the Sukarno period of a bloated bureaucracy, political instability, and a poor health structure.

The total fertility rate, estimated at 5.5 for 1967–70, had fallen to 3.3 by 1984–87.[3] This 40 percent decline, while not as large or as rapid as that in some other Asian countries, is substantial in terms of the initial expectations.

The most important immediate (proximate) cause of the fertility decline was an increase in the use of contraception by married couples to limit the number of children and to increase the spaced interval between births. In the 1960s, the contraceptive prevalence rate was probably less than 10 percent. By 1976, it had increased to 19 percent, and by 1987 it was 48 percent.[4] There was still significant regional and provincial variation in 1987. The rate was 51 percent in Java-Bali, where the program began, and 41 percent in outer Java-Bali II, where the program began later. Within the Java-Bali region, the lowest prevalence rate was 46 percent (West Java) and the rates were as high as 68 percent in Bali and Yogyakarta.

The increasing use of contraception led to fertility decline, not only by reducing the number of children each couple had, but also by increasing the interval between births, as some couples used contraception to space as well as to limit the number of births. Increasing the interval between births reduces annual fertility rates, in addition to the effect of the smaller total number of births per couple.

Part of the fertility decline is attributable to a steady but gradual increase in the age of marriage, which decreased the period of risk of pregnancy. The mean age at marriage increased from 19.3 in 1971 to 21.1 in 1985.[5] It is estimated that 20-25 percent of the fertility decline between 1967-71 and 1987 is attributable to changes in marital patterns.[6] The increasing age at marriage is probably related to greater education, fewer arranged marriages, and greater independence of young people. Later age at marriage generally must be a result of such social changes. China increased age at marriage by sanctions and vigorous action through its family planning program, but this was not the cause of the age-at-marriage increase in Indonesia.

Other changes in the marriage institution[7]—declines in the incidence of divorce and widowhood—had the effect of increasing fertility, thus partially offsetting the opposite effect of the rising age of marriage.

3. Central Bureau of Statistics, *National Indonesia Contraceptive Prevalence Survey, 1987*, Jakarta, January 1989, p. 53. This report is abbreviated as NICPS in subsequent references.

4. Data for contraceptive prevalence, desired number of children, and other aspects of reproductive behavior cited in this paper for 1976 are from Central Bureau of Statistics and World Fertility Survey, Indonesia Fertility Survey, 1976: Principal Report, Jakarta, 1978. This report is abbreviated as IFS in subsequent references. The comparable data for 1987 are from NICPS.

5. Terence H. Hull, "Fertility Decline in Indonesia: An Institutionalist Interpretation," Research Note No. 72, International Population Dynamics Program, Department of Demography, Australian National University, May 1987.

6. The 25 percent estimate for 1967-71 to 1976 is from T.H. Hull, V. Hull, and M. Singarimbun, "Indonesia's Family Planning Story: Success and Challenge," *Population Bulletin*, Vol.32, No.6, November 1977, p.45. The 20 percent estimate of the percentage of change between 1976 and 1987 attributable to contraception and changing marital patterns due to the latter is from M. Adietomo, S. Kitting, and S. Taufik, *Fertility Transition in Indonesia: Trends in Proximate Determinants* (Jakarta: Lembaga Demografi, 1989).

7. The discussion of marriage, divorce, non-consummation, post-partum abstinence, and arranged marriages draws on the article by Hull cited in footnote 5, as well as his "Marriage and Divorce Trends in Indonesia," Research Note No.87, International Population Dynamics Program, Department of Demography, Australian National University, March 1988.

Traditional marital patterns of early marriage followed by a period of non-consummation and a practice of postpartum abstinence — common in some parts of Java — had the effects of keeping fertility lower than it otherwise might have been. These practices may help to account for the fact that fertility was not especially high in Java, even before the rise of contraceptive prevalence. The apparent decline in the last 20 years of periods of non-consummation and of postpartum abstinence[8] should have had a pro-natalist effect, further offsetting the effects of rising age at marriage.

There is no firm evidence for Indonesia of a decline in the incidence or duration of breastfeeding which, in some developing countries, has had pro-natalist effects offsetting the early effects of adoption of contraception. Neither the 1976 IFS survey nor the 1987 NICPS survey indicates any change in breastfeeding patterns. However, some micro-studies indicate a decline in some sub-populations.[9] The negative relation of education to mean duration of breastfeeding, amenorrhea, and postpartum abstinence[10] suggests that the antinatalist effects of breastfeeding should be declining as the education level has been rising.

A rising incidence of abortion is usually common during the early period of rises in contraceptive practice. This is because, during such a period, many couples have not yet adopted contraception or have used it ineffectively. As a result, many have unwanted or mistimed pregnancies and are likely to turn to abortion. According to the 1987 NICPS, 6 percent of the births in the preceding five years occurred to women who wanted no more children and an additional 18 percent occurred earlier than wanted. Further, among those with three or more children, substantial numbers said they would have preferred fewer children if they could start family-building over again. Among those with five or more children, more than 50 percent made such a report. In 1987, 21 percent of NICPS respondents said they wanted no more children but weren't using contraception. There are no reliable data on the incidence of abortion in Indonesia, but insofar as it occurs because of unwanted or mistimed pregnancies, it would account for some part of the fertility decline.

Overall, then, it appears that the decline in fertility was mainly due to the rise in contraceptive prevalence. The increasing age at marriage and a possible increase in abortions could account for some of the fertility decline, but this was at least partially offset by the decreased incidence of divorce, widowhood, early non-consummation, and postpartum abstinence. Thus, the major proximate cause of the fertility decline was the increased use of contraception, the factor most subject to the effects of the family planning program.

An important primary cause of increased use of contraception during the transition from high to low fertility is a decline in the number of children parents want. There has been such a decline in Indonesia. Between 1976 and 1987 the percentage of wives with any specific number of children who said they wanted no more children increased and the mean number of children wanted decreased as follows:

Number of Living Children	*Percent Wanting No More Children*		*Mean Number of Children Wanted*	
	1976	*1987*	*1976*	*1987*
0	4	5	2.9	2.5
1	9	12	3.2	2.7
2	29	42	3.5	2.9
3	45	67	4.0	3.3
4 or more	57	81	5.7	4.1
Total	39	51	4.2	3.2

Source: 1976 IFS and 1987 NICPS.

Changes in such a fundamental value as the number of children wanted usually arise in large part as a result of changes in the family and in the society at large. However, as we will see, the BKKBN's intensive information and education program probably reinforced the effects on demand for children of considerable social and economic change.

8. Geoffrey McNicoll and Masri Singarimbun, Fertility Decline in Indonesia: Analysis and Interpretation, Report No. 20, Committee on Population and Demography, National Academy of Sciences (Washington, D.C.: National Academy Press, 1983); and Terence H. Hull, "Marriage and Divorce Trends in Indonesia," Research Note No. 87, International Population Dynamics Program, Department of Demography, Australian National University, March 1988.

9. Geoffrey McNicoll and Masri Singarimbun, *Fertility Decline in Indonesia: Analysis and Interpretation*, Report No. 20, Committee on Population and Demography, National Academy of Sciences (Washington, D.C.: National Academy Press, 1983).

10. Indicated in both IFS and NICPS.

3. Social Changes as Probable Causes of Rising Use of Contraception

Later age at marriage, a decline in the number of children desired, and the increasing use of contraception to have smaller planned families in Indonesia are plausibly results of profound social and economic changes, the powerful family planning program, and the interaction between the social changes and the family planning program in Indonesia.

The dynamic social and economic development programs introduced by the New Order under President Suharto in the late 1960s must have had profound effects over time on family life, on the life view of young married couples, on the aspirations of parents for their children, and on the children's own aspirations.

The success of the Indonesian development program (including the family planning program) has depended to a substantial degree on the stable and effective administrative system developed under the New Order. Vertical lines of authority were strengthened to insure that orders and responses flow up and down between various levels. Military personnel have been effectively used in civil positions within the administrative system. Of critical importance has been the ability of this system to mobilize attention, action, and response at the village level. While their political systems differ in many respects, Indonesia and China are similar in their effective linkages between the national government and the village base. In this respect, they differ from India. The success of the Indonesian family planning program cannot be understood without reference to the administrative-political system within which it operates.

A primary development program for a massive increase in educational levels succeeded in making primary education virtually universal, in greatly increasing secondary school enrollment, and in greater equity of education for boys and girls.[11] More years in school exposed the new generation to new ideas, in part through the school itself, but also through the life-long effect of greater functional literacy in linking the younger generation to the world communication system and to modern technology through the mass media, written instructions, advertising, and other messages.

Education was perceived, with some justification, by both parents and young people as providing entry to better jobs in the government and in the growing private sector. Most secondary school graduates, indeed, did get civil service jobs.

The expansion of education was a major thrust of the government development program. Under the INPRES program initiated in 1974, there was a 250 percent increase in the education share of the second Repelita Program budget (1974-78). This program resulted in its first five years in over 145,000 new primary schools and the rehabilitation of 56,000 others. Primary school enrollment increased from 13 to 27 million between 1973-74 and 1984-85. This education expansion brought changes to tens of thousands of villages. It was accompanied by continuing emphasis on the growth of new opportunities for the younger generation, both in the mass media and in communications to the villages through the political system.

While the increase in educational achievement was substantial, a sober view needs to consider also that the quality of education still leaves much to be desired. There is little support for recurrent essential supplies and equipment. Much learning has been of the rote variety, and textbooks often are lacking. The mobilization of parents to support schools is commendable, but it often has the effect of the enrichment of programs in the urban and wealthier areas.

While the specific ways in which education influences reproductive behavior are not certain, it is clear that educational attainment has been related in Indonesia, as

11. The discussion on education in this paper draws on an internal World Bank report and on interviews with specialists at the Bank on the Indonesian education sector.

elsewhere, to wanting fewer children, to greater knowledge and use of contraception, and to actually having fewer children. Longer periods in school probably had the effect, also, of making young people more independent of their families.

At the same time as educational levels rose, there were major increases in mass media communications via radio, television, printed media, and government-organized information and education programs at the village level. These affected both the educated, younger generation and the less literate older generation, linking them not only to the system of ideas involved in government programs, but also to the world-wide communication system, whose messages transcend the local and the national. Between 1978 and 1984 alone, the proportion of the population who watched television in the preceding week increased from 20 to 58 percent, while the proportion who listened to the radio increased from 50 to 75 percent.[12]

A parallel trend was the development of a more extensive and improved road network and of buses, trucks, and small motorized vehicles, which greatly increased the circulation of people, goods, and ideas. The network was especially dense in Java-Bali, where 62 percent of the Indonesian population lives. There was a considerable increase of migration and urbanization. Especially important was circulatory migration, in which family members commuted to new employment opportunities, either on a daily basis or for longer periods, while maintaining their links to their families in the villages. Circulatory migration helps to integrate villages into larger social, economic, and ideational networks.[13]

Between 1972 and 1987 the number of licensed motorized vehicles increased as follows:[14]

	1972	*1987*
	(thousands)	
Trucks	131	953
Buses	26	303
Motorcycles	615	5554
Passenger cars	277	1170
Total	1049	7980

The expansion of the Indonesian transportation and communication network was associated with rapid growth in the availability of consumer goods: bicycles, small motorized vehicles, radios, blue jeans, commercially-prepared foodstuffs, and other popular goods of the world consumer markets. While all Indonesians could not afford all the new goods, there is little doubt that even the poor aspired to have them.

T. Hull, a long-time, perceptive student of Indonesian society, writes that,[15] "Even as some people remain poor, the majority of the society is becoming oriented to higher forms of consumption. A wide variety of consumer goods and services is promoted through advertising and exemplary use, and are distributed through the far-flung archipelago by a growing network of traders and retailers. Most of the new consumer goods and the middle class styles are outside the reach of the mass of the Indonesians...Full participation in the new consumerism is not necessary for this innovative institution to have a strong influence on people's decision-making. More important is the strength and immediacy of the images of a new life which are created and desired, if not immediately for themselves, then in the future for their children. In this way mass consumption...is clearly related to the development of elements of ideology." "There is no traditional village in Indonesia. Change has swept the bulk of the population along quickly, but even the backwaters are caught up in new patterns of consumption, trade, education, and migration."[16]

Improvements in health, in infant mortality, and in life expectancy are of special relevance to family decisions about childbearing.[17] Infant mortality is estimated to have declined from 142 in 1971 to 112 by 1980 and to 71 by 1985. Child mortality declined from an estimated 134 in 1972-76 to 101 by 1982-87. Life expectancy is estimated to have increased from 43-45 in the 1960s to 56 by 1980-84, and to 60 by 1988. Lower mortality, especially of infants and children, can contribute to lower fertility through several mechanisms. It is likely that the declines in infant and child mortality were a result in part of the declines in fertility. Smaller families and greater spacing between births increased family resources and attention for each child and increased the access of many infants to prolonged breastfeeding.

Undergirding all of these changes were broad improvements in the economy.[18] In 1967, Indonesia was still very poor, with a per capita GNP of only US$50 and with a majority of the population classified as below the poverty line.

12. Central Bureau of Statistics, *Welfare Indicators*, Jakarta, 1988, Table 3.4.

13. Graeme J. Hugo, "Population Movement, Economic Development, and Social Change in Indonesia since 1971," Paper prepared for the Annual Meeting of the Population Association of America, Chicago, April 1987; and Graeme J. Hugo, Terence H. Hull, Valerie J. Hull, and Gavin W. Jones, *The Demographic Dimension in Indonesian Development* (Singapore: Oxford University Press, 1987).

14. Central Bureau of Statistics, *Environmental Statistics of Indonesia* and *Statistical Pocketbook for 1972/1973*, Jakarta.

15. Terence H. Hull, "Fertility Decline in Indonesia: An Institutionalist Interpretation," Research Note No. 72, International Population Dynamics Program, Department of Demography, Australian National University, May 1987.

16. Personal communication.

17. Data from NICPS, p. 69; and from World Bank, *Indonesia: Family Planning Perspectives in the 1990s* (Washington, D.C.: World Bank, 1990).

18. This discussion draws on Graeme J. Hugo, Terence H. Hull, Valerie J. Hull, and Gavin W. Jones, *The Demographic Dimension in Indonesian Development* (Singapore: Oxford University Press, 1987); and several internal World Bank reports.

The New Order government made a commitment to broad-based economic development and, especially, to rural development. With the oil boom, there was a surge in economic growth, with emphasis on productive use of labor and resources, and with relatively little in the way of direct transfers, consumer subsidies, or public employment. Between 1974 and 1978, economic growth was rapid, but the effect on poverty reduction was modest due to slower initial growth in the rural sector. There was considerable reduction in poverty beginning in 1978, as the Indonesian version of the Green Revolution dramatically increased rice production and the government invested more heavily in rural development.

Beginning in 1983, the sharp drop in oil income and changes in the international economy led to some sharp, drastic shocks and retrenchment in some development activities. However, Indonesia is credited by World Bank economists with mounting a successful macro-economic adjustment program, so that per capita incomes increased between 1984 and 1987. In these new adjustment initiatives, private investment was stressed and did increase substantially. Non-oil sectors have grown considerably. Agriculture, with some government protection, continued to do well. The manufacturing sector has grown rapidly. While the resource-based plywood sector has been number one, number two has been in textiles and clothing. This is especially important for the population, since this sector predominantly employs women. In general, the government acted to free up the private sector. It stimulated labor-intensive, export-oriented production and helped to develop a supporting infrastructure.

It is estimated that as much as 50 percent of rural households in Java-Bali have significant income from the non-agricultural sector.[19] Another indicator of rising standards of living is an increase in the proportion of households with electricity, from 6 percent in 1971 to 31 percent in 1985.

According to an internal World Bank study, the net result of economic changes is the following estimated decline in the proportion of the population below the poverty level:

Time	*Percent Below Poverty Line*
Early 1960s	70-75
Late 1970s	40
Late 1980s	22

Such estimates depend heavily on the concepts used to define poverty and are affected by the relatively poor data base. However, it is likely that the basic trend is correct.

19. Verbal report from scholars at Gadja Mada University.

The scope of economic change should not be exaggerated, since very considerable numbers of Indonesians still are just above the poverty level. Per capita GNP is still not high, but in the last two decades, enough Indonesians have improved their standard of living so there is some evident basis for aspirations for a better material standard of living.

Associated with the social and economic changes reviewed have been fundamental changes in the outlook of the young adult generation and in its relation to the older generation.[20] Young people are more independent of familial direction. This is evident in later marriages, a sharp decline in arranged marriages, and increased influence of peer groups. Greater education links the younger generation to new ideas transcending the family and the community. The mass media brings images of romantic rather than traditional relations between husbands and wives and constantly reinforces the consumption orientation of young adults and their children. The family is becoming more child-centered and less oriented toward service to parents.

These basic ideational changes probably have contributed to the openness of young couples to the family planning program's message that the small planned happy family is good for them and for Indonesia. This message has been widely and repetitively transmitted through the mass media and the political and administrative system. It is so pervasive that it may well have contributed to, as well as being strengthened by, the broader ideational changes affecting the younger generation.

The ongoing transformation of Indonesian society just described is relevant to understanding the success of the family planning program. The changes in education, health, transportation and communication networks, consumption levels and aspirations, standards of living, the family, and the increasing linkage to the world system of ideas are in directions generally believed to be conducive to lower fertility.[21]

Based on the 1976 and 1987 studies, there is specific evidence for Indonesia that the number of children desired is negatively, and the use of contraception positively related to education.[22] There is also evidence from the 1976 study that the rapid rise in contraceptive use from 1970 to 1976 in-

20. This discussion draws on Terence H. Hull, "Fertility Decline in Indonesia: An Institutionalist Interpretation," Research Note No. 72, International Population Dynamics Program, Department of Demography, Australian National University, May 1987; Nathan Keyfitsz, "An East Javanese Village in 1953 and 1985: Observations on Development," *Population and Development Review*, Vol.11, No.4, December 1985, pp. 695-719; and interviews with Indonesian social scientists.

21. Ansley J. Coale, "The Demographic Transition Reconsidered," International Union for the Scientific Study of Population, *International Population Conference, Liege, 1973*, Vol. I, pp. 53-72; John C. Caldwell, "Toward a Restatement of Demographic Transition Theory," *Population and Development Review*, Vol.2, Nos. 3-4, September-December 1976, pp. 321-366.

22. In IFS and NICPS.

volved relatively high use rates for those with a high standard of living, high ownership of consumer durables, high household income, and high occupational status. This suggests that the general social and economic trends previously discussed were sufficiently favorable to a reduced demand for children and an increased use of contraception so that they should have facilitated the work of the family planning program.

However, a simple explanation in terms of modernization trends and higher living standards is not sufficient for Indonesia, because contraceptive use was also relatively high among the very poor, among those with low living standards and low household income, and among those in farming. For example, consider the following 1976 data for a standard of living index which includes components for housing, lighting, water supply, and ownership of modern consumer durables:[23]

Standard of living index	*Percent Using Modern Contraception*	
	Unadjusted	*Adjusted*[a]
Very low	38	39
Low	31	35
Medium	31	36
Medium-high	30	37
High	42	55

[a]Adjusted for effects of region, number of living children, wife's age, wife's education, and husband's occupation.

This is illustrative of a curvilinear relationship for a number of economic variables with relatively high rates for the most disadvantaged and the most advantaged groups. The relatively high rate of use for the very poor with the lowest standard of living is remarkable. These were couples in housing made of the poorest materials, without electricity, with water available only from a river or public well, and without any of the 13 modern consumer durables entering the index.

It has been suggested[24] that two different processes produce these patterns of contraceptive use. The conventional modernization effects of better education, higher occupational status, and higher living standards produce the rising levels of use as expected among those who are better off. At the same time, a Malthusian principle is at work for the very poor. The hypothesis is that those who live in the most dire poverty adopt contraception when they are linked to the outside world with higher living standards and are presented with the idea and means for family limitation by a legitimate organization that reaches the village level. The conventional wisdom has been that the very poor in LDCs want to have a large number of children because for them, even young children are a net economic asset, apart from the security they offer in old age. However, a contrary argument is that there are situations in which the resources per capita are so low that having additional children is not rational from the point of view of the individuals involved. It is possible that in rural Indonesia, where there often was extreme pressure of population on very limited land, the family planning program may have helped large numbers of couples to define their desperate situation as being a result of having too many children. Large numbers of poor villagers, while ambivalent about such a definition, might under their circumstances be led to adopt it by the pressure of authority figures in the local community.

It seems very unlikely that the most disadvantaged couples would have adopted contraception so quickly and in such large numbers without the influence of the family planning program. For them, the role of the program was probably particularly important in the early part of the 1970s, before the substantial effect of the social and economic changes could have their significant effects later in the decade.

It does not detract from the appreciation of the achievements of the family planning program to take into account the changing social setting in which it operated. For those who were better off, modernization may explain the motivation to accept program services. In the case of the disadvantaged—the mass of the Indonesian population—the program probably had to work much harder to crystallize latent demand.

Apart from its effect on the motivation of potential acceptors, social change produced an infrastructure which facilitated the work of the family planning program. For example, improvements in transportation and communications strengthened the program's capacity to interact with its staff, both face to face and through the exchange of messages, to transmit IEC messages to the public, and to manage an efficient supply line.

Lapham and Mauldin[25] have shown that the strength of family planning program effort depends on a country's development level. Sixteen of 17 countries ranked low on social setting (as of 1970) were ranked "weak"or "very weak or none"on program effort (as of 1982). Fifteen of 18 ranked "low-middle"on social setting were "weak"or "very weak or none"on program effort. Indonesia's social and economic development improved its capacity to mount an effective population program, but its program effort ranked higher than that of other countries with similar development levels.

23. Ronald Freedman, Siew-Ean Khoo, and Bondan Supraptilah, "Modern Contraceptive Use in Indonesia: A Challenge to Conventional Wisdom," World Fertility Survey, *Scientific Reports*, No. 20, March 1981.

24. *Ibid.*

25. Robert J. Lapham and W. Parker Mauldin, "Contraceptive Prevalence: The Influence of Organized Family Planning Programs,"*Studies in Family Planning*, Vol 16, No. 2, May/June 1985, Table 4.

4. The Role of the National Family Planning Program

The Indonesian family planning program (BKKBN) has been immediately responsible for the rise in contraceptive prevalence and, therefore, for much of the fertility decline, at least in the sense that contraceptive information and supplies have come to the increasing millions of users through its network of services. BKKBN clearly deserves credit for what happened on the supply side. To what extent it is also responsible for creation of demand—the motivation for contraception—is a more difficult question, to be discussed later.

Prior to the inception of the BKKBN in 1970, there was little use or knowledge about modern contraception. Up to 1967, the subject was taboo in the mass media and not mentioned by public officials. In a 1968 KAP survey in Jakarta, three-quarters of the respondents claimed not to know of any method of fertility regulation.[26] There was then a profound change, as family planning became an important issue for the New Order Government, with strong leadership by President Suharto. By 1976, three-quarters of the married women under 50 surveyed in Jakarta said that they had heard of at least one modern method, and the percentage was similar for Java-Bali as a whole. By 1987, 94 percent indicated knowledge of at least one modern method.

The rapid rise in the use of modern contraceptives from very low levels to 26 percent (in Java-Bali) by 1976 and 51 percent by 1987 (48 percent for all of Indonesia) occurred through the rapidly expanding information and service network coordinated by the BKKBN. The source of contraceptive services in 1987 was still overwhelmingly (87 percent) reported as facilities organized and coordinated by the BKKBN: family planning clinics, hospitals, health centers, and various other public services at the village and hamlet level. Even in urban areas, where private sector sources were more common, 78 percent still reported such program-based sources in 1987.

The number and variety of service points has expanded rapidly. During its first phase (1970–73), a clinic-based family planning program worked through the Ministry of Health's maternal and child health program. In this initial period, 2,200 clinics were built and 6,600 field workers were recruited. In subsequent stages, the outreach of the program was greatly expanded to provide community-based service points, first in Java-Bali and then in successive phases to the outer islands. By 1988, there were 63,000 village and more than 190,000 sub-village posts (VCDC) which are operated by village family planning volunteers organized and supervised by family planning workers. This means that there are VCDC posts in virtually every village and in a large number of hamlets in addition—a remarkable outreach network. In addition, as of 1988, there were about 225,000 Posyandus scheduled to serve children under five in villages once a month, through a mobile team which brings not only clinical family planning services, but also MCH services—immunization, nutrition, and oral rehydration therapy. It should not be surprising that all these supplementary services are not always available every month. It was estimated in 1990 that about 85 percent of the Posyandus were in place and that they were covering 50 percent of the targeted children.[27]

An important additional instrument of the program is the acceptor groups that are intended to reinforce efforts to recruit users and maintain practice. An estimated 240,000 such groups in 1986 may have included three to six million individuals.

BKKBN is a coordinating agency, not a line ministry. It works to a substantial degree by organizing information and supply services through the Ministry of Health and

26. Haryono Suyono, *The Adoption of Innovation in a Developing Country: The Case of Family Planning in Indonesia*, (Chicago: University of Chicago, Community and Family Study Center, 1974).

27. Estimates by UNICEF personnel in February 1990 interview.

through the Home Ministry's civil administration at the provincial, district, subdistrict, and village levels. It also involves such other ministries as Education, Religion, Defense, and Information. Because it is not a line ministry, BKKBN has had the flexibility needed for its bold policy of decentralization and for varying the program to meet the circumstances of different provinces. It has been able to use innovative approaches crossing bureaucratic boundaries.

While the BKKBN is primarily a coordinating agency, it also has important direct implementation capacities, for example, by using its field workers to organize local volunteer groups, through its considerable IEC activities, its massive training activities, and in the important area of contraceptive supply.

In its coordinating activity, the BKKBN staff works very closely with the government officials at every level, as well as with relevant officials from other ministries.

Free-standing, coordinating agencies such as the BKKBN have failed in a number of other countries because they did not have the power or skill to win the cooperation of line agencies. The success of the BKKBN in mobilizing action, despite the rigidity and sometimes the opposition of line agencies, is due in no small part to the high level of political commitment of President Suharto to the family planning program. This is evident not only in his frequent public statements, but also in strong financial support from the central Government. Success in meeting family planning targets is one important way in which officials at every administrative level have their work appraised. Failure to achieve targets at one level is quickly followed by an inquiry from a higher level and by steps to correct the situation.

A major source of strength of the BKKBN has been the unusual continuity of its able leadership. The charismatic chairman and his principal deputies have led the program for more than 15 years. Such unusual continuity might have had a stultifying effect, but the program continues to be innovative. Further, there is a consensus among observers that the leadership has been politically adept in the difficult task of working through line agencies jealous of their authority and prerogatives. The BKKBN has also been skillful in getting strong financial support and technical assistance from international donor agencies. Donors have been happy to share the credit that comes from supporting a successful program.

The BKKBN has mobilized local governments and local groups on an awesome scale to bring informal community pressure on couples to practice contraception. It has also made contraceptive supplies so universally available at the local level that supply is not the major issue for the decision to use or not to use them typical in many other developing countries.

Key aspects of the operation are summarized by Warwick[28] on the basis of study of a good sample of villages:

> "The government's strategy in recruiting implementers has been to work downward in the administrative hierarchy and then outward. Senior officials began by putting pressure for results on those below them, who did the same with their subordinates. Officials at each level then worked outward to involve others, starting with their wives and close acquaintances. Since in most cases clients are recruited in their village of residence, the activities of village heads were particularly important...Sometimes these potential program implementers co-operated with little urging, but in other cases regional government leaders spoke of ordering or obliging subordinates...
>
> "The core strategy for recruiting clients has been a combination of individual persuasion and community influence. Our village studies suggest the following characterization of the style of field operations in the Indonesian family planning program in the 1970s and early 1980...If an intended program client...was unresponsive to persuasion or accepted but later dropped out of the program, the village head, other administrators, their wives, or members of acceptors' groups were likely to stop by to talk about family planning. Local religious leaders may have argued...that fertility control was not only not against religion, but...was a religious obligation. The greater the number of local program implementers, the greater were the opportunities for them to exert an influence on unresponsive members of the community. And the larger the number of acceptors, the smaller was the room of movement for holdout. Particularly strong influence could be exerted on poorer members of the community, who, moreover, were highly susceptible to influence from motivators."

Such a comprehensive community-based program is the goal of many other developing countries and even exists on paper in many places where the reality on the ground is different from program rhetoric. However, successful implementation of such a program is rare. China may be the only other country to be as successful as Indonesia in such a strategy.

Given the ethnic and socioeconomic diversity of Indonesia and the thousands of villages and sub-villages of varying size and population to be covered, it should not be surprising that the degree of implementation varies considerably. Warwick[29] has done an important study of how the variation in program inputs at the village level is related to

28. Donald P. Warwick, "The Indonesian Family Planning Program: Government Influence and Client Choice," *Population and Development Review*, Vol. 12, No. 3, September 1986, pp. 470-471.

29. Donald P. Warwick, "The Indonesian Family Planning Program: Government Influence and Client Choice," *Population and Development Review*, Vol. 12, No. 3, September 1986, p. 477.

contraceptive prevalence rates. He summarizes his findings as follows:

> "...the best quantitative predictors of success in the family planning program were the presence and activity level of implementers, acceptors' groups, and trained birth attendants and lateral integration with other programs and availability of medical backup. These data strongly support the strategy of the Indonesian family planning program, which puts heavy emphasis on persuading clients and supplying services with proper medical backup."

The fact that such program inputs are strongly related to the desired program outcome in a study independently collecting data at the village level is good evidence that the program does make a substantial difference. Negating this proposition would require evidence that program inputs are placed where demand is greatest, which might have led to higher contraceptive prevalence rates there even without the program. There is undoubtedly some bias in the placement of medical facilities, because these follow the program of the health department and are not controlled by BKKBN. A recent Bank study has indicated that the placement of such health facilities affects the availability of such effective, more permanent methods as the IUD, sterilization, and implants. This affects the mix of available contraceptives which, in turn, affects the prevalence rate.

The scale of the management, personnel, and logistical problems on such a large and growing program, operating in so many diverse places, and dealing with sensitive issues, is impressive. An essential element is the steady and appropriate flow of contraceptive supplies to service points, varying in their contraceptive mix. Further, tens of thousands of workers of different types had to be selected and trained. During the Third Five-Year Plan alone, 323,000 people were trained for over 100 categories of work. In 1990, BKKBN had a staff of 42,000: about 1,000 at national headquarters, 25,000 field workers and supervisors, and 16,000 at provincial and district offices. A sophisticated communication and management information system had to be developed to send and receive messages to and from the thousands of service training, supply, and other facilities. Large numbers of buildings had to be planned, built, and maintained for clinics, supply depots, training schools, and BKKBN offices at various administrative levels.

The evolution of the program from an initial clinic basis to outreach by field workers, and then a radical expansion through use of village volunteers, followed small-scale experimental trials of the new approaches. Since the small-scale trials were supervised by the program managers, their replication on a large scale did not face the problems associated with pilot projects external to the system. These major changes in the scale of activity were associated with reorganizations of the BKKBN, which troubled Bank staff, who preferred a more stable organization.

The BKKBN has been unusually successful in working with Muslim religious leaders, in contrast to programs in most other Muslim countries. This has been facilitated by an Indonesian tradition of working out problems through frequent conferences and discussions in which confrontation is avoided and accommodation and consensus are stressed. Muslim leaders were asked for advice and co-opted to a common enterprise. The effectiveness of this approach is evident in the relatively high acceptance rates in areas of Java known to be more orthodox in their Muslim identification. It is also relevant that Muslim fundamentalism is not strong in some parts of Indonesia.

A comparative view of the standing of the Indonesian family planning program can be derived from the Mauldin-Lapham rankings[30] for 1982 of the strength of family planning program effort for 100 developing countries. Indonesia ranked fifth among 100 countries. It ranked first for the "service and service-related activities,"fourth with respect to "policy and stage setting,"and third with respect to "record-keeping and evaluation."Its overall ranking would have been higher were it not for its ranking of 24th on "availability and accessibility"of different fertility control services, resulting from the fact that safe sterilization and abortion services were not easily available. Indonesia was also one of only nine countries (among the 88 rated) whose overall program effort score increased by at least 25 percent between 1972 and 1982.[31] Indonesia was the only country classified as having "strong"program effort (as of 1982) among the 18 countries ranked as "low-middle"on the development level of its social setting (as of 1970). This suggests that Indonesia's program success exceeded expectations on the basis of its development level. However, the considerable social and economic change since 1970 might have reduced this discrepancy.

BKKBN's performance was very favorably assessed as a model for other agencies in an internal Bank report on Indonesia's management development done in the mid-1980s.

As a further indication of reputation among external observers, the family planning program was cited as a "success,"exemplifying a high quality of strategic management,

30. W. Parker Mauldin and Robert J. Lapham, "The Measurement of Family Planning Inputs,"in Robert J. Lapham and George B. Simmons, eds., *Organizing for Effective Family Planning Programs*, (Washington, D.C.: National Academy Press, 1987), pp. 545-582.

31. W. Parker Mauldin and Robert J. Lapham, "Conditions of Fertility Decline in LDCs: 1965-1980,"Paper prepared for Annual Meeting of the Population Association of America, Minneapolis, May 1984.

in the highly regarded book by Samuel Paul[32] on the management of development programs.

The success of the BKKBN in designing and managing the complex and changing program is impressive both in absolute terms and in comparison with other countries. However, a proper perspective also requires consideration of the limitations and problems of the program as well as the achievements.

First, the achievement of about a 50 percent contraceptive prevalence rate in about 20 years is notable, but did not go as far or as rapidly as the rise in Thailand, China, Korea, and Taiwan, China. To be sure, those countries had some facilitating cultural and socioeconomic factors not found in Indonesia. The comparison underscores the fact that the achievement of family planning programs is not simply determined by their vigor, resources, and intelligent management. It is also affected by the social, economic, and cultural circumstances of the country. Unfortunately in Indonesia, very large population increases going well into the next century are almost inevitable, unless the already significant pace of progress in family planning is accelerated.

Second, in the drive to meet quantitative targets in a relatively short time period, less-than-optimal attention has been given to the quality of services, as indicated by the level of understanding by acceptors of the methods offered and accepted and by the availability of adequate medical backup for the problems of acceptors. A number of program observers have called for higher-quality services, even at the cost of a possibly slower pace.[33] These are problems of which the BKKBN is aware. The Chairman of the BKKBN indicated in 1986 that the program must do more to provide "... accurate, true, and honest information [about contraception] without intimidation and false expectations."[34]

Third, the Indonesian program, like others which have a strong target-achievement orientation, faces the problem of over-reporting of performance by local service points. The information system, which produced credible estimates of prevalence until at least 1976, subsequently greatly exaggerated the rise of prevalence rates, especially between 1982-83 and 1985-86. Exaggeration of prevalence rates by 15-20 absolute percentage points resulted in gross overestimates of resources needed for maintenance and gross underestimates of new users required to reach targeted levels. The illusion that abnormally large reported prevalence increases were real created a temporary euphoria that was misleading about what was possible in a short time period. Independent measurement of contraceptive use in good social surveys is more reliable for national and provincial estimates, but it does not provide estimates needed for assessing and modifying performance in local areas. The accuracy of the program's system of local estimates is a continuing problem. Changes made since a Bank internal review of these problems in the mid-1980s are still producing prevalence rates acknowledged to be too high by the BKKBN official in charge of the system in February 1989.

Fourth, some critics of the Indonesian family planning program allege that acceptance of family-planning services sometimes results from strong social and administrative pressures that are morally coercive. It is probable that there were such pressures in East Java in the 1970s. Acceptances in "special"high-pressure drives near the end of the program's fiscal year were shown to have lower continuation use rates than those in the normal program.[35] This suggests that special drive acceptances involved a lower level of voluntary commitment. Something of the same character may have been involved more recently in "safari"drives, in which thousands were brought together for carnival-like events, including recruitment for family planning. The consequences of social pressure in the program are much less in Indonesia than in India or China, because abortion and sterilization are not part of the program. The line between education and information, on the one hand, and occasionally heavy-handed persuasion by local groups and authorities, on the other, is sometimes hard to draw. There has been a tension between social pressure to meet targets and encouragement of genuinely voluntary, community-based support for the program.[36] Insofar as the program depends on external influence rather than personal choice, it does not bode well for recent program initiatives for major shifts of program services to the private sector. It is also problematic for intentions to scale down promotion of community socialization for family planning, on the assumption that self-motivation is enough because "small-family"values have already been internalized. The BKKBN leadership has expressed concern as to whether contraceptive prevalence

32. Samuel Paul, *Managing Development Programs: The Lessons of Success*, (Boulder, Colorado: Westview Press, 1982).

33. T. H. Hull and V. J. Hull, "Health Care and Birth Control in Indonesia: Links through Time,"paper presented at the Annual Meeting of the Population Association of America, San Francisco, 1986, mimeo, p. 15; cited in Donald P. Warwick, "The Indonesian Family Planning Program: Government Influence and Client Choice,"*Population and Development Review*, Vol. 12, No. 3, September 1986.

34. H. Suyono, "Success, Challenge and Future Prospect of National Family Planning Program in Indonesia,"National Family Planning Coordinating Board, 1986, mimeo, p. 7; cited in Donald P. Warwick, "The Indonesian Family Planning Program: Government Influence and Client Choice,"*Population and Development Review*, Vol. 12, No. 3, September 1986.

35. J. Sullivan, H. Suyono, W. Bahrawi, A. Hartoadi, "Contraceptive Use-Effectiveness in Mojokerto Regency, Indonesia: A Comparison of Regular Program and Special Drive Acceptors,"*Studies in Family Planning*, Vol. 7, No. 7, July 1976, pp. 188-196.

36. T. H. Hull and V. J. Hull, "Health Care and Birth Control in Indonesia: Links through Time,"paper presented at the Annual Meeting of the Population Association of America, San Francisco, 1986.

rates would continue to rise if the government relaxed efforts to mobilize community influence for acceptance.

Fifth, representatives of all the major donors believe the BKKBN is currently administratively top-heavy.[37] While insisting that administrative and technical staff at provincial and district headquarters are essential, BKKBN leadership has been moving to reduce higher-level administrative staff levels.

Despite these problems, there is no doubt that the family planning program was successful on the supply side. On the demand side, whether the program has persuaded many couples to want fewer children is more difficult to assess. The program certainly conveyed such a message to millions through its community-based information and education system. That message could have reinforced the effects of the social and economic forces which were working in this direction. The role of the program was probably particularly important in the early 1970s, especially for poor, rural couples, before the substantial effects of the social and economic changes came into play later in the decade.

However, no one has yet developed a methodology for disentangling the changes in the desired number of children which are induced by social change, and those which arise from the direct communication of such ideas by an organized program or in other ways. That such ideas have an autonomous force and are not simply a reflexive result of social change is part of the "ideational hypothesis."[38] It is very plausible that the strong social pressure of the program and its extensive IEC and service programs helped to crystallize latent demand for smaller numbers of children created by other social changes. However, the extent to which it independently, substantially changed values about family size is an open question. It is likely that the overall increase in effective demand was a synergistic joint effect of the broad social changes and the strong family planning program. Given what is at stake and the independent value of both development and the service aspects of the program, it is prudent to consider both as essential parts of the Indonesian population policy.

The program very probably led to more rapid adoption of contraception by those who wanted no more children. It probably also led many ambivalent couples to decide they wanted no more children. What is less certain is whether it converted many who definitely wanted more children to decide to have no more.

Assessing whether population programs reduce fertility requires cross-national analyses. There is support for the proposition that they do in such studies.[39] For Indonesia specifically, it is possible to say in summary that it is very probable that the program contributed substantially to the fertility decline, because:

- fertility fell mainly because of the increased use of contraception, and the program is responsible for most of the supply of contraceptive services;
- Indonesia's family planning effort and contraceptive prevalence were both higher than expected on the basis of the socioeconomic indicators alone; and
- it is unlikely that, without the program, the unexpected considerable adoption of family planning by poor, uneducated, and rural couples would have occurred so rapidly.

37. As of January 1990, BKKBN had 42,180 employees: 25,026 were field workers and supervisors; 980 were administrative and other support staff at national headquarters; and 16,174 were administrative and support staff at 27 provincial and 301 regency/ municipal offices.

38. John Cleland and Christopher Wilson, "Demand Theories of the Fertility Transition: An Iconoclastic View," *Population Studies*, Vol. 41, No. 1, March 1987, pp. 5-30.

39. Robert J. Lapham and W. Parker Maulding, "Family Planning Program Effort and Birthrate Decline in Developing Countries," *International Family Planning Perspectives*, Vol. 10, No. 4, December 1984, pp. 109-118.

5. The Bank's Contribution to the Indonesian Program's Success

Overview and Background

The World Bank plausibly can be credited with contributing to the success of the Indonesian family planning program. A continuing series of Bank loans have supported both specific family planning projects and Indonesia's general development program from the beginning of the New Order Government. Three Bank projects have been completed, a fourth is almost completed,[40] and the negotiations are underway for the fifth. The loans for the first four projects totalled US$122.4 million.[41] The population sector loans have financed important specific aspects of the program. Especially after the first project, the major emphasis was on buildings, equipment, and vehicles, but there was also more limited input into such software components as training programs, population education, research and evaluation, and field staff. More diffuse is the Bank's influence through policy dialogue with top Indonesian leaders and the reported influence in the development of the program's management structure.

More indirect, but possibly as important as the Bank's specific work in the population sector, has been the Bank's large-scale support (almost US$15 billion) for Indonesia's development efforts in education, health, transportation and communications, electrification, agriculture, and other support for the economy. Development in these other sectors has been changing Indonesian society in ways which probably affect the population's interest in smaller families and family planning.

The Bank's distinctive characteristics affected its role in population in Indonesia, as in many other countries:

1. The Bank—uniquely—was involved in the broad range of development activities which affect population trends, although these were not designed for that purpose.
2. Because it made very large loans for all major aspects of development, it had access to the highest levels of leadership in the Government.
3. Its sector analysis and research had an excellent reputation, so it was potentially influential.
4. It was able to finance large projects, and the Bank's system of accounting for time and overhead appears to favor larger rather than smaller loans.
5. The Bank's operational style in population in Indonesia involved:
   - Loans for five-year periods, corresponding more or less to the Indonesian plan periods (Repelita) and specifying projects and budgets for the whole period.
   - Project development, supervision, and review by staff members based in Washington who made recurrent trips to Indonesia. Unlike other donors, the Bank did not have resident field representatives for population for most of the period covered.
6. The fact that the Bank made loans rather than grants probably helps to account for its emphasis on hardware (buildings, equipment, and vehicles) rather than software (training, service, IEC, etc.). Third World borrowers generally prefer grant rather than loan funds to support software activities. Software grants are available from other donors less prepared to fund capital hardware projects.

40. Information about the four Bank projects as reported by the Bank was drawn from the four appraisal reports, project completion reports for the three completed projects, and audit reports for the first two projects.

41. Includes actual disbursement for the first three projects and the amount of the loan for the fourth.

These distinctive characteristics of the Bank both facilitated and limited what it could accomplish in various aspects of its work.

The Bank and Policy Dialogue

Compared with other donors, the Bank potentially has an important advantage in policy dialogue about population because Bank officials and staff are frequently negotiating with such key government officials as ministers of finance, planning officials, and even with presidents or prime ministers. This results partly from the fact that the Bank makes loans rather than grants, but mainly because its loan portfolio is so large. While countries naturally prefer grants rather than loans, especially for the social sectors, this is offset, at least in part, by their interest in large loans in the economic sectors.

Nevertheless, this potential comparative advantage of the Bank has not been realized in many countries where there is disinterest in or opposition to population policy. Several reviews of the Bank's work in population have reported that Bank economists in such countries are reluctant to advocate or even discuss this issue.

In Indonesia, however, the Bank officials have worked with leaders who saw population issues as important for development policy from the early days of the New Order. After the announcement of a national family planning policy in 1968 and even before the creation of the BKKBN in 1970, the Bank had a series of missions and officers discussing family planning in the context of health with the Indonesians and with other donors. A joint initial mission with WHO and UNFPA occurred in November 1969. In May 1970, President Suharto, already a warm advocate of family planning, had further discussion with Robert McNamara, President of the Bank, about a mission to develop a project with support from the Bank and other donors. In the course of seven Bank missions between 1969 and 1971, the first project, eventually a joint one with UNFPA, was formulated. Several Bank officials successfully encouraged a substantial expansion of the scale and geographical coverage of the family planning program. Also, the Bank staff collaborated closely with government officials in selecting, budgeting, and coordinating specific project components for the First Project. Dr. Widjojo Nitisastro, an economist and leader of BAPPENAS and Coordinating Minister for Economic, Financial, and Industrial Affairs, at that time had a strong interest in this issue. He was an important figure in these developments.

The Bank, indeed, has had frequent interaction with key Indonesian officials, a by-product of the almost US$ 15 billion in financing of 221 loans to Indonesia from 1968 through 1989. Such special leverage probably was not required to discuss population issues with the Indonesian leadership, who favored an aggressive population policy throughout this period. However, the Bank's support probably helped to legitimate the BKKBN's strong policy within Indonesia, where there has always been some ideological and bureaucratic opposition.

The Bank has had much less influence over the last 20 years, as compared with USAID, with respect to more specific operational policies through which the broad policies are implemented. The first project (joint between IDA and UNFPA) involved more software and less hardware (53 percent) than later projects and influenced the early course of the program. However, during most of the 1970s, when the basic Indonesian program was further developed, USAID had continuously resident in the country three officers who spoke Indonesian, were in almost daily contact with their Indonesian counterparts, were often in the field, and helped the BKKBN to develop its changing operational program. The USAID team worked closely with the BKKBN in developing the important shift from clinic-based to village-based contraceptive supply, information, and motivation in 1975-76.[42] The USAID mission had flexible funds which could be committed on short notice without reference to Washington. In 1976, the BKKBN director for a major province with a successful program told an interviewer for the Berelson Committee that the Bank could not give him the kind of flexible and timely support for new initiatives that he got from USAID staff who knew his province well.

By contrast, for most of the period since the first Bank population loan, there was no resident Bank field representative for population. There were such residents for two limited periods, but neither spoke Indonesian and neither had supporting technical staff. Almost all of the Bank's work in population was done by staff based in Washington who came to Indonesia for visits of 2-4 weeks a few times a year, supplemented by occasional missions for planning new loans, reviewing loan completion, and other special purposes.

Half a dozen international and bilateral donor representatives in Indonesia, interviewed in 1976 and 1978, were unanimous in the view that the Bank's influence on the na-

42. T. Reese, a USAID population officer, and Dr. Haryono Suyono, longtime Chairman of the BKKBN, were co-authors of reports on this important phenomenon. The reports acknowledge the role in preparation of the reports of the field notes of another USAID officer. This kind of immediate participation in program policy development is inconsistent with the Bank's operating style. It can well be argued that the Bank should not be so involved, but, absent such participation, the Bank is less likely to play an important, innovative role in the development of program policy. The relevant reports are: H. Suyon, S. H. Pandi, I. B. Astawa, Moeljono, and T. Reese, "Village Family Planning—The Indonesia Model, Institutionalizing Contraceptive Practice,"National Family Planning Coordinating Board, Technical Report Series, Monograph No. 13, Jakarta, July 1976; and H. Suyono and T. Reese, "Integrating Village Family Planning and Primary Health Services—The Indonesian Perspective,"Jakarta: BKKBN, 1976.

ture of the program was limited by its failure to have a resident staff with some authority to change projects. While the BKKBN staff, interviewed at that time, were naturally restrained in any criticism, the project completion report for the second population loan indicates that the BKKBN had suggested that Bank projects would go more smoothly if there were such representation.

When this issue was raised with the director of the Bank's Indonesia office by a Berelson Committee member in the mid-1970s, he indicated that the kind of detailed work done by USAID's mission staff was technical assistance which was not appropriate for the Bank. He indicated that, if such assistance were needed, it should be provided by creating a special agency for this purpose as part of a loan project.

While part of the explanation for the Bank's emphasis on hardware is the fact that they worked through loans rather than grants and their extensive experience with hardware, it was also a result of the BKKBN perception that the Bank's operating style did not permit the year-to-year flexibility desirable for many software activities.

Since a good case can be made for a division of labor among donor agencies, it can be argued that little would have been gained if the Bank had replicated USAID's resident staff and done more on programmatic software. However, this means accepting the fact that, without a resident staff the Bank had much less influence on program decisions than it might have had. Since the important macro-level political decisions about population policy were made relatively early, it is the policy decisions at the changing program level which determined its course for most of the period under review.

Support for the Family Planning Program

Most of the Bank's effort in population has been in direct support of the family planning program.

With respect to specific project components, the distinctive characteristics of the Bank's population work in Indonesia has resulted in a *de facto* division of labor with such other donors as USAID, UNFPA, and UNICEF. This has determined the balance among the specific components of the Bank's projects. The Bank has specialized in providing hardware: infrastructure, buildings and their furnishings, equipment, and vehicles. New ideas for the program generally were developed and tested by BKKBN in collaboration with other donors who concentrated on the software of program design and implementation. The Bank sometimes provided the resources for large-scale extension of already-tested program initiatives, but did not lead in software components.

Unlike the other major donors, the Bank has not had a significant resident staff for population, except for limited periods. Traveling Bank missions from Washington, however qualified, could not have the knowledge of Indonesia or the relations with BKKBN staff necessary for cooperatively developing and testing ideas in a very dynamic program. USAID, for example, in addition to a resident staff of three population officers, has had many resident expatriate and Indonesian consultants working day-to-day with the BKKBN in operations research and in other ways. The Bank has done this only in a very limited way.

The Bank has been less flexible than other donors, partly because its typically infrastructure components did not require the flexibility needed for software components. Its projects, designed for five-year periods, have taken two years or more to develop. Once developed, the project components have been difficult to change, largely because such decisions were referred to Washington. In addition, because the projects were financed as loans rather than grants, time-consuming approvals were required from the Indonesian government. By contrast, USAID reviewed and revised its program annually and had the capacity to authorize new expenditures locally on short notice. An Indonesian official who has observed the whole human resource field for many years said in an interview, "We say that, if you want to develop ideas for a new social institution, don't go to the Bank."

The net result was that the Bank has been perceived by the Indonesians and other donors primarily as well-qualified to provide essential hardware infrastructure and to support the large-scale extension of ideas first tested and developed by others. The Bank is not perceived as having provided intellectual leadership. Bank staff have not played an important role in helping the BKKBN to develop the major ideas guiding the program since the first project. Such a view of the Bank's role in population is in sharp contrast to its acknowledged important intellectual leadership role in Indonesia's general development program and in macro-economic policy for Indonesia. The Bank has population staff capable of exercising such leadership, but, at least in Indonesia, the implicit or explicit choice was to let other donors who had competent resident staff lead the way in policy for software operations.

While these perceptions about the Bank's role in population appear to be generally correct, the Bank deserves credit for its support — in a more limited way — of such specific program components as training, population education, and IEC activities.

It is not possible to assess in any precise way the effect of the Bank's loans and activities in the population field on the rise of contraceptive prevalence and the decline of fertility, which are the ultimate marks of program success, because the program is large and complex. It involves multiple Indonesian agencies. There are multiple donors with overlapping agendas and activities. The program is dynamic,

changing in many respects over the years. Such change and flexibility have contributed to its success. For this changing, complex situation, it is not feasible (especially after the fact) to establish direct links, for example, between the Bank's loans for building training schools and contraceptive prevalence.

Nevertheless, the Bank can reasonably be credited with a significant role in BKKBN's success insofar as:

- It is plausible that these elements have contributed to program success in changing reproductive behavior and norms.

Unfortunately, the evidence that can be cited from systematic evaluation of specific project components is rather thin. Project completion reports rarely provide evidence of systematic evaluation in terms of the component's continuing operation and impact. Most of the evidence provided has to do with *pro forma* completion of project components during the project period. Evaluation, according to predetermined criteria, was called for in various audits and project reports. However, this was not done systematically over the years.

Assessing Specific Components of the Bank's Projects

Hardware

In terms of civil works, furniture, equipment, and vehicles account for about two-thirds of the expenditure of Bank loans in the first four projects.[43] Even during the first project, when there was more emphasis than later on software and program operations, 53 percent of the credit went for buildings, vehicles, and equipment. Part of the explanation for the Bank's emphasis on hardware was that the Indonesians (like other borrowers) preferred grants rather than loans for software components. Loans were more acceptable for capital costs and other hardware. These are types of assistance with which the Bank has long experience in many sectors and countries. A number of Bank audits and reviews indicate that these were relatively easy for the Bank as compared with software elements. Further, hardware project components can absorb relatively large investments which fit nicely with established Bank procedures. Approximately 40 percent of all expenditures during the four population projects was for buildings and 26 percent was for equipment, furniture, and vehicles. The buildings provided the physical base for the program as it expanded throughout the islands. The Bank provided headquarters and supply warehouses not only in Jakarta and the 27 provincial capitals, but also in the 301 district capitals. This was supplemented by a network of important training facilities. An extensive building program during the third project provided infrastructure for decentralization of program management.

While there were delays and shortfalls on quality, the building programs were reasonably well executed. An Indonesian official with extensive experience with building programs indicated recently that Bank standards and procedures resulted in buildings substantially better than other government buildings, especially outside of Jakarta.

Buildings are in use and in general, funds are available for their maintenance. Buildings have been used for significant program purposes: training that appears to be important for the program went on in the training centers built; the program has been administered from BKKBN offices in 27 provinces and 301 district population and family planning centers; warehouses have been used for storage of contraceptives and supplies; inpatient annexes to health centers were being utilized.

It is plausible that having buildings, furniture, and equipment to carry on such activities helped the program. Beyond that, BKKBN officials believe that the buildings have had an important value in symbolizing the importance the Government and important international agencies attach to family planning/MCH goals.

Vehicles

This major component of all the projects provided the mobility essential for field services, supplies, training, IEC work, and administration. It facilitated reaching the population at the grass roots, especially in less accessible and less densely-settled areas. There is some evidence of higher acceptance rates associated with mobile clinic services and with increasing the mobility of field workers by providing them with motorcycles.

Training

Training of large numbers of family planning officials and various kinds of workers at various levels presumably contributed to the effectiveness of BKKBN's thousands of workers at every level. Sixteen training centers were built in Java-Bali during the first project period with Bank support, and were provided with vehicles and other equipment. In these centers, a yearly average of 8,100 officials were trained in 1970-76, 10,000 in 1976-79, and 15,000 during 1978-83. Under the second project, 10 provincial training centers were built in the Outer Islands-I area. These trained over 42,000 participants between 1979 and 1986—a shortfall from the 75,000 targeted in the project design. Under the Third Project, additional training centers were built in the Outer Islands-II area, and there was sup-

43. Actual expenditures for projects one through three, plus appraisal estimates for project four.

port for a wide range of training activities throughout the country. The reported numbers trained included:

Teachers in population education	24,020
Supervisors of family planning workers	2,529
Doctors	27
Subdistrict and health center midwives	2,494
Traditional birth attendants (retrained)	21,500
Primary health care nurses	1,186
Nursing school teachers	790
Paramedical personnel (for IUD insertion)	6,613

Such a volume and range of training, indicative of the complexity of the program, was made possible by the development of the training infrastructure in all three of the initial Bank projects.

Population Education

Support for large-scale population education programs has produced materials and curricula and trained trainers, as well as thousands of teachers. An evaluation of this component indicated that large numbers were exposed to it, learned a reasonable amount of the material taught, and retained it at least until an examination. It is plausible—but by no means certain—that this contributed to ideational changes in the younger population about the desirability of lower fertility, smaller families, and family planning.

The Bank support for population education included buildings and their furnishings, audio-visual equipment, consultants, training materials, fellowships, vehicles, and staff support. During the third project period, 117,000 copies of population-education instructional materials were produced and were being used in primary and secondary schools throughout the country. The materials were again reproduced and circulated under the fourth project.

Research and Evaluation

The Bank (and, for that matter, the BKKBN and other donors) has not been very successful in helping to improve the indigenous infrastructure for research and evaluation activity. As recently as the current Fourth Project, important goals in this area were the creation of three research centers in the BKKBN, a regular series of KAP and continuation-rate studies every two years, and the strengthening of 10 provincial university centers.

The Demographic Institute at the University of Indonesia and the Population Studies Center at Gadja Mada University are the premier national Indonesian academic centers in the population field. The latter is well-known for its sociological-anthropological micro-studies. Qualified Indonesian and foreign observers are agreed that the attempt to create population centers at 10 or more provincial universities exceeds the supply of trained and capable leaders.

The new BKKBN research centers supported by the Bank, while doing some useful work, are not yet operating at a very high level, according to both Indonesian and foreign observers. They are handicapped by a shortage of experi enced staff for a very ambitious program that is not sufficiently focussed. The 1987 KAP survey (NICPS) has been very useful and another is planned for 1991. Continuation-rate studies are under way.

Such micro-studies as those being done at Gadja Mada University provide insights into the changing Indonesian family structures and reproductive behavior. However, there apparently is no provision in Indonesia for surveys on the family to provide national and regional parameters on such issues as changing authority and dependency relations between the younger adults and their parents and how these are related to changing reproductive behavior. This is an important research challenge in Indonesia, relevant to population policy because of the inter-action of social and economic change, vigorous development and population programs, and regional cultural variations. The Bank should have special interest and expertise in such studies because of its involvement in both the population and broad development programs.

As previously indicated, the BKKBN system for estimating contraceptive prevalence, initiated with strong USAID support early in the program, served the program very well for a time in quickly providing data at every level down to the village. and it was not far discrepant from the 1976 IFS. However, in the last decade, that system produced large overestimates of prevalence, with serious consequences for planning and policy. The recent revision of the system still produced a probable overestimate of prevalence of approximately 10 percent in 1989.

So far, the program has done quite well without the benefit of many sound research studies on the relationship between specific program inputs, socioeconomic development, and reproductive behavior. Research on what does and does not work in program operations has not yielded the kinds of reports that should be possible, given the level of program success. In April 1985 the appraisal report for the fourth Bank project indicated that the BKKBN still had only limited capacity for undertaking operational research. There has been only modest improvement since then.

However, the successful expansions of the program from clinic basis to outreach by field workers, and then to large-scale use of village volunteers were based on experimental pilot projects by BKKBN with the collaboration of USAID. These trials did not result in scientific reports. However, because of their supervision by program managers, the large-scale expansion following testing did not face the

problems associated with pilot projects external to the operating program.[44]

The Bank's undoubted capacity for analytical sector studies was not much utilized in population in Indonesia during the Bank's early projects. Even when such reports were later done, they do not appear to have affected the design of the Bank's four loan projects very much. In the two instances in which Bank projects included potentially important operations research projects to test new ideas, the results were not very useful, in part because of inadequate collaboration with Indonesians in the initial design. However, two recent reports are highly relevant to program needs and are likely to influence the fifth population loan now being negotiated. One deals with the prospects for the program in the 1990s. The other is a much-needed economic analysis of the program.

Support for Field Staff

The Bank helped to finance field staff salaries during the first project and later, for the special outreach effort for trans-migration resettlement areas. With these exceptions, the Bank generally has left the direct support of the largely recurrent costs of field staff to the Indonesian Government. The Bank's initial support of field staff salaries was recently cited by BKKBN officials as especially helpful at a crucial stage of the program.

Information-Education-Communication (IEC)

The Bank has provided support in several projects for IEC equipment, consultants, other training costs, field production costs, operating costs for media centers, and vehicles for IEC work. While there are qualitative reports of wide-spread exposure to posters, films, pamphlets, and other IEC activities, there are few data on the sizes of audiences and none on possible effects on reproductive behavior or values.

Hospital Postpartum Program

This component helped to increase the number of hospitals providing postpartum family planning services as part of the international programs coordinated by the Population Council. A Bank mission reported in 1977 that 25 percent of abortion and obstetric cases became new family planning acceptors.

The Ministry of Population and Environment

The Bank has supported several kinds of activity in training, research, population policy development, and other activities of the Ministry of Population and Environment. This Ministry is charged with encouraging and coordinating a broad range of population activities in various ministries. While the mandate of the Ministry is important, for a variety of reasons, the achievements are still mainly potentials for the future. A recent Bank sector report[45] characterizes the population section of the Ministry as "... a small office supported by consultants, and it has a limited capacity to fulfill its functions."

Other donors have always recognized the Bank's special contribution in hardware infrastructure. However, for many years, other donors as well as some Bank staff saw the Bank as being at a disadvantage in software components. Uneasiness about the software components was expressed as follows in the audit of the second Bank project:

> "Some concern has been expressed by certain donor agencies that the Bank is expanding into areas such as research and evaluation in Indonesia, where the other agencies have already spent considerable resources and in which they are better equipped to monitor, given their representation in the field. Given resource constraints, countries may be better off obtaining resources for certain software elements from elsewhere, especially when these can be financed from grants and/or when these software components require close supervision which the Bank is not equipped to provide."

However, in recent years, this evaluation has been modified to some extent. For example, appreciation of the role of the Bank in implementing on a large scale projects developed by others is illustrated in a recent UNFPA evaluation report.[46] UNFPA supported the development of six media projection centers in Java-Bali. The Bank then responded favorably to a BKKBN request to replicate them in all other provinces. The UNFPA initiated an IEC project covering the cost of developing training materials and of educating master trainers, with the understanding that the costs of training the supervisors and field workers would be covered by the Bank. The UNFPA also reported cooperative large-scale assistance from the Bank in supporting the institutionalization of population education in both the formal and informal sectors.

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44. This aspect of the program is given particular emphasis as an important basis for its success by Samuel Paul in *Managing Development Programs: The Lessons of Success*, (Boulder, Colorado: Westview Press, 1982).

45. World Bank, *Indonesia: Family Planning Perspectives in the 1990s* (Washington, D.C.: World Bank, 1990).

46. United Nations Population Fund, *Report on the Evaluation of Indonesia Country Programme*, New York: United Nations, November 1988.

Similarly, UNICEF staff recently reported[47] that their work in developing the program for Posyandu posts was greatly facilitated by the Bank's support to BKKBN for rapid early expansion of these posts to the 25,000 mark before its subsequent expansion to 225,000 in over 60,000 villages.

In summary, the preceding review indicates reasonable but variable achievement in implementing specific project components, which plausibly could contribute to program success. Given the considerable success of the program, it is likely that the specific Bank inputs, taken together, made a significant contribution to program success. The major Bank investment in buildings and vehicles, providing essential program infrastructure, could not have been provided by other donors. Most of the software components were useful, although in this area the Bank was a follower rather than a leader. While its software functions could have been carried out by other donors, it is unlikely that they could have absorbed the costs of doing that. Besides, the Bank's important role in hardware components and policy dialogue might have had less credibility without some involvement in funding the program's actual operations.

Developing Management Capacity

The Bank staff have frequently claimed in their reports that it has helped to develop BKKBN's management capacity, presumably through its very methodical appraisal, reporting, supervision, and review procedures.

A number of knowledgeable observers, interviewed in the 1970s and more recently, claim that the Bank's requirements are onerous in terms of reporting and planning and related documents, together with the time required from BKKBN staff to work with numerous supervisory missions and to correspond with Washington.

Another major donor also has reporting requirements that are no less time-consuming and detailed than those of the Bank. However, BKKBN's ability to deal with these are facilitated by the resident staff of the other agency.

A very knowledgeable Indonesian government official indicated in an interview that administrative rigidities were as often those of the Indonesian Government as of the Bank. He indicated further that the administrative problems of working with the Bank arose mainly from having to correspond with Washington rather than working with a resident representative for population.

During the First Project, the Bank was constantly concerned about the failures of BKKBN and GOI management. The audit report for Project One cites 12 of 13 supervision reports as indicating that BKKBN management was an implementation problem. The Berelson Committee heard this point given exceptional stress during its briefing on Indonesia in 1976.

This litany of complaints about management occurred just when the BKKBN was having great success in providing services and information to rapidly growing numbers of contraceptive users. Was the Bank failing to understand what was, apparently, a very successful indigenous management style because it had a preconceived, non-Indonesian view of what management should be? In documents covering the third and fourth loan periods, there is a greater readiness to acknowledge management strengths at BKKBN, and indeed, to claim credit for them.

Understandably, the BKKBN has had many management problems. Initially, the inexperienced BKKBN staff had to deal with the politics and arcane procedures of multiple Indonesian agencies, as well as those of international foreign donors. The fact that the Bank provided loans rather than grants increased the problem, because loans required special procedures with BAPPENAS and the Ministry of Finance. Significant recurrent problems for the Bank and BKKBN were delays by the GOI in releasing required counterpart funds. The Bank itself was also initially inexperienced in dealing with the multiple Indonesian agencies and the other donors. During the first Bank project, the Bank's resident population officer was reported to have spent most of his time on relations with multiple agencies, dealing not with substantive issues, but with internal Bank and GOI procedures and paperwork. BKKBN not infrequently suffered from the inconsistencies between the Bank's procedures and those of the rest of the Indonesian government.

During the third Bank project, the Bank staff spent 140-150 weeks for supervision.[48] BKKBN apparently could not remedy an exceedingly slow rate of disbursement of project funds. It was necessary for Bank missions to persuade BAPPENAS and the Ministry of Finance to release the necessary counterpart budget allocations. An able staff member in residence might have been more effective and, in the end, less expensive than so many missions from Washington.

BKKBN's management problems, as described in Bank reports, seem to have occurred much less with the agencies and personnel it was supervising and coordinating to carry out the program than with the Indonesian and donor agencies from which it obtained its resources.

The Bank's audit of the second project stated that, "Overall the BKKBN was a well-managed organization and, in general, it implemented the project well. However, its effectiveness has, in the audit's view, been impaired from time to time by extensive reorganizations, and this continues to be a cause of concern."Similar concerns with the changes in

47. In interviews in Jakarta, February 1990.

48. This included some time spent in supervising several other Bank projects and in preparing for a later project — time which could not be separated out.

BKKBN organization appear in later Bank reports. There does not appear to have been adequate recognition by the Bank that changes are to be expected—indeed, may be desirable—in a program whose character necessarily changes with rapid technical, social, and economic change and with changes in the public's knowledge and acceptance of the program's basic ideas.

The Bank often has tried to micro-manage and micro-supervise from a distance. The Appraisal Report on Project Four has an astonishing list of "agreements and recommendations"on which assurances were obtained as part of loan negotiations. These involve requirements for detailed actions and reports with specified early deadlines. Some of these seem clearly unattainable in the time specified and, indeed, this has proved to be the case. After 20 years of successful experience, the BKKBN might well regard such requirements as unnecessary and condescending.

The contributions of the Bank and of other donors to developing management skills should be evaluated in the perspective of the primary role of the Indonesian government and leadership. The BKKBN has been imaginative and effective in molding the program to fit Indonesian institutions. The considerable financial, technical, and intellectual resources provided by international and bilateral donors, no doubt, have been important. However, the Indonesian leadership has been unusually successful in negotiating for and utilizing these resources in the Indonesian context. Some other Asian countries which have had similar resources available to them have not had similar success. It is indicative of the BKKBN's attention to managing donor relations that it has prepared manuals for its staff, laying out the operating style and the detailed requirements of each donor.

The independent role of the Indonesians in managing their own program may be indicated by the rising share of program spending financed by the Government of Indonesia during the first three completed projects:

- Repelita I (1969-70 - 1973-74) 40 %
- Repelita II (1974-75 - 1978-79) 52 %
- Repelita III (1979-80 - 1982-83) 72 %

A Bank audit suggested that the major Indonesian contribution to program funding reduced its need "to accommodate to widely divergent views of population experts or to the substantial political sensitivities of donors."Such problems were reported as occurring in another Asian country where the Bank and other donors provided a large share of the program funding.

The BKKBN is regarded by knowledgeable Indonesian and foreign observers as being much more effectively managed than other Indonesian human resource agencies and departments. While other Indonesian agencies are unable to spend out their annual budgets, BKKBN does so regularly because its data-based MIS system provides accurate month-by-month accounts of its financial status in relation to its detailed forward plans. Several donor representatives also regarded it as better managed than family planning programs in other Southeast and South Asian countries.

No doubt, the interaction over many years on many projects of the BKKBN with the Bank and other donors has contributed to the development of better management structures and skills. But the Indonesians themselves deserve major credit in the managerial area on the basis of successful program results from the early years, the adaptation of the program to the Indonesian environment on a regional basis, and such specific administrative indicators as its ability to spend out its budget according to plan.

BKKBN now faces new managerial challenges. It is seriously trying to shift as much of the program as possible to the private sector (K-B-Mandiri) and to increase cost recovery in the public sector to contain the mounting costs of the increasing number of acceptors. Such a transition will require both experimentation and substantial reorganization. USAID, which is heavily involved in the privatization program, has indicated that it intends to radically reduce its general participation in the program after 1995. The Bank may have to decide whether Indonesia will need assistance with the new management problems and whether the Bank is capable of providing it.

Is Indonesia ready to make its own decisions and manage its own program? The Bank and other donors have been making grants and loans for almost 20 years and the three principal donors all claim to have helped to build program management infrastructure. And, after all, the program is eminently successful. If, as is likely, continuing financial assistance is needed, especially in foreign exchange, perhaps such loans could be made with less supervision, but with final accountability according to broad guidelines. This could be done by allowing more flexibility on project loans or by providing sector or program loans.

Relations with Other Donors

When the Bank was developing its first project, many other donors were already active in Indonesia (USAID, UNICEF, WHO, IPPF, the Population Council, the Ford Foundation, and the Swedish and Japanese Governments). The entry of the Bank and the UNFPA onto the scene, with major funding for a joint project, involved a readjustment which was described in the first project completion report as "... long and somewhat contentious, with each agency attempting to strengthen its own institutional position, while simultaneously expecting co-operation from the others."Resentments resulted from the perception that the

Bank saw itself as the coordinating agency. Indeed, the Bank did become the executing agency for the joint Bank/UNFPA project, with several of the other agencies implementing specific aspects of the work.

Resentments developed during this initial period persisted for many years, exacerbated by the fact that the Bank usually had no resident representative who could develop informal personal ties with the resident representatives of the other donor agencies. Representatives of the other donor agencies told a member of the Berelson Committee in 1976 that the Bank was "standoff-ish"and "arrogant."They complained that they often were interviewed by visiting Bank mission staff who didn't know Indonesia well, but that they almost never got feedback on the Bank's reports, ideas, or intentions until after decisions were made that often affected them. An outside mission evaluating USAID in 1979 reported that "There is little contact with the World Bank, because it does not have a resident technical staff for population. The experts it brings in for specific loan arrangements do consult with USAID staff, but there is little opportunity for sustained contact once they depart."

In recent years, relations with other donors have been very much improved because of a determined effort by a relevant Bank staff member to keep other major donors informed about what happens during and following visiting missions. Donor representatives with many years of experience reported a cooperative change for the better in relations with the Bank. There has been cooperation in funding specific projects. There have been helpful exchanges of information and cooperation in evaluation of program components of mutual interest. Also, in recent years, Bank sector reports in population and in such related fields as health have won the respect of staff of other donor agencies, both in Indonesia and in the central offices of the agencies. References to such reports have recently appeared in publications of other agencies.

These recent developments indicate that, with sufficient sustained effort by a motivated staff member, donor relations can be improved even without a resident population representative.

More formal and comprehensive joint planning and budgeting by the donors, even if it were feasible, would not necessarily be desirable. An integrated program design in this sensitive area by a consortium of outsiders would be resented and probably rejected by the Indonesians, who take justifiable pride in the successful program they have designed and executed. The BKKBN coordinates the donors to suit Indonesian needs and sensibilities.

Possible Bank Influence on Fertility through Assistance in Non-population Sectors

Discussions of the Bank's role in population almost always call attention to the potential leverage from the Bank's investments in other social and economic sectors. While the idea of linking population and other sectors is plausible, there is little evidence that this is done very often, either in Indonesia or elsewhere. For example, while the Ministry of Health (MOH) provides a substantial portion of the family planning services in Indonesia, neither the Bank loans for health nor those for population provide direct support of family planning activities by the MOH. Similarly, while the Bank projects have provided support for the population education program, this has been done through the BKKBN without direct support to the Ministry of Education. While such direct linkages with other sectors are probably desirable, they would be unlikely to have as powerful effects on reproductive motivation and behavior as general progress in the social and economic sectors.

The World Bank's loans and projects in such other sectors as education, agriculture, health, transportation and communication, and, more generally, for economic development have contributed to the major social and economic changes of the last 20 years in Indonesia. As previously indicated, these in turn could have played a role in the decrease in the number of children wanted, the increased use of contraception, and the fertility decline.

The Bank's spending for the Indonesian development program has been substantial for a broad range of development programs. The scope of the Bank's loan program is indicated by the following distribution of Bank commitments to Indonesia for fiscal years 1968-89, by sector:

Sectors	*US$ millions*
Agriculture and rural development	3,794
Education	1,536
Health and nutrition	156
Industry	540
Population	119
Power/energy	3,305
Small-scale enterprise	798
Telecommunications	27
Tourism	16
Transportation	2,016
Urban development	960
Water supply and sewerage	147
Other economic[a]	1,372
Total	14,786

[a]Development finance companies, trade policy, private sector development.

These data provide concrete evidence of the Bank's major support for a wide array of crucial development sectors. Most population specialists would agree that substantial progress in these sectors taken together should facilitate

social and familial changes generally associated with fertility decline. Chapter 2 indicates that substantial social and economic changes have indeed occurred. There is little doubt that the Bank has contributed to the Government's efforts in these sectors.

The fact that the population sector accounts for less than 1 percent of the Bank's total lending program suggests that, if a larger population lending program were deemed desirable, it could be done with little increase in the total of development lending to Indonesia.

Specific comments may be useful on the education and health sectors — the two generally believed to have the closest connection to changes in reproductive behavior.

The Bank has made 29 education loans since 1965. The proportion of Bank lending for education has been larger for Indonesia than for any other country. (The substantial progress in education has been described in Chapter 2.) Education is the social factor with the clearest evidence of effects on reproductive behavior, both in general and for Indonesia specifically. While much of the Bank's education lending has been for higher education, the lending for primary education (US$61 million), secondary education (US$293 million), and teacher training for primary and secondary schools (US$275 million) was not inconsiderable. Emphasis on textbook production and teacher training aimed to improve the quality of education. Emphasis on technical education was especially relevant to elevating economic aspirations of young people and their parents. The Bank's strong support for higher education (US$596 million) gave Indonesia greater latitude to invest its own funds in primary and secondary education.

The Bank's efforts in health are more recent than in other sectors. In general, Bank health projects have not yet dealt with the central problems in Indonesia's health system. According to a recent internal health sector report by the Bank, Indonesia's health programs do not compare favorably with those of other countries in Southeast Asia and, in some respects, to those of even poorer countries elsewhere. Indonesia spends much less of its GNP or of its budget on health than other countries in the region. It spends 2.5 percent of its budget on health as compared to an average of 5 percent in the region. In comparative terms, there is a low density of health services and low utilization of both the inpatient and outpatient services available, perhaps in part because of the low density. The density of services and their utilization is lower in poorer areas, raising substantial questions of equity. Skilled personnel are disproportionately in better-off places and at leading hospitals located there. There is a stress on curative services as compared with preventive and child-centered services. Hospital beds per capita are an extremely low 0.6 per thousand, compared with 0.9 in low-income countries and 1.3 in the lower middle-income countries with which Indonesia should be compared. During the fiscal crisis of the 1980s, central government expenditures on health fell by more than 40 percent between 1982-83 and 1987-88. These were far greater than the declines for the family planning program. The Ministry of Health recognizes the difficult problems in the health system and is attempting to address them.

The rather poor status of the health system suggests that the mortality declines in Indonesia may have been associated with rising standards of living as much as with improvement in health services. As previously indicated, the family planning program's success in reducing fertility probably has facilitated the decline in infant and child mortality.

The health system is important for fertility decline, both because lower infant mortality affects reproductive intentions and because the health system provides much of the essential family planning services. A recent internal Bank report found that BKKBN bears about half of family planning delivery costs: the Ministry of Health, 40 percent: and the community, the remaining 10 percent. The massive Posyandu system depends to a considerable extent on the system of health clinics for the medical aspects of its monthly services in several hundred thousand hamlets. Further, there is general agreement by BKKBN and the donors that the future success of the program will depend to a considerable extent on a shift toward such more permanent contraceptive methods as Norplant, requiring more clinical medical services. More clinical services would also be required if there was an increase in voluntary sterilization, which is the most used method in the United States. There is similarly a requirement of better health services for the goal of improving the quality of family planning services, especially with reference to side effects.

All of this suggests that the Bank might usefully have considered both a more integrated approach to population and health and more substantial strategic assistance to upgrading the health system as a whole. This would have served both health and population objectives. It is pertinent that in current negotiations for the fifth population project, a major maternal and child health component is contemplated involving a large loan element going directly to the Ministry of Health, with expectation of a major additional component in the next health loan.

More generally, since population trends are influenced by intersectoral forces, the Bank could exercise greater leadership in developing an explicit intersectoral strategy for the population field.

The benefits flow not only from the other development sectors to population, but in the reverse direction as well. A Bank staff member has recently estimated[49] a rate of return of 12 percent per annum for expenditures on family planning, based on savings in the health and education sector resulting from births averted.

49. World Bank, *Indonesia: Family Planning Perspectices in the 1990s* (Washington, D.C.: World Bank, 1990).

The Role of the Bank in the Next Decade

The Indonesian population and development programs still face a formidable task in further reducing fertility and bringing population growth rates to the desired zero-growth level. Despite the considerable success in reducing fertility through increased use of contraception, the annual rate of increase of the population only fell from 2.35 percent in 1965–70 to about 2.00 in 1985–88.[50] The rate of population growth did not decrease more rapidly, mainly because the decline in fertility was offset to a considerable extent by a decline in mortality. Despite its effect on retarding the growth rate decline, the mortality decline is, of course, valued not only for the intrinsic value of saving lives, but also because lower child mortality facilitates further fertility decline.

Indonesia still has a very young population, a result of formerly high (and presently still moderately high) fertility. This young age structure is partly responsible for the continued relatively high crude birth rate and rate of natural increase. Even when total fertility rates reach the replacement level, the population will continue to grow for decades because of the large number of couples of childbearing age produced by earlier high fertility rates. Further, while the decrease in total fertility rates to 3.3 is a considerable achievement, reaching replacement-level fertility of about 2.1 will take considerable time, even assuming continued good progress.

Therefore, large increases in population are almost inevitable. The size of projected population increases depends on the assumptions made about fertility and mortality, but all credible projections indicate large population increases. For example, recent projections by the United Nations Population Division[51] indicate a population of 216 to 253 million by 2010 and 228 to 305 million by 2025, depending on the assumptions made. Actual zero population growth may not be attained before the end of the twenty-first century, even if replacement-level fertility is reached by 2010.

For the immediate future, a recent Bank sector report[52] presents an excellent but sobering picture of the challenge for Indonesia in the population field in the 1990's: "Further declines in fertility and in the population growth rate will take considerably more effort, because the program will need to reach unprecedented numbers of contraceptive acceptors and motivate couples with high-fertility attitudes, less likely to know about family planning and to seek services (e.g., remote areas, urban poor). The detailed programming of family planning operations will need to adopt innovative strategies and targeting for these groups. Strong public program efforts should be maintained at the same time that the private sector is encouraged to become a more significant partner in family planning."

To achieve the targeted reduction of total fertility rates from 3.41 in 1988 to 2.88 in 1994 is estimated to require an increase in the number of contraceptive users from 14.2 to 19.4 millions—a 27 percent increase. The Bank report estimates that, to achieve the contraceptive prevalence rates for 1994, the BKKBN budget would have to grow by 13 to 16 percent per annum. Projections for longer periods into the future, with much larger increases in numbers of contraceptive users, involve very large budget increases, if it is assumed that most services will continue in the public sector with little cost reimbursement. For this reason, the BKKBN has launched a major long-term drive to increase the proportion of services provided by the private sector (the K-B-Mandiri program) and for greater cost reimbursement in the public sector. USAID is devoting a major share of its current Indonesia budget funds to this purpose, but intends to phase out most of its program support by 1995. The Bank is supporting this privatization initiative, although it is less sanguine than USAID about how rapidly privatization can take place.

Estimates of probable trends in contraceptive practice depend on estimates of demand as they appear in different strata of the population whose composition is changing. The demand, in turn, depends not only on the program, but also on the extent to which continuing social and economic development will affect the demand for children and contraception. However, given the central importance the GOI attaches to reducing population growth, it is likely that it will continue to support the program strongly, until it is assured that autonomous actions by individuals will meet the need. Presumably the Bank ought to take a similar approach while holding a watching brief on the development of strongly internalized small, planned family norms and the availability of services in the private sector.

If USAID does radically reduce its participation, the Bank may need to consider larger loans, unless privatization is much more rapid than expected or other major donors appear on the scene. Large building programs are no longer needed, although there is a major need to replace obsolescent vehicles. As USAID phases out its program, there will be major unmet needs in the software areas it has been covering. Programs to develop structures appropriate for the transition to privatization and self-motivation require considerable software elements. As already indicated, the Bank is not presently well-equipped to field such software projects effectively, if they require the kind of in-country continuing technical assistance USAID has given, with its considerable staff and consultant group. If the Bank does decide to move into such software areas, it should consider having field staff resident in Indonesia and giving them some latitude for changing projects and re-allocating funds.

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50. United Nations, Department of International Economic and Social Affairs, *World Population Prospects, 1988*, Population Studies No. 106, (New York: United Nations, 1989).

51. *Ibid.*

52. World Bank, *Indonesia: Family Planning Perspectives in the 1990s* (Washington, D.C.: World Bank, 1990).

6. Lessons from the Bank's Indonesian Experience

In current negotiations for a fifth loan, a major expansion in software areas is being discussed. It is significant that this comes with a plan to make the Bank's relations with BKKBN "more flexible" by having an annual review of BKKBN-prepared plans for the next year, with the Bank's supervisory missions having authority to make reasonable changes in the field including budgetary reallocations within broad categories. If this innovation develops, it will be important to know whether such flexible annual reviews are feasible without a resident representative and with the present very limited authorized time for supervisory missions.

However, a different course of action is possible, on the assumption that after 20 years BKKBN is competent to devise and manage its own programs without detailed oversight and consultation. On that assumption, a sector loan would be appropriate, involving design and implementation of the program by the Indonesians within broad guidelines and with provision for accountability for expenditures and program results.

In interviews in Indonesia in February 1990, it appeared that BKKBN was ready for something like a sector loan, but that BAPPENAS preferred the discipline and checks of something closer to present procedures.

In several provinces of Indonesia, where prevalence levels are at about 70 percent, there are many subdistricts in which contraceptive prevalence is virtually at saturation levels. These provide an opportunity to experiment with changes in the deployment of staff and resources in such maturing programs. A recent internal economic analysis of the program suggests that In areas in which the program is well-established and not too dependent on outreach activity, as in Yogyakarta, savings may occur by reducing the BKKBN's field staff and limiting their activity to IEC. In interviews in 1990, BKKBN staff at central headquarters and in the field were not sympathetic to the idea of reducing resources in such areas. They insisted that, even where the rates were at such high levels, the staff needed to work to maintain the motivation for practice and also to work in other aspects of family welfare defined as part of BKKBN's general mission.

Eventually, in the life of any family planning program, there should be a time when the program can function independently, at first in terms of program design and implementation, and eventually, in financial terms as well. The strength of the BKKBN suggests that the Indonesian program may be one the Bank should study closely from this point of view.

What factors account for the success of the Indonesian program? To what extent are these factors ones to which the Bank made a contribution? To what extent is that experience relevant elsewhere? What could the Bank have done better or differently which might have made its contribution greater?

Consider first the favorable factors:

Strong, continuing, and reliable political support for the family planning program.

- The Bank's influence through policy dialogue was significant, especially in the early years, but also later in providing continuing legitimation for a program has always been somewhat controversial.
- Providing such support was not difficult, because the Indonesian leadership was always favorable.
- The Bank has the potential for such broad policy support everywhere it functions, but its influence is conditioned by the extent of indigenous leadership support.
- However, the Bank had relatively little influence in working with the BKKBN to develop specific operational policies through which the broad policies were implemented.

Skillful, charismatic, and stable leadership.

- While the Bank's financial support and appreciation strengthened the hands of the BKKBN leaders, the Bank probably had little influence on their selection and successful career advancement. The leadership knew how to develop and implement a program suitable for the Indonesian social environment.
- This was a fortunate given indigenous asset.
- It is not transferable. Advice to choose and support good leadership is gratuitous.

A good general administrative structure with the capacity for communication to and from the local community level and for mobilizing local community involvement.

- The BKKBN used and skillfully adapted the general administrative-political system to its special needs.
- This important institutional asset was not developed by the Bank or any other donor.
- It is basically a result of Indonesia's distinctive social, political, and cultural history.
- It is not easily transferable or created *de novo* elsewhere.

A strong and successful development program which produces both social and economic changes favorable to fertility decline and an infrastructure which facilitates family planning program operations.

- Indonesia has had such a successful development program and its leaders appreciate its links to the population program.
- The Bank has contributed substantially to the broad development program in a range of sectors generally believed to be relevant to lower fertility and mortality.
- Among sectors believed most closely linked to population, the Bank did much in education but considerably less in health. Such sectors as transportation and communication, not generally thought of as population-relevant, may have had considerable effect indirectly, both on ideas and attitudes and in facilitating the program operations.
- Supporting development broadly is something the Bank works at wherever it operates. How best to do this transcends population issues.
- By reducing the numbers of children to be served, the Indonesian family planning program is saving resources in the education and health sectors, so there are reciprocal benefits in the linkage of population and other development sectors. Further, smaller planned families improve maternal and child health.
- While the interdependence of population trends and development usually gets nominal acceptance, citation of the Indonesian example may be useful in policy dialogue elsewhere. Specifically, it may be useful to emphasize that relatively small marginal expenditures for the population sector helped move Indonesia's fertility decline more rapidly than expected from the general development program alone. Population should be seen as an integral part of a general development effort, with reciprocal effects involving relatively small direct costs for the population sector.

A pervasive network of community-based volunteer groups and workers providing information, services, and most important, social support and pressure for the legitimacy and desirability of small, planned families.

- The BKKBN has been exceptionally successful in building this network.
- The Bank and other donors have supported this effort in various ways.
- However, the success of this massive effort rests mainly on the consensus-building meetings and group activities, the central Government's ability to mobilize action at the village base effectively, and on the BKKBN's high-priority effort toward building this important network and maintaining its vitality over many years.
- Within Indonesia, the BKKBN is a leading model for development efforts utilizing this community-based, voluntary-effort approach.
- The basic idea of using voluntary groups in community-based service and social support networks is relevant for almost all countries. Each country must build such networks to fit its own situation, but it may require social innovations. It will be difficult where governments do not have strong capacities for communication interchanges with the villages and for mobilizing community involvement. However, since program success will be difficult without such networks, how to implement these ideas deserves close attention almost everywhere.

The BKKBN as an effective, free-standing coordinating agency.

- The ability of the BKKBN to move regular ministries to action has depended on its very strong political support.
- Its effectiveness has also depended on its capacity for direct implementation when needed.
- The Bank and other donors supported the creation of the BKKBN and contributed substantially to its development.
- Such an agency deserves serious consideration in other countries, as an alternative to placing this function with typically weak ministries of health. However, agencies on the BKKBN model will be unable to elicit action from the agencies they are supposed to co-ordinate without very strong political support.

Strong support for the BKKBN by both multilateral and bilateral donors.

- While primary credit for program success belongs to the BKKBN, the financial, technical, and intellectual support of the donors was considerable.
- The Bank's distinctive contribution was in hardware elements, where it has a comparative advantage:

1. The network of buildings and equipment and the vehicles provided under Bank loans were essential infrastructure for the program. The Bank specialized in providing these elements successfully.
2. The Bank has long experience with hardware elements in many sectors and countries.
3. The hardware elements may seem prosaic, but they are important, providing other donors are supporting the program software elements which the buildings and vehicles must serve.
4. These are desirable and deliverable elements in most other countries, although the infrastructure necessary for good building and transportation components will vary considerably.

- The Bank's contribution in the software area consisted of implementing ideas developed by others to a significant extent.
  1. A *de facto* division of labor existed between the Bank and other donors, in which the Bank implicitly accepted their leadership in advising on program design.
  2. Implicit recognition by the Bank of this division of labor is to its credit. Especially in recent years, this has involved co-operation with other donors in evaluation and implementation of software project elements.
  3. Such a division of labor was reasonable as long as the Bank did not wish to allocate the resident staff and consultants needed to develop and test software ideas in the field. However, this meant that the Bank did not exercise leadership or gain experience in program software areas which are of increasing importance.
  4. If such a division of labor is recognized and fostered, it is probably transferable to other countries, providing other donors are available for the complementary roles.

What might the Bank have done better or differently that could have increased its contribution to the population program?

- Especially during the first decade, a resident Bank presence probably would have speeded and improved even the hardware components. A resident field representative for population could have made the Bank's projects more flexible and efficient by facilitating changes in project components as needed. Further, it might have led the Bank to a larger and more innovative role in the related software areas. However, substantial gain from a resident staff would have required giving that staff latitude in making changes in projects and in reallocating funds. That the Bank did not do more in the software areas in Indonesia probably was not important for the Indonesian program, because other donors met that need. However, in places like Sub-Saharan Africa, the Bank's role will be very limited if it does not have the capacity to assist in the software aspects of IEC, creation of effective demand, and service delivery. These are particularly important where the existing infrastructure is poor and general development levels are low.
- The Bank could have been more sensitive and cooperative in its relation to other donors. The benefits of a better relationship have become evident in recent years. More regular reporting of the division of labor and relationships with other donors would have been a helpful part of project completion reports, audits, and other documents. This is still desirable.
- The Bank could have taken earlier and stronger initiatives in the health sector, which has both direct and indirect effects on the population sector. Emphasis on the intersectoral linkage of health and population might have strengthened the case for improving the health system, especially in maternal and child health. This opportunity still exists, since the Indonesians are well aware of the linkage and of the inadequacies of their health system.
- More generally, Indonesia is a place in which the Bank, cooperatively with the Indonesians, might have developed and tested strategies for intersectoral connections between population and other sectors. The Bank is certainly the best-qualified among donors to take a lead in this direction. The BKKBN's efforts in linking income-generation and other development activities to the population program have not been systematically evaluated. The Community Incentive scheme under the second Bank project did not produce useful results for various reasons. However, the Bank has not given this general problem the sustained attention it merits, either in Indonesia or elsewhere.

The Bank might have provided more intellectual leadership in analyzing:

- The interconnections between development, the population program, and the socio-cultural structure in Indonesia. Indonesia is a good example of these inter-sectoral and inter-institutional connections which are at the heart of the Bank's general mission.
- The elements making for success in a program which is eminent in its ability to field a truly successful community-based program. There is enough variability between areas in the country in program achievements to make a study of determinants worthwhile.

To carry out or to commission and monitor such studies requires commitment of staff working on Indonesia and other selected countries for some period of time. The PHN staff allocation is too small to add this to its other responsibilities. The knowledge base in human resource areas is not as well-developed as in areas with greater hardware

components. Social and economic history is being made in the human resource areas in places like Indonesia. The Bank should consider more than average allocation of analytical staff time to the PHN area. If additional justification is needed, investment in this area can be considered as relevant for the indirect population component of the general development programs.

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