POPULATION CRISIS

HEARINGS

BEFORE THE

SUBCOMMITTEE ON FOREIGN AID EXPENDITURES

OF THE

COMMITTEE ON GOVERNMENT OPERATIONS UNITED STATES SENATE

EIGHTY-NINTH CONGRESS

SECOND SESSION

ON

S. 1676

A BILL TO REORGANIZE THE DEPARTMENT OF STATE AND THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

APRIL 7, 8, AND 11, 1966

PART 4

Printed for the use of the Committee on Government Operations

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POPULATION CRISIS

THURSDAY, APRIL 7, 1966

U.S. SENATE,
SUBCOMMITTEE ON FOREIGN AID EXPENDITURES,
COMMITTEE ON GOVERNMENT OPERATIONS,
Washington, D.C.

The subcommittee met at 10 a.m., pursuant to recess, in room 3302, New Senate Office Building, Senator Ernest Gruening (chairman of the subcommittee) presiding.

Present: Senators Gruening and Metcalf.

EXHIBIT 127

The witness who testified on S. 1676 before the Subcommittee on Foreign Aid Expenditures on Thursday, April 7, 1966, was the Honorable John W. Gardner, Secretary of Health, Education, and Welfare. Secretary Gardner was accompanied by Dr. Philip R. Lee, Assistant Secretary for Health and Scientific Affairs; Dr. William H. Stewart, the Surgeon General; and Dr. Arthur Lesser, Deputy Chief of the Children's Bureau. (Pictured, left to right: Senator Ernest Gruening, chairman; and Secretary Gardner.)

Also present: Herbert W. Beaser, chief counsel; Laura Olson, special consultant on population problems; Carole Ransom and Harriet Eklund, editors; Mary A. Miller, clerk; and William J. Walsh III, professional staff member.

Senator GRUENING. Before proceeding to my opening statement, I will ask that a photograph taken today of our distinguished witness be placed in the record.

OPENING STATEMENT OF THE CHAIRMAN

Senator GRUENING. The hearing will be in order.

The Honorable John W. Gardner, Secretary of the Department of Health, Education, and Welfare, was president of the Carnegie Corp. of New York and the Carnegie Foundation for the Advancement of Teaching at the time of his appointment to the Cabinet by President Johnson on July 27, 1965.

When John Gardner was sworn in as Secretary in the Rose Garden at the White House on August 18, 1965, President Johnson said, most appropriately:

"This administration is seeking new ideas and it is certainly not going to discourage any new solutions to the problem of population growth and distribution."

I hope the author of "Excellence: Can We Be Equal and Excellent Too?" will take the President at his word.

I direct that the official biographic statement of Secretary Gardner be included at this point in the record.

BIOGRAPHIC STATEMENT: JOHN W. GARDNER

John W. Gardner, Secretary of Health, Education, and Welfare, was president of the Carnegie Corporation of New York and of The Carnegie Foundation for the Advancement of Teaching at the time of his appointment to the Cabinet by President Johnson on July 27, 1965.

He was born in Los Angeles, California, in 1912.

He is an Honorary Fellow of Stanford University where he received his A.B. and M.A. degrees. He received his Ph.D. degree at the University of California and holds honorary degrees from numerous colleges and universities in the United States and Canada.

Before World War II, Mr. Gardner taught psychology at Connecticut College for Women and Mount Holyoke College.

In 1942, Mr. Gardner served as chief of the Latin American Section of Foreign Broadcast Intelligence Service of the Federal Communications Commission.

The following year he joined the U.S. Marine Corps and was assigned to the Office of Strategic Services. He served with the OSS in Washington, Italy, and Austria. At the time of his release from active duty, he held the rank of Captain.

Mr. Gardner joined the Carnegie Corporation in 1946 as executive associate. He became president in 1955, and the same year was made president of The Carnegie Foundation for the Advancement of Teaching.

He has at various times served as consultant to the U.S. Delegation to the United Nations, the Air Force, the Department of Defense, the

Agency for International Development, the U.S. Office of Education, and the White House. He served on the special Task Force on Education established by President Kennedy shortly after his election in 1960. He was chairman of the U.S. Advisory Commission on International Educational and Cultural Affairs (1962–1964), President Johnson's Task Force on Education (1964), and of the White House Conference on Education (1965).

Mr. Gardner holds the U.S. Air Force Exceptional Service Award, and in 1964 was awarded the Presidential Medal of Freedom, the highest civil honor in the United States.

Prior to his appointment, Mr. Gardner served as a member of the board of the Metropolitan Museum of Art and the American Association for the Advancement of Science; and is a fellow of the American Psychological Association and of the American Academy of Arts and Sciences. He is a member of the Council on Foreign Relations and the society of Sigma Xi.

As chairman of the Panel on Education of the Rockefeller Brothers Special Studies Project, he was chief draftsman of the report, "The Pursuit of Excellence." He is the author of the chapter "National Goals in Education" in the report of President Eisenhower's Commission on National Goals (Goals for Americans) and also wrote the chapter "Can We Count on More Dedicated People?" in the book "The National Purpose." He is the editor of President John F. Kennedy's book "To Turn the Tide." He is the author of the books "Excellence: Can We Be Equal and Excellent Too?" and "Self-Renewal: The Individual and the Innovative Society."

Mr. Secretary, we are happy to have you here and to hear what your Department's reactions are to this legislation and what you propose to do in this field.

Please proceed in your own way.

STATEMENT OF HON. JOHN W. GARDNER, SECRETARY OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY DR. PHILIP R. LEE, ASSISTANT SECRETARY FOR HEALTH AND SCIENTIFIC AFFAIRS; DR. WILLIAM H. STEWART, THE SURGEON GENERAL; AND DR. ARTHUR LESSER, DEPUTY CHIEF OF THE CHILDREN'S BUREAU

Secretary GARDNER. Mr. Chairman and members of the subcommittee, I am pleased to appear before you today to summarize the Department's activities and its position on S. 1676.

". . . ALL OF US . . . SHARE IN A DEEP CONCERN FOR THE PROBLEMS OF INCREASING WORLDWIDE POPULATION PRESSURES"

I feel certain that all of us in this room, and probably most of us in this Nation, share in a deep concern for the problems of increasing worldwide population pressures. In recent months, that concern has been expressed repeatedly, clearly, and forcefully. It has been expressed by the President, by members of his Cabinet, and by many Members of the Congress.

Over the past 9 months, in your most informative and constructive hearings, this committee has heard from more than 75 distinguished

citizens from a variety of backgrounds who presented their views on many aspects of this complex problem.

I can add nothing to what they have said about the nature of the problem, its scope, or its implications. Instead, with your permission, I shall indicate briefly what we are now doing to deal with the problem, and review the Department's policy, program, and plans as they relate to the proposed legislation.

HEW POPULATION POLICY DEFINED

On January 24, 1966, I issued a memorandum on the subject of population dynamics, fertility, sterility, and family planning. This defined our Department policy. It read as follows:

"The policy of this Department is to conduct and support programs of basic and applied research on the above topics; to conduct and support training programs; to collect and make available such data as may be necessary to support, on request, health programs making family planning information and services available; and to provide family planning information and services, on request, to individuals who receive health services from operating agencies of the Department.

"The objectives of the departmental policy are to improve the health of the people, to strengthen the integrity of the family and to provide families the freedom of choice to determine the spacing of their children and size of their families.

"Programs conducted or supported by the Department shall guarantee freedom from coercion or pressure of mind or conscience. There shall be freedom of choice of method so that individuals can choose in accordance with the dictates of their consciences.

"The Department will make known to State and local agencies that funds are available for programs of the sort described above, but it will bring no pressure upon them to participate in such programs.

"Each agency shall assure the effective carrying out of this policy, the regular evaluation of programs and the reporting of information on programs to this office.

"The Assistant Secretary for Health and Scientific Affairs will serve as the focal point for departmental policy and program coordination; will review and evaluate policies and programs; will conduct liaison with other departments; and will cooperate with interested public and private groups."

All the activities specified in the statement I have just read were already being carried on by the Department's constituent agencies. But the Office of the Secretary had never expressed a departmental position on such matters. I thought it would be useful to say to the constituent agencies just what I conceived departmental policy to be.

Let me review our present activities:

1. Programs of basic and applied research and research training are being expanded.

2. Training programs in many fields related to population growth and family planning are being supported.

3. Information is being furnished upon request to State and local health agencies developing or expanding local planning programs.

4. Family planning information and services are being supplied, on request, to individuals—including many American Indians and

other beneficiaries—who receive health services from the Public Health Service.

5. Family planning information and services are becoming increasingly available to public welfare recipient families as State public health and welfare departments adopt appropriate policy positions and expand their health services.

6. Through the Bureau of Family Services, the Children's Bureau, and the Public Health Service, we have already made known to universities, research centers, State agencies, and local organizations that funds are available for research, training, and service in this field, and such funds are now being so used.

7. The Assistant Secretary for Health and Scientific Affairs, who has been given the responsibility for departmental policy and program coordination, is serving effectively in that capacity, and has been doing so for many months.

8. Each agency in the Department is evaluating and reporting its operations in this field, and furnishing accounts to the Office of the Assistant Secretary for Health and Scientific Affairs. We will soon be submitting our report on these activities.

YEARS BEFORE VALUE OF PROGRAMS CAN BE MEASURED

The value of these various activities can be measured only by their lasting effectiveness in improving health, strengthening family integrity, and providing families with knowledge and with the freedom of choice to determine the size of their families. It will probably be years before such yardsticks can be applied.

There are, however, other yardsticks which we can use to give some measure of our efforts.

FERTILITY RESEARCH FUNDING DOUBLES: FROM $1 MILLION TO $2 MILLION

In terms of manpower, throughout the Department some 165 professional and technical staff members are engaged in work directly related to the population field. The number is not large, but it is twice the number so employed a year ago.

We estimate that $6.5 million are being expended for basic and applied research in population studies during fiscal year 1966. This includes the spectrum of activities in family planning, in fertility, demography, human reproduction, and related fields. Of the funds available for research, approximately $2 million will be spent for research directly related to human fertility regulation. This is double the figure for fiscal year 1965.

For training of professional and technical personnel, $1.7 million are being expended in fiscal year 1966.

For identifiable family planning services, $3.1 million are being expended in fiscal year 1966. The figure for fiscal year 1965 was $2 million. In addition, family planning services play an unidentifiable but probably significant role in the aid now being provided to public assistance beneficiaries and to recipients of care under the maternal and child health program.

The major departmental support for family planning programs is through the Children's Bureau formula and project grants to the States.

More than 30 of our States are now providing some service to families who request family planning assistance. Two years ago, the number was only 13.

THE DEPARTMENT "IS NOT MOVING AHEAD AS RAPIDLY AS ALL OF US MIGHT HOPE"

These developments, and others like them, may be taken as evidence that the Department is moving ahead to seek solutions for the many problems related to population growth and family planning. It is not moving as rapidly as all of us might hope, and it has not achieved the goals which we are hopeful of reaching in the future. We are not satisfied, and we can never be satisfied, but it is evident that we are making progress.

OFFICE OF POPULATION PROBLEMS NOT NEEDED

Section 3(a) of S. 1676 calls for the creation, within the Department of HEW, of an Office of Population Problems, and an Office of Assistant Secretary for Health, Medical Services, and Population Problems. I believe it is evident from our policy statement, from the assignment of responsibilities to the Assistant Secretary for Health and Scientific Affairs, and from the programs currently implemented and planned, that we are already achieving most of the objectives sought in that section of the bill. We believe it would be undesirable to establish by statute an Office of Population Problems and to specify the duties of an Assistant Secretary of the Department.

Section 3(b) calls for an annual report to the President and to the Congress. As I indicated earlier, a detailed report is in preparation and will soon be available to you.

Development of a 1967 White House Conference on Population, proposed in section 4, would ultimately be the decision of the President. Should the President decide such a White House Conference is indicated, and if the Department were delegated to arrange it, we would, of course, carry out our responsibilities. The President, however, has not made this decision.

SECRETARY GARDNER CALLS NECESSITY FOR 1967 CONFERENCE "DOUBTFUL"

The necessity for such a conference in the immediate future appears to us to be doubtful. In making his decision, the President would be forced to consider the costs—in terms of dollars, manpower, effort, and time—against a multitude of competing major public issues.

It is important to note here that, since the beginning of the most informative hearings on this bill, there have been numerous conferences—local, regional, national, and international—in which population dynamics, fertility, sterility, and family planning have been considered in great detail.

These subjects were likewise given high priority during the White House Conferences on Health and International Cooperation Year.

Many conferences and meetings in these fields are scheduled in the months ahead.

DENIES NEED FOR ADDITIONAL STATUTORY AUTHORITY IN POPULATION FIELD

For these reasons, it is our feeling that a White House Conference on Population is not required in 1967.

We also believe that, at this time, additional statutory authority for this Department is not necessary to enable us to carry out our responsibilities in this field and to achieve the objectives presented in S. 1676. We defer, of course, to the views of the Department of State with respect to section 2 of the bill, proposing an Office for Population Problems in that Department.

"THE HEARINGS OF THIS COMMITTEE HAVE CONTRIBUTED IMPORTANTLY TO PUBLIC UNDERSTANDING . . ."

As you can see, we are moving ahead vigorously in this field, and I do not believe that enactment of S. 1676 would contribute a great deal to what we are already doing. At the same time I wish to say that everyone of us active in this field is indebted to the distinguished chairman of this committee for the moral and intellectual support he has provided toward the objectives which we share. The hearings of this committee have contributed importantly to public understanding of the problems we are all trying to solve.

Mr. Chairman, in conclusion, I thank you for the opportunity to meet with you today. Dr. Philip R. Lee, the Assistant Secretary for Health and Scientific Affairs; Dr. William H. Stewart, the Surgeon General; and Dr. Arthur Lesser, Deputy Chief of the Children's Bureau, are with me. We would be happy to respond to any questions you may have.

Senator GRUENING. Thank you very much, Mr. Secretary.

Now, I notice that you propose to do nothing new and merely to continue to do just what you say you have been doing. You will place this activity in the Office of the Assistant Secretary for Health and Scientific Affairs; is that correct?

Secretary GARDNER. Yes. sir.

SENATOR GRUENING CALLS HEW PRESENTATION "NEGATIVE" AND "DISAPPOINTING"

Senator GRUENING. Now, you have six Assistant Secretaries in the Department. You have an Assistant Secretary for Legislation, you have an Assistant Secretary for Water Pollution, you have an Assistant Secretary for Education, you have an Assistant Secretary for Individual and Family Services, you have an Assistant Secretary of Program Coordination, and yet, you are going to lump all of this major assignment into the office of the Assistant Secretary who already has the two major tasks of taking care of both health and scientific affairs. It seems to me this is a very negative presentation. All you are saying is, "We are going to do what we are doing. We are not going to do anything new." In view of the importance of this subject, in view of the President's pronouncement on this subject, I think it is a very disappointing presentation.

A VERY INADEQUATE PROSPECTUS

You are going to do under the table what has been done before and this is precisely what is wrong with this whole program. Instead of dramatizing this problem and meeting its challenge and saying you are going to tackle this problem head on and in the open, you are saying you are doing all this now. Actually, you are not doing much of anything in this field. It is a very inadequate prospectus and it does not meet the challenge at all in my judgment.

I am going to ask you a few questions.

You say the policy of the Department is to conduct and support programs of basic and applied research on the above topics; to conduct and support training programs; to collect and make available such data as may be necessary to support, on request, health programs making family planning information and services available.

SECRETARY SAYS POPULATION SERVICES INCLUDE THE SUPPLYING OF CONTRACEPTIVES

When you say "services available," does that mean that you are going to furnish contraceptive techniques—that you are going to supply contraceptive materials to those who request them?

Secretary GARDNER. Yes, sir; this is part of the program in the States.

Senator GRUENING. How much are you going to spend on this program?

Secretary GARDNER. I will have to ask Dr. Lee to answer that question.

Senator GRUENING. The subcommittee will be pleased to hear from Dr. Lee. I will insert into the hearing record his biographic sketch which indicates that he has also worked at the Agency for International Development in fields related to health and family planning.

BIOGRAPHIC STATEMENT: PHILIP R. LEE

Dr. Philip R. Lee was born in San Francisco, April 27, 1924. He received his A.B. degree from Stanford University in 1945 and his M.D. from the Stanford University School of Medicine in 1948.

Following internship at Massachusetts Memorial Hospital in Boston, he became assistant resident physician at Stanford University Hospital in Stanford, Calif.

In 1949, Dr. Lee volunteered for active duty in the U.S. Navy, and served for 2 years as a lieutenant in the Medical Corps. He spent most of this time on active sea duty, except for 1 year in the Korean theater.

He then became a fellow at the Bellevue Medical Center of New York University.

From 1953 to 1955, as a fellow at the Mayo Clinic in Rochester, Minn., Dr. Lee continued his training at the University of Minnesota Graduate School, from which he received a master of science degree.

Following a year of teaching and research at New York University's Bellevue Medical Center, Dr. Lee returned to California as a staff member of the Palo Alto Medical Clinic and assistant clinical professor of the Stanford University School of Medicine.

From March 1963 to August 1965, Dr. Lee served as Director of Health Services in the Agency for International Development, Office of Technical Cooperation and Research. In May 1965 he was given AID's Superior Honor Award. He was cited for establishing "new policies, priorities, and programs in the fields of health, nutrition, and population."

Dr. Lee served as Deputy Assistant Secretary of Health, Education, and Welfare from August 16, 1965, to November 2, 1965, and since that time has been Assistant Secretary for Health and Scientific Affairs.

He is the author of numerous scientific articles and has contributed to many textbooks. He is a member of Alpha Omega Alpha, the American Medical Association, the American Public Health Association, the American College of Physicians, and the American Federation for Clinical Research.

He and his wife, Clara, have five children. The family resides in Tulip Hill, Md.

Dr. Lee, please proceed.

Dr. LEE. Senator, the amount the Department will spend depends upon the rate at which local and State programs are developed. As the Secretary indicated in his testimony, these programs have increased from 13 States several years ago to over 30 States at the present time. The expenditure by the Department has increased from $2 million in 1965 to $3.1 million in 1966. It is difficult to estimate the amount of money that will be required to develop the necessary services through the public assistance programs administered by the Welfare administration; the formula and project grants to the States administered by the Public Health Service; and the maternal and child health formula grants to the States and the maternal and infant care grants to local institutions, administered by the Children's Bureau.

We see these within a context of comprehensive health services and particularly as part of good maternal health care.

It is difficult, as I indicated, to give a precise figure for the amount of money that will be expended. For example, it is difficult when you are providing maternity care to a woman, including post-partum care and family planning services, to say how much of that care was for family planning.

Senator GRUENING. What are the scientific affairs which you have jurisdiction over? Could you list them?

Dr. LEE. The scientific affairs in the Department, Senator, include the scientific activity in the Public Health Service, the research activities of the National Institutes of Health, the scientific activities in the Food and Drug Administration, and the scientific activities related to other operating agencies.

My concerns are particularly with departmental policies area, with the development of new programs, with budget review, and with the development of new legislation. We are not directly involved in the operating programs. Those are the responsibilities of the heads of the operating agencies such as the Surgeon General, Dr. Stewart.

Senator GRUENING. What specific instructions have been issued by the Department and to its constituent and regional offices and the State agencies with respect to family planning? Have you issued any such instructions?

Dr. LEE. We could ask both the Surgeon General and Dr. Lesser to indicate what information they have given to their respective people in the States and in the regional offices.

Senator GRUENING. We would like to hear from the Surgeon General. Before you begin, Dr. Stewart, I will place your biographic sketch in the hearing record.

BIOGRAPHIC STATEMENT: WILLIAM H. STEWART

Dr. William H. Stewart was named Surgeon General of the Public Health Service by President Lyndon B. Johnson on September 24, 1965. Six days later, the U.S. Senate confirmed his appointment as 10th Surgeon General in the 167-year history of the Service.

As Surgeon General, Dr. Stewart administers the 100-odd programs of the Public Health Service, whose 1965 budget approximates $2 million and whose personnel numbers in excess of 38,000 persons.

Born in Minneapolis, Minn., on May 19, 1921, he attended the University of Minnesota and Louisiana State University, and received his medical degree from Louisiana State University School of Medicine in 1945. His internship at Philadelphia General Hospital was followed by 2 years' duty with the U.S. Army Medical Corps. Upon completion of his residency in pediatrics at Charity Hospital, New Orleans, he was in private practice in Alexandria, La., until he entered the Public Health Service in 1951. He was certified by the American Board of Pediatrics in 1953.

His first 2 years as a Public Health Service career officer were spent in Thomasville, Ga., where he headed the epidemiological unit of the Communicable Disease Center. He came to PHS headquarters in 1953 to serve the next 4 years with the National Heart Institute and the heart control program of the Bureau of State Services. The next 8 years, he spent in a staff capacity, first to the Surgeon General and, later, to the Secretary of Health, Education, and Welfare.

In 1957, he became Assistant to the Surgeon General and the following year was named Chief of the Division of Public Health Methods, major staff planning arm to the Surgeon General. During the 3 years he held that post, he also served as Executive Director of the Surgeon General's Committee on Medical Manpower which issued "Physicians for a Growing America"; was a member of the study group on the mission and organization of the Public Health Service; and was Staff Director for the study of environmental health, conducted by the National Advisory Health Council and for the special report of the same Council on the role of the Service in medical care.

In early 1963, after organizing the new Division of Community Health Services, he was named to the immediate office of the Secretary of HEW as Assistant to the Special Assistant to the Secretary (Health and Medical Affairs). He left that post last August to become Director of the National Heart Institute, the office he held when he was named Surgeon General.

Dr. Stewart is author of scores of publications and presentations dealing with a wide range of public health issues including spread and control of various diseases, health status of the population, education for the medical and health professions, and medical care administration.

He is a member of the American Academy of Pediatrics, the American Medical Association, the American Heart Association, and the American Public Health Association. Dr. and Mrs. Stewart and their two daughters reside at 9108 Ewing Drive, Bethesda, Md.

Please proceed.

Dr. STEWART. Just after the policy statement was issued by the Secretary's Office I issued a memorandum to all of the bureaus of the Public Health Service and to our regional health directors in the regional offices attaching a copy of the policy statement and requesting that they reexamine their programs in these areas and assure that they were brought into full accord with the policy.

Senator GRUENING. Were those instructions given in writing?

Dr. STEWART. Yes, sir.

Senator GRUENING. Would you let the subcommittee have copies of those instructions?

Dr. STEWART. Certainly.

(Material submitted to the subcommittee follows:)

EXHIBIT 128

MEMORANDUMS PERTAINING TO DEPARTMENTAL POLICY ON POPULATION DYNAMICS, FERTILITY, STERILITY, AND FAMILY PLANNING

(From Surgeon General William H. Stewart to the Chief, Bureau of Medical Services; Chief, Bureau of State Services (CH); Director, National Institutes of Health; Director, National Center for Health Statistics, Jan. 24, 1966)

Attached is a copy of the memorandum on this subject which was signed by Secretary Gardner on January 24, 1966.

Please reexamine your programs in these areas and assure that they are brought into full accord with both the spirit and the letter of this policy statement.

WILLIAM H. STEWART,
Surgeon General.

MEMORANDUM TO HEADS OF OPERATING AGENCIES

Subject: Departmental Policy on Population Dynamics, Fertility, Sterility, and Family Planning

The policy of this Department is to conduct and support programs of basic and applied research on the above topics; to conduct and support training programs; to collect and make available such data as may be necessary to support, on request, health programs making family planning information and services available; and to provide family planning information and services, on request, to individuals who receive health services from operating agencies of the Department.

The objectives of the Departmental policy are to improve the health of the people, to strengthen the integrity of the family and to provide families the freedom of choice to determine the spacing of their children and the size of their families.

Programs conducted or supported by the Department shall guarantee freedom from coercion or pressure of mind or conscience. There shall be freedom of choice of method so that individuals can choose in accordance with the dictates of their consciences.

The Department will make known to State and local agencies that funds are available for programs of the sort described above, but it will bring no pressure upon them to participate in such programs.

Each agency shall assure the effective carrying out of this policy, the regular evaluation of programs and the reporting of information on programs to this office.

The Assistant Secretary for Health and Scientific Affairs will serve as the focal point for Departmental policy and program coordination; will review and

evaluate policies and programs; will conduct liaison with other Departments; and will cooperate with interested public and private groups.

S/JOHN W. GARDNER.

Addressees:
Commissioner of Aging
Commissioner of Education
Commissioner of Food and Drugs
Acting Commissioner, Federal Water Pollution Control Administration
Surgeon General, Public Health Service
Superintendent, Saint Elizabeths Hospital
Commissioner of Social Security
Commissioner of Vocational Rehabilitation
Commissioner of Welfare

CC:
Under Secretary
Assistant Secretary for Legislation
Assistant Secretary for Environmental Health
Assistant Secretary for Education
Assistant Secretary for Program Coordination
Assistant Secretary for Individual and Family Services
Assistant Secretary for Health and Scientific Affairs
Assistant Secretary for Administration
Comptroller
General Counsel
Director, Office of Public Information
Acting Director, Office of Field Administration
Mr. Meier
Mr. Levy
Mr. Naisbitt
Mr. Libassi

Senator GRUENING. Now, Dr. Lee, I notice in this table of Assistant Secretaries' duties nothing whatever is said about population control. I would like to ask this of Secretary Gardner.

GIVE PROPER CREDIT FOR THE IMPORTANCE OF THE SUBJECT

Do you not think that the subject is sufficiently important so that the Assistant Secretary, if you are going to lump this population control activity with his other duties, should be given this additional title? Should not he be named an Assistant Secretary for Health, Scientific Affairs, and Population Programs?

SECRETARY GARDNER CONCERNED ABOUT LIMITING FLEXIBILITY

Secretary GARDNER. Perhaps in my testimony I did not express how strongly I feel about the disadvantages of a formal designation of duties for the Assistant Secretaries. I think if we had an Assistant Secretary for every significant problem in our Department we would have 30 or 40 of them. I believe that if we lodged in the title of each Assistant Secretary the full range of his duties we would seriously limit our flexibility.

To me, the titles are of relatively little importance. The important thing is the quality of the men and their understanding with me as to what their duties are. Those are lodged in writing.

Senator GRUENING. There is absolutely no evidence from your words and actions that you are really concerned about population problems.

Secretary GARDNER. That is a matter of record.

Senator GRUENING. It is sufficiently important for the President to have made 20 statements on the gravity of the population explosion

and urging appropriate action. It is almost without precedent for the President of the United States, since his election, to have made 20 statements in favor of action on any one issue. And yet this Department which has—which would have the major responsibility for this program does not even list it among its activities. I would hope that there would have been an Assistant Secretary for Population Problems exclusively, instead of which you do not even add population problems to the multiple duties of the Assistant Secretary for Health and Scientific Affairs. I consider this an evasion of the issue.

Secretary GARDNER. Sir, I issued a memorandum over my signature stating very clearly the responsibilities of the Assistant Secretary for Health and Scientific Affairs in this field. That memorandum is a matter of record now and a matter of public record.

HEW PROGRAMS DONE "UNDER THE TABLE" AND WITHOUT ENTHUSIASM

Senator GRUENING. The difficulty with this whole problem is that people have been afraid of it and your Department is still afraid of it. Instead of facing it frankly and forthrightly, you are continuing to do it under the table. You say we are doing these things all in very vague terms, but you do not state positively and definitely that you are going to tackle this with the kind of enthusiasm that it seems to me the President of the United States in his repeated messages demands.

I am going to take the liberty of reading these messages because I think it is important that this be made part of the record.

PRESIDENT JOHNSON'S MANDATE

1. State of the Union address before Congress, January 4, 1965:

"I will seek new ways to use our knowledge to help deal with the explosion in world population and the growing scarcity in world resources."

2. Twentieth Anniversary of the United Nations at San Francisco, June 25, 1965:

"Let us in all our lands—including this land—face forthrightly the multiplying problems of our multiplying populations and seek the answers to this most profound challenge to the future of all the world. Let us act on the fact that less than $5 invested in population control is worth $100 invested in economic growth." I would say that this was a mandate to his Department.

3. Swearing-in ceremony of John W. Gardner as Secretary of Health, Education, and Welfare in Rose Garden, the White House, August 18, 1965:

"This administration is seeking new ideas and it is certainly not going to discourage any new solutions to the problems of population growth and distribution." Yet, there are no new solutions. You say we are going to continue to do what we are doing.

4. Text of letter to U.N. Secretary General U Thant at Second United Nations World Population Conference opening in Belgrade, August 30, 1965:

"My Dear Mr. Secretary General:

"The United States Government recognizes the singular importance of the meeting of the second United Nations World Population Conference and pledges its full support to your great undertaking.

"As I said to the United Nations in San Francisco, we must now begin to face forthrightly the multiplying problems of our multiplying population. Our Government assures your Conference of our wholehearted support to the United Nations and its agencies in their efforts to achieve a better world through bringing into balance the world's resources and the world's population.

"In extending my best wishes for the success of your Conference, it is my fervent hope that your assemblage of population experts will contribute significantly to the knowledge necessary to solve this transcendent problem. Second only to the search for peace, it is humanity's greatest challenge. This week, the meeting in Belgrade carries with it the hopes of mankind."

NINETEEN HUNDRED AND SIXTY-SIX

5. State of the Union address before Congress, January 12, 1966:

"That is what I have come to ask of you * * *."

"I recommend that you give a new and daring direction to our foreign aid program, designed to make a maximum attack on hunger, disease, and ignorance in those countries that are determined to help themselves, and to help those nations trying to control population growth.

6. "I will also propose the International Health Act of 1966 to strike at disease by a new effort to bring modern skills and knowledge to the uncared-for suffering of the world—and by wiping out smallpox, malaria, and controlling yellow fever over most of the world in this decade, to help countries trying to control population growth, by increasing our research, and we will earmark funds to help their efforts."

7. Ceremony held at the Harry S. Truman Center for the Advancement of Peace, January 20, 1966, Independence, Mo.:

". . . we will increase our efforts in the great field of human population. The hungry world cannot be fed until and unless the growth in its resources and the growth in its population come into balance. Each man and woman—and each nation—must make decisions of conscience and policy in the face of this great problem. But the position of the United States of America is clear. We will give our help and our support to nations which make their own decision to insure an effective balance between the numbers of their people and the food they have to eat. And we will push forward the frontiers of research in this important field."

8. Foreign aid program message to the Congress, February 1, 1966:

"Yet today the citizens of many developing nations walk in the shadow of misery: half the adults have never been to school; over half the people are hungry or malnourished; food production per person is falling; at present rates of growth, population will double before the year 2000.

"These are the dominant facts of our age. They challenge our own security. They threaten the future of the world.

"OUR RESPONSE MUST BE BOLD AND DARING"

"Our response must be bold and daring. It must go to the root causes of misery and unrest. It must build a firm foundation for progress, security, and peace.

9. "Only these people and their leaders can—

"Invest every possible resource in improved farming techniques, in school and hospital construction, and in critical industry;

"Make the land reforms, tax changes, and other basic adjustments necessary to transform their societies;

"Face the population problem squarely and realistically;

"Create the climate which will attract foreign investment, and keep local money at home."

10. "In many other countries food output is also falling behind population growth. We cannot meet the world food needs of the future, however willing we are to share our abundance. Nor would it serve the common interest if we could."

11. "We stand ready to help developing countries deal with the population problem.

"The United States cannot and should not force any country to adopt any particular approach to this problem. It is first a matter of individual and national conscience, in which we will not interfere.

"But population growth now consumes about two-thirds of economic growth in the less developed world. As death rates are steadily driven down, the individual miracle of birth becomes a collective tragedy of want.

"In all cases, our help will be given only upon request, and only to finance advisers, training, transportation, educational equipment, and local currency needs.

"Population policy remains a question for each family and each nation to decide. But we must be prepared to help when decisions are made."

12. "Technical cooperation: This request—$231 million—will finance American advisers and teachers who are the crucial forces in the attack on hunger, ignorance, disease, and the population problem. The dollar total is relatively small. But no appropriation is more critical. No purpose is more central."

International education and health programs message, February 2, 1966:

13. "We have committed ourselves for many years to relieving human suffering. Today our effort must keep pace with a growing world and with growing problems."

14. "Therefore, I propose a program to—Create an international career service in health; help meet health manpower needs in developing nations; combat malnutrition; control and eradicate disease; cooperate in worldwide efforts to deal with population problems."

15. "But food production has not kept pace with the increasing demands of expanding population."

16. In part 5, the President carefully spells out his proposal—"to cooperate in worldwide efforts to deal with population problems:

"By 1970, there will be 300 million more people on this earth. A reliable estimate shows that at present rates of growth the world population could double by the end of the century. The growing gap—between food to eat and mouths to feed—poses one of mankind's greatest challenges. It threatens the dignity of the individual and the sanctity of the family.

"WE MUST MEET THESE PROBLEMS"

"We must meet these problems in ways that will strengthen free societies—and protect the individual right to freedom of choice.

"To mobilize our resources more effectively, I propose programs to:

"(1) *Expand research in human reproduction and population dynamics.*—We are supporting research efforts through the Department of Health, Education, and Welfare, AID, and the World Health Organization. I am requesting funds to increase the pace and scope of this effort. The effort, to be successful, will require a full response by our scientific community.

"(2) *Enlarge the training of American and foreign specialists in the population field.*—We are supporting training programs and the development of training programs through the Department of Health, Education, and Welfare and AID. We will expand these programs at home and abroad.

"(3) *Assist family planning programs in nations which request such help.*—Here at home, we are gaining valuable experience through new programs of maternal and infant care as well as expansion of private and public medical care programs. Early last year we made clear our readiness to share our knowledge, skill, and financial resources with the developing nations requesting assistance. We will expand this effort in response to the increasing number of requests from other countries."

War on hunger message, February 10, 1966:

"POPULATIONS ARE EXPLODING"

17. "Populations are exploding under the impact of sharp cuts in death rate * * *"

18. "A balance between agricultural productivity and population is necssary to prevent the shadow of hunger from becoming a nightmare of famine. In my message on international health and education, I described our increased efforts to help deal with the population problem."

19. Domestic health and education message, March 1, 1966:

"Family Planning—

"We have a growing concern to foster the integrity of the family, and the opportunity for each child. It is essential that all families have access to information and services that will allow freedom to choose the number and spacing of their children within the dictates of individual conscience.

"In the fiscal 1967 budget, I have requested a sizable increase in funds available for research, training, and services in this field. The National Institute of Child Health and Human Development will expand its own research and its grant program to study human reproduction. The Children's Bureau and the Office of Economic Opportunity will support family planning to the maternal and infant care programs in local communities when requested. States agencies will be aided by Federal welfare funds to provide family planning services to mothers."

20. Message on economic aid to India sent to the Congress on April 1, the President said:

"The Indian Government believes that there can be no effective solution of the Indian food problem that does not include population control. The choice is now between a comprehensive and a humane program for limiting births and the brutal curb that is imposed by famine. As Mrs. Gandhi told me, the Indian Government is making vigorous efforts on this front."

"AN EVASION OF THE WHOLE SUBJECT"

Now, Mr. Secretary, I am really shocked that one who is such an expert in excellence can believe that this presentation is an example of excellence. It is nothing of the kind. It is an evasion of the whole subject. Here we have conducted hearings for the past year on population problems, we have had some 80 of the most distinguished witnesses on earth from home and abroad, and we have had Nobel Prize winners, scientists, educators. We have had social scientists of all kinds. They have all testified as to the urgency of this need and you come up with a program in which you do not even mention it and I think it is shocking that you lump this in the Assistant Secretary's office who has the major task of taking care of health and scientific affairs.

SENATOR GRUENING ASKS GARDNER TO "REVISE YOUR REPORT"

I would suggest to you that you revise your report and come up with something that really will show that you mean business.

Secretary GARDNER. May I comment?

Senator GRUENING. I certainly hope you will.

SECRETARY GARDNER DEFENDS HEW PROGRAM

Secretary GARDNER. You and I have enjoyed a relationship of mutual respect for some years and it grieves me to find that we are talking at cross purposes here, but I must disagree with you as earnestly as I possibly can and try to have you see my point of view. From where I sit we are doing a job and what you have proposed, the proposals which you have made on which we appear to be negative, and are in fact negative about, seem to be quite formalistic and superficial with respect to the problem at hand.

I would not in any sense question your sincerity. You have proven over and over again that your approach to this is a profound and effective one. But the proposals in S. 1676 have to do with organizational boxes and the assignment of duties and matters which do not go to the point of getting the job done, and I am saying that we are proceeding with the job and I have cited the figures which indicate our progress and, simply because our progress has not been formalized in terms of an Assistant Secretary with the title indicated on the existence of an office with that name, does not mean that we are not doing the job.

The activities are going on, they can be looked at. The progress can be measured in terms of dollars. In the past year we have more than doubled the expenditures for research, and increased by 50 percent the funds made available to provide family planning services in communities. These activities are moving along and I regret that we differ on these points. But I feel very strongly that we are doing a good job,

that we will do a better job and that ultimately, the concerns that you and I share will be well served by this Department.

Senator GRUENING. You see no reason to change the title of the Assistant Secretary who has now been given the responsibility for health and scientific affairs to say, "and Population Problems"?

SUBSTANTIVE TITLES DO NOT SEEM IMPORTANT

Secretary GARDNER. I have very little regard for the substantive titles involved. They do not seem to me important. They have never seemed to be important to me. What is important to me is what duties I assign these individuals and the clarity of our understanding as to what those duties are.

WHERE IS HEW'S "NEW APPROACH"?

Senator GRUENING. Well, I am sorry, we disagree on the subject, but it seems to me in view of the great concern in the world, the tremendous concern which the President of the United States has shown, who has made a unique record in recording his views on numerous public occasions—I can think of no issue in our history to which a President in his relatively short term in office has given such repeated and reiterated emphasis to one problem—that in view of all this your presentation should have reflected more concern.

In these repeated Presidential statements there is a mandate to the executive departments to do something new, do something different, something dynamic, to match his urgency with some relatively tangible demonstration that you are really concerned about this. And here you lump this great activity into anonymity into an already overburdened assistant secretaryship.

You say you are not concerned with the title, but I maintain the title is very important. Yours is an indication that you do not consider the population problem a major matter. You merely say it is included with duties which are already being carried on.

Where is this new approach that the President asked for?

Where is the visible sign of it?

All you say is, "We are going to continue to do what we have been doing." There is nothing in that approach which indicates any reaction to the tremendous change in public sentiment which is taking place, this tremendous urgency which is being manifested throughout the country, the breakthrough in public opinion. There is no response in your presentations and in your organization to any of this.

BIRTH CONTROL "CONSPICUOUSLY ABSENT"

I do not see how you can refute my position on that subject. You say you are not interested in titles. Well, you have individual titles for all the other Secretaries. You have a Secretary in charge of water pollution. You have a Secretary in charge of education. You have a Secretary in charge of family services. Why not a Secretary who, if you must give him these additional duties, that you can designate as also having responsibility for population control? We have been dealing with health for a long time and it is our health progress in the last century that has created this population problem. That is why the population problem is new and pressing.

It is time now that we start something about birth control as well as death control and this is conspicuously absent in your presentation.

WHAT ABOUT A WHITE HOUSE CONFERENCE ON POPULATION?

Now, we go on to the White House Conference. Why is it that you object to the White House Conference? Has the President indicated to you that he did not want one?

Secretary GARDNER. I would like Dr. Lee to answer that.

Dr. LEE. As you know, I have been very much interested in the development of our policies and involved in the context within which the programs are developing.

I would like to say a word about that first and then go on to the White House Conference.

DR. LEE SAYS POPULATION PROGRAMS "MUST BE CONSIDERED WITHIN THE HEALTH CONTEXT"

We feel very strongly that these programs must be considered within the health context. The solution to the problems will be based on the expanded research efforts which are being developed at an increasing pace through the National Institutes of Health.

As you know, it was only a few years ago that the Institute of Child Health and Human Development was organized. This year that Institute has been reorganized with special emphasis—a special division established on human reproduction. We have noted an increasing interest in the scientific community, but this is slow to mobilize. To carry out research in this field, both in the biological sciences and in the behavioral sciences, is so important to the long-term solution to these complex problems. We must have competently trained and interested individuals.

I think we will see in the next few years a steeply rising rate of funding for research in this area which will provide us many new solutions to some of these complex problems. We would not want to isolate that effort from the mainstream of health and human biology.

HEW SAYS 1967 WHITE HOUSE CONFERENCE "NOT INDICATED AT THIS TIME"

On the White House conference, as the Secretary indicated in his testimony, it is our view and certainly not the President's view, because we are only speaking for the Department, that it is not indicated at this time. We feel it is very important that a number of local meetings, State meetings, and regional meetings be held and both the Children's Bureau and the Public Health Service are developing plans to carry out these meetings. They are planning scientific meetings, meetings of professional people, and meetings involving both the general public and the professions. If, after these meetings have been held over a period of time, it appears indicated, we certainly would recommend to the President that a White House Conference on Population Problems be held.

As the Secretary indicated also, the White House Conferences on Health and on International Cooperation Year, which were held only last November, both included sections on population—the White House Conference on Health and a panel on family planning, the

ICY Conference, a section on population problems. A great deal of information was exchanged in these meetings. We felt that this was a very valuable exchange and these were the first White House conferences at which this very important subject was discussed.

LOCAL, STATE, AND REGIONAL CONFERENCES "AN ESSENTIAL STEP"

We believe, at this time, that local conferences and State and regional conferences are an essential step and subsequent to these meetings that a White House conference may well be indicated.

Senator GRUENING. Will the Department of Health, Education, and Welfare help organize these regional and State conferences?

Dr. LEE. Yes, sir. Several have already been funded. The Children's Bureau funds have been used in Kansas to support local meetings. Funds will soon be made available to the University of California to support meetings in regions 9 and 8 on this very important subject.

Senator GRUENING. Would you be kind enough to submit for the subcommittee a statement on what you are doing specifically to encourage regional conferences and where?

Dr. LEE. Yes, sir.

(The information requested by the subcommittee follows:)

EXHIBIT 129

FOUR MEMORANDUMS CONCERNING NINE HEW REGIONAL MEETINGS ON FAMILY PLANNING; DATED JULY 13, 15, AND 28, 1966; AND SEPTEMBER 16, 1966

JULY 13, 1966.

MEMORANDUM

To: Dr. Philip R. Lee, Assistant Secretary for Health and Scientific Affairs.
From: Dr. Milo D. Leavitt, Deputy Assistant Secretary for Science and Population.
Subject: HEW Regional Meetings on Family Planning.

Nine Regional Meetings are now being proposed on Family Planning (schedule attached). The initial one day meetings are intended for policy and program briefings for Regional Office personnel and also for the purpose of planning the larger conferences to be held some two months later.

The briefing teams will be composed of five or six representatives of the Office of the Deputy Assistant Secretary for Science and Population, the Office of Education, the Welfare Administration, and the Public Health Service. The Regional Conferences will include approximately two hundred participants—half of whom will represent Federal, State and local agencies. The expenses of Government participants will, no doubt, be borne by their own agencies; however, I believe it will be necessary to pay the travel and per diem expense of non-Government participants. Based on the above, the following budget is submitted for approval. It is suggested that the Public Health Service, the Office of Education, and the Welfare Administration each be requested to provide one-third of the costs.

Travel and per diem	$90,000
Punchcards for list of invitees	4,000
Steno and 1-time services (6 stenos, 6 months)	18,000
Travel and per diem for briefing teams	10,000
Reproduction and printing	20,000
Miscellaneous	5,000
Total	147,000

It is further requested that the programming and computer services to be provided by the Bureau of Health Statistics which is best qualified to deal with the problems associated with preliminary planning of conferences. An early ap-

proval for these services is urgently required to initiate and implement this program.

1-Day Team Conference (Regional Offices)
Atlanta, Dallas: Week of September 19.
New York, Boston: Week of September 26.
Kansas City, Chicago: Week of October 17.
Denver, San Francisco: Week of November 7.

Regional Conferences on Family Planning:
Roanoke: September 7 and 8.
Atlanta: November 16 and 17.
Dallas: November 30, December 1.
New York: December 14 and 15.
Boston: January 4 and 5.
Chicago: January 11 and 12.
Kansas City: January 25 and 26.
Denver: February 8 and 9.
San Francisco: February 15 and 16.

JULY 15, 1966.

MEMORANDUM

To: All Regional Directors (see below).
From: James C. Callison, Acting Associate Director of Field Coordination.
Subject: Regional Family Planning Conferences.

The Department is planning a series of Regional Conferences on Family Planning during the next several months. Their purpose is to explain the Department's policy in the area of family planning, to explore the broad background and implications of family planning activities, to provide insights into the development and operations of family planning services under a variety of auspices, and to describe resources available to support family planning services. The first of these conferences is to involve the States in the Appalachian Region and will be held in Roanoke, Virginia, on September 7 and 8. The preliminary agenda for that meeting is attached.

The Roanoke meeting is being planned as the pilot and prototype for 8 other Regional Conferences. These are tentatively being scheduled as follows:

Atlanta: November 16–17.
Dallas: November 30–December 1.
New York: December 14–15.
Boston: January 4–5.
Chicago: January 11–12.
Kansas City: January 25–26.
Denver: February 8–9.
San Francisco: February 15–16.

Since the first conference may involve some States which are outside Region III and does not include either the District of Columbia or Puerto Rico, owing to its Appalachian focus, it may be necessary to make some adjustments in the States and localities involved in the conference at New York and Atlanta. As presently visualized, the New York conference will primarily focus upon family planning services in urban areas, and may involve the District of Columbia.

Boston	Atlanta	Dallas
New York	Chicago	Denver
Charlottesville	Kansas City	San Francisco

These conferences will be planned by the Office of the Assistant Secretary for Health and Scientific Affairs, in close collaboration with the Regional Offices. The Assistant Secretary has, as you know, overall responsibility for the Department's activities in the area of family planning.

It is the Assistant Secretary's and this office's desire that the Regional Offices be intimately involved in the planning and operation of the conferences. The headquarters staff planning the conferences would like to meet with the Regional Director and the appropriate program staff, including representatives from the Public Health Service, Children's Bureau, Bureau of Family Services, and Office of Education prior to completing the plans for the conferences in each Region. These meetings, to be scheduled for one day, have a two-fold purpose: to discuss and answer any questions about the Department's policy on population dynamics, fertility, sterility, and family planning, and to discuss specifically the plans for

the Regional Conference. The present schedule for these Regional Office meetings is as follows:

Week of September 19: Atlanta, Dallas.
Week of September 26: New York, Boston.
Week of October 17: Kansas City, Chicago.
Week of November 7: Denver, San Francisco.

The group would like to meet with staff in the first Region listed for each week on Monday, and with the second Region on Tuesday.

In preparation for these conferences, there are several things which the Regional Offices are being asked to do:

1. Please check on available conference space, either in the Regional Office, in a hotel, or elsewhere, for the dates indicated for your Region. The conferences are being planned for 200–225 participants. The conference space required will be one room large enough for general sessions and five small conference rooms, suitable for discussion meetings of about 40 participants each. Would you please let me know as soon as possible where you would recommend the conference be held. If the dates presently being planned for the conference in your Region are not suitable either because of conflicting meetings or because no facilities are available, would you please let me know immediately, with a suggestion for alternate dates.

2. We would appreciate your having the Regional Staff suggest possible persons to participate in the conference. We would suggest that the following groups be represented:

State and local public health officials.
State and local welfare officials.
State education officials.
Representatives of medical associations and physicians' groups.
Representatives of hospitals.
Medical school faculty.
School of Social Work faculty.
Representatives of voluntary agencies interested in family planning.
Any other individual or group interested in family planning.

The participants should include adequate representation from minority groups.

3. Two panels with non-Federal participants are being planned as a part of the program. Suggestions for participants in these panels are requested. The first panel deals with several broad aspects of family planning. Subjects are indicated on the attached agenda for Roanoke. The second panel focuses upon the organization and operation of family planning services under a variety of auspices. We would appreciate the Regional Office's suggestions for participants on these two panels.

4. We need an indication as to whether the proposed date for meeting with you and appropriate Regional Office staff is satisfactory.

May we have your reactions to the proposed dates for the Regional Office meetings and the Regional Conference as soon as possible? We will notify you later as to the timing on the lists of persons suggested for invitation to the Conference and, if possible, panel participants.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
OFFICE OF THE SECRETARY,
July 28, 1966.

MEMORANDUM

To: Mr. Harold Howe II, Commissioner, Office of Education.
From: The Secretary.
Subject: Family Planning Conferences.

The Department is planning a series of Regional Conferences on Family Planning during the next several months. Their purpose is to explain the Department's policy in the area of family planning, to explore the broad background and implications of family planning activities, to provide insights into the development and operation of family planning services under a variety of auspices, and to describe resources available to support family planning services.

These conferences will be directed by Dr. Milo D. Leavitt, Deputy Assistant Secretary for Science and Population.

Funds for this activity are not available within the Office of the Secretary and as these conferences will encompass activities relating to Health, Education, and Welfare programs, I am requesting that the Public Health Service, Office of

Education, and Welfare Administration each transfer $50,000 for FY 1967 and have asked the Comptroller to assist in the funding transfer.

CONFERENCE OF APPALACHIAN STATES ON FAMILY PLANNING, HOTEL ROANOKE, ROANOKE, VA., SEPTEMBER 7–8 1966

Tuesday, September 6

4:00 p.m. Registration

Wednesday, September 7

8:00 a.m. Registration

9:30 Opening of Conference—Mr. Bernard V. McCusty, Regional Director, DHEW Region III—presiding
Keynote Address—Dr. Philip R. Lee, Assistant Secretary for Health and Scientific Affairs, DHEW

10:15 Coffee Break

10:30 General Session—"Current Status of Family Planning Programs"—Dr. Mack Shanholtz, Commissioner, State Department of Health, Virginia—presiding
"Social and Economic Aspects of Family Planning"—Miss Geraldine Gourley, Assoc. Professor of Maternal and Child Health, School of Public Health, Univ. of North Carolina
"Community Health Services in Family Planning"—Dr. Matthew Taybeck, Assistant Commissioner, Baltimore City Health Department
"Family Planning and Family Health"—Dr. Winslow Tompkins, Consultant in Obstetrics, Children's Bureau DHEW
"Family Planning's Challenge to Education"—Dr. William E. Johnston, Education Research and Program Specialist, Office of Education, DHEW

12:15 p.m. Luncheon—Mr. McCusty—presiding
Dr. Paul Maddox, Campton, Wolfe County, Kentucky, "Family Planning in Private Practice in a Rural Community"

1:45 General Session—"Organization and Administration of Family Planning Programs: A look at family planning in various settings"—Dr. Mildred Mitchell-Bateman, Commissioner, Department of Mental Health, West Virginia—presiding
Dr. Moye Freyman, Director, Center for Population Planning, Univ. of North Carolina
Mrs. Katherine Knott, Chief, Public Assistance, Mecklenburg County Welfare Department, N. Carolina
Dr. Louis G. Hutchins, President, Mountain Maternal Health League, Berea, Kentucky
Dr. Dan Thompson, Chairman, Department of Obstetric and Gynecology, Emory University
Dr. Robert W. Jessee, Virginia State Department of Health

3:15 Coffee Break

3:30 Work Session—"Discussions on Current Status, Organization, and Administration of Family Planning Programs"—moderators presiding

5:00 End of First Day

5:30 Reception

Thursday, September 8

9:00 a.m. General Session—"Resources to Support Family Planning Programs in Education, Services, and Research"—Mr. Charles Clark, Superintendent of Schools, Floyd County, Kentucky—presiding
Miss Lizbeth Bamberger, Health Division, Community Action Program, Office of Economic Opportunity
Dr. Charles Boettner, Appalachian Advisory Health Committee, Appalachian Regional Commission
Dr. Edward O'Rourke, Asst. Chief, Bureau of Medical Health Service, U.S. Public Health Service
Dr. Winslow Tompkins
Miss Reba E. Choate, Chief, Family and Child Services, Bureau of Family Services

10:30 Coffee Break

10:45 General Session—Mr. McCusty—presiding
Presentation—Dr. Samuel Wishik, Assoc. Dean for Academic Affairs, Graduate School of Public Health, University of Pittsburgh "The Goal—Accessible & Effective Family Planning"
Summary Reports—Groups I, II, III, IV, and V
Follow-up State Conferences of Family Planning
12:00 noon Adjournment

WORK SESSION GROUPS

Group I—Moderator, Dr. Emil Palmquist, Regional Health Director, Public Health Service, DHEW Region III
Resource persons: Dr. Boettner, Mrs. Knott, Dr. O'Rourke.
Group II—Moderator, Dr. Madeline Morcy, Regional Medical Director, Children's Bureau Health Services, DHEW Region III
Resource persons: Dr. Hutchins, Dr. Taybeck, Mr. Clark.
Group III—Moderator, Mr. George Narensky, Regional Representative, Bureau of Family Services, DHEW Region III
Resource persons: Miss Gourley, Dr. Tompkins, Miss Choate.
Group IV—Moderator, Dr. Carl Seifert, Regional Representative, Office of Education, DHEW Region III
Resource persons: Dr. Mitchell-Bateman, Dr. Jessee, Dr. Freyman.
Group V—Moderator, Dr. George Moore, Assoc. Regional Health Director for Community Health, Public Health Service, DHEW Region III
Resource persons: Dr. Thompson, Dr. Johnston, Miss Bamberger.

MEMORANDUM

SEPTEMBER 16, 1966.

To: Members of the Departmental Task Force on Family Planning.
From: Dr. Milo D. Leavitt, Jr., Deputy Assistant Secretary for Science and Population.
Subject: Schedule of DHEW Regional Conferences on Family Planning.

The following schedule has been arranged for the series of Regional Family Planning Conferences sponsored by the Department. Operational responsibility for these meetings has been assumed by each of the nine regional offices. Each regional office has recently designated a member of its staff to serve as Conference Coordinator to manage local details of the meetings for which it is responsible.

The Office of the Assistant Secretary for Health and Scientific Affairs is the focal point for overall conference coordination, policy review, and clearance of Departmental issuances relating to these conferences.

September 7–8, 1966[1]—Region III—Charlottesville, Virginia

Regional Director: Mr. Bernard V. McCusty.
Conference Coordinator: Dr. Stephen Cornett, Economic Opportunity Coordinator.
Address: 220 7th Street, N.E., Charlottesville, Va., 22901.
Telephone: Area Code 703, 296–1220.

November 16–17, 1966—Region IV—Atlanta, Georgia

Regional Director: Mr. William J. Page, Jr.
Conference Coordinator: Mr. Robert Brown, Asst. Regional Director.
Address: 50 7th Street, Atlanta, Georgia, 30323.
Telephone: Area Code 404, 526–5817.

November 21–22, 1966—Region VII—Dallas, Texas

Regional Director: Mr. James H. Bond.
Conference Coordinator: Mr. Roy E. Westerfield, Staff Assistant.
Address: 1114 Commerce Street, Dallas, Texas, 75202.
Telephone: Area Code 214, 749–3396.

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[1] Conference of Appalachian States on Family Planning held in Roanoke, Virginia. It included representatives from each of the twelve states which comprise the Appalachian Region.

November 29–30, 1966—Region VI—Kansas City, Missouri

Regional Director: Mr. James W. Doarn.
Conference Coordinator: Mr. Ralph Johnson, Asst. Regional Director.
Address: 601 East 12th Street, Kansas City, Missouri, 64106.
Telephone: Area Code 816, 374–3436.

December 1–2, 1966—Region VIII—Denver, Colorado

Regional Director: Mr. William T. Van Orman.
Conference Coordinator: Mr. James Quinn, Staff Assistant.
Address: 19th and Stout Street, Denver, Colorado, 80202.
Telephone: Area Code 303, 297–3373.

December 13–14, 1966—Region V—Chicago, Illinois

Regional Director: Mr. Melville H. Hosch.
Conference Coordinator: Mr. James Brawley, Asst. Regional Director.
Address: 433 West Van Buren Street, Chicago, Illinois, 60607.
Telephone: Area Code 312, 828–5160.

December 14–15, 1966—Region II—New York, New York

Regional Director: Mrs. Bernice Bernstein.
Conference Coordinator: Mr. Robert Cornell, Economic Opportunity Coordinator.
Address: 42 Broadway, New York, New York, 10004.
Telephone: Area Code 212, 363–4600.

January 4–5, 1967—Region I—Boston, Massachusetts

Regional Director: Mr. Walter W. Mode.
Conference Coordinator: Mr. John F. Bean, Jr., Assistant Regional Director.
Address: 120 Boylston Street, Boston, Massachusetts, 02116.
Telephone: Area Code 617, 223–3550.

January 25–26, 1967—Region IX—San Francisco, California

Regional Director: Mr. Charles Shreve.
Conference Coordinator: Dr. R. Leslie Smith, Regional Medical Director.
Address: 50 Fulton Street, San Francisco, California, 94102.
Telephone: Area Code 415, 5565–6746.

Should you wish invitations extended to certain individuals within your agency, or non-governmental persons having an interest in family planning, please communicate directly with the Director of the appropriate regional office.

OKLAHOMA LEGISLATURE AWAITS PASSAGE OF S. 1676

Senator GRUENING. The State of Oklahoma Legislature recently passed a resolution from which I will now read:

"Now, therefore, be it

"Resolved by the Senate of the 30th Legislature of the State of Oklahoma, and the House concurring therein:

"SECTION 1. In the event of the enactment of S. 1676 or similar legislation by the Federal Congress, the Oklahoma Public Welfare Commission is directed to:

"(a) Cooperate with the U.S. Department of Health, Education, and Welfare in carrying out such Federal policies and programs as might be promulgated by such Federal Department relating to population growth and controls;

"(b) Organize and conduct a State conference on population;

"(c) Be the official agency of the State of Oklahoma to receive and administer Federal grants and funds to be used in planning and conducting such State conference on population;

"(d) Participate in the White House Conference on Population.

"Whereas there is increasing concern over the population growth, and a recognition of the necessity of controls therewith; and

"Whereas some of the States have developed and established programs to cope with population problems; and,

"Whereas the President of the United States, in his 1965 state of the Union address, announced that the United States should expand and intensify its efforts to contribute to the solution of the problems connected with the rapid world growth; and,

"Whereas there is now pending in the Senate of the United States proposed legislation in the form of S. 1676 to deal with rapid population growth and problems arising from or connected with such growth:

"Now, therefore, be it

"Resolved by the Senate of the 30th Legislature of the State of Oklahoma, and the House concurring therein:

"SECTION 1. In the event of the enactment of S. 1676 or similar legislation by the Federal Congress, the Oklahoma Welfare Commission is directed to:

"(a) Cooperate with the U.S. Department of Health, Education, and Welfare in carrying out such Federal policies and programs as might be promulgated by such Federal department relating to population growth and controls;

"(b) Organize and conduct a State conference on population;

"(c) Be the official agency of the State of Oklahoma to receive and administer Federal grants and funds to be used in planning and conducting such State conference on population;

"(d) Participate in the White House Conference on Population."

We will have to inform the Legislature of Oklahoma that the Department is opposed to the enactment of S. 1676, that this program cannot be carried on. What would you say to that?

CONFERENCES WITH SCIENTISTS AND MEDICAL EDUCATORS ARE IMPORTANT

Dr. LEE. We would be very pleased to meet with Oklahoma officials and work with them in developing a conference on population at the State level. This could be accomplished either through the Children's Bureau or the Public Health Service. Not only are these conferences with health and welfare officials at the State level important, but also very important, we feel, are conferences with scientists to indicate to them the need for more research and to bring them more actively into the program of research.

We also feel that it is important to have meetings with medical educators, nurse educators, public health educators, and others, to stimulate the development of better teaching programs in the professional schools, particularly in the medical schools, nursing schools, and in the schools of public health. It is a very broad educational effort that is required. This has been emphasized—the National Academy of Sciences reports emphasized the need for more adequate training in professional schools. We are in agreement, I believe, on the need for both programs of improved professional education and information exchange programs at the State and local level and with these various professional groups and other groups concerned with the problem.

SUBCOMMITTEE REQUESTS INFORMATION ON FAMILY PLANNING CONFERENCES

Senator GRUENING. Would you be so kind as to inform the subcommittee when you make these arrangements with States such as Oklahoma? Yesterday we had the testimony of a State senator from Colorado telling what they had done there, that the legislature had passed a bill making contraceptive information available, and this is happening in other States. I think it would be very helpful, so that the subcommittee may keep track of what is being done by the Department, if you will keep us informed as to when these conferences are being set up and how they are being carried out.

Dr. LEE. We would be glad to do so.

Senator GRUENING. Then we will see how long it will take before you decide to move in a little more definite manner.

Senator Metcalf, do you have any questions or comments?

DOES HEW HAVE AUTHORIZATION FOR PURPOSES OF S. 1676?

Senator METCALF. I have listened with a great deal of interest, not only to your testimony, Mr. Secretary, but to the colloquy you have had with the chairman of the subcommittee. I think you have made some very remarkable statements.

Is it your concept that there is enough authority in your Department so that you do not need any further authorization to carry out the purposes that we seek in S. 1676? Is that your contention?

SECRETARY BELIEVES HEW HAS "BASIC AUTHORITY" TO PROVIDE BIRTH CONTROL INFORMATION

Secretary GARDNER. Basically, yes.

Senator METCALF. What statutes are you relying on?

Secretary GARDNER. Well, I believe that we have—our basic authority to provide health services and maternal care.

Senator METCALF. You mean your Department of Health, Education, and Welfare has an inherent right to carry out this program?

Secretary GARDNER. We have authority to provide health services. I would like to get the Surgeon General to comment on this.

"A REMARKABLE STATEMENT OF GOVERNMENT, MR. SECRETARY"

Senator METCALF. I would like to have you be a little more specific—because you know we are passing water pollution acts, aid to education acts, and so forth, and perhaps we have just been spinning our wheels if you have a constitutional inherent right to carry out all health, education, and welfare programs. According to the statement that you have made, you do not like to have them boxed or compartmentalized and you do not want us to give you specific authorization. You are not relying upon duties prescribed by statutes but upon the kind of men you appoint to your Department. That is a remarkable statement of government, Mr. Secretary.

Secretary GARDNER. And a very sound statement, I believe, sir.

Senator METCALF. That is a statement that I would expect from the administration, but it is the kind of statement that would eliminate Congress completely.

Secretary GARDNER. No, sir.

WHAT IS THE STATUTE THAT GIVES AUTHORITY OF S. 1676 TO HEW?

Senator METCALF. Well, will you please cite the statute that gives you the authority to carry out the program which is outlined in S. 1676 and allows you to go to the Appropriation Committee and ask for an appropriation that will withstand a point of order?

Secretary GARDNER. I have here, sir, two memorandums from our counsel which are so lengthy and involved that I would have to read them to you and I do not know whether you want me to do that. I would be glad to put them in the record.

Senator METCALF. We have a crowd here who heard all the rest of the statement. Why do you not go ahead and read them?

Senator GRUENING. I would appreciate it if you would and we will make both memorandums with their legal citations a part of the printed hearing.

Secretary GARDNER. First, support of family planning services, constitutional issues. This is from our legal counsel. [Reading:]

HEW SEES NO CONSTITUTIONAL OBJECTION

"You have asked my opinion whether there is constitutional objection to any of the activities described in the Secretary's memorandum of January 24, 1966, entitled 'Departmental Policy on Population Dynamics, Fertility, Sterility, and Family Planning.' You have requested me, in this connection, to consider the statement of William B. Ball, Esq., general counsel of the Pennsylvania Catholic Conference, presented in August of 1965 before the Subcommittee on Foreign Aid Expenditures of the Senate Committee on Government Operations.

"It is altogether clear that the legislation authorizing the activities described by the Secretary falls within the power of Congress under the 'general welfare' clause, and that no constitutional objection exists unless any of the activities is prohibited by the Bill of Rights. The congressional power of expenditure has been so broadly defined by the Supreme Court as to leave no doubt that the objectives stated in the Secretary's memorandum are within the ambit of that power. Nor does the efficacy of the expenditures to accomplish these objectives present a justifiable issue; once the congressional power is established, the wisdom of its exercise is for Congress, not the courts, to determine.

"In my judgment the Bill of Rights imposes no obstacle to any of the activities described by the Secretary. In this connection I note his cautionary statements: 'Programs conducted or supported by the Department shall guarantee freedom from coercion or pressure of mind or conscience. There shall be freedom of choice of method so that individuals can choose in accordance with the dictates of their consciences. The Department shall make known to State and local agencies that funds are available for programs of the sort described above,

but it will bring no pressure upon them to participate in such programs.'

"It is of course true, as Mr. Ball points out, that the Supreme Court has in recent years given increased emphasis to the protection of the individual freedoms assured by the Bill of Rights, and has recently, in the Connecticut birth control case, given specific recognition to the right of privacy. It is also true that governmental action may, through merely the persuasive use of the power of expenditure, so far encroach on these freedoms as to contravene the Bill of Rights. One cannot deny the possibility that some family planning clinic or local welfare agency, for example, might so far disregard the Secretary's injunction that its actions would raise a constitutional issue. Mr. Ball's statement well indicates the kinds of pressure—subtle or not so subtle—that could be exerted to limit effective freedom of choice in this matter. There is no need to consider at what point such pressures might rise to a level warranting constitutional objection, since any exertion of pressure would be objectionable on policy if not on legal grounds.

"The possibility of such abuse, although it imposes an obligation to exercise all practicable precautions, does not in my opinion afford a basis for constitutional challenge to the Federal expenditures, or to State and local programs which are conducted in accordance with the Secretary's injunction. To argue otherwise would be to challenge many other Federal grant-in-aid programs as well as these. Thus, we are aware of complaints that constitutional rights have been violated in the administration of public assistance, and although we have sought to correct practices that trespass on protected areas we have never supposed that the entire public assistance program was put in constitutional jeopardy. More closely in point, perhaps, are the many programs supporting medical services, in which there is always the risk of invasion of individual freedom—the risk, for example, that surgery will be performed without valid consent of the patient.

"Mr. Ball stresses the rights of conscience and of privacy, which admittedly are among the most fundamental of our freedoms. Among the ways in which he foresees encroachment on these rights is the questioning that is prerequisite to the giving of advice, and he points out that when a governmental agent does the questioning there may seem to be constraint to provide the answers. Here again, caution is plainly called for, but here again, to find in this danger a challenge to the constitutionality of the legislation is to challenge many publicly provided services. The social worker may have to ask very personal questions, and to do so in a context of strong economic pressure to answer. Almost any health service may require questioning of the most intimate kind, as well as actions that, apart from consent, would plainly constitute violation of personal rights. Finally, any health service that is broadly available is likely to expose itself to some individuals who have conscientious objection to acceptance of the services, and who would perhaps resent even being asked about matters of health.

"In short, I find no basis for distinguishing family planning services from many other public services which pose similar risks of invasion of personal liberties. Certainly, there is risk that improper pressure

may be exerted in an occasional instance, but the risk seems less than in public assistance where an economic incentive is built into every case-work interview. Certainly, the subject matter is highly personal and delicate, but this is true of many other health services as well. These considerations dictate administration that is sensitive to individual rights, but in my opinion they do not engender constitutional doubt respecting the programs of the Department in this area or the policy of the Secretary."

SENATOR METCALF CONSIDERS SECRETARY GARDNER'S STATEMENT "IRRELEVANT"

Senator METCALF. May I comment on that? That is merely a declaration that if Congress did authorize by legislation such a proposal as S. 1676 it would be constitutional. Now that is not what I asked you, Mr. Secretary. I asked you to cite the statutes under which you are acting in population control at the present time, or is it your contention that without statute you have the inherent right to proceed under this—without this authorizing legislation?

Secretary GARDNER. I do not believe we have the right to proceed without statute and I would like—if you prefer—that I not read the second statement.

Senator METCALF. Is it a constitutional question, too?

Secretary GARDNER. No sir, but——

Senator METCALF. The first statement was completely irrelevant. The first statement said that if Congress chose to act in this field and gave legislation, in the opinion of Mr. Ball it would be constitutional. Now, that means that, in his opinion, if this legislation that is before the subcommittee were enacted it would not be violative of the Constitution. But now, what are the statutes under which you are acting—is that what your second opinion is about?

(The two memorandums mentioned by Secretary Gardner and requested by Senator Gruening follow:)

EXHIBIT 130

MEMORANDUM TO MR. WILBUR J. COHEN, UNDER SECRETARY OF HEW, FROM MR. ALANSON W. WILLCOX, GENERAL COUNSEL OF HEW, ON "SUPPORT OF FAMILY PLANNING SERVICES—CONSTITUTIONAL ISSUES," APRIL 1, 1966

You have asked my opinion whether there is constitutional objection to any of the activities described in the Secretary's memorandum of January 24, 1966, entitled "Departmental Policy on Population Dynamics, Fertility, Sterility and Family Planning." You have requested me, in this connection, to consider the statement of William B. Ball, Esq., General Counsel of the Pennsylvania Catholic Conference, presented in August of 1965 before the Subcommittee on Foreign Aid Expenditures of the Senate Committee on Government Operations.

It is altogether clear that the legislation authorizing the activities described by the Secretary falls within the power of Congress under the "general welfare" clause, and that no constitutional objection exists unless any of the activities is prohibited by the Bill of Rights. The Congressional power of expenditure has been so broadly defined by the Supreme Court[1] as to leave no doubt that the objectives stated in the Secretary's memorandum are within the ambit of that power. Nor does the efficacy of the expenditures to accomplish these

[1] *Helvering* v. *Davis*, 301 U.S. 619 (1937); *Cleveland* v. *United States*, 323 U.S. 329 (1945); *United States* v. *Verlach Live Stock Company*, 339 U.S. 725 (1950).

objectives present a justiciable issue; once the Congressional power is established, the wisdom of its exercise is for Congress, not the courts, to determine.[2]

In my judgment the Bill of Rights imposes no obstacle to any of the activities described by the Secretary. In this connection I note his cautionary statements: "Programs conducted or supported by the Department shall guarantee freedom from coercion or pressure of mind or conscience. There shall be freedom of choice of method so that individuals can choose in accordance with the dictates of their consciences. The Department will make known to State and local agencies that funds are available for programs of the sort described above, but it will bring no pressure upon them to participate in such programs."

It is of course true, as Mr. Ball points out, that the Supreme Court has in recent years given increased emphasis to the protection of the individual freedoms assured by the Bill of Rights, and has recently, in the Connecticut birth control case,[3] given specific recognition to the right of privacy. It is also true that governmental action may, through merely the persuasive use of the power of expenditure, so far encroach on these freedoms as to contravene the Bill of Rights.[4] One cannot deny the possibility that some family planning clinic or local welfare agency, for example, might so far disregard the Secretary's injunction that its actions would raise a constitutional issue. Mr. Ball's statement well indicates the kinds of pressure—subtle or not so subtle—that could be exerted to limit effective freedom of choice in this matter. There is no need to consider at what point such pressures might rise to a level warranting constitutional objection, since any exertion of pressure would be objectionable on policy if not on legal grounds.

The possibility of such abuse, however, although it imposes an obligation to exercise all practicable precautions, does not in my opinion afford a basis for constitutional challenge to the Federal expenditures, or to State and local programs which are conducted in accordance with the Secretary's injunction. To argue otherwise would be to challenge many other Federal grant-in-aid programs as well as these. Thus, we are aware of complaints that constitutional rights have been violated in the administration of public assistance, and although we have sought to correct practices that trespass on protected areas we have never supposed that the entire public assistance program was put in constitutional jeopardy. More closely in point, perhaps, are the many programs supporting medical services, in which there is always the risk of invasion of individual freedom—the risk, for example, that surgery will be performed without valid consent of the patient.

Mr. Ball stresses the rights of conscience and of privacy, which admittedly are among the most fundamental of our freedoms. Among the ways in which he foresees encroachment on these rights is the questioning that is prerequisite to the giving of advice, and he points out that when a governmental agent does the questioning there may seem to be a constraint to provide the answers. Here again, caution is plainly called for, but here again, to find in this danger a challenge to the constitutionality of the legislation is to challenge many other publicly provided services. The social worker may have to ask very personal questions, and to do so in a context of strong economic pressure to answer.

Almost any health service may require questioning of the most intimate kind, as well as actions that, apart from consent, would plainly constitute violation of personal rights. Finally, any health service that is broadly available is likely to expose itself to some individuals who have conscientious objection to acceptance of the services, and who would perhaps resent even being asked about matters of health.

In short, I find no basis for distinguishing family planning services from many other public services which pose similar risks of invasion of personal liberties. Certainly, there is risk that improper pressure may be exterted in an occasional instance, but the risk seems less than in public assistance where an economic incentive is built into every casework interview. Certainly, the subject-matter is highly personal and delicate, but this is true of many other health services as well. These considerations dictate administration that is sensitive to individual rights, but in my opinon they do to engender constitutional doubt respecting the programs of the Department in this area or the policy of the Secretary.

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[2] See *Helvering* v. *Davis*, *supra*, at page 644.
[3] *Griswold* v. *Connecticut*, 381 U.S. 479 (1965).
[4] See, e.g., *Sherbert* v. *Verner*, 374 U.S. 398 (1963).

EXHIBIT 131

MEMORANDUM TO MR. ALANSON W. WILLCOX, GENERAL COUNSEL OF HEW, FROM JOEL COHEN, ASSISTANT GENERAL COUNSEL, WELFARE AND REHABILITATION DIVISION, ON "FAMILY PLANNING SERVICES—NOTES ON LEGAL AUTHORITY," APRIL 6, 1966

The Secretary's Statement

In the policy statement of January 24, 1966, the Secretary specified that:

"Programs conducted or supported by the Department shall guarantee freedom from corecion or pressure of mind or conscience. There shall be freedom of choice of method so that individuals can choose in accordance with the dictates of their consciences."

Implementation of these requirements presents no problems in the case of so-called discretionary grants, where the Department has clear authority to impose reasonable conditions. Under the State plan programs, however, the Secretary must approve any plan which contains the statutorily-prescribed provisions, and the Federal agency is somewhat limited in its power to specify the scope and conditions of the program activities. Nevertheless, there appears to be a clear basis for support of the requirements stated above.

Under both the public assistance titles of the Social Security Act and the provisions on maternal and child health services, the State plan must provide such methods of administration as are necessary for the proper and efficient operation of the plan. The Secretary's statement that family planning activities supported by the Department shall guarantee freedom from coercion or pressure of mind or conscience comes squarely within the scope and purpose of the statutory provision. In absence of such procedure and practice, there could be instances of violation of constitutional protections.

That the plans must provide several methods of family planning, with individual freedom to choose among them, also is legally supportable. It is recognized that there are several methods of implementing family planning services, and that there are groups in the community which for reasons of mind or conscience of their own may be able to accept and benefit by one method but not the others. To offer a limited range of services which would have the effect of excluding the members of such groups from the services would seem to be an unequal application of the underlying law. We have consistently maintained that an unreasonable exclusion from the program is unacceptable, even in absence of a specific provision in the statute on this point.

Basic Authority for Family Planning Services

The authority for the Welfare Administration to support family planning services rests on the assumption that these are health services or medical services. Thus the State programs of maternal and child health services under title V, part 1 of the Social Security Act are for the purpose of extending and improving services for promoting the health of mothers and children. Section 502(b) of the Act authorizes grants for special projects of regional or national significance which may contribute to the advancement of maternal and child health. Section 531 of the Act provides for grants for special projects for the provision of necessary health care to prospective mothers and their children. The AFDC program under title IV of the Act authorizes vendor payments for medical or remedial care recognized under State law in behalf of dependent children and their responsible relatives with whom they are living.[1] The other public assistance titles of the Act have similar provisions, with title XIX specifying the items of medical or remedial care in great detail. As an exception to the foregoing, the Bureau of Family Services apparently would support the position of Family Life Consultant in public welfare agencies as part of their social service activities.

While most of the Welfare Administration activities in family planning have been and will continue to be carried on under the above authority, other potential authority includes section 533 of the Act, grants for research projects relating to maternal and child health services, and section 1110 of the Act, grants or contracts for research or demonstration projects relating to the prevention and reduction of dependency.

[1] The summary of Departmental activities in family planning which we saw recently, makes only one brief and vague reference to services furnished or paid for by State and local welfare agencies under the public asssistance titles. Presumably quite a bit is or might be going on under this authority. Perhaps details were left out because BFS does not know exactly what is happening, or where, or how much money is being spent.

Services to the Unmarried

In general, the Welfare Administration activities in relation to family planning make no distinction on the basis of whether or not the women receiving the services are married. However, the various programs of the Children's Bureau and the Bureau of Family Services, referred to above, are concerned, by and large, with mothers and their children. It would probably be unusual, if not outside the scope of the particular program activity, for birth control services to be given to unmarried females who were not mothers, e.g., teenagers.

It is not clear what rules are applicable to projects under title V of the Economic Opportunity Act, work experience programs. Families under these projects ordinarily receive at least the services furnished under the regular public assistance program. According to the newspapers, OEO will not support birth control services for unmarried women. I don't know whether services of this type are furnished at all under any of these projects and, if so, whether HEW or OEO policy would govern as to who would receive the services.

Secretary GARDNER. I think the simplest way to answer this is to ask the Surgeon General for the Public Health Service and Dr. Lesser for the Children's Bureau to tell you the statutory authorities of the various programs under which they provide these services.

Senator METCALF. I would be delighted to hear them.

THE SURGEON GENERAL CITES THE PUBLIC HEALTH SERVICE ACT . . .

Dr. STEWART. Section 315 of the Public Health Service Act gives authority to the Surgeon General to disseminate information to the public, information which relates to the health of the public. This is a very broad authority. Section 314(c) authorizes the Surgeon General to make grants to the States for carrying out general public health programs and included within this would be the use of these funds at the discretion of the State for family planning programs.

Also, I cannot cite the section but the act that created the Institute of Child Health and Human Development authorized the Surgeon General to make grants for research and for research training, to conduct research and to disseminate the information in fields related to human development, including human reproduction.

Finally, the Public Health Service Act authorizes the Surgeon General to provide medical care for certain designated beneficiary groups which include the American Indian, the Alaskan native, the merchant seaman, and other dependent groups. Included in medical care for medical reasons is birth control information and services. These, I think, are the statutes that are the basic ones under which the programs of the Public Health Service in this area would be conducted.

. . . BUT SENATOR METCALF QUESTIONS THAT THE HEALTH LEGISLATION INCLUDES AUTHORITY FOR ACTIVITIES PROPOSED IN S. 1676

Senator METCALF. I helped draw that bill to transfer the Indian portion of the Public Health Service. I think many of my colleagues would be surprised that that bill is authorizing legislation for the kind of things that Senator Gruening is attempting to do with his bill.

Dr. STEWART. I might also add, Senator Metcalf, we do have the basic authority to collect the vital statistics and the health survey data which form the basic health statistics of the country. The Bureau of the Census collects the census data.

CHILDREN'S BUREAU CITES 1912 ACT

Dr. LESSER. The Children's Bureau, under the act of 1912 creating the Children's Bureau, has authority for factfinding and reporting to the public on all aspects of childlife. The grants for maternal health services, grants for studies in this area and grants for training are authorized under the Social Security Act, title V, parts 1 and 4. These sections authorize grants to State health departments for the promotion of the health of mothers and children and also grants for comprehensive maternity care of mothers, especially those living in areas of concentrations of low-income families.

Senator METCALF. Is that part of the original Social Security Act?

Dr. LESSER. Title V, part 1 was. Part 4 was added in 1963. Now, it is particularly through these two grants-in-aid programs that an increasing number of women in rural areas and women in low economic circumstances in our large cities have for the first time had access to family planning services. The comprehensive maternity and infant care projects which have been in existence now for about a year and a half have admitted over 70,000 women to these programs in that time. It was this program that was instrumental in a number of large cities in changing local public policy with respect to the use of public funds for these purposes. So we think that these are directly related to the subject.

Senator GRUENING. What purpose? Would you specify what the purposes are? You talked about maternal welfare. What services do you actually give?

FAMILY PLANNING SERVICES OF CHILDREN'S BUREAU

Dr. LESSER. Through these programs there are provided the means of location of women for prenatal care, hopefully at an early period through reaching out processes. We find many of these women, especially in our large cities, through churches, laundromats, stores, and other places, where women are accustomed to come for various purposes, quite unrelated to public health.

Prenatal care is provided, also hospital maternity care, including delivery, for women in low economic circumstances, is paid for. Public Health nursing services are provided. The post partum visit is the occasion at which family planning services are made available, although discussions with women regarding the importance of this is instituted at the prenatal period.

Physicians tell us that since these programs began to offer family planning service, visits to post partum clinics have more than doubled, and this also has the additional dividend in providing the opportunity for Papanicolaou smears and in a number of cases cervical cancer has been discovered through these means.

FAMILY PLANNING "FOR THE FIRST TIME AN OPEN AND INTEGRAL PART OF THE MATERNAL HEALTH SERVICES"

Mr. Chairman, I would like to say as a person who has been involved in the administration of maternal and child health programs for a number of years, that I think you underestimate the significance of the Secretary's policy which has just been issued. We have had to

work for many years in these programs under circumstances under which we have to be absolutely passive. We were neither for family planning officially, nor were we opposed to it and little was actually ever said about it.

HEW POLICY CHANGING, SAYS CHILDREN'S BUREAU HEAD

But now for the first time we can speak of this publicly, we see that family planning services are incorporated as an integral part of maternal health services. We speak about this freely and we can encourage the inclusion of such services as part of maternal health programs in the same way we encourage the inclusion of medical social services or Papanicolaou smears or whatever.

In other words, family planning has become for the first time an open and integral part of the maternal health services which we support. I think this is really a very significant step. We are also for the first time approving project grants for training of public health people, nurses, physicians, social workers and others in this area, as well as beginning to support a few small studies that are related to the delivery of maternal health services in the area of family planning and population.

Senator GRUENING. When you talk to these visitors to your clinics about family planning do you offer them contraceptive information or offer them an opportunity to have it if they wish it?

Dr. LESSER. This is done in a variety of ways, depending on how the local people wish to go about it. But where family planning services are provided and they are in virtually all these programs now, the subject is introduced, if the woman herself does not ask for it. In one program right near here, as the patient gets off the elevator into the clinic here, a large sign says, "For birth control information come into this office." The subject is freely discussed and a variety of methods are available so that there is freedom of choice with respect to this.

Senator GRUENING. I direct that the biographic statement on Dr. Lesser be included at this point in the record of this hearing.

BIOGRAPHIC STATEMENT: ARTHUR J. LESSER

Dr. Arthur J. Lesser received his B.A. degree from Amherst College, Amherst, Mass., and his M.D. degree from Washington University in St. Louis in 1934.

After 2 years in private practice as a specialist in pediatrics in New York City, Dr. Lesser served for a year as a member of the New York City Health Department. In 1941, he received his degree as master of public health from Harvard University and later in that year joined the staff of the Children's Bureau as a specialist in services for crippled children. Dr. Lesser became Director of the Division of Health Services in January 1952.

On February 15, 1965, Dr. Lesser became Deputy Chief of the Children's Bureau.

Dr. Lesser has been certified by the American Board of Pediatrics and the American Board of Preventive Medicine and Public Health.

Senator GRUENING. Senator Metcalf, you have something to add?

Senator METCALF. One of the sections that you cited was the Indian Health Service Act. What are you doing on Indian reservations?

PUBLIC HEALTH SERVICE FAMILY PLANNING PROGRAMS REACH 7–8 PERCENT OF ELIGIBLE AMERICAN INDIAN WOMEN

Dr. STEWART. In 1965, more than 2,600 women were provided with oral contraceptives with an expenditure of drugs of $28,000, approximately.

Senator METCALF. On Indian reservations?

Dr. STEWART. Yes. This is of the 380.000 American Indians who receive health services from the Public Health Service.

There are about 71,000 women in the child-bearing age. There were 2,600 women provided with oral contraceptives, 1,200 provided with intrauterine devices, and roughly 1,600 women received prescriptions for oral contraceptives for nonmedical reasons. That figure—that last figure is a little shaky but the total is somewhere around 4,000 or 5,000 women. Summed up, this is around 7 or 8 percent of the women in the child-bearing age who are beneficiaries of the Public Health Service who are involved.

The Bureau of Indian Affairs, following a statement of policy by the Secretary of the Interior, is providing Indians and Alaskan natives with information on family planning, and this has and will result in an increase in services. We are into fiscal year 1966 now, and it has actually involved an increase in requests for services. The Bureau of Indian Affairs has transferred some money to us for meeting this increasing load and I do not know what the final figures will be for fiscal year 1966. The program among the American Indians which has been carried out, with careful attention to the medical reasons, the objectivity, and the freedom of choice for individuals, has been a good one. I think it is well accepted by the American Indians and we feel we are providing a health service which is improving the health of the American Indian.

Senator METCALF. On what reservations do you operate?

Dr. STEWART. We are operating mostly in the Navajo, Hopi area of New Mexico and Arizona. We have some money for the second half of fiscal 1966 to expand our services in Alaska. We have not had an opportunity to get it started for the Alaskan natives I am talking about.

INDIAN HEALTH SERVICES CONCENTRATED IN SOUTHWEST

Senator METCALF. This is it. You are operating in the Southwest largely?

Dr. STEWART. Yes, sir. That is where the largest concentration of health services is and where we have the largest concentration of beneficiaries. As far as that goes, though, it is available in any of the places we provide health services.

Senator METCALF. I picked out the Indians because they have a peculiar and special relationship. I can see how you are trying to shove off on to the States a good deal of the responsibility for this. And you have made a great deal of emphasis about the fact that you have come from 13 to 30 States but you cannot shove on to the States the responsibility for the dissemination as far as Indians are concerned. I am

pleased that you started it in 1965 on the authority that you have had for many years before that.

Dr. STEWART. A little bit before that but the only data I have here were for that which started in fiscal year 1965.

Senator METCALF. Now, as I understand it, it is the Secretary's contention that since as long ago as the beginning of the welfare system, you had authority to do these things and yet you are just beginning to put a program into operation.

Secretary GARDNER. I would say the chief gains have been quite recent.

Senator METCALF. So when Senator Gruening spoke about new ideas and new solutions, you are not putting—there are no new ideas and new solutions. You have had the authority for several decades.

SECRETARY SAYS UTILIZING EXISTING AUTHORITY . . . "REPRESENTS VERY CLEAR GAINS"

Secretary GARDNER. The authority is one thing and what we do with that authority is another. What we are contending is that having had the authority for quite a while, what we have been doing recently represents very clear gains. I really very earnestly believe that.

SENATOR METCALF ASKS WHERE ARE THE "NEW IDEAS AND NEW SOLUTIONS"

Senator METCALF. I would certainly agree anything you did recently would represent clear gains from some of the things that started from a standing start. But it does not seem to me as if you are coming up here with, as you said, as was said at your swearing-in ceremony, new ideas and new solutions when you merely carry out the ideas and programs and the solutions that have been in existence for many, many years.

Secretary GARDNER. Senator, I believe that a situation has existed in which a very great deal needed to be done and could be done and remains to be done with existing knowledge and existing ideas, and the gains that we have made are new ground covered.

HEW DOES NOT WANT NEW AUTHORITY OR SUGGESTIONS?

Senator METCALF. But you do not want any new authorization or you do not want any new authority or you do not want any suggestions for embarking beyond the area that you have had all these years?

Secretary GARDNER. No, sir. I wish to correct that impression—

Senator METCALF. It was a leading question. I did not mean it as a statement.

". . . WE WILL NEED PLENTY OF NEW IDEAS . . ." PERHAPS NEW AUTHORIZATIONS

Secretary GARDNER. I am at fault in the way I phrased my earlier comments. I certainly believe that in this growing field, in this immensely important field, we will need plenty of new ideas, we will need programs as we move along.

We will perhaps need new authorizations, and I am completely open on that. I am prepared to discuss those specifically. I did not feel,

as I said in my testimony, that the specific ideas proposed in S. 1676 would add materially to it.

HEW HAS TAKEN "A COMPLETELY NEGATIVE APPROACH"

Senator METCALF. I believe that is why Senator Gruening and I have been disappointed in your statement.

Not that perhaps you do not have the authority at the present time but instead of coming in and talking about some of these new ideas, these new solutions, you certainly must have, as a result of the experience that you have had putting the programs into effect, you have taken, as Senator Gruening has said, a completely negative approach in saying the large scale of S. 1676 will not do anything, and you do not want anything else, and there is no use holding a conference to find out where we are going.

". . . WE ARE CONTINUALLY HOLDING CONFERENCES . . ."

Secretary GARDNER. I think I made the point, and Dr. Lee made the point that we are continually holding conferences and we regard this as immensely important and will continue to do so. We did not rule out the possibility that a White House conference would be a very useful thing at some point down the line.

Senator METCALF. I think your testimony has been very helpful. I am somewhat disappointed, as I say, some of you people who are expert in this field did not come in with some new ideas and some of the new solutions that the President has been suggesting in all those areas that you suggested yourself. I hope that you will think about it, you and your very capable and competent staff; and if this proposal is not the solution—and apparently you think it is not—would you tell us some of the things that we can do to help you and give you additional authorization and give you additional strength to go for appropriations to solve this very urgent problem.

Secretary GARDNER. Senator, that is a very reasonable and valid suggestion, thank you.

Senator METCALF. Thank you very much.

Senator GRUENING. Mr. Secretary, you just said, "perhaps we need new authorizations." Perhaps. Well, now, in the President's first statement, he said this administration is seeking new ideas and certainly is not going to discourage any new solutions to the problems of population growth and distribution.

If you think maybe you need new authorization, why do you not ask for it? Why is not that part of your approach in this effort? I do not consider that this legislation is necessarily the answer, but it certainly is no answer to say we do not want any of it. You have done absolutely nothing legislative to further this problem. All you have done is to say we are doing it now.

If you think maybe you will need new authorization why do you not ask for it?

Secretary GARDNER. Because we have no clear notion——

Senator GRUENING. Congress only meets at certain times. If you do not get it in this session, pretty soon you are not going to get it for another year, and this is a burning problem.

Secretary GARDNER. Well, Mr. Chairman, I have a feeling that Congress is in session quite a lot of the time. I want to address myself earnestly to a question that was sincere and deserves a serious answer.

". . . WE HAVE BEEN SO OCCUPIED IN DOING ADEQUATELY WHAT WE SHOULD HAVE BEEN DOING THAT WE HAVE NOT ADDRESSED OURSELVES TO NEXT STEPS"

We really believe that the things that need doing now are to make our programs effective, and perhaps because of past inadequacies, this remains to be done. But we are straining every effort to do some things which are clearly not very striking in terms of the appearance of innovation and yet they must be done and they will meet objectives which you share. And it is because we have been so occupied in doing adequately what we should have been doing that we have not addressed ourselves to next steps. But, believe me, the gains have been considerable.

Senator GRUENING. The gains have been made because there has been a rising public sentiment, and this committee has been giving the public a chance to be heard. But I have seen no corresponding gains in the action of the Federal Government as witnessed by your testimony and your adverse report on this legislation. You find nothing in this legislation sponsored by 12 Senators, and with various similar bills pending in the House, that you can recommend. You do not want an Assistant Secretary. You do not want the words "population control" mentioned in your program. You do not want a White House conference, and you leave it to the State Department to come up with probably the same kind of answer that you are making, namely, that you are doing it now.

Now, what was the statement that you first read in response to Senator Metcalf's request for the authority? What was that statement? Is that a statement that you drafted?

Secretary GARDNER. As I indicated, this is a statement prepared by our General Counsel, Alanson Willcox, addressed to the Office of the Secretary.

Senator GRUENING. I notice in the statement there are frequent references to Mr. Ball. It is a curious fact that of all the witnesses we have heard, over 80 of them, Mr. Ball is the only one who had a completely adverse attitude toward this legislation.

We have opened this hearing to anybody who wants to testify. We want to get every point of view. We have invited people whom we knew were adverse to it to come. He is the only one of them who has come and testified, and yet this memo of yours seems to be built largely on Mr. Ball's testimony. It is a curious thing.

Secretary GARDNER. No, sir. He is the one who raised the constitutional issue. And I agree with Senator Metcalf this was not directly responsive to his point and I was simply trying to set the whole legal background in responding to his question. But remember it came up—his name comes up because he raised the question.

Senator GRUENING. Did your General Counsel agree with his reservation?

Secretary GARDNER. No, sir. Totally disagreed.

Senator GRUENING. I meant to ask you another question. Does the Department have plans for a controlled study of Dr. Rock's pill?

Secretary GARDNER. Pardon me?

Senator GRUENING. Does the Department have plans for a controlled study of the pill?

Secretary GARDNER. May I ask Dr. Lee to answer that?

HEW STUDYING THE PILL

Dr. LEE. The Department, through the Food and Drug Administration particularly, Senator, maintains a continuing evaluation of the pill and the new drugs that are being developed in this area. And there are a number of them, as you know. They have an advisory committee—as a matter of fact it is meeting today and tomorrow on obstetrics—which is reviewing all the available data with respect to the present pills. They have also made several contracts with universities and they have made a special contract with the Kaiser Foundation Research Institute in San Francisco to evaluate adverse drug reactions. We can supply the subcommittee the specific information. I do not have it immediately before me.

Senator GRUENING. We would appreciate having that.

(The information requested follows:)

EXHIBIT 132

INFORMATION ON HEW CONTRACTS TO EVALUATE ADVERSE DRUG REACTIONS, SUPPLIED BY HEW

The contract for the Kaiser Foundation Research Institute for $90,594 was effective on February 1, 1966. It is designed to provide comprehensive data on adverse drug reactions occurring in patients receiving care covered by the Kaiser-Permanente Medical Plans. This would also include data on the frequency rate of diagnoses of various illnesses, the development of a drug monitoring system for early warning indicators of previously unrecognized reactions, and the compilation of drug utilization statistics.

A contract with the Johns Hopkins Hospital in the amount of $6,100 was effective on April 5, 1965. This is a retrospective scientific study regarding the use of oral contraceptives and possible morbidity from selective thromboembolic conditions.

A contract with the University of Pittsburgh School of Pharmacy in the amount of $21,581 was effective on April 1, 1966. This is an epidemiological study on the incidents of adverse reactions following the use of oral contraceptives in Lawrence County, Pennsylvania, covering women between the ages of 15 and 45. Ten drugs of primary interest have been identified for the study.

CONTRACEPTIVE PILL "OBSERVED FOR ADVERSE REACTIONS"

Senator GRUENING. We all have a very favorable impression of the new Director of the Food and Drug Administration, Dr. Goddard, who seems clearly to have been reversing some of the previous policies which were subject to criticism. If the Food and Drug Administration under his aegis carries out his policies as they appear to be doing, I am sure they will be well done and effectively done.

I wonder why the Kaiser-Permanente Corp. is engaged in this research. I thought they manufactured cement.

Dr. LEE. They have a very extensive medical program on the west coast and Hawaii. This is the Permanente Medical Group, the Kaiser Foundation, and Kaiser Hospitals, and it is through this organization—they have a large number of prepaid subscribers for health programs. They have a population therefore that can be carefully followed and it is in this population group that they are doing a study

for the Food and Drug Administration—adverse drug reactions. One of the drugs of course that is being prescribed and will be observed for adverse reactions on a continuing basis in this group that is essentially a closed population will be the oral contraceptives. There are many other drugs that will be studied there also.

IS BIRTH CONTROL TAUGHT IN THE MEDICAL SCHOOLS?

Senator GRUENING. I think it would be useful—I do not know whether this would come under your supervision, Dr. Lee, or in the program of education under Mr. Keppel. What reports do you get from medical schools? Up to very recently medical schools were seldom teaching anything about the contraceptive techniques or birth control. Have you information as to their changes in teaching methods?

Dr. LEE. I cannot give you the most recent information. I know that people from the National Institutes of Health have been meeting with scientists from medical schools. I have also been personally with a number of them. We have discussed this and perhaps Dr. Lesser may have also been meeting with people from the medical schools. Dr. Lesser, would you wish to comment on that?

MEDICAL SCHOOLS FOLLOWING PUBLIC SENTIMENT ON FAMILY PLANNING

Dr. LESSER. I think there is no question that the medical schools are participating in this great upsurge of interest which we see all about us today. I think it is true, as you pointed out earlier, Mr. Chairman, that they were not necessarily leaders but are following the general public sentiment in favor of this. And there is no question, medical schools, schools of public health, schools of nursing, and schools of social work are all adding this subject to their curriculum.

Senator GRUENING. Senator Metcalf?

Senator METCALF. Mr. Chairman, before we close, I wonder if we can have submitted to the committee the kind of material that is sent out to those State conferences from the U.S. Public Health Service and Children's Bureau? A representative pack that is sent out.

Senator GRUENING. I would like to second that suggestion of Senator Metcalf's. I think we should have available all the material that the Department issues on the subject of contraception and family planning so that we know exactly what it is doing, because from the statements made today we can know only in a general way what the Department is interested in but there is no particularization—nothing very tangible to show us what you are doing.

(The following material was subsequently supplied by the Department of Health, Education, and Welfare:)

EXHIBIT 133

[*Part 1.*—"Family Planning," a pamphlet introducing the concept of family planning, published by the Children's Bureau]

FAMILY PLANNING*

The birth of a new baby can be a happy time for you. This is more likely to be so when you are able to give the care and love that your baby needs.

*For sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C., 20402. Price 5 cents; $2 per 100.

But some families have a new baby every year. Then there can be problems. It is bad for some mothers' health to have babies come too close together. Your home may be too small for another baby. The new baby may come before you have paid for the last one. The mother may have too much on her hands to care for another new baby. Feeding, diapering, bathing may not leave energy or time to give all of your children the attention that each needs.

When you plan your family and space your babies as you want them, life can be more rewarding. Both you and your husband will be happier. You both won't be worrying about having the next baby until you are ready.

Today if you want to plan your family, there are safe and easy ways to do so. Your doctor can tell you about family planning. By using some method of birth control, you can have your babies only when you want them. Your doctor can help you pick the way that suits you and your husband best.

Some husbands and wives want babies but for some reason do not have them. If that is your problem, talk with your doctor about that. Today, doctors know a great deal about how to help a husband and wife when they want babies but have not been able to have them. That, too, is good family planning.

[*Part 2.*—A copy of the January 24, 1966, memorandum from Secretary Gardner concerning: "Departmental Policy on Population Dynamics. Fertility. Sterility and Family Planning," the full text of which appears on pages 783, 784]

The policy of this Department is to conduct and support programs of basic and applied research on the above topics; to conduct and support training programs; to collect and make available such data as may be necessary to support, on request, health programs making family planning information and services available; and to provide family planning information and services, on request, to individuals who receive health services from operating agencies of the Department.

The objectives of the Departmental policy are to improve the health of the people, to strengthen the integrity of the family and to provide families the freedom of choice to determine the spacing of their children and the size of their families.

Programs conducted or supported by the Department shall guarantee freedom from coercion or pressure of mind or conscience. There shall be freedom of choice of method so that individuals can choose in accordance with the dictates of their consciences.

The Department will make known to State and local agencies that funds are available for programs of the sort described above, but it will bring no pressure upon them to participate in such programs.

Each agency shall assure the effective carrying out of this policy, the regular evaluation of programs and the reporting of information on programs to this office.

The Assistant Secretary for Health and Scientific Affairs will serve as the focal point for Departmental policy and program coordination; will review and evaluate policies and programs; will conduct liaison with other Departments; and will cooperate with interested public and private groups.

JOHN W. GARDNER,
Secretary.

[*Part 3.*—Chapter 1-3936 of the Organization Manual of the Department of Health, Education, and Welfare relating to Departmental Policy on Population Dynamics, Fertility, Sterility, and Family Planning, February 25, 1966]

1-936-00 *Purpose*

This chapter states the Department policy on population dynamics, fertility, sterility, and family planning and the general assignments of responsibility for implementing the policy.

1-936-10 *Policy*

A. The policy of this Department is to: conduct and support programs of basic and applied research on the population dynamics, fertility, sterility, and family planning; conduct and support training programs; collect and make available such data as may be necessary to support, on request, health programs making family planning information and services available; and provide family planning

information and services, on request, to individuals who receive health services from operating agencies of the Department.

B. The objectives of the Departmental policy are to: improve the health of the people; strengthen the integrity of the family; and provide families the freedom to choice to determine the spacing of their children and the size of their families.

C. Programs conducted or supported by the Department shall guarantee freedom from coercion or pressure of mind or conscience. There shall be freedom of choice of method so that individuals can choose in accordance with the dictates of their consciences.

D. The Department will make known to State and local agencies that funds are available for programs of the sort described above, but it will bring no pressure upon them to participate in such programs.

1-936-20 *Responsibilities*

A. The Assistant Secretary (Health and Scientific Affairs) will: serve as the focal point for Departmental policy and program coordination; review and evaluate policies and programs; conduct liaison with other Departments; and cooperate with interested public and private groups.

B. Each operating agency will assure the effective carrying out of this policy, the regular evaluation of programs, and the reporting of information on programs to this office.

[*Part 4.*—The June 8, 1965, recommendations of the National Advisory Child Health and Human Development Council on Research in Fertility, Sterility, and Population Dynamics appeared earlier in the 1965 "Population Crisis" hearings on S. 1676, Volume 2-A, pp. 1049-1050]

[*Part 5.*—A copy of the January 24, 1966, Gardner memorandum concerning departmental policy on population dynamics, et cetera, sent on March 4, 1966, to State Agencies Administering State Plans for Public Assistance and Child Welfare Services by Fred H. Steininger, director, Bureau of Family Services, and Katherine B. Oettinger, chief, Children's Bureau. The full text of Secretary Gardner's memorandum appears on pages 783, 784 of this hearing]

[*Part 6.*—The full text of Mrs. Katherine B. Oettinger's March 31, 1966, address entitled "The Right To Know" before the annual meeting of the Planned Parenthood League of Massachusetts, Boston, Mass.]

If she is in this audience tonight, I would like to give my own special salute to the woman who recently complained that she would have to take up some cause other than family planning because she only liked to back unpopular causes.

Who of us would have dreamed that the propelling forces of the last few years could have so nearly erased the strictures surrounding the right of individuals to plan their families? Who would have dreamed that we are charged with taking a role of active assistance to the families of the poor, who for so long have been deprived of this right?

In our present national climate, we face a new challenge, which will require the finest spirit of cooperation between public and voluntary sectors: to make this the last of the tongue-tied generations. To do this we must extend to all parents the information which will give them a sense that they have as much mastery over their own destiny in planning for the number of children they desire and can truly nurture as new scientific findings now permit.

In the founding days of this republic, Thomas Jefferson again and again set forth the principles that the people have a right to *know*.

Now President Johnson in his significant Health and Education Message to the Congress has specifically underlined this right in an area so long buried in controversy. He stated:

"We have a growing concern to foster the integrity of the family, and the opportunity for each child. It is essential that all families have access to information and services that will allow freedom to choose the number and spacing of their children within the dictates of individual conscience."

In those 49 historic words, the President has added a new dimension to our national policy which can have an impact on the future greatness of our Nation that we tonight can only dream of.

Ours is the task to close the veritable abyss of misinformation or complete lack of information about family planning. For so long it has significantly contributed to the problems of the poor, not only in their despair, but in the degree to which they have felt frantic and helpless victims of a fate which gave them more children than they could care for. With each succeeding birth they were weighted down with an additional sense of the utter futility of trying to cope with a situation which seemed completely beyond their control.

In carrying out President Johnson's charge to foster the integrity of the family through a free choice about child spacing, the Children's Bureau has been given a clear mandate to support family planning in the maternal and infant care programs in local communities when requested to do so. The Office of Economic Opportunity has also been instructed to extend family planning services as part of its war on poverty. These are service functions which can be augmented, as well, by State agencies, using Federal Public Welfare funds to provide family planning services to individual mothers who request them.

This is a good beginning toward the effective utilization of all community health and welfare resources in the whole area of family planning.

The President also has asked the National Institute for Child Health and Human Development to expand its own research and grant programs to study human reproduction.

The need for this expanded research was dramatically underlined by your president, Dr. Alan Guttmacher, when he predicted recently that "contraception 1966" will seem antiquated by 1971, because of the tremendous opportunities for progress which will be possible in the next five years.

In this connection, you might be interested in a conversation I had recently with Dr. James L. Goddard, newly appointed Commissioner of the Food and Drug Administration, who assured me that FDA will be keeping very close tabs on all oral contraceptive tablets which are developed to assure their general safety within the limits of any drug. Of course, a physician's advice will be necessary to take care of individual differences in patients since we already know that there is no single magic formula for everybody.

There are few today who would quarrel with the premise that the role of the Federal Government in the whole area of family planning must be expanded, as the Planned Parenthood Association has so actively recommended. We in the Children's Bureau are also attuned to the many requests at last fall's White House Conference on Health, for more active Federal participation in the support of services, professional training and research which is so critical to the success of an adequate program of family planning.

Family planning services are being included to an increasing extent in the State maternal health programs supported by grants administered by the Children's Bureau, as well as in special project grants derived from the 1963 amendments to the Social Security Act for comprehensive maternity care for women in low-income families. In the fiscal year 1965, it is reported that 25 States spent nearly $2 million of maternal and child health and maternity and infant care funds specifically for family planning services.

During the current fiscal year, we estimate that $3 million will be spent by 32 or more States for this purpose and that the figure will rise to an estimated $5 million in 1967. We are encouraged that nearly all of the maternity and infant care projects so far approved make provision for family planning services and as these projects reach their maximum authorization, undoubtedly the number offering this service will rise correspondingly.

Mr. Fred Steininger of the Bureau of Family Services and I have recently issued a joint memorandum to the directors of State welfare agencies offering our help in their implementation of a new policy statement issued by Secretary John W. Gardner.

Let me emphasize that if the true meaning of President Johnson's insistence on freedom of choice is to be carried out, it will not be the role of the Federal Government to dictate which women shall or shall not have family planning services if they desire them.

Our practice has been and will continue to be that these services shall be made available to the women who request them at the discretion of the clinic director or State health officer in charge of the program. This of course does not rule out room for experiments with different types of services according to local need. And we can learn from these experiments.

I would like to come back for a moment to my challenge to us all to make this the last tongue-tied generation. It is high time we faced the fact that the poor have been tongue-tied in asking about birth control information. There has been little enthusiasm in helping them get it and less ability to communicate in their own language.

The findings of studies underway at Tulane University, funded by the Children's Bureau, are enough to make us face the true facts of the situation. In a survey of families in a cross section of socioeconomic levels in metropolitan New Orleans, ninety-one percent agreed that couples have the right to decide for themselves when to stop having children. An even higher percentage, in both the Catholic and Protestant respondents surveyed, stated that they would be in favor of providing tax-supported family planning services for the medically indigent who could not afford these services from private sources.

I can think of few other questions on which we could get such a unanimity of opinion in any section of our Nation today.

But this eagerness for family planning information was coupled with a simply frightening ignorance about causes of pregnancy and the ovulatory cycle, as well as effective means of contraception, in the lower socioeconomic group.

There was a direct relationship between knowledgeability and formal education. Only 53 percent had even rudimentary knowledge of reproductive physiology in this group.

In this same lower socioeconomic group surveyed, three-fourths of the women never want to get pregnant again, two-thirds of them want more information about how to keep from getting pregnant and nine-tenths of the same want their sons and daughters to be informed of birth control techniques.

These people, in other words, do not want to be tongue-tied any longer about what the consider crucial individual needs in their own life cycles. Other studies and service evaluations in New York City confirm this experience of patients' follow-through in family planning advice, particularly when proper supportive services are incorporated in comprehensive health care. They have the basic motivation to accept help, and it is up to us to see that they get it.

Five years ago, we could have despaired at our ability to move effectively to meet this appeal for help. This was before the rapid advances in technology which have made a number of simple contraceptive devices available.

It was before most legal barriers to this kind of information had been removed. When a Supreme Court decision struck down a Connecticut law prohibiting physicians or hospitals from giving information about or dispensing the use of contraceptive devices, it represented a major stride forward in the legal area.

Now, only here in Massachusetts do legal barriers still exist, so that those who cannot afford the cost of private medical care are denied competent guidance in a selection of methods of family planning consistent with their beliefs.

Most importantly, we now have a clearly enunciated national policy which spells out the essential nature of freedom of choice in family planning as a way of bolstering the integrity of the family in any State and locality that chooses to do so.

The Children's Bureau's mission in carrying forward this national policy will be to use family planning services as a positive way to improve the health of mothers both during pregnancy and in the interpregnancy interval so that not only her own health is enhanced, but that she will have a more healthy family by exercising a wish of self-determination which has too often been cruelly denied.

Even with the way clear, the job ahead is of such enormous magnitude that it staggers the imagination.

It falls into three major dimensions.

First, we must learn how to communicate with the poor. The best example I can think of to illustrate this point occurred in one of the Bureau's maternity and infant care projects. One of the women who was being cared for by the project was asked if she wanted to avail herself of family planning.

Her answer was, "What do I need with family planning? I've got my seven children."

Communication takes many forms. Even the most highly motivated woman who would eagerly accept family planning services will not be easy to reach if she follows the classic pattern of poor—educational deprivation. It is alarming that a high percentage of the poor never finish high school; how many, indeed, never even became literate at the eighth grade level.

It is a fact that it is our national policy that there should be no coercion in offering family planning services but we cannot expect that every parent who

might want these services will come knocking at our doors asking for them. She may have a basic distrust, even fear, of anything outside her immediate environment. Old attitudes of silence may influence her. Mr. James Dumpson recently told me of receiving a letter from the mother of five children born out of wedlock who was complaining about her clinic experience. "I was ashamed," she wrote to this New York City Commissioner of Welfare, "to listen when I heard all the stuff they told me." Added to the failures in communication, there are far too many instances where women simply are not aware that fertility control is possible.

In the maternity and infant care programs for which the Children's Bureau administers grants, we have been very impressed with the proportionate numbers of women who have chosen to avail themselves of family planning services. Through their word-of-mouth stories to their neighbors and the efforts of public health nurses and social workers to reach pregnant women in the project area, attendance at prenatal and postnatal clinics is mounting where such help is being offered.

But never think for a moment that we are complacent about this success. We are reaching only a very small proportion of the women in childbearing age in these clinics and in our regular maternal and child health programs. I know the Family Planning Federation is acutely aware of the small beginning our combined services are making when only one out of ten impoverished couples in the country who want and need to plan their families are receiving care.

To establish the kind of communication that we need to reach the much larger numbers we seek to serve, we must not only fully utilize every available tool, but forge new ones.

I had the pleasure recently of attending a Conference on Youth and Leisure at which Prince Philip was the honored guest. Accompanying him was Sir John Hunt, a leader in Britain's Youth Services. We had a lively discussion about some of the ways England is now trying to reach its youth with the kinds of accurate information about sex which can help them to understand its appropriate place in the whole scheme of family life.

The crux of the matter, whether we approach the women seeking family planning advice on an individual or small group basis, is to ensure a spontaneity of approach.

It is grossly inefficient, with manpower so scarce, that skilled specialists should be used exclusively in imparting information about family planning in order to meet all the demands for this help. Their skills should be used at the highest level, supplemented by the use of appropriate audiovisual materials that can be demonstrated by less skilled personnel.

At the same time, we have every reason to believe that the women who will be getting this information, in simple, clearly understandable language, are not women who are accustomed to long-range planning. There is nothing in their past lives that has prepared them for having to deal with anything but immediacy—crisis immediacy—and they have little faith that they are the movers of their own fate in any area.

To overcome these significant factors, we must make use of the audiovisual materials which now are so highly developed and so widely applicable. A well-recorded message—with suitable visual aids—spoken by a voice that carries the authority of conviction but the warmth of human understanding, can be used a thousand times and still seem spontaneous.

In our maternity and infant care projects, we have also found that information on maternity care, presented in picture books, has wide appeal to clinic patients.

I need not tell this audience how useful many of the materials you have developed have been in reaching those who previously have sought information about family planning. The wealth of your pioneer achievements can strengthen our partnership in widening our joint efforts to communicate with the poor. We are especially appreciative of your efforts over the years here in Massachusetts to reach new mothers identified through birth certificates.

The second major dimension of the job that lies ahead is teaching the communicators how to communicate.

I think we must frankly admit that our educational time lag is tremendous in the helping professions, the medical, parimedical and social work professions relating to exact target disciplines. We are suffering from a massive case of scientific indigestion because the rate at which new knowledge is being

thrust upon us about developments in the physiological, biological and behavioral sciences is accelerating so rapidly.

An effective network of preventive health and social programs is a goal to which we all aspire. We will move steadily toward it to the degree that we are able to so alter human behavior that our preventive measures, in whatever area, have the optimum chance of success.

This is particularly true in the area of family planning. We must fill the gaps in professional training that now exist among practitioners. Further, we must make sure that those who are now preparing to enter the helping professions will be equipped with the information they need to feel comfortable in this basic field.

The Children's Bureau is taking positive steps in these two directions. It is encouraging short-term refresher courses for those now working in the field, and stimulating training for physicians, nurses, social workers, and nutritionists as a part of their graduate curricula.

In addition to urging the inclusion of material on population dynamics in graduate curricula, we are also giving direct grants to a number of colleges and universities to carry forward this training.

We also are supporting grants in nine graduate schools of public health and in five schools of nursing for courses with family planning content.

We are delighted at the recognition in the fields of public health and social work that this training bridge must link quickly with the well-developed pathways of training which the Planned Parenthood Federation has so well developed. As you know, the American Public Health Association has an Area Committee on Population and Family Planning. Members of the Children's Bureau staff are working with the committee to develop family planning content in social work education.

Even though the combined efforts of all of us cannot accomplish an overnight miracle in the critical area of professional training, it is exciting to think how, once we fill out this new dimension in our service programs, we can look forward to a whole range of opportunities which can build self-confidence among those we seek to reach and to make their universe more manageable.

The Children's Bureau's interest in facilitating training in the whole subject of family planning does not stop at our national borders. I am sure you are aware of the tremendous increase in interest among other countries in developing adequate family planning services. Under an agreement with AID, the Children's Bureau is developing training facilities in the United States for nurses, nurse-midwives and professional midwives from other countries. The first phase of this provides top-level nonmedical personnel with refresher experience in maternal and child health into which a component of family planning has been introduced.

Later, other levels of personnel will be trained, and coordination will be sought with the training of physicians now taking place in universities such as Johns Hopkins, North Carolina and California.

The third major dimension of the job that lies ahead is to put what we have learned about population dynamics to work in the most positive and far-reaching manner at the same time that we beam research at those problem areas where we do not yet know the answers—either in basic studies of reproduction or in program planning and management.

I would like to cite two examples of where we are in applying what we have learned about population dynamics in the field of practice.

Washington, D.C., represents what can be accomplished in a public family planning program in a relatively brief span of time.

1. The local Planned Parenthood Association has been active in Washington in the field of family planning since 1937, serving more than 12,000 patients a year. But it was not until 1961 that discussions first began between the Congress and the Health Department on the possibility of providing public funds for this purpose.

2. The initial appropriation in fiscal year 1963 to the Health Department of $1,000 has now grown to $200,000 per year. Public health officials in the Nation's Capital now estimate they will be able to see about 13,000 persons per year in the family planning program and that this number will increase as technological advances in birth control devices are added to the program.

3. Until the Washington program got underway, the press, radio and television, and the public generally were reluctant to discuss the subject of birth control. Once the program came into operation, there has been active cooperation from all media.

On the other hand, the well-known birth control program in the Mecklenburg County Health Department in North Carolina, because it has been a part of postnatal care since 1937, gives us a longer view on the possible effects of a family planning program.

1. There is reason to believe that the service has attracted many women who, by demographic criteria applicable to that county, would be considered hard to reach. A factor in clinic attendance may be the effort made by the clinic staff to improve the patient's self-image.

2. Over a ten-year period, there has been a three percent drop in illegitimate births after a woman has delivered one child out of wedlock. This figure, while not numerically dramatic, indicates a hopeful trend. Part of the significance of the decline lies in the energetic efforts of the program to reach women (through a review of birth certificates) who might want birth control advice and services.

3. Communication among and with the poor coupled with community interest are vital elements in the success of this undertaking. Clear, easily understandable facts helped support both these elements. For example, a study made in the Charlotte birth control clinic showed that mothers *wanted* one or two children, while the average number *born* was nearly five per family.

This is, admittedly, a rather sketchy picture of where we are, although I have attempted to illustrate program developments which can have universal significance for the future.

What do we need to learn?

The Children's Bureau is supporting research which we hope will give us more complete answers than we now have to such questions as:

Why do some low-income families totally reject family planning or accept it only on a limited or temporary basis?

How do prevailing community attitudes and the individual's own psychology work to promote or impede the adoption of birth control measures?

Here again, the deep seated problems surrounding motivation, and the ways in which human behavior can be altered, will be examined in depth.

We are also supporting research which will project what our national birth rates might be in 1975 so that we can begin now to develop those alternative plan requirements which will be necessary for future maternal and child health services throughout the country.

At the Tulane University School of Medicine, the project which I mentioned earlier is continuing to study fertility, and examine attitudes relevant to fertility and family structure. A concomitant result has been a change in the interpretation of the law regarding dissemination of information which started with the Louisiana Attorney General, received formal acceptance by the Governor, the Chiefs of the Medical School and the State Medical Society so that, for the first time, public family planning clinics could be established.

At the University of California, a cooperative study is going forward on intra-uterine contraceptive devices and other family planning methods to learn how day-by-day practice influences clinic procedures.

Under provisions of the International Health Program, the Bureau has as yet made no grants in the field of family planning, but groundwork has been laid for a study of abortions in a European country where abortion is legal and the rate is very high.

We will continue, through our maternal and child health extra-mural research grants program, to develop research which can enhance practice in connection with the programs and services as part of maternal care programs.

There has been a good deal of talk about the seven-year decline in the Nation's birth rate. Opponents of family planning particularly point to this decline as a compelling reason for not instituting more family planning services. But the number of women in the main childbearing ages will increase by 19 percent during the next ten years and, even though the current birth *rate* remains constant, the *number* of babies born is almost certain to increase.

And so, if our growth rate continues as expected, a child born this year will be living in a Nation with three times as many people as now by the time he retires at age 65.

I have selected this as a most graphic picture of the warnings demographers are repeating, not only in terms of international concern but of the domestic population rise. These are factors with which scientists are grappling. Our responsibility lies in an accelerated recognition of the social and health consequences if we ignore the current opportunities to take action.

Only a few months ago, Planned Parenthood Federation was urging a clear statement of public policy that family planning was a duty of government, that

such a massive problem demanded publicly-supported programs. Such a major social policy has now been enunciated at the Federal level. It remains for the States to make effective decisions, directed at specific objectives, about the utilization of the total community of health and social welfare agencies, to the end that public and voluntary agencies will mesh their efforts to deliver services simply, cheaply, and directly to include the needs of all population groups.

My focus in talking to you here has been based on the premise that society's highest achievement for the future should be that each baby is a wanted child. Each child should have a right to upward mobility in a free society. Each child should have a chance to reach the higest pinnacle of attainment and fulfillment of which he is capable.

The job ahead for us—and by us I mean those at the Federal, State and local level of government as well as you interested citizens who have been pioneers in the whole field—is to develop a blueprint which will show us how best to achieve maximum coverage in providing the services which are needed to make the most of manpower through training and—most importantly—to preserve human dignity for those who seek our help.

[*Part 7.*—The full text of the February 10, 1966, address by Dr. Philip R. Lee, Assistant Secretary for Health and Scientific Affairs, Department of Health, Education, and Welfare, delivered at the seminar on population policy, held at the University of North Carolina, Chapel Hill, N.C.]

The recent growing concern with problems related to the present rates of population growth through the world has been increasingly evident among the public and the leaders of the United States and other nations. Equally evident have been the changing attitudes of the public and the leaders.

Many factors were responsible for the growing concern and the changes in attitudes. Birth rates remained steady but death rates began to fall dramatically, with a resultant rapid rate of population growth, particularly in the less developed countries. Knowledge of present and projected population trends was accumulated and disseminated, bringing recognition of the overwhelming implications for social and economic progress. Despite assistance programs in the under-developed countries, it became apparent that agriculture, educational, and social developments were lagging under the weight of population growth. Massive urban-rural shifts occurred in our growing population, with attendant problems of over-crowding—land shortages, traffic congestion, air pollution, and juvenile unemployment. There was an evident and growing desire of families to limit family size and thus raise expectations for the education and welfare of their children.

During the past 50 years, and especially during the past 20 there had been a growing impact of private individuals and groups which had continuously advocated the right of all families to plan their families. These groups have provided essential leadership during many difficult years.

There was growing awareness by some families that other families were controlling their family size, not only in the United States but in many other nations. Today, it must be recognized, one-half of all the families in the world live under governments with officially approved population control policies.

Finally, there appeared two new family planning techniques of major significance—the pill and the IUD.

The mounting influence of these and other factors has been clearly evident. In the United States, they helped to create attitude changes which have been reflected in actions by the three branches of the Federal Government—the Executive Branch, the Congress, and the Supreme Court.

The change in attitude is nowhere more dramatically reflected than in statements and actions by Presidents Eisenhower, Kennedy, and Johnson.

In 1959, President Eisenhower said: "I cannot imagine anything more emphatically a subject that is not a proper political or governmental activity . . . . This Government will not . . . as long as I am here, have a positive political doctrine in its program that has to do with this problem of birth control. That's not our business."

This remained the policy of the Federal Government until 1961, when President Kennedy, in a special message on foreign aid, said: "The magnitude of the problem is staggering. In Latin America, for example, population growth is already threatening to outpace economic growth. And in some parts of the

continent living standards are actually declining . . . and the problems are no less serious or demanding in other developing parts of the world."

This recognition of the problem was translated into policy in 1962. In December of that year, the United Nations General Assembly discussions on population problems included a statement of U.S. policy which indicated that the United States was concerned about the social consequences of its own population trends; that the U.S. would oppose any efforts to dictate to another country its population policies; that the U.S. would help other countries, upon request, to find potential sources of information and assistance in ways and means of dealing with their population problems; and that the U.S. believed that there was need for additional information in the field.

In January 1963, the Department of Health, Education, and Welfare released the long held confidential report by the Public Health Service "Survey of Research on Reproduction Related to Birth and Population Control." The report listed 758 projects costing $8.2 million a year, of which $5.2 million came from Federal research funds. The report did not define a policy, but it was evident that Federal funds were used to support research on human reproduction and fertility control.

In a statement to the press in April 1963, President Kennedy publicly supported research and the full exchange of information in this field.

The most significant Presidential statement, however, was by President Johnson in his State of the Union Message, delivered to a joint session of Congress on January 4, 1965. In 25 words President Johnson offered mankind new hope. He said: "I will seek new ways to use our knowledge to help deal with the explosion in world population and the growing scarcity of world resources."

Since that time, the President has given repeated indications of his concern. Among his statements are the following:

Text of letter to U.N. Secretary General U. Thant at Second United Nations World Population Conference opening in Belgrade, August 30, 1965:

"MY DEAR MR. SECRETARY GENERAL: The United States Government recognized the singular importance of the meeting of the Second United Nations World Population Conference and pledges its full support to your great undertaking.

"As I said to the United Nations in San Francisco, we must now begin to face forthrightly the multiplying problems of our multiplying population. Our Government assures your conference of our wholehearted support to the United Nations and its agencies in their efforts to achieve a better world through bringing into balance the world's resources and the world's population.

"In extending my best wishes for the success of your conference, it is my fervent hope that your great assemblage of population experts will contribute significantly to the knowledge necessary to solve this transcendent problem. Second only to the search for peace, it is humanity's greatest challenge. This week, the meeting in Belgrade carries with it the hopes of mankind.

Sincerely,

LYNDON B. JOHNSON."

State of the Union Address before Congress, January 13, 1966:

"To give a new and daring direction to our foreign aid program designed to make a maximum attack on hunger, disease and ignorance in those countries determined to help themselves . . . and to help those nations trying to control population growth . . . I will also propose the International Health Act of 1966—

"to strike at disease by a new effort to bring modern skills and knowledge to the uncared for suffering of the world—and by wiping out smallpox, malaria and controlling yellow fever over most of the world in this decade,

"to help countries trying to control population growth, by increasing our research—and by earmarking funds to help their efforts."

Further emphasis on the population problem was clear in both the Foreign Aid message and the International Health and Education messages which were sent to Congress on February 1 and 2, 1966.

"By 1970, there will be 300 million more people on this earth. A reliable estimate shows that at present rates of growth the world population could double by the end of the century. The growing gap—between food to eat and mouths to feed—poses one of mankind's greatest challenges. It threatens the dignity of the individual and the sanctity of the family.

"We must meet these problems in ways that will strengthen free societies—and protect the individual right to freedom of choice.

"To mobilize our resources more effectively, I propose programs to—

"(1) Expand research in human reproduction and population dynamics.—We are supporting research efforts through the Department of Health, Education, and Welfare, AID, and the World Health Organization. I am requesting funds to increase the pace and scope of this effort. The effort, to be successful, will require a full response by our scientific community.

"(2) Enlarge the training of American and foreign specialists in the population field.—We are supporting training programs and the development of training programs through the Department of Health, Education, and Welfare and AID. We will expand these programs at home and abroad.

"(3) Assist family planning programs in nations which request such help.—Here at home, we are gaining valuable experience through new programs of maternal and infant care as well as expansion of private and public medical care programs. Early last year we made clear our readiness to share our knowledge, skill, and financial resources with the developing nations requesting asistance. We will expand this effort in response to the increasing number of requests from other countries."

Departments and Agencies of the Federal Government have been gradually developing, modifying and clarifying policies related to population dynamics, fertility, sterility and family planning. I will discuss only the Departments of State and Health, Education, and Welfare because I have some personal familiarity with the way in which the policies were evolved.

Shortly after the inauguration of President Kennedy a small work group was established within the Department of State to examine existing policies and make recommendations. It was after long and careful study by this group that the U.S. policy was stated at the United Nations General Assembly in December 1962. At about the same time several significant changes took place in the Agency for International Development. In the fall, Dr. Leona Baumgartner accepted the post as Assistant Administrator for Human Resources and Social Development. In December, Mr. David Bell became the Administrator of AID.

In early 1963 more intensive study of population problems was initiated by AID and the Department of State, particularly in the Offices of the Assistant Secretary for International Organizations and the Assistant Administrator for Human Resources and Social Development.

Late in 1963 Congress amended Section 214 of the Foreign Assistance Act, which authorizes Development Research and Analysis, to provide specifically for "research into problems of population growth." This subsection was added at the recommendation of the Senate to encourage research in the field and provide explicit authority for it. The original Senate amendment provided for "technical and other assistance" in addition to research. The Senate—House Conference Committee deleted the reference, which went beyond the general subject matter of Section 214. There was existing authority in Section 211 of the Foreign Assistance Act, which provides for the promotion of economic development ". . . with emphasis upon assisting the development of human resources. . . ." for AID to provide technical and other assistance in the population field. Indeed the Agency had long provided assistance to developing countries in improving maternal and child health services, their statistical offices and census bureaus. The Agency had not, however, provided any direct support for family planning programs.

In the fall of 1963 steps were initiated to create a population unit, later named the Population Reference and Research Branch, in AID. This unit was created and became operational in June 1964. The staff of this unit, with individuals in other offices of AID, developed a series of background papers and special studies which resulted in the approval by the Senior Staff of an AID policy in December 1964. This policy was fully supported by the President's State of the Union Message in January 1965. The AID policy was dispatched to AID Missions in March 1965, after a rather prolonged process of clearance and drafting changes within the Agency. The message placed particular emphasis on the following points:

That each AID Mission should assign one of its officers, as Latin American Missions had already done, to become familiar with the problems of population dynamics and program developments in the country and to keep the Mission Director, Country Team personnel and AID headquarters in Washington appropriately advised;

That AID does not advocate any particular method of family regulation, and that freedom of choice should be available in any program for which technical assistance is requested;

That requests for AID assistance in this field, as in others, will be considered only if made or approved by appropriate host government authorities;

That AID is now prepared to entertain requests for technical, commodity, and local currency assistance in support of family planning programs;

That AID will not consider requests for contraceptive devices or equipment for manufacturers of contraceptives, since experience has made it clear that the cost of these latter items is not a stumbling block in countries that are developing effective programs.

Just as in many state and local programs, the development of operating programs has lagged well behind the development of policies. At the present time only Korea receives financial assistance, and this is not earmarked, to support its family planning program. In Taiwan, "second generation" local currencies are used to support the program. In Turkey, a $3.5 million loan should soon be signed to provide needed vehicles and educational equipment. Advisory teams have been to India, Pakistan, Egypt, Turkey, Korea, Taiwan, Thailand, and Jamaica to discuss family planning programs and to many other countries to discuss population problems. Research studies, training programs, demographic and statistical resources have been strengthened in a number of countries. Grants have been given to U.S. universities to strengthen their capacity for study, training, and the provision of consultant services relevant to the needs of developing countries.

It is evident that 1966 will witness a substantial increase in AID support for research, training, and service programs.

Parallel with the developments in our bilateral foreign assistance program has been an effort by the U.S. to work cooperatively on population problems with multilateral international agencies. In 1964 the U.S. made a voluntary contribution to the World Health Organization to support research in human reproduction and the U.S. supported the creation of a special WHO staff in this field. In early 1965 the United Nations sent a special team to provide technical assistance to the India Government on the development of its family planning program. The World Bank sent a team to India at about the same time to review population problems and family planning programs in relation to India's economic development program. The United States supported both the United Nations and the World Bank in these missions. In addition, at a series of regional and international meetings, the U.S. participated in discussions of population problems and gradually our policy was clarified for these groups.

The development of population policy in the Department of Health, Education, and Welfare has followed a somewhat different course over the years. In 1942, the Surgeon General of the Public Health Service made a permissive ruling that funds allocated for local health services might be used for family planning if the State so chose. At that time there were only seven States—all of them in the South—that provided such services. The situation was little changed prior to 1959, the year that President Eisenhower made his clear and restrictive policy statement on birth control.

The pace of change in the Federal Government has roughly paralleled the change in State and local programs. In 1961, California became the second major State outside of the South to develop a policy on family planning and the first to begin a major program. The State Department of Public Health in California supported local action with technical and financial assistance. Gradually the number of States and local health units providing services increased, just as did the number of women obtaining birth control services from private practitioners. The use of oral cotraceptives by women in these middle and upper income brackets has far outpaced their availability to those women in low income families who also may wish to better space their children or limit the size of their families. It is interesting to note, I think, that purchases of contraceptive drugs rose more than 150 percent between 1962 and 1964. The current expenditures are well above the $158 million spent in 1964, but accurate current figures are not available. In 1965, the number of States using Federal funds to provide financial assistance to local health department family planning programs had increased to more than 20. The funds were provided by the Maternal and Child Health Program (14 States) and the Maternal and Infant Care Program (13 States) of the Children's Bureau; by the Public Health Service (1), and by the Office of Economic Opportunity (2).

Funds to support research and research training by the Public Health Service have increased from the $5.2 million reported in January 1963 to an estimated $23 million in 1965. The Children's Bureau has also provided support for some small scale research and training programs.

Federal beneficiaries served by the Department of Health, Education, and Welfare, such as American Indians and Alaska natives, have been provided family planning advice and services, on request, by the Bureau of Medical Services in the Public Health Service.

These various domestic federal research, training, and service programs have been carried out without any specific Department of Health, Education, and Welfare policy in the fields of population dynamics, fertility, sterility and family planning. Last month, the Secretary of Health, Education, and Welfare issued such a policy statement to the heads of all operating agencies. He stated:

"The policy of this Department is to conduct and support programs of basic and applied research on the above topics; to conduct and support training programs; to collect and make available such data as may be necessary to support, on request, health programs making family planning information and services available; and to provide family planning information and services, on request, to individuals who receive health services from operating agencies of the Department.

"The objectives of the Departmental policy are to improve the health of the people, to strengthen the integrity of the family and to provide families the freedom of choice to determine the spacing of their children and the size of their families.

"Programs conducted or supported by the Department shall guarantee freedom from coercion or pressure of mind or conscience. There shall be freedom of choice of method so that individuals can choose in accordance with the dictates of their consciences.

"The Department will make known to State and local agencies that funds are available for programs of the sort described above, but it will bring no pressure upon them to participate in such programs.

"Each agency shall assure the effective carrying out of this policy, the regular evaluation of programs and the reporting of information on programs to this office.

"The Assistant Secretary for Health and Scientific Affairs will serve as the focal point for Departmental policy and program coordination; will review and evaluate policies and programs; will conduct liaison with other Departments; and will cooperate with interested public and private groups."

A major step was taken in the U.S. Senate on April 1, 1965, when Senator Gruening introduced a bill to provide for certain reorganizations of the Department of State and the Department of Health, Education, and Welfare to create an Assistant Secretary in each Department for Population Problems and to support a White House Conference on Population Problems in 1967. Hearings were held on the bill in 1965 and have been initiated again this year. In the House of Representatives, Congressmen Todd and Udall have introduced similar legislation.

The present assignment of population policy and program coordination activities to an Assistant Secretary in the Department of Health, Education, and Welfare is clearly consistent with the intent of the legislation.

In addition to the Gruening hearings and the so-called Fulbright Amendment to Section 214 of the Foreign Assistance Act, the Congress has provided direct support for family planning programs through appropriation to the District of Columbia. In 1963, the initial appropriation was for $1,000, but the following year $24,000 was provided for a pilot program for approximately 2,400 women who might wish information and services. This program has been expanded, with additional support from the Children's Bureau and the Office of Economic Opportunity planned for the future.

The Supreme Court added its voice to those of the Congress and the Executive Branch when, on June 7, 1965, it declared Connecticut's birth control law unconstitutional.

The evolution of Federal policies and programs related to population problems has been very rapid in recent years. The policy development has clearly been consistent with the wishes of the public in our pluralistic society.

The goals of these changes in United States policy, both at home and abroad, are the provision of assistance, the development of research, and the support of training and service programs, together with full provisions for freedom of choice. They will help to bring better health for the people of this country and for people of many other countries of the world.

[*Part 8.*—Excerpt from "Maternity Care in Low Income Families" by Arthur J. Lesser, Deputy Chief, Welfare Administration, Children's Bureau, May 3, 1966]

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One of the outstanding contributions being made by the maternity and infant care program is to make family planning increasingly available to low-income families especially in the larger cities where, until recently, few of them have had access to such services. Most of the projects are including family planning services either directly or through arrangements with another agency. Such services are voluntary, greatly welcomed by patients and are included as one of the clinical services of a maternity program. In a number of cities, it was the maternity and infant care program that changed local public policy to include family planning services in a tax-supported program. In Baltimore, Dr. Matthew Tayback recently reported that in 1965 the city's birth rate dropped 10% to the lowest level in 20 years. At least one-half of the decrease is attributed to the city's family planning services which are provided in its maternity clinics. Dr. Tayback states ". . . probably no more important thing is happening which will have a solid impact on the question of poverty than this recent trend toward smaller families among low-income families."

The offering of family planning services has resulted in a great increase in the number of women returning for the postpartum visits. It is generally reported that such return by patients has more than doubled since family planning has been provided. In the large New York City program, 80% of the maternity and infant care project patients return for the postpartum visit and well over 90% of these receive family planning services.

There are many other interesting aspects of this program which cannot be reviewed at this time. In its administration we are concerned with the reduction in maternal and infant mortality and morbidity, in influencing a favorable outcome of pregnancy and in taking steps which will assist communities in reorganizing their maternity programs so as to improve the quality of care and to make use of the best available resources in providing care for these patients.

[*Part 9.*—The full text of Dr. Richard A. Prindle's remarks of April 27, 1966, entitled "Family Planning and the Public Health Service" before the American Association of Planned Parenthood Physicians Meeting, Denver, Colorado. Dr. Prindle is Assistant Surgeon General of the United States and Chief, Bureau of State Services, Public Health Service. His remarks in Denver were read by Dr. Robert B. Dorsen, Medical Director, Division of Public Health Methods, Public Health Service]

Every time someone from the Public Health Service makes a statement or a speech about family planning which reaches a fair number of people, whether directly or through newspaper or magazine reports, we get a spate of letters on the subject. I am glad to be able to report that not more than about 1 percent of the writers are opposed to family planning—a degree of consensus that I find startling because I believe it is true that people are more likely to write letters when they are opposed to a line of action than when they approve it.

Another interesting thing about these letters is the variety of reasons they give for urging us to promote family planning. They point to the lack of educational opportunity when families are large and incomes small, the culturally debasing effect of overcrowded housing, overcrowded cities, unemployment among the unskilled, political instability as world population increases, the depletion of natural resources, the anomaly of offering information on birth control to other countries while withholding it from our own people. Very few mention health.

To those of us who have responsibility for the health of others, the protection of health as a reason for family planning seems paramount. All of us know from our own observation how destructive too many children, or unwanted children, can be to the physical and the mental health of both parents and children.

To continue for just a moment about the letters we receive, we are sometimes asked why we call it "family planning" instead of "birth control." There are two reasons. For one thing, the term "birth control" is misunderstood by many. To some people it means abortion. To others the word "control" is interpreted to mean control by others rather than control by the potential parents. The second reason is that in actuality we mean more than just birth control. By family

planning we mean not only the prevention of too many pregnancies but also the deliberate spacing of children, the provision of assistance to people who want children but have not been able to have them, and help with adoptions. It is probably true that if the kind of a program we hope to achieve were to be completely successful, the result would be a slowing of population growth. However, that is not our goal, however desirable a goal it is to many of our correspondents. Our goal is the promotion of the physical and mental health that would result if every child were a wanted—a planned for—child who could be properly care for.

On January 24, 1966, John W. Gardner, Secretary of Health, Education, and Welfare, issued a memorandum on the subject of population dynamics, fertility, sterility, and family planning which defined our Department's policy. The memorandum read:

"The policy of this Department is to conduct and support programs of basic and applied research on the above topics; to conduct and support training programs; to collect and make available such data as may be necessary to support, on request, health programs making family planning information and services available; and to provide family planning information and services, on request, to individuals who receive health services from operating agencies of the Department.

"The objectives of the Departmental policy are to improve the health of the people, to strengthen the integrity of the family and to provide families the freedom of choice to determine the spacing of their children and the size of their families.

"Programs conducted or supported by the Department shall guarantee freedom from coercion or pressure of mind or conscience. There shall be freedom of choice of method so that individuals can choose in accordance with the dictates of their consciences.

"The Department will make known to State and local agencies that funds are available for programs of the sort described above, but it will bring no pressure upon them to participate in such programs.

"Each agency shall assure the effective carrying out of this policy, the regular evaluation of programs and the reporting of information on programs to this office.

"The Assistant Secretary for Health and Scientific Affairs will serve as the focal point for Departmental policy and program coordination; will review and evaluate policies and programs; will conduct liaison with other Departments; and will cooperate with interested public and private groups."

This memorandum did not establish any new policy, but it did for the first time give a clear, public endorsement by the Department's Secretary to the Department's activities in this field.

The Department has programs in three major areas—research, training, and services.

Family planning services are provided in Public Health Service hospitals and clinics to those who are eligible for medical care in those facilities—American Indians, Alaskan natives, and certain other groups. They are provided indirectly by support given, through the States, by the Welfare Administration and the Public Health Service. Other service centers are supported by grants from the Office of Economic Opportunity in its anti-poverty drive.

There are not anywhere nearly enough places where these services are available, but the encouraging thing is that the number is growing as rapidly as it is. For instance, the number of States supporting family planning clinics has more than doubled within the last 2 years.

In this case more than in any other I can think of, the success of the program depends upon public acceptance. In one sense we have had a head start in gaining that acceptance. It has been apparent for a long time that birth control measures were widely used especially by urban people who had access to and who could afford the necessary devices not only sometimes but at any and all times they wished to use them. I suspect that if it had been a requirement that those devices had either to be made available to everyone or else to no one, we should have long since had free and widely distributed contraceptives.

The people who used contraceptives were protecting themselves and their families. There was no overpowering motive to compel them to crusade for the protection of the families of the more benighted. After all, too many children wasn't a contagious condition. It was only after a too rapidly growing population became a threat to all that real concern began to develop. As someone put it, possibly one of the first instances of real indignation came about when a prosperous manufacturer of baby food came home to find a bill for heavily increased school taxes.

The fact that contraception was widely accepted and practiced among those who are sometimes called the opinion-makers has combined with 50 years of uphill pioneering work by Planned Parenthood to gain public acceptance for governmental support for family planning services in a remarkably short time once the President set the stage for it. All that remains now is to get the administrative machinery operating adequately. This may not be the first time that our citizens have been out ahead of their local, State, and Federal Governments, but I suspect it is one of the most outstanding examples of it.

In the meantime our research effort has been stepped up but not as rapidly as we should like. How soon we can reach an adequate level of research depends upon the interest that can be generated among competent investigators both here and abroad.

Last June, the National Advisory Child Health and Human Development Council pointed out that it was one of the paradoxes of this era of progress in scientific knowledge that there is relatively limited understanding in the area of human reproduction, that human fertility and sterility remain shrouded in mystery. The Council pointed out that some types of research on reproduction cannot be carried out on human beings for medical, moral, or legal reasons, but that they can be carried out on primates. It urged that such research opportunities be exploited to the utmost. The Council then went on to list some of the types of required research involving human beings:

1. Basic research in the complex biological and behavioral phenomena involved in reproduction.
2. Normal human reproductive cell development, with particular emphasis on finding means to predict or produce ovulation with certainty as to timing in the menstrual cycle.
3. The processes of fertilization, implantation and early embryonic development. These can frequently be studied in humans, particularly when such studies are carried out at the time of procedures done for patient care, such as hysterectomy for disease or a curettage for a spontaneous abortion.
4. Investigations of the causes of human infertility.
5. Studies of population levels and growth rates as related to basic research in fertility, sterility, and population dynamics.
6. An examination of the complex social, psychosexual, and motivational factors which help determine both the desired family size and that achieved.
7. The influence of family size on the development of personality and character of children and parents.
8. The development and testing of new techniques of family planning.
9. Field investigations of various methods of family planning with emphasis on the measurement of their efficacy, safety, acceptability, social and psychological impact in actual use by different kinds of population groups.

We plan conferences with selected groups to explore with them the possibilities of research in human fertility in an effort to promote increased interest.

The Children's Bureau of the Welfare Administration is supporting related research. One of its grants supports a study designed to get at the complexities surrounding the question of motivation for family planning. Another will project what United States birth rates might be in 1975 to serve as a basis for developing alternative planning requirements for future maternal and child health services throughout the country. And a third studies the fertility and attitudes relevant to fertility and family planning among a group of 1,000 mothers living in the New Orleans metropolitan area.

If we are to make the progress that we must make in both services and research, the one thing we must emphasize is training. Manpower shortages are common to all the health fields, and this one certainly is no exception.

There are training programs in some of the schools of public health and others within the Department of Health, Education, and Welfare. More and more, medical schools are teaching fertility regulation. The number of these opportunities will grow, and grow rapidly, I believe. We in the Public Health Service are certainly promoting their growth. I hope you will join us in encouraging the establishment of training opportunities and in encouraging appropriately trained people to take advantage of those opportunities. I hope you will take every opportunity to point out to those who need to know that Federal funds are available to help in the establishment of family planning services.

It is our conviction in the Public Health Service that family planning services should be a part of the health care available to every potential parent. Our correspondents have a variety of other reasons for thinking such services should be made available. Fortunately, we do not hold to the belief that there can be only one truly valid reason for a course of action. I seem to recall that, in dis-

cussion of that philosophical point, a professor once said, "I go home in the evening because I want my supper and because I love my wife. Which is the wrong reason?"

[*Part 10.*—The full text of the address entitled "This Most Profound Challenge" by Mrs. Katherine B. Oettinger, Chief of the Children's Bureau, appeared earlier in the printed hearings on S. 1676 as part of Exhibit 210 of Part 3-B of the 1965 "Population Crisis" Hearings, pages 1789–1790]

[*Part 11.*—Transmittal letter from IH Manual, Division of Indian Health Circular, No. 63–2 Concerning Dissemination of Birth Control Information, Department of Health, Education, and Welfare, Public Health Service, Division of Indian Health, Washington, D.C., January 21, 1963]

Sec.
1. Purpose
2. Policy
3. Sterilization

1. Purpose. To set forth the policy of the Division of Indian Health in the dissemination of birth control information.

2. Policy. Information on the prevention of pregnancy similar to that provided in the normal course of a doctor-patient relationship may be provided Indian beneficiaries of the Public Health Service.

For various personal reasons an Indian beneficiary may decide that pregnancy is to be avoided, or may have physical or mental disorders that would become more severe or endangering to life if pregnancy occurred, and may request medical advice on the methods. The physician, in such a case, has a responsibility to provide advice on medically acceptable methods that do not endanger the health of the patient.

3. Sterilization. When properly authorized, sterilization operations may be performed by Public Health Service physicians when it is determined that such operations are necessary to cure, treat or alleviate a patient's disease, illness or injury. Sterilizations for exclusively social or economic reasons are not performed.

For additional guidance on sterilization, Division of Indian Health Operating Memorandum No. 59–27, "Sterilization and Therapeutic Abortions" and Indian Health Circular No. 61–21, "Use of Form PHS–3808, Authorization for Sterilization Procedures", should be consulted.

CARRUTH J. WAGNER, M.D.,
Assistant Surgeon General, Chief, Division of Indian Health.

January 21, 1963
Distribution: P–ABCDG under d and B, C under d (IH Manual holders)

[*Part 12.*—DHO Transmittal Letter No. R–125, February 5, 1963, followed by "Clinical Standards, Policy and Procedures; Subject: Sterilization and Therapeutic Abortions" from Division of Hospitals, Operations Manual, Chap. 1, Part C, Section 7.1]

To: Medical officers in charge.
U.S. Public Health Service Hospitals.
U.S. Public Health Service Outpatient Clinics.
Others concerned.

Transmitted herewith for Insertion in the Division of Hospitals Operations Manual:		Supersedes and Cancels the Following:
Part C		
Chapter 1. Clinical Standards, Policy and Procedures		
Section 7. Surgical Procedures		
C1. 7.1	Sterilization and Therapeutic Abortions	C1 7. 1 (DHO Tr. Ltr. #R–115).
C1. 7. 1a	Accreditation Commission's Recommendations	C1. 7. 1a (DHO Tr. Ltr. #R–115).

Explanation: Adds a statement of policy that medical officers of the Service may furnish patients information on the prevention of pregnancy similar to that provided in the course of the normal doctor-patient relationship.

MYRON D. MILLER, M.D.,
Assistant Surgeon General, Chief, Division of Hospitals.

DIVISION OF HOSPITALS OPERATIONS MANUAL

PART: C
CHAPTER: 1
SECTION: 7. 1

CLINICAL STANDARDS, POLICY AND PROCEDURES

Subject: Sterilization and Therapeutic Abortions.

Policy on Sterilization & Therapeutic Abortion	C1.7.1.1
Establishing Therapeutic Abortion Committees	.2
Accreditation Commission's Recommendations	.3
Prevention of Pregnancy	.4

POLICY ON STERILIZATION AND THERAPEUTIC ABORTION

.1 Regarding the performance of surgical procedures for sterilization and therapeutic abortions, the Division of Hospitals establishes the following provisions as applicable to all medical officers of the Division:

(a) *Sterilization.* The Office of the General Counsel has indicated on several occasions that the authority of the Public Health Service to provide medical services is limited in that they must be intended and selected solely to cure or alleviate the mental or physical injury, disease, or illness that occasions the patient's treatment or hospitalization and must be reasonably related to such a result. Therefore, officers of the Service would be without authority to perform on a patient a sterilization operation not necessary, as a matter of professional judgment, to fulfill the medical needs of that patient. Officers of the Service would be authorized to perform sterilization operations which might be reasonably necessary to cure, treat, or alleviate a patient's disease, illness, or injury. Sterilizations for exclusively social or economic reasons clearly may not be performed.

If, as a matter of professional medical judgment, a therapeutic sterilization is indicated, the findings of two or more physicians to that effect should be made a part of the patient's medical record in addition to the usual measures adopted for surgery.

(b) *Therapeutic Abortions.* The abortion statutes of the various states vary as to the exceptions under which a *therapeutic* abortion may be performed, e.g., one necessary to save the life of the woman or to preserve her life.

In any event, the provisions of state law where the Public Health Service facility is located should be ascertained and strictly observed. Conformance to the established professional standards in each state, including the obtaining of proper consent, and consultation with other physicians (the number may vary according to state law) for concurrence of medical opinion as to necessity are important procedures to be followed.

ESTABLISHING THERAPEUTIC ABORTION COMMITTEES

.2 Many hospitals have made efforts to evaluate more properly cases presented for therapeutic abortion, practically all of which present problems in management. Therapeutic abortion committees have been established in some hospitals. In most instances where committees have been utilized they have supplanted the former methods of sanctioning therapeutic abortions, i.e., the use of consultation with one or two other physicians by the attending doctor. Such a committee consists of the pathologist, two internists, two surgeons, and two obstetrician-gynecologists; it evaluates all patients presented for termination of pregnancy before viability. If necessary, other specialists in the field concerned with the pregnancy complication are consulted. The committee then approves or rejects the case under consideration and notifies the attending physician.

Whenever adequate medical staff exists, Medical Officers in Charge may appoint a therapeutic abortion committee to evaluate patients seeking termination of pregnancy before viability. Consultation with other physicians may supple-

ment the work of the committee, and such consultations should be continued to be held when local laws, established professional standards, or other circumstances so direct.

ACCREDITATION COMMISSION'S RECOMMENDATIONS

.3 With regard to the foregoing, your attention is invited to the excerpt from the "Model Medical Staff By-Laws, Rules and Regulations" issued by the Joint Commission on Accreditation of Hospitals, given in Attachment C1. 7. 1a.

PREVENTION OF PREGNANCY

.4 Beneficiaries of the Public Health Service may be furnished information on the prevention of pregnancy similar to that provided in the course of the normal doctor-patient relationship.

Women beneficiaries may have physical disabilities or mental disorders that would become more severe or life endangering if pregnancy occurred. The physicians treating such patients have the responsibility to advise them and their husbands of the dangers that exist and to provide adequate information on how to avoid pregnancy. A beneficiary may make a decision that pregnancy is to be avoided for various personal reasons and request medical advice on the methods. The physician has a responsibility to provide professional advice on medically acceptable methods that do not endanger the health of either spouse. (As indicated in paragraph .1 above, a Service physician may not perform any sterilization procedure for exclusively social or economic reasons.)

ATTACHMENT CL. 7. 1A

RULES AND REGULATIONS

* * * * * * *

"Except in emergency, consultation with another qualified physician shall be required . . . in all curettages or other procedures by which a known or suspected pregnancy may be interrupted. The same requirement shall apply to operations performed for the sole purpose of sterilization on both male and female patients. The rules and regulations of each hospital should spell out the clinical indications for . . . sterilizations. In major surgical cases in which the patient is not a good risk, and in all cases in which the diagnosis is obscure, or when there is doubt as to the best therapeutic measures to be utilized, consultation is appropriate. Judgment as to the serious nature of the illness and the question of doubt as to diagnosis and treatment rests with the physician responsible for the care of the patient. It is the duty of the hospital staff through its chiefs of service and Executive Committee to see that members of the staff do not fail in the matter of calling consultants as needed. The consultant must be well qualified to give an opinion in the field in which his opinion is sought. A satisfactory consultation includes examination of the patient and the record and a written opinion signed by the consultant which is made part of the record. When operative procedures are involved, the consultation note, except in emergency, shall be recorded prior to operation. To insure impartiality and to share the burden of rendering required consultations, a panel of consultants to furnish consultations in order of rotation is suggested. . . ."

* * * * * * *

Above is an excerpt from paragraph 14 of the suggested rules and regulations set forth in the "Model Medical Staff By-Laws, Rules and Regulations" issued by the Joint Commission on Accreditation of Hospitals.

"COME UP WITH SOMETHING MORE CONSTRUCTIVE"

Senator GRUENING. I would like to suggest to you, Mr. Secretary, that you take back your report and study it and come up with something a little more constructive. Here we have had a most impressive list of witnesses. We have the testimony of people from all over the country, from all over the world, people who have come long distances to testify, including the ex-President of a great country in Latin America.

The feeling for action in this field is tremendous; it is growing. No one can read the hearings without coming to that conclusion. And I feel it is very regrettable that you have not met this challenge. I think you ought to take your report back, and reconsider it and come up with some positive approach, at least to what this legislation is going to do.

Your answer has been an absolute rejection. You do not want this legislation, you do not want this Assistant Secretary, you do not want a White House Conference, you do not want to mention the words "population control" in the title of a man who already has health and scientific affairs—a major assignment and an assignment which is far larger than that of all the other secretaries put together. His is a broad, comprehensive responsibility which includes almost everything we are concerned with, and I hope you will reconsider that and come up with something a little more constructive because it is extremely regrettable that a Department which, after your appointment to head it, started off with such high promises and made such a splendid showing in some fields. I refer to the case of the Food and Drug Administration which is so completely negative on a program, on a subject that is now of such vital concern to everybody—one of the most urgent problems of our time.

EISENHOWER SUPPORTS FAMILY PLANNING

Former President Eisenhower, when he was President, took the position that the Government should take no part in this activity and yet later reversed himself, and we opened our hearings last year with the statement from the former President pointing out that this is one of the most pressing problems of our time, and all you come up with is—nothing. So I would like to suggest to you that you reconsider this and come up with something a little more constructive.

On June 4, 1965, the Subcommittee on Foreign Aid Expenditures wrote to the Secretary of Health, Education, and Welfare, who was at that time the Honorable Anthony S. Celebrezze, requesting a detailed description of the organization procedures instituted by the Department to assure coordination and dissemination upon request of information on birth control. Mr. Celebrezze's response of June 18, 1965, was prompt and courteous but nearly devoid of detail. He said that the Department knew that 25 States provide family planning services but did not list these States.

Secretary Celebrezze said the Department was in the process of getting more information on family planning activities within the States and had requested recommendations from its agencies as to "what further steps should be taken periodically to obtain essential information regarding State and local family planning activities."

He advised the subcommittee, further, that members of the staff of the Children's Bureau and Public Health Service were then working with a committee of the American Public Health Association which "is undertaking a detailed census of State and local family planning activities."

The Secretary pointed out that State and local direct medical care programs were initiated and operated locally and that as a result "there are no Federal regulations governing their operations with respect to the scope of such services or the manner of their provision."

I shall at this time make the full text of the letter sent to Secretary Celebrezze and his response part of the hearing record.

(The two letters above referred to, follow:)

EXHIBIT 134

JUNE 4, 1965.

DEAR MR. SECRETARY: As chairman of the Senate Government Operations Subcommittee on Foreign Aid Expenditures, I will hold hearings starting June 22 on my bill, S. 1676. This proposed legislation would make possible the better coordination and dissemination upon request of information available on birth control in the Department of State and the Department of Health, Education, and Welfare. An Assistant Secretary would head an Office for Population Problems in each Department. My bill also authorizes President Johnson to call a White House Conference on Population in 1967.

It would be appreciated if you would furnish the subcommittee with a detailed description of the organizational procedures instituted by the Department of Health, Education, and Welfare to assure coordination and dissemination upon reqeust of information on birth control. Information should include any manual material establishing procedures, title, and job descriptions of the individual or individuals charged with responsibility for supervising the carrying out of such procedures, when such procedures were instituted, previous procedures, et cetera.

It would be appreciated if you could supply this information by June 17. If the members of your staff to whom you assign this request have questions they should contact Laura Olson of my staff on extension 3004.

With best wishes, I remain,

Cordially yours,

ERNEST GRUENING, *Chairman.*

THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE,
Washington, D.C., June 18, 1965.

Hon. ERNEST GRUENING,
U.S. Senator,
Washington, D.C.

DEAR SENATOR GRUENING: This is in response to your letter of June 4, 1965, in which you requested a description of the organizational procedures instituted by the Department to assure coordination and dissemination upon request of information on birth control.

Programs of research, of advice and consultation, and assistance are located in various agencies within the Department.

The Public Health Service supports research and training programs through the National Institutes of Health and the Bureau of State Services. State and community health clinics and programs are assisted by Federal funds made available through the Bureau of State Services. These programs are devised by and funded through the States within the context of their public health programs.

The Welfare Administration provides funds to States, through the Bureau of Family Services, for medical care of the indigent and by the Children's Bureau for maternal and child health. Some of these funds are being used for family planning programs. The amounts of funds represented in such programs are unknown, but it is known that 25 States provide family planning services.

Coordination of activities in the field of birth control in the Department is done in my office by the Special Assistant for Health and Medical Affairs, who works closely on this subject with the Commissioner of Welfare and the Deputy Surgeon General of the Public Health Service and the heads of the principal programs in this field.

We are, at present, in the process of obtaining through each of the constituent agencies of the Department which are involved in family planning activities information regarding State and local activities in this field financed through grant-in-aid funds. Such information would include the scope of services provided, the eligibility for such services and, if available, statistical and expenditure data. In addition, we have requested each agency to recommend what further steps should be taken periodically to obtain essential information regarding State and local family planning activities.

Members of the staff of the Children's Bureau and Public Health Service are also working with a committee of the American Public Health Association which is undertaking a detailed census of State and local family planning activities.

The attached manual issuances govern the procedures used in the direct medical care programs for Federal beneficiaries. Since the State and local programs, assisted by the Federal government, are initiated and operated locally, there are no Federal regulations governing their operations with respect to the scope of such services or the manner of their provision.

Sincerely,

ANTHONY S. CELEBREZZE,
Secretary.

Senator GRUENING. Thank you very much, Secretary Gardner.

Do you have any further comments?

Secretary GARDNER. No, sir.

Senator GRUENING. We will recess.

(Whereupon, at 11:25 a.m., the subcommittee recessed, to reconvene at 10 a.m., Friday, April 8, 1966.)

(The following material was subsequently placed in the record at this point by direction of the chairman:)

EXHIBIT 135

(The first departmental "Report on Family Planning," issued by the Department of Health, Education, and Welfare, prepared in response to the request of the Government Operations Subcommittee on Foreign Aid Expenditures and its accompanying September 28, 1966, letter of transmittal from Secretary John W. Gardner.)

THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE,
Washington, D.C., September 28, 1966.

Hon. ERNEST GRUENING,
Chairman, Subcommittee on Foreign Aid, Committee on Government Operations, U.S. Senate, Washington, D.C.

DEAR SENATOR GRUENING: I am pleased to forward, in response to your request, the Department's report on activities in family planning, fertility, sterility and population dynamics.

The report indicates the steps that are being taken to develop programs that will be fully responsive to the needs of our society. We believe that the regional meetings will be of great help to us in further shaping policies and programs. The first regional meeting (for the Appalachian region) was held September 7 in Roanoke and it proved to be an excellent forum for exchange of views.

Sincerely,

JOHN W. GARDNER,
Secretary.

REPORT ON FAMILY PLANNING

ACTIVITIES OF THE U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE IN FAMILY PLANNING, FERTILITY, STERILITY, AND POPULATION DYNAMICS

[September 1966]

INTRODUCTION

On January 24, 1966, the Secretary of Health, Education, and Welfare established, for the time being, a Department policy on population dynamics, fertility, sterility, and family planning. The policy statement was as follows:

"The policy of this Department is to conduct and support programs of basic and applied research on the above topics; to conduct and support training programs; to collect and make available such data as may be necessary to support, on request, health programs making family planning information and services available, and to provide family planning information and services, on request, to individuals who receive health services from operating agencies of the Department.

"The objectives of the Departmental policy are to improve the health of the people, to strengthen the integrity of the family and to provide families the freedom of choice to determine the spacing of their children and the size of their families.

"Programs conducted or supported by the Department shall guarantee freedom from coercion or pressure of mind or conscience. There shall be freedom of choice of method so that individuals can choose in accordance with the dictates of their consciences.

"The Department will make known to State and local agencies that funds are available for programs of the sort described above, but it will bring no pressure upon them to participate in such programs.

"Each agency shall assure the effective carrying out of this policy, the regular evaluation of programs and the reporting of information on programs to this office.

"The Assistant Secretary for Health and Scientific Affairs will serve as the focal point for Departmental policy and program coordination; will review and evaluate policies and programs; will conduct liaison with other Departments; and will cooperate with interested public and private groups."

The issuance of the policy statement has been followed by these developments:

The post of Deputy Assistant Secretary for Science and Population has been established to advise the Secretary on policy development, program evaluation and coordination, and to maintain liaison with other Departments and agencies as well as non-governmental organizations.

A Departmental Committee on Population and Family Planning has been created to evaluate policies and programs and to assist in program coordination.

A Departmental Task Force on Family Planning has been established to plan and organize nine regional meetings which will provide information to States and communities on Federal resources available for programs of service, training, and research.

The Public Health Service has issued a policy statement on family planning and is placing increased emphasis on program development and research. An office, under the direction of the Assistant Chief, Bureau of Medical Services, has been created to serve as the PHS focus for the development and evaluation of programs.

The Office of Education has established a new policy on family life education and sex education: "To assist communities and educational institutions which wish to initiate or improve programs in this area, the Office of Education will support family life education and sex education as an integral part of the curriculum from pre-school to college and adult levels; it will support training for teachers and health and guidance personnel at all levels of instruction; it will aid programs designed to help parents carry out their roles in family life education and sex education; and it will support research and development in all aspects of family life education and sex education."

The Welfare Administration has issued a new policy statement to all State welfare agencies. The Bureau of Family Services is revising its instructions governing Federally aided public assistance programs to facilitate the establishment and expansion of family planning services by State and local public welfare agencies. In addition, the Welfare Administration is preparing a public information program on family planning.

The Children's Bureau has developed and distributed policy statements on the use of grants-in-aid funds for family planning, training, research, and services. Family planning services have been included in the reporting system of State and local health department maternal health programs for the first time. The Children's Bureau has published a pamphlet for the public on family planning.

The Food and Drug Administration has received the report on oral contraceptives submitted by its Advisory Committee on Obstetrics and Gynecology and is taking steps to implement the major recommendations of the Committee.

The present report summarizes the activities of the Welfare Administration, the Public Health Service, the Office of Education, and the Food and Drug Administration. The other operating agencies of the Department of Health, Education, and Welfare have neither direct responsibilities nor programs in the field of family planning.

This is the first Departmental report on family planning. We plan to issue a report annually, based on the activities of the operating agencies.

PHILIP R. LEE, M.D.,
Assistant Secretary for Health and Scientific Affairs.

I. Welfare Administration

The Welfare Administration supports family planning information and services at State and local levels. It also conducts and supports research, demonstration projects, and training programs in the field of population dynamics, fertility, infertility, and family planning.

Programs conducted or supported by the Welfare Administration must guarantee freedom of conscience and freedom from coercion.

Basic policy determination and administrative responsibility for these programs, together with coordination of the total effort, rest in the Office of the Commissioner. The programs are carried out through the Children's Bureau, the Bureau of Family Services, and the Division of Research of the Office of the Commissioner.

Children's Bureau

The objectives of family planning programs supported by the Children's Bureau are to improve the health of families and to provide services which enable families to determine the spacing and number of their children, thereby strengthening the integrity of the family unit. Participation in these family planning programs is voluntary; the methods available permit individuals to choose in accordance with their beliefs and consciences. The Children's Bureau supports family planning programs under Title V, Part 1 (Maternal and Child Health Programs) and Part 4 (Maternity and Infant Care Projects) of the Social Security Act.

Information and Services

Maternal and Child Health.—Formula grants are authorized to enable State health departments to extend and improve "services for promoting the health of mothers and children, especially in rural areas and in areas suffering from severe economic distress.[1]"

The appropriation for this program in fiscal year 1966 was $45 million and for fiscal year 1967 $50 million has been requested.

State and local health departments use the Federal funds, together with State and local funds, for such preventive health services as well-baby clinics, prenatal clinics, family planning, immunization, school health examinations, screening examinations, mental retardation, clinics, public health nursing, and nutrition services, especially in rural areas.

As a result of the rapidly growing interest in family planning, an increasing number of State and local health departments are providing family planning services. More than 40 states now provide family planning services in some parts of the State. Two years ago the number was 13. The programs are supported primarily by grants for Maternal and Child Health.

The District of Columbia Department of Public Health has a rapidly growing family planning program which is supported by a special appropriation from the Congress to the District Government, and by Maternal and Child Health funds, including a special project grant from the Children's Bureau. Having started with a special appropriation of $1,000 for this purpose in 1963, the D.C. Health Department currently has $200,000 per year specifically for family planning. It is estimated that this makes possible a program to provide services for approximately 13,000 persons per year.

The Maryland program is also an excellent example of the recent trends. Although a clinic was started by a group of Johns Hopkins' physicians in 1927, it was not until 1962 that a decisive step was taken by the State Board of Welfare in adopting an affirmative position on making referrals for family planning services. The Baltimore City Health Department began to provide family planning services in 12 weekly maternity clinics in 1964 and, since then, funds have increased for this purpose from State and local sources as well as from the Children's Bureau. The program, which is now in operation in 21 of the 23 counties in Maryland and in Baltimore City, incorporates family planning services as an integral part of the Maternal and Child Health Program. In the Baltimore Maternity Care Program last year, 2,500 patients received family planning services.

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[1] The 1965 amendments to the Social Security Act require that State Health Departments must progressively extend these services in order to make them available in all parts of the State by 1975.

The family planning program in North Carolina was begun in 1937 by the State Director of Maternal and Child Health. Since that time the State Health Department has continued to provide family planning services as part of postnatal care. The program was a small one until 1964 when the availability of oral contraceptives and the intra-uterine contraceptive device resulted in a greatly accelerated development of the program. In 1965 more than 1,500 patients were admitted to the program—approximately 4 times the number admitted in 1963.

Approximately $3 million of Maternal and Child Health funds were used specifically for family planning services during fiscal year 1966. This figure does not include the cost of the medical examinations which accompany the provision of these services because the examinations are also necessary for general maternal health care.

Maternity and Infant Care.—The Maternity and Infant Care Program was authorized by the Maternal and Child Health and Mental Retardation Planning Amendments of 1963.

The statute authorizes a 5-year program of grants to provide comprehensive maternity care for women who are unlikely to receive necessary health care because they are from families with low incomes. In addition to medical care for the mother, health care to mothers and infants following childbirth is included. The health care is directed to prospective mothers who have or are likely to have conditions associated with childbearing which increase the hazards to the health of mothers or their infants, including those which may cause physical or mental defects in infants.

The grants are available to the State health agency or, with the consent of the State agency, to the health agency of any political sub-division of the State. The grant may not exceed 75 percent of the cost of any project.

The appropriation for this program in fiscal year 1966 was $30 million and the same amount has been requested for fiscal year 1967.

Fifty-one projects have been approved in 30 states, Puerto Rico, and the District of Columbia. Over two-thirds of the approved projects are in major cities. Nearly all of the projects include family planning services as part of the comprehensive maternity care. In fiscal year 1966 over 80 thousand women were provided services in these projects.

The Maternity and Infant Care Projects are making family planning services available to an increasing number of women in low-income families who have never before had access to these services. All but a few of these projects are providing family planing services directly. In some cities, it was this program that enabled local agencies to change their public policies and to include family planning services in tax-supported programs. One result of providing family planning services in these programs has been a great increase in the number of women who return for their postpartum visit following delivery. In the New York City project, which is currently providing maternity care for 500 patients a month, approximately 80 percent of the patients returned for postpartum visits and over 90 percent of these received family planning services during 1965.

Training.—Grants for 4 training programs with significant family planning content have been approved by the Children's Bureau during fiscal year 1966:

Emory University, 1966: Instruction in Family Planning, Pregnancy Aspects of Mental Retardation and Birth Defects	$3,748
Marquette University, 1966: Continuing Education for the General Practitioner in Obstetrics-Gynecologic Care	79,866
New York Medical College, 1966: Training Nurses in Clinical Specialization of Maternal and Newborn Nursing	151,848
Adelphi University School of Social Work, 1966: Institute on Mothers at Risk	32,785

The following training projects are under review:

University of California: Family Planning Seminars for HEW Regions VIII and IX[1]	5,305
Tulane University: Family Planning Research and Training	87,262

[1] Region VIII includes Colorado, Idaho, Montana, Utah, and Wyoming. Region IX includes Alaska, Arizona, California, Guam, Hawaii, Nevada, Oregon, and Washington.

Children's Bureau grants also support the teaching of maternal and child health in 9 graduate schools of public health and 5 schools of nursing, including material on family planning and population dynamics.

At the request of the American Public Health Association's Area Committee on Population and Family Planning, the Children's Bureau's Medical Social

Work Section is assisting the Committee regarding the development of family planning content in social work education.

Research and Demonstration.—The maternal and child health extramural research grants program of the Children's Bureau is concerned with family planning information and services as part of maternal care programs. The objective of these research efforts is to shed light on the utilization of family planning services through studies of the motivation, attitudes, and opportunity of different cultural, socioeconomic, ethnic, and religious groups.

The Children's Bureau is currently supporting the following studies with grants under Title V, part 4, Section 533:

Tulane University School of Medicine, 1966: Fertility, Attitudes Relevant to Fertility, and Family Structure in Metropolitan New Orleans	$161,592
University of Chicago, Community and Family Study Center, 1966: Community and Personal Factors in Adoption and Non-Adoption of Family Planning Services: Development Research	38,400
Hudson Institute, Harmon-on-Hudson, 1966: Alternative Birthrate Projects for Planning Maternal and Child Health Services	44,221
University of California, Berkeley, 1966: Cooperative Study of Intrauterine Contraceptive Devices and other Family Planning Methods (Western Region Maternal and Child Health Research Program)	76,367
University of California, Berkeley, 1966: Demographic Study on the Correlates of Infant Mortality in the Western U.S., Particularly in Reference to Spanish-American Cultural Groups	24,000

Public information.—A pamphlet on family planning addressed to parents has been printed, and information on family planning is being included in new printings of major Children's Bureau publications—*Prenatal Care, Infant Care, Your Child From One to Six, Your Child From Six to Twelve, Your Baby's First Year,* and *When Your Baby Is on the Way.* Children's Bureau officials have also given a number of speeches to inform the public about family planning.

BUREAU OF FAMILY SERVICES

It is the policy of the Bureau of Family Services to promote responsible parenthood, strengthen the health and social competence of the family, and encourage the development of programs which permit families freedom to determine the spacing and number of their children. The individual's right to family planning services is viewed by the Bureau as an integral part of its health and welfare programs.

The Bureau supports medical and social family planning services for needy families and individuals and other low-income groups through public assistance grants to State welfare departments.

Information and Services

Federal matching funds are available to State Public Welfare Agencies for the costs of medical services, social services, and family life education related to family planning and to employ and train personnel to carry out family planning programs. Medical family planning services, for which Federal funds may be utilized, include physicians' services, devices, drugs, supplies, and transportation. Public welfare agencies may use medical resources under either public or voluntary auspices. Social services include the provision of information on family planning resources, family counseling, and assistance in having access to and using medical and related community resources.

The Federal matching funds are available under the pertinent public assistance titles of the Social Security Act: Title IV, Aid to Families with Dependent Children; Title X, Aid to the Blind; Title XIV, Aid to the Disabled; Title XVI, Combined Programs for Blind, Disabled and Aged; and Title XIX, Medical Assistance Program.

State and local welfare agency participation in facilitating and providing family planning services has been steadily increasing during the past few years. Policies of referring recipients for such services, and of making payments to health agencies for medical services, are in effect in public welfare agencies in 17 states and the District of Columbia. The States are: Florida, Georgia, Illinois, Iowa, Kansas, Kentucky, Maryland, Michigan, Nebraska, Nevada, New York, North Carolina, Oregon, Pennsylvania, Rhode Island, Tennessee, and Washington. In addition, laws have been enacted authorizing or encouraging

public health departments and/or welfare boards to provide family planning services at public expense in California and Colorado.

Policies governing the operation of Federally aided public assistance programs are contained in the Handbook of Public Assistance Administration. The Bureau of Family Services is revising the Handbook to clarify policies and standards for the establishment and expansion of family planning services by State public welfare agencies in cooperation with health and community planning agencies.

As revised, the Handbook's definitions of "medical care and services" will include professional advice and service with respect to family planning, and "service" specifically identifies drugs, supplies, and devices.

States have been urged to examine the limitations they have placed on the provision of drugs in their medical assistance programs and, when possible, to remove restrictions whose effect is to limit the scope of family planning services. Examples of such restrictive provisions regarding drugs are: "for alleviation of pain only"; "when in a hospital or nursing home"; and "for one month with no more than two refills for a total of 90 days."

In addition, the Bureau's policy statement on social services has been expanded to specify that information and family life education counseling, in the area of family planning, are an integral part of the provision of social services.

Freedom of choice and freedom from coercion or pressure on mind or conscience must be maintained in such counseling, and specific assurances are required that failure to accept family planning services will not jeopardize a family's right to financial assistance.

State Departments of Public Welfare are also being encouraged to add to their staffs a Family Life Consultant, appropriately trained in the social, psychological, and educational aspects of family planning. The responsibilities of this consultant would include assistance to local welfare agencies in the initiation and provision of appropriate family planning services through cooperative work with clinics and other community agencies; the development of demonstration projects; the preparation of informational material; and the conduct and support of social service and educational activities related to family planning.

State public welfare agencies have been advised that professional staff members of the Bureau of Family Services are available for planning, consulting, and preparing policy and guide materials on family planning programs. Close liaison with the Division of Research of the Office of the Commissioner and the Children's Bureau is being maintained in the development and implementation of these programs. In addition, there is close cooperation with the Public Health Service in the medical and related aspects of the program.

In order to evaluate the scope of family planning activities undertaken by State and local public welfare agencies, the Bureau of Family Services has directed State agencies to report on such activities for the year ending December 31, 1966, and to report on an annual basis thereafter.

Training

State public welfare agencies have been urged to incorporate in their staff training programs general information on contraceptive methods and more intensive training on social, psychological, and educational factors affecting the adequate development utilization of family planning services. Short-term training programs have been recommended, with the suggestion that they be interdisciplinary and make use of university faculty members from various fields.

Research and Demonstrations

Research projects are not supported directly by the Bureau of Family Services. States are being urged to apply for demonstration project grants in the field of family planning, under Section 1115 of the Social Security Act. Currently there are no Federally financed demonstration projects in this field in State or local welfare agencies.

Public Information

Two publications—*The Role of Public Welfare in Family Planning* and *Family Planning: One Local Public Welfare Agency's Approach*—are being printed for wide distribution in State and local welfare agencies. Both deal with the appropriate role played by public welfare agencies in promoting the development of family planning, information and services at State and local levels. The Bureau is also continuing to emphasize family planning in general publications and speeches.

DIVISION OF RESEARCH, OFFICE OF THE COMMISSIONER

The Division of Research of the Office of the Commissioner carries out research in the social and behavioral sciences related to population dynamics and family planning and also supports research and demonstration projects through grants to universities and public and private non-profit agencies.

Grants for such projects are made available under Title XI, Section 1110, of the Social Security Act as amended in 1956.

The Division assists in the preparation of guidelines for research, demonstration, training, and program activities of other units of the Welfare Administration with respect to population dynamics and family planning.

Particular research and program emphasis is placed on low-income families, both in this country and in those countries in which projects may be carried out under Public Law 480.

Under the research and demonstration grants program, the following projects related to family planning have been completed, or are in progress:

Projects related to family planning

COMPLETED PROJECTS

Grantee	Project No.	Title	Total amount
Community Council of Greater New York (Mignon Sauber).	059	Unmarried Mothers Who Keep the First Out-of-Wedlock Child.	$101,233
University of Michigan (Ronald Freedman).	107	Economic Status, Unemployment, and Family Growth.	45,698
University of North Carolina (Charles Bowerman).	189	Unwed Motherhood: Personal and Social Consequences.	8,980
Florida State University (Lewis Killian)	155	Consequences of a State Suitable Home Law for ADC Families in Florida.	40,536

PROJECTS IN PROGRESS

Merrill-Palmer Institute Detroit (Hyman Rodman).	243	Lower Class Attitudes Toward Deviant Actions.	$15,288
Bowman Gray School of Medicine, North Carolina (Clark Vincent).	283	Family Planning and Birth Control Among Poverty Level Negro Families.	48,060

Plans for future research related to family planning include such subjects as: social, psychological and economic factors associated with the use of family planning programs among low-income men, as well as women; the social, psychological, and economic side-effects of contraceptive use among individuals and families; family planning attitudes and practices of diverse cultural groups; optimal child spacing in terms of total child development and family relations; and the role of family life education and personal counseling in family planning.

A research project is currently being launched by the Division of Research to evaluate the effectiveness of work-training experience for mothers who are recipients of assistance under the program of Aid to Families of Dependent Children. The project will include study of the availability of family planning services to these mothers.

Public information

One of the activities of the Division of Research has consisted of an overview and analysis of existing social science research related to population dynamics and family planning. A series of interpretative articles is planned on these topics for *Welfare in Review*, the monthly publication of the Welfare Administration. The first of these articles, "Population Dynamics and Poverty in the United States: Implications for Family Planning Programs," appeared in the June-July 1966 issue.

Another publication of the Division, *Growing Up Poor*, issued in June 1966, discusses the impact of the poverty environment on children and families. Research evidence is presented delineating the need for further studies related to family planning and sex education.

II. Public Health Service

The objectives of the Public Health Service's family planning programs are to improve the health of the people and to provide families the freedom of choice to determine the spacing and the number of their children, thereby strengthening the integrity of the family.

The Public Health Service provides financial support for State and local public health services, including family planning; offers family planning services to specific beneficiaries whom it serves directly; and carries out research and supports training in population dynamics, fertility, infertility, and family planning through grants to and contracts with non-governmental institutions and organizations.

The Public Health Service has increased its activities in the field of family planning in recent years. Impetus was provided by the establishment by Congress of the National Institute of Child Health and Human Development in 1962.

BUREAU OF MEDICAL SERVICES

Information and services

Family planning services are made available by the Bureau of Medical Services to specific beneficiaries who are eligible for comprehensive health services. These beneficiaries include American Indians, Alaskan Natives, and dependents of uniformed services personnel. The Bureau of Medical Services projects an expenditure of $195,000 in fiscal year 1967 to provide family planning services and resources to its beneficiaries.

The Bureau's Division of Indian Health has issued a memorandum establishing policy and procedures for the Division. The memorandum defines family planning as one element of comprehensive health care. The Division's policy ensures the availability of family planning services to its beneficiaries upon request and ensures that any assistance "meets the individual's needs, desires, and religious beliefs."

The Division has assigned to each of its hospitals and health centers a trained physician who is qualified to offer a complete spectrum of family planning services. All of the Division's 47 hospitals and 52 health centers—which serve American Indians and Alaskan Natives—offer family planning services to their beneficiaries. During fiscal year 1966, over 7,900 of these beneficiaries received such services, and approximately $36,300 was spent for this purpose. An additional 1,800 beneficiaries received information and prescriptions which were filled at non-government facilities. As a result of increasing activities by the Division, an estimated 18,000 patients are expected to request and receive family planning services in fiscal year 1967. During fiscal year 1966, the Bureau of Indian Affairs of the Department of the Interior made $20,000 available to the Division of Indian Health to help provide information and services to beneficiaries.

The Division of Hospitals offers beneficiaries of the Public Health Service family planning services, "similar to those provided in the course of the normal doctor-patient relationship," at its 10 general hospitals, 3 special hospitals, and 27 outpatient clinics. It is the Division's policy to offer family planning information and services upon request. A monthly reporting and analysis mechanism has been established to inform the Chief of the Division of the family planning activities of each of the Division's facilities.

Training

Approximately 150 physicians of the Division of Indian Health have received training in family planning techniques, with particular emphasis on the insertion of intrauterine devices.

Research and demonstrations

In 1964, the Division of Indian Health initiated a study, founded by the Population Council, at the Public Health Service Indian Hospital at Gallup, New Mexico, to evaluate the safety and effectiveness of intrauterine devices in a population group living remote to medical facilities. Approximately 1,800 patients have been included in the study. This research program is being expanded to include 9 other Indian hospitals and health facilities. It is projected that 1,000 to 1,500 patients will be added to the study each year.

BUREAU OF STATE SERVICES

Information and services

Graduate Public Health Training Grants authorized under Section 309 of the Public Health Service Act are awarded for the purpose of strengthening and expanding training through curriculum development. Grant funds may be used for faculty salaries, travel, consultant and guest lecturer fees, equipment, and other expenses necessary to the successful development of training programs.

Public Health Traineeships authorized under Section 306 of the Public Health Service Act are awarded to students enrolled in graduate or specialized public health training programs. The various types of traineeships are: (a) General Purpose, awarded in blocks to accredited schools of public health for distribution to their students; (b) Special Purpose, awarded in blocks to special training programs selected on a competitive basis for distribution to students who would be enrolled in these programs; (c) Short-Term, awarded in blocks to institutions or agencies offering special training programs selected on a competitive basis, and designed to cover the expenses of offering such programs and stipends for students; (d) Residencies in Public Health and Preventive Medicine, awarded to residents through applicant institutions or agencies whose residencies must be approved by the American Board of Preventive Medicine and Public Health; and (e) Apprenticeships, awarded in blocks to institutions and agencies for the support of field experience in public health and preventive medicine for medical students.

Through these mechanisms the following training activities related to family planning have been carried out:

Graduate public health training grants:	
University of Pittsburgh, 1965–66: Teaching of Population Studies	$46,000
University of Hawaii, 1966–71: Development of a Training Program for Population Studies	36,000
University of Puerto Rico, 1966–73: Training Program in Demography	[1] 35,000
Special purpose traineeships:	
University of California at Berkeley, 1965–70: Training in the Administration of Family Planning Programs (6 traineeships)	[1] 32,000
Short-term traineeships:	
University of California at Berkeley: Health Education Responsibilities in Family Planning Programs in Official Agencies (50 traineeships, 1966)	7,300
Planned Parenthood of Maryland, Inc., Professional Training Division	4,600
Family Planning and Public Health (30 traineeships, 1966)	4,600
University of Colorado Medical Center: Population Dynamics, Genetic Counseling, and Birth Control (70 traineeships, 1966)	4,976
Planned Parenthood Federation of America, Inc.: Agricultural Migrants and Family Planning Services (50 traineeships, 1966)	4,950

[1] Per annum.

During the last two years the Communicable Disease Center has assigned an Epidemic Intelligence Service Officer for training to the Emory University-Grady Hospital family planning services clinic project. In addition to his activities with the project, the officer provided consultation on the development of family planning services to the Georgia State and local health departments.

During the last fiscal year an Epidemic Intelligence Service Officer was sent to Johns Hopkins for special course work in population control.

This year 4 officers have been assigned for family planning training, 1 to each of the following projects: The Emory University-Grady Hospital clinic; a Tulane University-Louisiana State Health Department project; a Muskogee County, Georgia, Health Department project; and an Alabama State Department of Health project.

Research and demonstrations

The Bureau of State Services is authorized to support research projects leading to new or improved methods of providing community health services. Studies and demonstrations related to family planning may also be supported by the Community Health Project Grant program which provides financial assistance to a broad variety of community based developmental activities. These grants are awarded on a competitive basis.

Two research grants projects in family planning are currently being supported: $61,000 was awarded for a 2-year period to the Planned Parenthood Center of Syracuse, New York, for "An Experiment in Bringing Family Planning To the Poor." The project began April 1, 1966.

Under Public Law 480, the Johns Hopkins University is administering a contract of 225,000 rupees with the Christian Medical College at Ludhiana, Punjab, India, for "A Study of Intrauterine Devices in a Rural Health Clinic." This project began May 1, 1966.

NATIONAL INSTITUTES OF HEALTH

Population research is carried out by several of the National Institutes of Health, particularly by the National Institute of Child Health and Human Development which Congress established in recognition of the need for research in human development and the factors necessary to healthful and responsible reproduction.

In June 1965, the Advisory Council of the Institute issued a policy statement which affirms the need for population research and delineates in some detail specific fields requiring attention. These fields include research into the biological and behavioral processes of reproduction; studies of the determinants of population growth rates and the psychological factors affecting family size; and the development of new techniques of family planning.

Legislative authority for population research by the National Institutes of Health is contained in the Public Health Service Act, which authorizes the conduct and support of health research and related activities. Specifically, Sections 441–445 of the Act authorize the establishment of the National Institute of Child Health and Human Development, an Institute for the "conduct and support of research and training relating to maternal health, child health, and human development, including research and training in the special health problems and requirements of mothers and children and in the basic sciences relating to the processes of human growth and development. . . ."

Information and services

Information and services directly related to family planning are not part of the National Institutes of Health intramural program, except in selected cases on an individual basis. Such services are, however, incorporated in many of the research and training programs supported by the National Institutes of Health.

Training

The National Institute of Child Health and Human Development currently supports more than 40 training grants, 75 research fellowships, and 35 career development awards in the field of reproduction. More than half of the training grants are in departments of obstetrics and gynecology and more than 200 trainees are currently receiving support. In fiscal year 1966, the Institute obligated an estimated $6 million for training in research on reproduction, $1.1 million of which was for training in population research.

Research

In fiscal 1966 an estimated $6.5 million was obligated by the National Institutes of Health for population research projects. Of this total, $3.8 million, or 58 percent, was obligated by the National Institute of Child Health and Human Development. These funds support investigators outside the National Institutes of Health, through the use of grants, and the number of such projects is expected to increase substantially. In addition, the National Institute of Child Health and Human Development is developing intramural and contract programs in this field which will substantially increase the total population research effort.

In order to encompass population research adequately, the attention of a wide range of disciplines is required. Both biological and social research into the processes of reproduction is being carried out by investigators within the National Institutes of Health and outside, through grants and contracts.

Emphasis has been placed on the study of the menstrual cycle in order to gain a better understanding of ovulation, with the goal of increasing the effectiveness of the rhythm method of contraception.

As a further means toward understanding ovulation, and also the mechanism of action of oral contraceptive agents, the National Institute of Child Health and Human Development is supporting research projects in reproductive endocrinology in humans and experimental animals.

Through grants and contracts the Institute is also supporting a number of studies concerned with the social determinants of family size. A contract has been awarded to Princeton University to conduct a survey of American family planning practices.

Both in the United States and abroad, there is growing concern for the social problems related to illegal abortion and its possible inverse relationship to the provision of adequate family planning services. Studies of this and associated factors are planned.

The Institute also supports research on the use of current family planning methods and the development of new methods. Several projects are underway on the mechanism of action of intrauterine devices in various experimental animals and human beings. In addition, the Institute is planning projects to monitor the long-term effects of various contraceptives—particularly oral contraceptives—on the health of women and children.

Public information

Information on the National Institutes of Health research programs and the means to obtain funds for research support is readily available. It is an important activity of the National Institute of Child Health and Human Development to make known its population research policy in order to stimulate such research. In addition, the Institute has established a Reproduction Information Center which will become a national and international resource for scientific information in the fields of reproduction and population research. When fully developed, this Center, in association with the National Library of Medicine, the Science Information Exchange, and other agencies, will provide bibliographic services, abstracts, and scientific consultations. In 1963 the Institute issued *A Survey of Research on Reproduction Related to Birth and Population Control.* This was brought up to date in 1965.

NATIONAL CENTER FOR HEALTH STATISTICS

The National Center for Health Statistics is responsible for collecting and analyzing the wide range of health and demographic statistics needed for health planning and program evaluation. As part of this responsibility, the Center is concerned with methodological research to devise effective statistical tools. In the field of demography, the Center has developed an active program of analysis and research to assist in defining the problems of, and solutions to, the rapidly increasing crisis of national and world population growth.

The authority for the activities of the National Center for Health Statistics in population derives from the general data collecting and research authorities of the National Health Survey Act of 1956 (Public Law 652); Reorganization Plan No. 2 of 1946, transferring certain functions of the Census Bureau relating to vital statistics to the Public Health Service (60 Statute 1095); and the authority to use certain foreign currencies for health research (Public Law 480, Section 104(k)).

The Center's current total rate of expenditures for all population-related activities is approximately $2 million. Of this, $1.5 million is for current and special data collection and analysis, $400,000 for methodological research, and $65,000 for a foreign training program which is financed by the Agency for International Development.

It is anticipated that the rate of expenditure for next fiscal year will be at approximately the same level with the addition of $400,000 for the cost of the proposed continuing nationwide fertility survey.

Information and services

The program of the National Center for Health Statistics in the field of population dynamics consists of data collection and analysis, methodological research, and training in demography.

In the area of data collection and analysis, the following examples illustrate the range of the National Center for Health Statistics' program:

The Center carries out continuing and special analyses of data on natality and fertility and on infant and perinatal mortality. A major analytical study of birth trends was issued in 1965 and was supplemented by an additional interpretive report to meet increasing requests for information on the current decline in fertility in the United States.

In 1965, a continuing program was begun to improve the quality of national data on multiple births.

A study being conducted of Puerto Rican data is examining the relationship of fertility to the educational attainment of parents and the duration of marriage.

A study is in process of trends in illegitimacy in the United States during the 10-year period 1955–1964. It will include comparisons of the health characteristics of legitimate and illegitimate births.

A study of seasonal patterns of live births in the United States was completed last year, and the National Center for Health Statistics has begun the monthly issuance of seasonally adjusted birth and fertility rates.

A study published last year examined the question of fertility statistics and made recommendations regarding the need for better data, improved analyses, and more research. The methodological recommendations are applicable not only to the United States but to many other countries.

The Center is sponsoring international studies of infant mortality which are being carried out in collaboration with several European countries. This project is an effort to obtain truly comparable data and to develop analyses which will explain the differences in levels of infant mortality among Denmark, England, and Wales, the Netherlands, Norway, Scotland, and the United States.

The Center's future program in the population field will continue the data-collection and research activities at the current level. In addition, the National Center for Health Statistics proposes to add a continuing national fertility survey.

This proposed interview survey will be conducted every two years with a nationwide sample of women in the reproductive years of life for the purpose of describing and analyzing factors associated with the fertility of the population. The variables under study will include past reproductive performance (the date and type of termination of each pregnancy), physiological limitations on the ability to reproduce, morbidity associated with pregnancy and delivery, future childbearing expectations, number of children wanted, and the degree of voluntary limitation of fertility. This information will be related to demographic and socioeconomic characteristics of the parents, such as age, educational attainment, religion, income, residence, and other background factors that may influence their fertility.

It is expected that every two years at least three major reports will be based on the data collected in the survey. The first will be an analysis of current trends in fertility, in which an attempt will be made to separate temporary fluctuations in annual measures of fertility from the long-term trends indicated by the survey material. The second report will deal with variations in the ability to reproduce and with trends and socioeconomic differentials in the effectiveness with which fertility is controlled. The third report will present a deeper analysis of factors affecting the fertility of groups in which there is a special interest—for example, those with incomes below the poverty level. In addition to these three main reports, others will be prepared on special topics.

Training

In fiscal year 1966 a training program was established for Vital Statistics and Measurement of Population Change. The program is conducted by the National Center for Health Statistics for the Agency for International Development which finances the program.

The objectives of this training program are twofold. The first is to broaden the skills of statisticians of countries in which vital statistics and measures of population growth are lacking or are insufficient to meet the country's needs. A practical knowledge of sample survey methods and data collection and processing techniques should enable trainees to develop short-term methods for estimating current population change.

The second objective is to provide a thorough grounding in efficient birth-and-death-registration methods and procedures. With the benefit of improved registration, vital statistics should improve on a long-range basis to the point where major reliance need no longer be placed on survey methods for measuring population change.

In the 1965–66 training year—the first year under the continuing program—nine statisticians from six countries were trained. The countries were: Ghana, India, Kenya, Nigeria, Sierra Leone, and Turkey.

Research and demonstrations

In the field of methodological research, the principal objective of the National Center for Health Statistics is to develop methods of compiling sensitive indicators of demographic changes as consequences of public health action programs.

The following are some of the Center's methodological projects:

A major study designed to test the possibility of developing a new method of estimating birth and death rates and population changes is being carried out by the Research Triangle Institute and the University of North Carolina under contract with the National Center for Health Statistics. The study is being done with the cooperation of the North Carolina State Board of Health and with the assistance of the Agency for International Development. If the effort is successful, it will provide a basis for developing a simplified procedure which can produce adequate measurements of birth, deaths, and population changes. The procedure being explored is the one-time retrospective household interview survey method.

The Center is sponsoring advanced theoretical research on a computer microsimulation technique for observing population changes under various assumptions regarding mortality, fertility, the effectiveness of public health action programs, and other population parameters. If such simulation can be achieved, it will provide a major advance toward better understanding and evaluation of the effect of programs, such as family planning, which are designed to affect population trends.

Under its Public Law 480 program, the Center is conducting methodological studies in India, Egypt, and Pakistan. The objective of these studies is to devise methods of collecting current vital data by the use of systems other than the conventional vital records system. The studies involve tests of various combinations of surveys and registration data collection methods.

III. Office of Education

The Office of Education recognizes that each community and educational institution must determine the role it should play in the area of family life education and sex education; that only the community and its agencies and institutions can know what is desirable, what is possible, and what is wise for them in this realm.

The Office of Education has established a new policy on family life education and sex education:

To assist communities and educational institutions which wish to initiate or improve programs in this area, the Office of Education will support family life education and sex education as an integral part of the curriculum from preschool to college and adult levels;

To support training for teachers and health and guidance personnel at all levels of instruction;

To aid programs designed to help parents carry out their roles in family life education and sex education;

To support research and development in all aspects of family life education and sex education.

The Office of Education will work closely with other agencies, both Federal and State, to insure the most effective use of our resources in the implementation of the recently issued policy on family life education and sex education.

Bureau of Elementary and Secondary Education

There are a number of programs receiving support that are concerned with family life and sex education. At least nine schools for pregnant adolescents, located in various parts of the country, are being supported under Title I of the Elementary and Secondary Education Act which provides aid to schools for the education of disadvantaged children. In addition to offering instruction in academic subjects, the schools bring in social workers, psychologists, and health personnel to provide group and individual counseling. A primary objective of the schools is to help develop attitudes which will result in responsible family life.

A survey of 2,000 projects being carried out under Title I of the Elementary and Secondary Education Act reveals many programs which are concerned with family life and sex education. Their treatment varies in quality and comprehensiveness. There are 645 projects funded under Title I with health components. Frequently those projects concerned with health education cover the area of family and sex education. This type of education may also be included within the home economics program. Under Title I, the Bureau has sponsored 19 projects in home economics training.

A program specifically related to sex education is being carried out under Title III of the Elementary and Secondary Education Act. Utilizing the staff

and facilities of a local hospital in Pennsylvania, sex education workshops have been established for teachers, other school personnel, parents, and students. Amherst, Massachusetts, has included courses in marriage and family living in its Title III project "Individualized Instruction Program."

The Bureau of Elementary and Secondary Education plans to take the following steps to implement the new Office of Education policy on family life and sex education:

1. A concerted effort will be made to inform State and, where appropriate, local officials of the oportunities for funding programs in family life and sex education. This will inculde such actions as—

Including in a memorandum from the Director of the Division of State Agency Cooperation, to Chief State School Officers, mention of the Office of Education's policy statement on family life and sex education indicating its relationship to Titles I, II, III and V of the Elementary and Secondary Education Act and Titles III and V of the National Defense Education Act. Copies of the memorandum will be sent to Titles I, III, and III Coordinators, to which a copy of the policy statement would be attached. Through a coordinated memorandum of this sort the Bureau will avoid duplication among the various Elementary and Secondary Education Act programs.

Sending the Title I field staff a copy of the policy statement with instructions to discuss the matter informally with State officials when it seems appropriate.

Discussing Office policy whenever appropriate in meetings with State and local officials.

2. A special mailing will be made to counselor-educators who are on the Office of Education mailing list, bringing the policy statement to their attention and proposing that they incorporate in their counselor preparation programs the development of skills in family life and sex education.

3. In the filmstrip on elementary school guidance and pupil personnel services—scheduled for preparation fiscal year 1967—family life and sex education will be included when giving examples of guidance programs. These areas will also be mentioned in leaflets to be prepared in fiscal year 1967 on each of the pupil personnel services.

4. A memorandum from the Director of the Division of Educational Personnel Training to all Title XI and V–B National Defense Educational Assistance programs and the handicapped training program, including a copy of the policy statement, will request that the institute directors consider incorporating discussion of family life and sex education in their training programs, as appropriate, utilizing the best resources available at the university. Care will be taken to avoid any suggestion that the institutes are obliged to include such a discussion.

BUREAU AND HIGHER EDUCATION

Several States have proposed projects dealing with family life education as part of their comprehensive plans for continuing education programs, to be funded under Title I of the Higher Education Act of 1965. The University of Delaware has proposed a project to inform persons working in the field of social problems about the latest research information on family interaction. Grambling College in Louisiana has initiated a project to utilize counselors, clergy, teachers, social workers, and lay persons in gathering and disseminating information concerning problems of family life.

In order to make clear the new policy of the Office of Education, the Bureau will inform applicant institutions of the opportunities for offering graduate fellowships in areas involving family life and sex education, as part of the Prospective Teachers Fellowship Program and the National Defense Graduate Program. Eligible areas include such fields as health and physical education, guidance and counseling, sociology, and elementary education. Description of the Office policy, including appropriate quotations from the policy statement, will be included in the guidelines and announcements for these graduate fellowship programs. Copies of the statement will be provided to the program staff, the advisory committee, and evaluation panels concerned with these programs as an additional criterion for future fellowship allotments.

BUREAU OF ADULT AND VOCATIONAL EDUCATION

Many adult basic education programs supported under Title II–B of the Economic Opportunity Act of 1964 include family life and sex education in their

course content. Such programs, which have been initiated at the local level, are designed to cover areas of particular concern to the participants. Family relations and personal development, including sex education, are foremost among these areas. The "Los Angeles Preschool Child and Parent Education Enrichment Classes" sponsored under Title II–B emphasizes family relationships and child development. It specifically includes sex education among the subjects to be discussed, particularly in relation to parents informing their children.

In addition to present activities, the following steps will be carried out for all appropriate programs, including those in vocational education (health occupations, home economics, and others), adult education and library services:

1. Bureau personnel will inform their counterparts at regional and State levels (including State Departments of Vocational Education, State library personnel, State university vocational educators, etc.) of the new policy of the Office of Education and arrange discussion with them to develop ways and means to strengthen family life and sex education programs. The Bureau will cooperate with States in establishing State and local advisory committees to help determine community needs for improved instruction in this area.
2. The Bureau will support the training of persons in the health occupations and of teachers of vocational and occupational education, including home economics. It will examine present education policies and curricula in these programs to determine their effectiveness in providing adequate preparation in family life and sex education, and encourage the inclusion of more adequate instructions where needed.
3. The Bureau will work with personnel responsible for programs under the Manpower Development and Training Act. They may include family life and sex education as an element in the basic education provided for MDTA trainees.

BUREAU OF RESEARCH

The Bureau of Research is currently considering several projects concerned with family life and sex education. A proposal submitted by the District of Columbia Teachers College on ways to improve teaching methods and attitudes toward sex education is now under review.

The Bureau of Research will plan, develop, and implement a program of research and development in family life and sex education. The Bureau anticipates that it will take two or three months to develop program alternatives among which the Office of Education leadership might choose and which might then be implemented by the Bureau as the first step in developing a continuing program in this area. Such a program might include—

(1) The encouragement and support of basic research into the educational implications of psychological, sociological, economic, and social factors which affect family life and sex education.

(2) The encouragement and support of research in the development of programs and educational materials in family life and sex education which include not only human reproduction but also consideration of the psychological, sociological, economic and social factors that may affect personality and personal adjustment to the family and society.

(3) The encouragement and support of research in the preparation of educational personnel, both pre-service and in-service, professional and subprofessional, as it relates to family life, sex education, human reproduction, and related concerns such as those of population problems.

(4) The encouragement and support of the dissemination of information derived from educational research and of the products of such research in the area of family life and sex education.

OFFICE OF DISADVANTAGED AND HANDICAPPED

The Office cooperates with sponsors of Institutes for Guidance and Counseling Personnel and Institutes for Teachers of Disadvantaged Youth in the field of sex education, family life and family planning.

The Office will disseminate the new policy statement and relevant materials developed by other agencies as a part of its packet of materials distributed, on request, relating to the education of the disadvantaged and the handicapped.

The Office of Disadvantaged and Handicapped will work with Office of Economic Opportunity personnel responsible for Community Action Programs, Indian, Migrant, and the rural population, Job Corps Centers, and Labor Department personnel directing the Neighborhood Youth Corps and MDTA experi-

mental and demonstration programs to encourage the inclusion of instruction and materials on family life and sex education to participants in these programs.

The Office of Disadvantaged and Handicapped will include discussions on Family Life and Sex Education at the various conferences it holds with grass roots minority groups throughout the Nation.

Through its liaison personnel with other Federal agencies and community organizations—i.e., Welfare and Health agencies of the Department of Health, Education and Welfare, the D.C. Board of Education sponsored school for pregnant girls, and State agencies—the Office of Disadvantaged and Handicapped cooperates in promoting programs and working with grass roots personnel in need of being made aware of family life responsibilities and sex education.

OFFICE OF PROGRAM PLANNING AND EVALUATION

As a part of its continuing evaluative responsibilities, the Office of Program Planning and Evaluation will monitor the carrying out of these steps.

OFFICE OF INFORMATION

American Education, the monthly publication of the Office of Education which is directed toward the broad educational community—including school boards, Parent-Teacher Associations, university faculties, and libraries—will publish two articles on sex education in its autumn issues. One will be concerned with existing curricula and school programs in sex education; the other will discuss adolescents' problems with, and attitudes toward sex.

IV. Food and Drug Administration

The responsibility of the Food and Drug Administration in the field of population dynamics and family planning is to ensure the safety and efficacy of contraceptive drugs and the safety of devices. Under the authority of the Food, Drug and Cosmetic Act, as amended, the Food and Drug Administration is responsible for approving contraceptive drugs for safety and effectiveness before they are marketed and for maintaining surveillance over the drugs after their approval. Currently, 8 oral contraceptives have been approved for sale, on prescription, and 28 others are in the investigational stage. Although the Food and Drug Administration does not have premarketing controls over contraceptive devices, it is responsible for maintaining surveillance over such devices to ensure their safety.

In August 1965, the Food and Drug Administration established an expert Advisory Committee on Obstetrics and Gynecology to obtain the best advice available on the safety of contraceptive drugs and intrauterine devices. This committee is responsible for considering the importance of reported side-effects of and adverse reactions to such drugs and devices and for making recommendations to the Food and Drug Administration based on its findings. The Committee submitted a comprehensive report on oral contraceptives on August 1, 1966. This report is now under review by the Food and Drug Administration. Several of the recommendations have already been implemented by the Food and Drug Administration.

Research

As a result of the recommendations by the Advisory Committee, the Food and Drug Administration has recently entered into contracts for 2 research studies on human experience with oral contraceptives. The purpose of both studies is to help determine whether a relationship exists between the use of such contraceptives and thrombo-embolism in women of child-bearing age.

The first contract is for a pilot study being conducted by Johns Hopkins University. This is a retrospective study involving a review of case histories of, and interviews with, women suffering from thrombosis.

The second contract is with the University of Pittsburgh. This calls for a prospective study involving virtually the entire population of child-bearing age in Lawrence County, Pennsylvania, a small rural county in the western part of the State.

In addition to these special studies, the Food and Drug Administration has operating programs for the accumulation and evaluation of adverse drug experiences, including oral contraceptives, as well as the development of disease morbidity data. These programs include the Adverse Reactions Reporting Program, the Armed Forces Institute of Pathology Registry of Tissue Reaction to

Drugs, and a long-range study under contract with the Kaiser Foundation Health Plan of Oakland, California.

The Kaiser study, presently being conducted at the Foundation's San Francisco hospital and to be expanded to their other hospitals in the future, is designed to help the Food and Drug Administration in making decisions with respect to the labeling of drugs for various diseases and conditions and with respect to directions to physicians for the use of drugs—including contraceptive drugs—in order to achieve better patient protection. The study will provide statistical reports on the diagnoses of conditions and diseases as related to drug usage among patients receiving regular and periodic medical care. The findings will be programmed for computer analysis to determine relationships between the use of various drugs and pharmacological reactions.

Since no drug is completely safe, especially when used by a large portion of the population, the need for continual close supervision and monitoring experiences with new drugs such as oral contraceptives is readily apparent.

The Food and Drug Administration expects to continue to expand its activities in the evaluation of contraceptive drugs and devices.

Public information

In August 1966 the Report of the Advisory Committee on Obstetrics and Gynecology was released to the public with wide-spread publicity. The Food and Drug Administration has kept the public informed on all major developments related to contraceptive drugs.

POPULATION CRISIS

FRIDAY, APRIL 8, 1966

U.S. SENATE,
SUBCOMMITTEE ON FOREIGN AID EXPENDITURES,
COMMITTEE ON GOVERNMENT OPERATIONS,
Washington, D.C.

The subcommittee met at 10:10 a.m., pursuant to recess, in room 3302, New Senate Office Building, Senator Ernest Gruening (chairman of the subcommittee) presiding.

Present: Senator Gruening.

EXHIBIT 136

The witness who testified on S. 1676 before the Subcommittee on Foreign Aid Expenditures, Friday, April 8, 1966, was the Honorable David E. Bell, Administrator, Agency for International Development, who was accompanied by Dr. Albert H. Moseman, Assistant Administrator for Technical Cooperation and Research; and Dr. Malcolm H. Merrill, Director, Health Service, Office of Technical Cooperation. (Pictured, left to right: Senator Ernest Gruening, chairman, and Administrator Bell.)

Also present: Herbert W. Beaser, chief counsel; Laura Olson, special consultant on population problems; William J. Walsh III, professional staff member; Carole Ransom and Harriet Eklund, editors; and Mary A. Miller, clerk.

(A photograph taken today of the distinguished witness, Hon. David E. Bell, Administrator, Agency for International Development, and Senator Gruening, is placed in the record by direction of the chairman.)

OPENING STATEMENT OF THE CHAIRMAN

Senator GRUENING. The hearing will please come to order.

Today the Government Operations Subcommittee on Foreign Aid Expenditures is holding its 26th public hearing on S. 1676, a bill to coordinate and disseminate birth control information upon request in the United States and in other nations. Our witness is the 91st to appear. He is David Bell, Administrator of the Agency for International Development. We look forward to learning what the Agency is doing overseas to implement President Johnson's 20 public statements concerning population and the need to face forthrightly the multiplying problems of our multiplying populations. Do other nations know the United States stands ready to help them if asked? How is the United States letting other countries know population information is available upon request? What is, in fact, the United States doing?

AID SHOULD BE CONCERNED WITH EFFECTS OF UNCHECKED POPULATION GROWTH

The Agency for International Development should be concerned with the effects of unchecked population growth. Economic assistance does little if any good where annual population growth is so high as to make the annual gross national product growth insignificant in terms of the economic progress needed by a developing nation for economic stability.

At the 20th anniversary of the United Nations at San Francisco on June 25, 1965, President Johnson spoke of the value of investing in population control when he said: "Let us act on the fact that less than $5 invested in population control is worth $100 invested in economic growth."

I might say that some subsequent witnesses have pointed out that that formula might be reduced to $1 versus $100. But in any event the point is an effective one.

President Johnson has called the population explosion the second greatest challenge to humanity, "second only to the search for peace."

When he delivered his state of the Union address before Congress this year on January 13, the President said he had come to ask us:

"To give a new and daring direction to our foreign aid program, designed to make a maximum attack on hunger, disease, and ignorance in those countries determined to help themselves * * * and to help those nations trying to control population growth * * *."

L.B.J. WANTS U.S.A. TO HELP NATIONS WHO WANT TO HELP THEMSELVES

I would say that of the many pertinent statements that President Johnson has made on the subject over 20 times since he was inaugurated—since his election—this is the most significant in terms of the foreign aid program, the point being that he wants us to help nations who want to help themselves in this field.

In his Foreign Aid program message to the Congress on February 1, 1966, the President said the citizens of many developing nations walk in the shadow of misery because they are unschooled, hungry, or malnourished, unable to grow more food per person, and on the way to doubling their present population growth before the year 2000.

These depressing facts, he said:

"* * * are the dominant facts of our age.

"They challenge our own security.

"They threaten the future of the world.

"Our response must be bold and daring. It must go to the root causes of misery and unrest. It must build a firm foundation for progress, security, and peace."

The President correctly calls on the people and leaders of the developing nations to face the population problem squarely and realistically. He correctly says the United States stands "ready to help developing countries deal with the population problem."

POPULATION CONTROL IS "A MATTER OF INDIVIDUAL AND NATIONAL CONSCIENCE"

The President properly emphasizes that the United States cannot and should not force "any country to adopt any particular approach to this problem" which truly is first a matter of individual and national conscience.

Further in his Foreign Aid message to Congress this year, he said his request of $231 million for technical cooperation including attack on the population problem came because "* * * no appropriation is more critical. No purpose is more central."

In his International Education and Health Acts message on February 2, 1966, the President proposed programs to "expand research in human reproduction and population dynamics, enlarge the training of American and foreign specialists in the population field, and to assist family planning programs in nations which request such help." The Agency for International Development was cited as one part of Government through which such efforts could be made.

The work in family planning proposed by the President on March 1, 1966, in his Domestic Health and Education message can have meaning, too, for other nations because what we learn about the study of human reproduction can be shared with other nations through an Office of Population Problems in the Department of State and the Department of Health, Education, and Welfare.

This subcommittee has received contributions to the population dialog from 90 distinguished men and women, including citizens of Sweden and the respected Latin American statesman, the former President of Colombia, Dr. Alberto Lleras Camargo.

The full text of their statements are available to all interested persons.

ALBERTO LLERAS CAMARGO SAYS—1. LATIN AMERICA'S CRISIS CAUSED BY SPEED OF POPULATION GROWTH

Dr. Lleras' testimony on July 9, 1965, cited the problems confronting Latin America. He said, in conclusion:

"What has caused the crisis is the speed at which Latin America's population has been growing. If the population increase were not proceeding at such an inordinate rate, the problem would be manageable. But at the current rate, it is beyond manageable proportions, and certainly beyond the capacities of the Latin Americans to cope with it. Latin America is breeding misery, revolutionary pressures, famine, and many other potentially disastrous problems in proportions that exceed our imagination even in the age of thermonuclear war."

2. REDUCTION OF RATE OF GROWTH IS ESSENTIAL FOR POPULATION CONTROL

"The only way to solve these problems is through population control. Today this can and must mean reducing the rate of growth. In the future, it might well be in order to step it up again, if the effects of the reduction should turn out to be excessive or unhealthy. But, as Huxley has said, since man has made it his business to control death—and in large part he has succeeded—he cannot escape the need to control birth."

3. LEGISLATION FOR POPULATION CONTROL IS BENEFICIAL

"Because I believe this, I also believe that any legislation that seeks to develop practical approaches to population control is beneficial. And the results of research in the vast field of demographic studies, as well as any practical applications that emerge from these studies should be made available to any nation that asks for assistance in this matter."

On March 9, 1966, a Swedish three-member delegation came, at its own expense, upon our invitation to tell what Sweden is doing to make family planning information available upon request overseas and at home. The delegation was headed by the Director General of the Swedish International Development Authority, Mr. Ernst Michanek. Sweden has pioneered in making birth control assistance an ever-increasing part of its foreign assistance program, having undertaken its first effort to help a developing country initiate a family planning program in 1958 when Ceylon requested assistance from Sweden.

SIDA DIRECTOR SAYS "THE PROBLEM OF HUNGER AND OVERPOPULATION . . . ONE AND THE SAME PROBLEM"

Director General Michanek told the subcommittee:

"We have come here to talk about the most urgent problem of the present-day world: The problem of hunger and overpopulation.

This is, I submit, one and the same problem. The starvation in the developing countries is increasing because of the increase in population. The starvation and death of many millions of men, women, and children can be checked only if the enormous increase in population is checked. We can do something about this situation—and we must do it.

"* * * We consider it a human right for all parents to plan the size of their families—including the case of subfertility—and to be assisted with a view to getting the number of children they can provide for.

"* * * We have no right to reserve this knowledge for a few. On the contrary, we are under obligation to disseminate it—for ethical reasons, for reasons of morale, for social reasons, and—let us not forget—for economic reasons.

"* * * All parties in Sweden are agreed that we must move still faster toward the goal of 1 percent of our gross national product being used for aid purposes."

Sweden, he said, would like to cooperate multilaterally with other governments in this area. It is helping Ceylon, Pakistan, Tunisia, Palestine refugees in the Gaza strip, and has studied family planning programs in Japan, Korea, Hong Kong, Singapore, Tanzania, Egypt, Turkey, Morocco, and Taiwan to see how help can best be given them.

Mr. Michanek spoke of the need for planning, personnel training, research, coordination and the role of women, for example. He believes it is true that $1 paid into family planning services can save $300 in costs for education. He called on all nations and particularly the United States to take action to find the solution to the "world's greatest problem" since "time is running short."

Mr. Bell, what is the Agency for International Development doing to help solve this problem about which Mr. Michanek spoke so movingly?

Mr. Bell, we are most happy to have you here. You have a distinguished record as a public servant, and your testimony will be most valuable, and eagerly listened to.

Your complete biographic statement will be included at this point in the hearing record.

Will you proceed?

(The biographic statement referred to follows:)

BIOGRAPHIC STATEMENT: DAVID E. BELL

David E. Bell took office as Administrator of the Agency for International Development on December 21, 1962. He came to AID from the Bureau of the Budget where he served as Director.

He joined the Budget Bureau's staff in 1942 as a member of the War Organization Section, Administrative Management Division. After World War II service with the United States Marine Corps, he returned to the Bureau of the Budget to serve as a budget examiner until December 1947 when he became a special assistant in the White House Office.

In September 1948 he returned to the Bureau as assistant to the Chief of the Fiscal Division. Early in 1949 he went back to the White House. He was named an Administrative Assistant to Presi-

dent Truman in 1951, a position he held until the President left office in January 1953. He received a Rockefeller Service Award in 1953.

From April 1954 until August 1957 Mr. Bell was field supervisor of a group of advisers to the Planning Board of the Government of Pakistan which had been recruited by Harvard University and financed by the Ford Foundation to assist in mapping the economic development of that country.

David Bell returned to Harvard in September 1957 as lecturer on economics in the Graduate School of Arts and Sciences and as research associate in the Graduate School of Public Administration. He became secretary of the graduate school.

Mr. Bell was born in Jamestown, North Dakota, on January 20, 1919. He has an A.B. degree with highest honors from Pomona College, an M.A. degree from Harvard University, and honorary LL.D. degrees from Pomona, Harvard, and the University of Vermont. He and his wife, Mary, and their two children live in Bethesda, Md.

STATEMENT OF HON. DAVID E. BELL, ADMINISTRATOR, AGENCY FOR INTERNATIONAL DEVELOPMENT; ACCOMPANIED BY DR. ALBERT H. MOSEMAN, ASSISTANT ADMINISTRATOR FOR TECHNICAL COOPERATION AND RESEARCH; AND DR. MALCOLM H. MERRILL, DIRECTOR, HEALTH SERVICE, OFFICE OF TECHNICAL COOPERATION

Mr. BELL. Thank you very much, Mr. Chairman.

We appreciate, very much, this opportunity to discuss the policies and programs of the Agency for International Development in the population field.

BELL CITES LEGISLATIVE AUTHORITY FOR POPULATION FIELD PROGRAM

AID's interests and programs in the population field derive from the authorities given in sections 201, 211, and 251 of the Foreign Assistance Act of 1961, as amended, and sections 104 (e) and (g) of Public Law 480, which provide the authority required to conduct programs in the field of population and family planning as part of the U.S. effort to support economic and social progress in the developing countries. Similar authority is provided in section 304(f) of the proposed Food for Freedom Act.

AID and its predecessor agencies, as you know, have been concerned and active in the population field for years, going back to the early 1950's. In the early years our work consisted largely of assistance in developing official statistics, including population censuses and vital statistics, and in training in such fields as public health and maternal and child welfare.

Beginning in 1961, growing encouragement was given to research in the dynamics of population growth and its impact on economic development; also to the expansion of programs by private organizations in the United States and abroad, by the United Nations, and by foreign governments.

L.B.J. IN 1965 SPARKED AID'S RENEWED INTEREST IN POPULATION FIELD

In 1965 we enlarged, substantially, our activities in the population field. The change was stimulated directly by President Johnson in his January 5, 1965, state of the Union message when he said, "I will seek new ways to use our knowledge to help deal with the explosion in world population and the growing scarcity in world resources."

In March 1965, the Agency for International Development circulated a comprehensive population guideline to its missions overseas stating, in essence, that the Agency was willing to consider requests for assistance in family planning activities from those governments in the less developed areas which were undertaking their own programs, provided such programs were based on freedom of choice for the individuals and families involved, and provided that we would not finance contraceptives or the machinery for their manufacture.

". . . DECISIONS ON MAJOR POPULATION POLICIES AND PROGRAMS MUST BE MADE BY THE COUNTRIES THEMSELVES . . ."

It is important to note, in this connection, that we consider decisions on major population policies and programs must be made by the countries themselves, without pressure from the United States. This is a very sensitive and complex area, involving very deep historical and emotional elements, and one in which policymaking clearly should be done by the governments and peoples concerned, not by the United States. At the same time, the United States has, of course, joined in international meetings and in other forums, such as the United Nations, in the general expression of concern which is shared by practically all countries today about the economic and social consequences of rapid population growth and the need for all countries to study these matters seriously in relation to their own programs of development.

AID WILL HELP GOVERNMENT REQUESTING FAMILY PLANNING PROGRAM ASSISTANCE

Since 1965, consistent with the guidelines just mentioned, AID has been responding to requests from governments for direct assistance to family planning programs.

The Republic of China is using AID-generated local currencies to support a family planning program.

Turkey has requested a loan to purchase transport vehicles for family planning workers and for educational materials, in addition to the services of a demographer.

Honduras has requested assistance for educational programs in family planning as it relates to maternal and child health.

From Pakistan have come requests for a wide range of technical assistance, transport vehicles, education aids and training in support of its family planning program.

India is discussing similar assistance with AID officials.

AID SUPPORTS RESEARCH AND TRAINING PROGRAMS HERE AND ABROAD

AID is supporting research and training programs at the following universities and institutions:

University of Pittsburgh for development of an economic model for estimating costs of family planning programs;

University of Notre Dame for studies on changes in traditional family patterns due to modernization and urbanization;

Bureau of the Census for population projections in selected countries;

Population Council for fertility studies and surveys;

Colombian Institute for Social Development for studying audio-visual techniques for public education programs.

AID has also signed contracts with the University of North Carolina and Johns Hopkins University to develop training programs in family planning for doctors and public health workers. Related programs are being developed for nurses and midwives in the Children's Bureau; for statisticians in the National Center for Health Statistics; and for census and surveys specialists in the Census Bureau. The Pan American Health Organization receives AID's help to establish and improve demographic training in Latin American medical and public health schools. So do the Latin American Center for Demography and Statistical Studies in Chile, the National Center for Studies of Population and Development in Peru, and the Central American Demographic Studies Unit in Guatemala.

1965–67 SEES INCREASE IN EXPENDITURES FOR "POPULATION ACTIVITIES"

AID's dollar obligations for population activities are estimated at $2 million for fiscal year 1965; about $5½ million in fiscal year 1966; and about $10 million in fiscal year 1967. We would anticipate further increases in subsequent years.

In this field, as in all others, it is AID's policy to encourage private organizations to do everything they can and to consider AID financing only as complementary to resources supplied by private organizations. We recognize and acknowledge the important role played in this field by private organizations such as the Planned Parenthood Federation, the Population Council, the Ford and Rockefeller Foundations, and the Population Reference Bureau. They and other private organizations have been vital sources of leadership in creating a body of important knowledge and experience on population matters. Their work remains critically important.

Looking ahead to AID's expanding work in this field, we do not consider that we need additional legislation. For our purposes there is adequate authority in existing legislation.

BELL OPPOSES EARMARKING OF FUNDS FOR FAMILY PLANNING PROGRAMS

Furthermore, we do not believe the earmarking of funds is necessary to insure effective action in the field. Specifically, we do not think it advisable to amend the food-for-freedom bill in a fashion which would require a fixed minimum percent of local currencies to be used for family planning programs. Not only might this be inter-

preted as implying direct pressure to adopt a particular population policy, but we also believe it would be unsound from the standpoint of effective administration; flexibility in the uses of these funds is important.

Our view of these matters is heavily influenced in the developing countries by our belief that public and private leaders there are already or are rapidly becoming as fully conscious of the urgent need for action on population problems as we are. They do desire to take appropriate measures, within the context of their own country's cultural, historical situation. This is true in Latin America as well as in Asia and Africa. It is conspicuously true in India where there is a very positive governmental commitment, supported by the great bulk of the private leaders.

AID PROPOSES TO CONTINUE PRESENT POLICY IN POPULATION FIELD

In brief, we propose to stand by the key elements of our present policy in the population field.

AID does not advocate any particular method of family regulation. Freedom of choice in this matter should be available in any program for which our assistance is requested.

AID will consider requests for assistance in this field, as in other fields, only if they are made or approved by the appropriate authorities of the requesting government.

AID is prepared to entertain requests for technical, commodity, and local currency assistance in support of family planning programs.

AID will not consider requests for contraceptive devices or equipment for the manufacture of contraceptives. Experience has made it clear that the cost of these items is not a stumbling block in countries which are developing effective programs.

". . . RESULTS CANNOT BE EXPECTED QUICKLY"

We expect that, under these policies, AID will be able to provide considerable help to the developing countries in the population field. I think it is important to recognize that results cannot be expected quickly. Of necessity there will be timelags between government decisions and effective programs; from the time a government makes an authorizing decision until a field team is recruited, trained and organized, supplied and ready for work on any substantial scale; until problems are worked out of the program and it settles down into an effective, efficient operation. Moreover, we must keep in mind the important lesson repeatedly learned through other efforts in developing countries; what works in one country, particularly in administrative and educational practices, will not necessarily work in another. Successful methods developed in one country may need considerable adaptation in another.

Nevertheless, the evidence from Korea and Taiwan gives us some real confidence that even in very low-income, village-based societies it will be possible to establish effective family planning programs. A great deal of research and action will be needed. We in AID will seek to do our part, supplementing the efforts of other governments, of the United Nations, and of private organizations, both United States and foreign.

Mr. Chairman, I have with me Dr. Albert Moseman, Assistant Administrator of AID for Technical Cooperation and Research, and Dr. Malcolm Merrill, Chief of Health Services in AID, who are directly responsible for guiding AID's work in the population field. We would be glad to respond to any questions the committee may have.

Senator GRUENING. Thank you very much, Mr. Bell, for your statement.

WHAT IS AID DOING TO HELP OTHER COUNTRIES?

We are glad to see that you are moving in various fields.

I would like to go through some of the countries that are the recipients of aid, and ask you to state in general whether there have been any requests for aid, either from the government or from units within the government, and what the response of AID has been.

I would like to take them in alphabetical order, and if you do not have the full answers now I would like to have the answer that you have and then perhaps you will supplement it in writing for the record.

Afghanistan—would you indicate whether there has been any request for this type of assistance in Afghanistan?

Mr. BELL. I do not have that in my head, Mr. Chairman. We will be glad to—if my colleagues do——

Senator GRUENING. Do you have any information on Afghanistan?

Dr. MERRILL. No specific request has come in to my knowledge.

Senator GRUENING. No specific request has come in?

Dr. MERRILL. That is right, sir.

Senator GRUENING. Do you know whether any interest has been shown in other fields, through private agencies?

Now, Sweden mentions Afghanistan as one of the countries which it is aiding.

Mr. BELL. Let us, if we may, Mr. Chairman, supplement our response on this particular country for the record.

Senator GRUENING. All right.

Argentina—do you have any information on whether there has been any request from Argentina?

Mr. BELL. I am sure there has been no request from the Argentine Government. We have not had any request from any private organizations in Argentina. This is conspicuously different, incidentally, from a number of other Latin American countries, where there has been a considerable increase of private interest in these matters. Numbers of private research organizations, clinics, and so on, are beginning to be established.

Senator GRUENING. In your written reply—I do not expect a full reply now—I hope you will also give what private activities you are aware of.

Mr. BELL. I will be glad to do so.

Senator GRUENING. These requests may not come directly from the government.

Mr. BELL. I understand.

Senator GRUENING. But they may come from individual groups and so forth, and they are part of the picture.

Mr. BELL. Right.

Senator GRUENING. Bolivia—have you any information as to whether there has been any interest shown in Bolivia?

Mr. BELL. Not offhand. We will be glad to supply it for the record.
Senator GRUENING. Brazil?

BRAZIL INCREASING FAMILY PLANNING ACTIVITIES

Mr. BELL. I know a little bit about Brazil. Again, the government has not made any requests of us. There are significant and increasing activities among private leaders in Brazil. There are a number of medical schools. They have established at least two organizations which are in touch with and are obtaining information from the Population Council in New York.

I will be pleased to supplement this, Mr. Chairman, but my impression is—and I am quite confident of this—that there are indeed significant beginnings of private activities in Brazil.

Senator GRUENING. Burma—have you any information on Burma?

Mr. BELL. No, I don't, offhand. I will be glad to put it in the record.

Senator GRUENING. If any of your colleagues have any contribution they may speak up.

Mr. BELL. I will ask them to speak up.

Senator GRUENING. Cameroon?

Mr. BELL. No, sir.

Senator GRUENING. Ceylon?

Mr. BELL. Ceylon, sir?

Senator GRUENING. Ceylon.

Mr. BELL. Only what you said about it.

I also have talked to Dr. Michanek from Sweden and received the same information from him.

Senator GRUENING. Chile?

Mr. BELL. In Chile; yes. Chile is a very interesting situation. There are in Chile today a number of research organizations, one or two of which have received some technical assistance and financial support from AID. They are located in Santiago. They are not necessarily limited in their scope of operation to Chile as such.

FAMILY PLANNING SERVICES AVAILABLE THROUGH NATIONAL HEALTH SERVICE IN CHILE

In the Chilean private sector, there are quite a substantial number of medical people and civilian leaders who are supporting the establishment of family planning clinics. Family planning services are now available in all health facilities—hospitals, clinics, and dispensaries—of the National Health Service in Chile. There are about 60 to 70 such facilities which service about 80,000 women per year. These clinics are primarily supported by private organizations, and the remaining costs are financed indirectly by the government. So that Chile is a case in which there is a very conspicious, a very clear increase in population activities.

Senator GRUENING. Previous witnesses have told us that in Chile a great number of abortions are performed, and that many of the hospital beds are filled with patients who have suffered infection and serious consequences of abortions. So I would imagine that there, as in other countries, where this is the case there would be a very fertile field for the introduction of contraceptive information to obviate these more tragic effects.

ABORTIONS PRESENT A PROBLEM

Mr. BELL. I have heard, sir, that there have been a very serious number of abortions in Chile, and that many of them have had unfortunate medical consequences for the women concerned. I am sure that no one is more anxious to change this than many of the leaders in Chile itself. Medical leaders and many of the religious leaders are concerned about this situation and want to see a solution brought about.

Dr. Moseman reminds me, incidentally, that Harvard University and the Ford and Rockefeller Foundations have supported significant work in Chile, as well as the Population Council.

Senator GRUENING. The Republic of China—I think you have already alluded to that in your statement.

Mr. BELL. Yes.

TAIWAN AND KOREA WELL AHEAD OF OTHER COUNTRIES IN EFFECTIVE FAMILY PLANNING PROGRAMS

The Republic of China on Taiwan, and the Republic of Korea are the two leading cases, so far as I am aware at the present time, of developing countries which have very broad scale and effective family planning programs. They are some years ahead of any other countries with programs of which we are aware.

In both cases the programs are operated as part of the program of the health ministry. The administrative system for carrying out the program is to operate through health clinics, both urban and rural.

In both countries the program has been underway for several years, 3 or 4 years. They have reached hundreds of thousands of families, and the statistical evidence is very impressive.

In both countries it is clear that families, even of very low income, do in fact wish to control the number and the spacing of their children. The motivation of the families seems to be very largely the desire to be sure that they can raise their children effectively, that they can provide the care that the children need—the schooling, the clothes, the food, the medicine and so on—so that they will be able to bring up healthy, strong, educated children.

This, it seems to me, is a motivation which is very familiar in our own country. It seems to be evident that low income families in widely different parts of the world probably share a very similar attitude toward these matters when they have the information which will enable them to carry out their own decisions, and when they have access to the kinds of contraceptives, if they choose to use them, and so on, which will enable them to follow up on the decisions that they make.

The goal in Taiwan is a very clear one. They propose, by the program that they have underway, to cut the birth rate in half by 1970. That would be 7 or 8 years after the program started. Now, it is too soon to say whether they will in fact achieve that goal, but the results are impressive. The statisticians see no reasons why objectives of that kind cannot be attained. All in all, the experience both on Taiwan and in Korea is very encouraging, Mr. Chairman. It leads to the view that we probably now have the knowledge and we have operating pilot examples which do show us how it is possible even in a low-income country, where most of the people live in rural areas,

to carry out effective family planning programs, which will have the effect of reducing birth rates and rates of population growth over a relatively short period of years.

Senator GRUENING. I suppose the problem becomes a little more evident in a small insular country where it is clear that there is limited space and where it is almost impossible for people to consider emigration. Taiwan would be one, Ceylon would be another. I imagine Cyprus might be a third.

Don't you think that would be a factor in bringing home the importance of this problem in these small insular countries?

Mr. BELL. It may well be, Mr. Chairman.

On the other hand, I think there is no country whose leaders are more deeply persuaded of the importance of this problem than the country of India, which is a large quasi-continental country which does not face the same tight boundaries that Taiwan and South Korea do.

Moreover, I think it is very important to recognize that the views of the leaders of these countries are not formed and, in our opinion, should not be formed, on the basis of—you might say—simple arithmetic. It is not simply a matter of the rates of growth of population being so high as to make it hard to get enough food for the additional members of the family.

VIEW OF PUBLIC AND PRIVATE LEADERS IMPORTANT

Equally significant, and in many cases more significant, is the view of public and private leaders in these countries that it is important to raise the quality of life and the standard of living of their people. This is more difficult to do with a high population growth rate. In other words, it is not simply a matter of keeping people alive. It is a matter of providing them with education and health facilities, with opportunities for employment and for self-expression and so on. And in addition to these motivations, there is the point that you have alluded to earlier in reference to Chile, in cases where families are saddled with large numbers of unwanted children. This makes for very large health problems which take different forms in different countries.

In Chile and throughout Latin America, there is a very high and unfortunate incidence of abortions and medical problems connected therewith. In many countries, there is the extremely difficult problem of large numbers of very small children in an environment in which there is not good nutrition available to the small children, and this can have permanent effects on the individuals involved.

So that I think there are strong reasons why the leaders of the developing countries, virtually without exception, whether they are small or large whether their territory is sharply limited or fairly broad, are coming to understand this problem as a most serious one. Virtually without exception they regard this as something to which they need to devote urgent attention.

Senator GRUENING. Have you any information on Colombia?

I know there was an important Conference on this subject at Cali, one of its larger cities, to which two Members of the House went—I think Representative Brademas and Representative Irwin went there.

Mr. BELL. Yes.

Senator GRUENING. And I believe they have made a start there.

Mr. BELL. I was going to refer to that Conference, Mr. Chairman. It was an important Conference. It was held last August and people from AID were there, including Mrs. Josephine Case, who is a member of our General Advisory Committee.

The Conference had people from all over Latin America, persons with public and private background, medical people, educators. It was a very impressive group of Latin American leaders, and it was by far the most frank and thoughtful discussion of the subject that has ever been held in Latin America. It was a very strong contribution to the increasing awareness of the problem and of the possibilities of dealing with it.

COLOMBIA HAS STRONG PRIVATE LEADERSHIP IN FAMILY PLANNING AREA

In Colombia itself, leadership has been taken by the Colombian Association of Medical Faculties. They have begun to organize research on medical and sociological aspects of population growth. There is really quite strong private leadership in Colombia to face this problem in all of its manifestations and to develop programs for dealing with it.

Senator GRUENING. Thank you.

What about the Congo?

Mr. BELL. I have no information on that, sir.

Senator GRUENING. Costa Rica?

COSTA RICA COLLECTING DEMOGRAPHIC STATISTICS

Mr. BELL. The Ministry of Health in Costa Rica has begun to develop programs to accumulate better statistics, including demographic statistics, and we hope to provide them some help along those lines. It is significant that the Ministry of Health, a government agency, while it does not have a family planning program, is nevertheless concerned with this general area of problems. It is beginning to develop broader statistical studies to inform themselves better about the nature of the problems.

Senator GRUENING. Cyprus?

Mr. BELL. No information, sir, on that.

Senator GRUENING. Dominican Republic? I suppose in view of the chaos there not much is going on.

Mr. BELL. I will be glad to put something in the record.

Senator GRUENING. Ecuador?

Mr. BELL. I don't know anything about Ecuador, either.

Senator GRUENING. El Salvador?

Mr. BELL. I think nothing significant, sir. I will put it in the record.

Senator GRUENING. Ethiopia?

Mr. BELL. No; I don't have anything on that.

Senator GRUENING. Ghana?

Mr. BELL. No; I have no information on Ghana offhand.

Senator GRUENING. Greece?

Mr. BELL. Well, Greece, sir, is no longer a country that receives economic assistance from the United States. We regard them as having graduated from——

Senator GRUENING. They have a lot of counterpart funds, though, over there, don't they?

Mr. BELL. There is very little left for programing. Greece is not an excess currency country.

Senator GRUENING. You don't think they could be encouraged to use these funds for that purpose?

Mr. BELL. Well, I just don't know, sir. It is not a country that I have any significant direct dealings with.

Senator GRUENING. Guatemala?

Mr. BELL. I have no information offhand.

Senator GRUENING. Guinea?

Mr. BELL. No.

Senator GRUENING. Haiti?

Mr. BELL. I know very little about Haiti. That is a country where our AID program was suspended in 1963.

Senator GRUENING. Except for malaria.

Mr. BELL. Except for malaria, exactly. We have continued the malaria program because that is important not just for Haiti but for the whole Caribbean.

MALARIA CONTROL AND BIRTH CONTROL MIGHT GO HAND IN HAND IN HAITI

Senator GRUENING. You might suggest to President Duvalier that malaria control and birth control might go hand in hand. They certainly need it in that country. It is terribly overcrowded.

Mr. BELL. It is an extremely difficult situation in many respects, sir. It is a very tragic circumstance.

Senator GRUENING. I realize that. Honduras?

Mr. BELL. No information. We will be glad to put something in the record on that, sir.

Senator GRUENING. Now, India, you mentioned.

Mr. BELL. Yes.

Senator GRUENING. Could you tell us pretty much what is going on there as far as you know?

Mr. BELL. I can tell you some of it, and Dr. Merrill has recently been out there and can tell you more. So has Dr. Moseman, for that matter.

INDIA TRIES TO SET UP FAMILY PLANNING PROGRAMS

The Indian Government has had a policy for better than 10 years, which has been favorable to family planning, the reduction of the birth rate, and so on. They have not had a distinguished record of action under that policy. The leadership in the central Government of India has not been dynamic, you might say. While there have been quite a few local clinics and research projects which have been impressive and valuable, the Government of India has not in fact succeeded to this date in mounting a significant national family planning program. That situation is changing.

Over the last year the Government of India, the central government, has come to understand much better than it did before, the nature of the problem. They had a group of United Nations consultants out there about a year ago. Dr. Leona Baumgartner, who was then with AID, was one of the members of that group. That commission made a series of recommendations to the Indian Government. There have

been changes in the Ministry of Health's organizational pattern. And in the recent months I have seen figures which indicate that for the first time there are now quite substantial programs underway.

In five of the Indian states over the last 3 or 4 months, the rate at which families were coming to the clinics and were deciding to participate in the program and were adopting one method or another for regulating the number and the spacing of their own children and the rate at which families were deciding to participate compares favorably with the rates in the early stages of the Korean and Taiwanese programs 3 or 4 years ago.

This is very encouraging news. It is very preliminary. We shouldn't bank too much on it. But it does indicate the likelihood that the Indian Government's program has in fact begun to move as it has not over the last decade or so.

There is no question about the seriousness with which the present Indian Government faces this problem.

Dr. Moseman or Dr. Merrill, would you like to add to what I have said?

Dr. MOSEMAN. I think India is also a country which is an example of the effective cooperation between AID and private organizations. The Ford Foundation has an extremely active program in India. Our mission director and his colleagues in New Delhi are keeping in close touch there, and we have an excellent cooperative relationship in that country.

GRUENING HOPEFUL FAMILY PLANNING PROGRAMS IN INDIA WILL SUCCEED

Senator GRUENING. Well, I would think in view of the massive aid which has recently been voted to India by the United States, that this would be the time when this program could really be advanced, and where it is so desperately needed in a race between starvation and population. There is perhaps the outstanding example of the population dilemma. I am hopeful that this will progress there.

Mr. BELL. Could I ask Dr. Merrill to add a word?

Senator GRUENING. Yes, indeed.

Dr. MERRILL. Mr. Chairman, I might indicate from an administrative standpoint we are really getting into position now to begin moving in terms of technical assistance to India. We have the director of the health services selected now. He has been out in India for the past month and will be going out on a continuing basis late in May. We will have initially a team of five or six technical experts to work with him in the AID mission in India. Thus, we will be in a much stronger position to bring all of the resources we have in AID immediately into play to assist not only the central government but the various states of India, which as Mr. Bell has indicated, are beginning to move.

Senator GRUENING. Now, Mr. Bell, you indicated in your statement that AID did not make contraceptive devices available. If they were asked for by the Indian Government, would you feel free to give them?

INDIA PRODUCING CONTRACEPTIVE DEVICES

Mr. BELL. We have legal authority to, sir, but as a matter of policy we would not do so, and we do not think it is necessary. The contra-

ceptive devices are relatively inexpensive. They are in fact being produced now in India in ample numbers so there is no requirement for us to do this.

The private organizations that are active in this field are prepared to provide contraceptives as and where that would be appropriate.

The Swedish Government is also prepared to assist in this area. We have set this policy limitation on ourselves, and we do not think that it in any sense has been or will be a limitation on the effectiveness of our support for these programs.

AID ADMINISTRATOR STRESSES NEED AND COST OF TECHNICAL ASSISTANCE AND TRAINING

The costly elements and the important elements that we can provide and do expect to provide are: first of all, in the fields of technical assistance and training. There are going to be very substantial numbers of persons involved in a country like India. There will be thousands and thousands of people who will need training, most of them in India but some of them, especially those who will need advanced and specialized training, may well receive training here in this country. We will be glad to provide that.

There will need to be advisers from here in substantial numbers, and the United States, as this committee knows better than anybody else, is not well equipped at the present time with large numbers of persons who are expert in this field.

One of the best things, one of the most important things AID has done so far, is to provide funds to North Carolina and Johns Hopkins Universities to enlarge their training programs, so that there will be larger numbers of Americans who are competent to deal in these difficult and complex fields in the future.

We are quite prepared to make funds like that available to other schools as well as to North Carolina and to Johns Hopkins.

TRANSPORTATION EQUIPMENT ESSENTIAL IN RURAL AREAS

Secondly, and in addition to the work of technical assistance and training, there will be need for substantial volumes of transportation equipment. When you are working in rural areas you have to enable people to get around. The loan, as I have referred to in my statement that the Turkish Government has asked us for, is almost completed. It will provide for over a thousand jeeps which will be needed for the workers in the rural areas of Turkey. A similar proposal is being considered right now by the Government of India. Assistance comparable to that being given in Turkey may well be helpful here also.

So I don't think our position on contraceptives is a significant deterrent. At least it has not been thus far.

If it becomes so, we will reconsider.

Senator GRUENING. What you are saying is although AID does not itself supply contraceptive devices there will be no shortage of them where there is a demand for them.

Mr. BELL. Exactly.

Senator GRUENING. In other words, they will be supplied through the local agencies of the government or through private enterprise. Is that correct?

Mr. BELL. Precisely. That is our expectation.

INCREASING DEMAND FOR FOOD HAS TWO SOURCES: EXPANDING POPULATION, GRADUALLY RISING INCOMES

May I, sir, before we go on, add one other point relative to something you said a couple of minutes ago, about the race between population and food supply? I think it is very important for everyone concerned with this subject to recognize that the increasing demand for food in the developing countries has two sources. One is the growth in population, which is very important in many cases. But in addition to that, the growing demand for food stems also from the gradually rising incomes in these low-income countries.

When families of very low income manage to get a little more income per week or per month, they put a substantial part of that increase in income into the purchase of more and of better foodstuffs. It doesn't take place in the United States. We all eat too much already and if we get more income, typically a very small part of it goes into more or better food.

There are some low-income families in the United States where the contrary would be true. But the great majority of the American people do not face this problem.

But in India as a family that receives a couple of rupees a day, or 50 cents a day, increases its income to 2½ rupees a day, a significant part of that additional half rupee is likely to end up as demand for more food and for richer and better food. That is a very significant element in the increasing demand for food.

So even if the output of food in India rose at the same rate as the population growth, that would not solve the food problem in India. That is the point I am making. We would still face a significant food problem. The output of food has to rise significantly higher than the population growth rate if we are to meet the real requirements in countries like India as they are developing.

Senator GRUENING. I understand in other aspects of your AID activities you are doing what you can to stimulate increased agricultural activities.

Mr. BELL. We are, sir; that is right.

Senator GRUENING. Indonesia—I imagine we have no activities there at the present time.

Mr. BELL. No, sir, we certainly do not; and I do not know what the current situation is in Indonesia.

Senator GRUENING. Iran?

Mr. BELL. We have an aid program in Iran. I don't recall offhand this element of it, and I will be glad to put something in the record.

Senator GRUENING. Israel—we have no further aid program there?

Mr. BELL. No.

Senator GRUENING. The Ivory Coast?

Mr. BELL. Can't say, sir.

Senator GRUENING. Jamaica?

JAMAICA SETS UP PRIVATE FAMILY PLANNING SERVICE

Mr. BELL. In Jamaica there is a private family planning service which has, with the approval of the government, begun to establish clinics on the island. We have provided some assistance in health education. This is a very new activity, which is just starting. It

is too soon to tell how effective it will be, but it has begun and we are providing help to it.

Senator GRUENING. Jordan?

Mr. BELL. I couldn't say about Jordan offhand.

Senator GRUENING. Kenya?

Mr. BELL. No, I don't know about Kenya.

Senator GRUENING. You have mentioned Korea.

Mr. BELL. Yes, sir.

Senator GRUENING. There is a good deal of activity there?

FAMILY PLANNING PROGRAM IN KOREA—"A VERY GOOD PROGRAM"

Mr. BELL. There is. Korea has a population of over 25 million, twice as large as Taiwan. Therefore, at the present time Korea is the largest of the developing countries in which there is a major program underway and it is a very good program. It has reached a very large part of the population, and it is moving right ahead. There are over 2,000 fieldworkers in Korea trained to work in the clinics and in the mobile health units which are moving in the rural areas in that country.

AID HELPS FINANCE HEALTH LEADERS' VISITS FROM DEVELOPING COUNTRIES TO TAIWAN AND KOREA

People who are running the health and family planning programs in Korea are very impressive as individuals. They and the Taiwanese Health Ministry people are being visited, as they should be, by delegations from other developing countries all the time in order to transmit the information about what has been done in their countries. We are helping to finance, incidentally, many of those visits of health leaders from other developing countries to Taiwan and Korea in order to see firsthand the results of the programs.

Senator GRUENING. Lebanon?

Mr. BELL. Couldn't say about Lebanon, sir.

Incidentally, Lebanon is another program where economic assistance was terminated some years ago.

Senator GRUENING. Liberia—do we have any activity there?

Mr. BELL. We have an economic assistance program in Liberia. I don't know anything about this particular element of it. I will be glad to put something in the record.

Senator GRUENING. Libya?

Mr. BELL. No, Libya's program was terminated last year.

Senator GRUENING. On account of their vast oil resources?

Mr. BELL. Exactly.

Senator GRUENING. Malaysia?

Mr. BELL. We have no economic assistance program in Malaysia. The Malaysians don't have vast oil resources, but they have a strong economy and they are moving ahead well. I will put in the record whatever we have in the way of information about it.

Senator GRUENING. Mali?

Mr. BELL. I couldn't say about Mali.

Senator GRUENING. Morocco?

Mr. BELL. Nor do I know about Morocco.

Senator GRUENING. Nepal?

Mr. BELL. I beg your pardon?

Senator GRUENING. Nepal?

Mr. BELL. I don't know anything about Nepal. I will be glad to put it in the record.

Senator GRUENING. Nicaragua?

Mr. BELL. I couldn't say offhand.

Senator GRUENING. Nigeria?

Mr. BELL. No, I don't know about Nigeria. It is a very large country. We have a very active program there. I just don't have in my hand what this aspect of it is.

Senator GRUENING. Pakistan? The Swedes are helping there very considerably.

AID HAS A COORDINATED PROGRAM OF ASSISTANCE WITH SWEDEN FOR PAKISTANIS

Mr. BELL. Yes, and so are we. At least we have begun, I should say, a series of steps to assist the Pakistanis on their request in this field. There are some people from the Health Ministry in Pakistan, either here now, or arriving next month, under a training arrangement. We have been discussing with the Pakistanis quite a sizable and substantial program of assistance in transportation equipment and educational, technical assistance, and training. All of this has been carefully discussed with the Swedish authorities so that we are working out a coordinated program of assistance. There have been sizable activities in Pakistan over recent years—by the Population Council, the Ford Foundation, I don't know about Rockefeller—so that there is quite a promising situation there.

PRESIDENT AYUB OF PAKISTAN BELIEVES FAMILY PLANNING PROGRAMS IMPORTANT

However, like India, in Pakistan there has not in fact been an effective program in the past. President Ayub and other leaders have made it quite plain that they do want and that they do believe it is important to conduct effective family planning programs. Those are still in the planning stage, still on the drawing board, and are not yet widespread and active.

Senator GRUENING. Panama?

Mr. BELL. Can't say about Panama.

Senator GRUENING. Paraguay?

Mr. BELL. No; I don't know about Paraguay.

Senator GRUENING. Peru? I know that the President, President Belaunde Terry, is quite interested in this program.

Mr. BELL. We have some research activity there. Notre Dame, for example, under our research financing has some field work studies underway in Peru. I am not aware of any significant public or private activity in Peru that we could or should be helping at the present time.

Senator GRUENING. Philippines?

Mr. BELL. There is considerable internal discussion going on in the Philippines at the present time, and our health people in our AID mission in Manila have been involved in this discussion to some extent. There is, however, no official program and no decision as yet as far as

the Government of the Philippines is concerned. There are private activities beginning in clinics and that sort of thing.

Senator GRUENING. Portugal?

Mr. BELL. Sir?

Senator GRUENING. Portugal?

Mr. BELL. Portugal, sir, does not receive economic aid, and has not for more than 10 years. I don't know what the situation is there.

Senator GRUENING. What about Somalia?

Mr. BELL. Somalia is an AID recipient all right, but I don't have the information offhand.

Senator GRUENING. Spain has been receiving a lot of economic aid.

Mr. BELL. We did provide aid, but not since 1962.

Senator GRUENING. You are giving military aid, aren't you?

Mr. BELL. There is a military assistance program, yes, sir, at the present time.

Senator GRUENING. But as far as you know, there is no activity in the field of contraception?

Mr. BELL. I just don't know, Mr. Chairman. I am sorry.

Senator GRUENING. You don't know what the attitude of President Franco is, do you?

Mr. BELL. I couldn't say.

Senator GRUENING. Sudan?

Mr. BELL. In Sudan we have an aid program. I don't know the situation in family planning.

Senator GRUENING. Surinam?

Mr. BELL. I don't believe we have an active economic aid program in Surinam. I think the Dutch, whose colony it is, are primarily responsible there.

Senator GRUENING. You give some aid to colonies even before they are independent, don't you?

Mr. BELL. Sometimes; yes, sir. We have in the past in Surinam, but we do not at the present time.

Senator GRUENING. Syria?

Mr. BELL. We have no assistance program in Syria at the present time.

Senator GRUENING. Tanganyika?

Mr. BELL. We do have an assistance program in Tanganyika. I don't think we have anything in this field.

Senator GRUENING. Thailand?

Mr. BELL. I don't recall the situation in Thailand. I have been there recently and I should have it in my head.

Dr. Moseman says there is nothing significant. We will fill out the record there.

Senator GRUENING. Tunisia?

TUNISIA INTERESTED IN FAMILY PLANNING

Mr. BELL. Yes; there is now considerable interest in Tunisia. There have been strong policy statements by the leaders of the government. There is a good deal of planning underway at the present time. They have a very dynamic Minister of Health who wants to start a major program. The Population Council, the Ford Foundation and AID—we have all been counseling with them as to how that might best be done. I do expect we will be active in Tunisia. We have indicated to

them we are prepared to consider any request they may make to us for assistance. But it is somewhat like Pakistan or India—well, not as far along as India. It is a case where the government is gearing itself up, is making ambitious plans, but they are still at that stage and they do not yet represent active current programs.

Senator GRUENING. It was my observation in Tunisia that this is one of the countries where the AID program is being best administered, and best handled.

Mr. BELL. I appreciate that, sir.

Senator GRUENING. And it is not a country with very great resources.

Mr. BELL. That is right; it isn't.

Senator GRUENING. But apparently they have a good spirit.

Mr. BELL. Yes, they do.

Senator GRUENING. And an honest administration.

Mr. BELL. That is right, sir.

Senator GRUENING. What about Turkey? You mentioned Turkey before.

TURKEY MODERNIZES ITS LEGISLATION TO INCLUDE FAMILY PLANNING

Mr. BELL. Yes. Something over a year ago the Turkish Government made a very significant and historic change in its national policy. This has been something like the change, I guess, in the attitude of the United States in recent years.

In Turkey a few years ago this was regarded as a field in which the government should take no part and, indeed, in which the legislation was negative rather than positive.

But the legislation was changed. It was a formal act of Parliament which authorized the undertaking of family planning, programs of information and help by the government, by the health ministry. Over the last year or so careful and detailed plans have been made, again with help from the Population Council. Today there is a good strong plan which the Turks are beginning to put into effect. They have asked us, as our part of the program, primarily to provide a large number of jeep vehicles for rural health workers who will need to travel in the countryside all over Turkey. The loan application is now in its final stages, in fact it may have been approved in the last 2 days. Anyway, it is all clear and will go ahead.

The only problem we have had about it is to be sure that there were plans that we could count on for keeping the jeeps in order and well maintained and running. This is a substantial motor pool for a ministry of health to operate, and we want to be sure that they will end up with vehicles that are in usable condition all the time and not simply a lot of "deadlined" jeeps.

They have also asked us for various kinds of technical assistance and we will be glad to do what we can along those lines, too.

Senator GRUENING. What about the United Arab Republic? I know there has been some activity there.

PRESIDENT NASSER STRESSES UNITED ARAB REPUBLIC CONCERN ABOUT POPULATION

Mr. BELL. Yes, sir; there, again, there is a very strong government policy that President Nasser has reiterated on a number of occasions.

The action program of the Government of the United Arab Republic is just in the stages of being laid out. They are, say, a year behind Turkey, something like that. They are serious. They do want to proceed in this field, and they have had recent conversations in Cairo. John Rockefeller was there and we had a team at the request of the Government of the United Arab Republic, Dr. Maslowski of Dr. Merrill's staff, who is now, incidentally, assigned to work in India, along with Dr. Taylor from Johns Hopkins. They were there for 3 weeks to size up the situation and to talk with the Egyptian Government about the ways and means by which we could be helpful. We stand ready to advise them or to offer such assistance as might be appropriate.

There is nothing as concrete as the request for vehicles from Turkey as yet, because the program in the United Arab Republic has not yet developed as firm and definite a form and outline as the program in Turkey.

Senator GRUENING. What about Uruguay?

Mr. BELL. I couldn't say about Uruguay, Mr. Chairman.

ECONOMIC PROBLEMS IN URUGUAY

Senator GRUENING. They seem to be having economic trouble down there.

Mr. BELL. Yes, although in recent weeks the situation has looked a little better. It is a very difficult problem.

Senator GRUENING. Venezuela?

Mr. BELL. I couldn't say about Venezuela, sir.

Senator GRUENING. I suppose there is no use discussing Vietnam in this context since it is in a state of chaos and war.

Mr. BELL. I think that is probably right. The medical services in Vietnam are being very extensively aided, of course, by the United States. There is no formal national program in this particular field.

Senator GRUENING. Well, I haven't mentioned all the countries. There are some like Algeria, Saudi Arabia, Yemen, which you may want to add and I would like to have you include if there is anything to be said about them in the field of birth control.

And if you would give us this summary of the various countries to which aid is going, to the extent that you have it, and where there is none, just so state. Give us an idea of what is being done presently and what the prospects are, so that we can have an idea of what is going ahead. I will ask the Department of State to supply information about family planning in the developed countries.

Mr. BELL. All right, I will be glad to do so.

(Preliminary information on the countries referred to follows. The concise surveys of family planning activities currently existing in the principal nations of the world as compiled by the Agency for International Development and the Department of State with the assistance of the Population Reference Bureau, the Population Council, Planned Parenthood—World Population, the Population Crisis Committee, and the International Planned Parenthood Federation, Western Hemisphere Division, appear on pp. 1007–1061. The delay in obtaining the information, which was not readily available, made it necessary for the subcommittee to hold up publication of the 1966 hearings. The surveys were sent to the subcommittee on October 14, 1966.)

EXHIBIT 137

PRELIMINARY SURVEYS OF AID POPULATION ACTIVITIES IN THE IDENTIFIED COUNTRIES

Through FY 1966, AID will have supported family and population planning activities in cooperating countries to the following extent:

Brazil.—Government and educational leaders have expressed an interest in developing professional resources in both research and training in population and related fields. Private institutions such as The Catholic University in Rio are planning fertility and attitude studies concerning population problems. The University of Bahia and the University of Brazil are conducting research in reproductive biology; the University of Sao Paulo is developing a demographic research training center with the assistance of the Pan American Health Organization and AID. In addition, AID is considering providing assistance to help: (a) Establish a National Population Center in one of the major universities to carry out training and research in this field and developing training and research programs in other institutions; and (b) Train a cadre of demographers and medical personnel for related teaching and research. By the end of FY 1966 AID will have provided $213,000 in technical assistance, participant training and commodities.

China (Taiwan).—Taiwan has no official government policy on family planning, but the central government has informally endorsed the family planning program. The Taiwan program has resulted from initial pilot projects partially financed by the Population Council. The current program is financed by the Council and the Joint Commission for Rural Reconstruction (JCRR), a semi-autonomous agency in Taiwan. An island-wide program has been in effect since 1965, and the goal is to cut the birth rate by 50 percent in the next 5 years.

AID's economic assistance program was terminated in FY 1965, and no AID dollar funds or technicians have been provided for the population program. However, the family planning program has been and will be financed in part by AID-generated local currency which has now been placed in a Special Fund in control of Chinese officials. For the years 1965–1970, the equivalent of U.S. $1.5 million has been reserved from this Fund for health and family planning clinics.

Costa Rica.—Costa Rica's Ministry of Health has expressed interest in a health-oriented program for the development of basic demographic and clinical statistics. Consideration also is being given to a program of mobile health clinics in rural areas including family planning services; also, to studies on communication of information to low income groups, particularly in rural areas. In cooperation with the Ministry of Health, AID is financing a study which currently is being carried out by the American International Association for Economic and Social Development (a local private organization), on popular attitudes toward family planning. The University of Costa Rica is also collaborating in the design of the project and in the analysis of the data. AID expenditures for assistance in this field through FY 1966 will have totalled $97,000.

Ecuador.—The Planning Board of the Government of Ecuador is developing a statistical model showing the relationship of population to various aspects of the country's economic development and is sponsoring a poll of public opinion concerning population problems. AID is providing $25,000 for the services of population consultants during FY 1966 as may be requested by the host government.

El Salvador.—Support will be provided for an educational program in family planning. The Government of El Salvador and a private family planning association will participate in the project. AID financing will cover costs of supplemental salaries of local personnel, participant training and medical and administrative supplies ($40,000).

Honduras.—The Government of Honduras has made available government facilities for family planning services which include 17 health centers, three hospitals and mobile health units in outlying rural areas. Upon request, AID is providing assistance in support of the program by supplementing salaries for medical and statistical personnel, transportation and training ($29,000).

India.—Population control is a new area of cooperation between AID and India. The first direct AID assistance was provided by one member team of consultants who visited India early in 1965 in response to a government invitation. The team reviewed progress to date and studied central and state Govern-

ment plans, organizational structures and facilities for population control efforts. Tentative plans for a joint USAID/India review in September 1965 of what kind of assistance might best be provided by AID were disrupted by the war between India and Pakistan. In February 1966, Dr. Franz Rosa, a U.S. Public Health Service Officer who is being assigned to India as Chief of the Public Health Division of the USAID, went to India to review the size of the problem and to determine the areas in which AID assistance could be most effective.

The Indian Government informally has asked us to consider a loan for vehicles to increase the service area of family planning technicians. While there is no doubt that lack of transportation hampers family planning activity, we do not yet know whether this is the most serious and immediate bottleneck, or whether India can develop a system for effective maintenance and utilization.

Iran.—During the period FY 1956 through FY 1962 AID provided advisory services to the Government of Iran in planning, carrying out and evaluating the results of the first national census of population. AID in FY 1965 provided consultant services in preparation for the 1966 census and will provide advisory services in taking the census and in its evaluation.

Jamaica.—The Government of Jamaica has actively encouraged the provision of advisory and other family planning services to those who desire them since 1964. In support of these activities and in accord with the policy of the Government of Jamaica, AID will have provided $159,000 through FY 1966.

Korea.—Since 1963 the Korean Government has included a family planning program in its budget. The Government plans to reduce the population growth rate from 2.9 percent to 2.0 percent a year by 1971. The Ministry of Health and Social Affairs operates about 190 health centers throughout the country and employs over 2,000 workers in the family planning field.

The Korean Government has made several specific requests for assistance from the U.S. To date AID assistance consists of:

1. AID-generated local currencies which support a substantial portion of the Korean Government budget which includes family planning as a line item. In FY 1966 the Korean Government has allotted 423.1 million WON (about U.S. $1.6 million) for the program.
2. Ten vehicles from U.S. excess property to be used as mobile clinics (these do not require AID dollar funding).
3. Four thousand dollars for a trip by Korean officials to observe family planning activities in Hong Kong, Taiwan, and Japan (the funds were provided from the Far East Regional Program funds).

Pakistan.—The Government of Pakistan has established a family planning program under its Third Five-Year Plan (1965–1970). The government has requested assistance from the United States. U.S. health advisors in Pakistan are devoting part of their time to assisting the Family Planning Council to formulate their plans. AID is considering assistance in FY 1967 concentrating on administrative and public health aspects of the program. The proposed assistance includes sending a team of family planning specialists and providing training for nurses, health educators and family planning organizers.

A portion of the FY 1966 commodity loan may be used to provide vehicles and miscellaneous equipment for the program.

Peru.—In 1964 Peru established the National Center for Population and Development. The Center serves as a focal point for demographic research, including studies of attitudes and levels of knowledge of various groups in the country. It also trains demographers and other specialists in population problems, and supplies population information necessary for planning and implementing development programs. Through FY 1966 AID will have provided $96,000 in assistance to this Center. In addition, AID has appointed a full-time population officer to work with the personnel of the Center.

Tunisia.—AID is assisting the Tunisian Government in its National Family Planning Program by furnishing short-term advisory services in health education and communications media. The financial and technical assistance from other donors is being provided by The Ford Foundation and The Population Council and follows upon assistance to the Government in an experimental program which began in 1963 and continued through 1965. In the next 2 years the Tunisian Government plans to provide 120,000 to 160,000 family planning devices to women of child-bearing age. The Government's financial contribution will be approximately $140,000 in 1966.

Turkey.—In early FY 1966 AID received a loan application from the Turkish Government requesting assistance for its family planning program. The Turkish

Government is seeking assistance in bringing its program to the rural areas where 75 percent of the population lives.

AID has prepared a loan agreement, which is in its final stages, for $4 million. Most of these funds will provide transport vehicles for mobile units to serve rural areas. A portion of the funds will be for educational aids.

U.A.R.—In the fall of 1965 the Government of the U.A.R. requested U.S. assistance. AID sent two short-term consultants to Cairo in January 1966 to determine types of assistance that might be furnished.

AID anticipates providing in FY 1967 administrative and technical guidance for creating an effective family planning organization and for developing educational programs.

Other Countries.—To date there has been no substantial contribution to family and population planning activities in the following countries currently receiving AID assistance; Algeria, Bolivia, Burma, Cameroon, Ceylon, Chile, Congo (Leopoldville), Cyprus, Ethiopia, Ghana, Haiti, Israel, Jordan, Kenya, Liberia, Mali, Morocco, Nepal, Nicaragua, Nigeria, Paraguay, Philippines, Somalia, Sudan, Tanzania, Thailand, Venezuela, and Yemen.

EXHIBIT 138

(Letter from Mr. William S. Gaud, Acting Administrator, Agency for International Development, in response to Senator Ernest Gruening's letter of June 4, 1965, requesting information on AID's work in the population area.)

DEPARTMENT OF STATE,
AGENCY FOR INTERNATIONAL DEVELOPMENT,
Washington, D.C., June 17, 1965.

Hon. ERNEST GRUENING,
U.S. Senate,
Washington, D.C.

DEAR SENATOR GRUENING: Thank you for your letter of June 4, 1965, requesting information on steps taken by the Agency for International Development in the poulation field.

I am sending along a short summary of Agency activities focussing on the current fiscal year. Also, please find enclosed additional papers that may be of interest, bearing on Agency studies, plans, and technical assistance programs in population work.[1]

Please let me know if we can be of further assistance.

Sincerely yours,

WILLIAM S. GAUD,
Acting Administrator.

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(1) AID ACTIVITY IN THE FIELD OF POPULATION

On January 4, 1965, President Lyndon B. Johnson said in his state of the Union message: "I will seek new ways to use our knowledge to help deal with the explosion of world population and the growing scarcity of world resources."

AID and its predecessor agencies have for a long time been concerned over the implications of rapid population growth rates in less developed countries for the achievement of their social and economic goals. This history of AID assistance in the statistical, demographic and public health fields now being used by certain countries as a basis for population studies and family planning programs is summarized in Dr. Philip R. Lee's speech of March 11, 1965 (Attachment 2). He went on to outline the assistance in the population field now available, on request, through AID Missions. Particular attention was called to the following:

> the importance of having each AID Mission assign one of its officers, as Latin American Missions had already done, to become familiar with the problems of population dynamics and program developments in the country and to keep the Mission Director, Country Team personnel and AID/Washington appropriately advised;

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[1] EDITOR'S NOTE.—The attachments are numbered 1 to 11, pp. 876–963.

the fact that AID does not advocate any particular method of family regulation, and that freedom of choice should be available in any program for which technical assistance is requested;

that requests for AID assistance in this field, as in others, will continue to be considered only if made by or approved by appropriate host government authorities;

that AID is now prepared to entertain requests for assistance in the family planning field including technical, commodity, and local currency assistance;

but that AID will not consider requests for contraceptive devices or equipment for manufacture of contraceptives.

Experience has made it clear that the cost of these latter items is not a stumbling block in countries that are developing effective programs.

Population officers have been appointed in each of AID's Regional Bureaus. Since March 4, 1965, these population officers have sent to the field follow-up information on population meetings; bibliographies of information available through AID/Washington in the population field; participant training opportunities in family planning and midwifery, and in demography and measurement of population change available in the Children's Bureau of Health, Education, and Welfare, the Census Bureau of the Department of Commerce, and the U.S. Public Health Service.

AID Staff.—In FY 1965, it is estimated that the time equivalent of eight full time staff positions was allocated to the population field by AID/Washington. This included major investment of time by Senior Staff; AID consultants in the field of demography, public health and economics; staff in the Office of Technical Cooperation and Research; in the Office of Program Coordination; and in the Regional Bureaus. Important allocations of staff time were also made by AID Mission field personnel, particularly in India, Pakistan, Republic of Korea, Republic of China, The Philippines, Thailand, Colombia, Costa Rica, Chile, Peru and Jamaica.

In AID/Washington, the population activities have in FY 1965 been centered in the Population Reference and Research Branch of the Health Service in the Office of Technical Cooperation and Research (TCR) and in the Latin American Bureau Population Office. These two special units employ three full-time experts as well as consultants. The units serve as focal points for coordination of population activities, dissemination of information, in policy and program development, and for liaison with multinational public and private groups in the population field.

With the high priority now assigned to responding to requests for assistance in the population field, an expanded staff is currently being organized for AID population programs. An enlarged population service in TCR is planned which will be staffed with fulltime professionals in the fields of public health, demography, and the social sciences, as well as administrative assistance. In the Program Coordination Office of AID/Washington, additional assistance will be provided by an Associate Assistant Administrator and the equivalent of a fulltime staff assistant. Specialized consultants will also continue to be used as needed. It is planned that each Regional Bureau will develop a fulltime staff for operational backstopping of country population programs. This was accomplished in February of 1964 in the Latin American Bureau, which is developing a group of experts in the various disciplines in the population field through negotiation of AID contracts with the Universities of California, Notre Dame, Michigan, Johns Hopkins, and North Carolina; contracts with the Population Council; and through participating agency service agreements with U.S. Government agencies, particularly the Department of Health, Education, and Welfare, and the Bureau of the Census.

The AID/TCR Office of Research and Analysis has a full time physician on its staff in the health and population field, and an advisory committee on population dynamics research. The committee is reviewing research requirements, particularly in the economic and program evaluation fields.

Provision of full time AID Mission population officers for FY 1966 and additional AID personnel to assist in studies, analysis and family planning program implementation in requesting countries is under active discussion in six Latin American AID Missions, as well as in the most populous countries of the Near East-South Asia AID Region.

Training.—Funding has been provided by AID in FY 1965 for assistance to meetings on population of private organizations in Puerto Rico in March 1964,

and in Seoul, Korea in May of 1965. As noted above, through participating agency service agreements with the U.S. Public Health Service, the Children's Bureau, and the Census Bureau, new training courses in vital statistics, midwifery and family planning and demography are being financed by AID and will be available to foreign students in September 1965.

Contracts have been negotiated in FY 1965 by AID with the University of California, Notre Dame, Johns Hopkins University, and the University of North Carolina for the development of training programs in the various disciplines required in population study and programs. These training programs are being developed for foreign nationals and for U.S. students.

The Latin American Bureau Population Office has negotiated a number of contracts with universities, the Pan American Health Organization, and multinational organizations for the expansion of training in the population field in Latin America and in the United States (Attachment 9).

During the year, field consultations to AID Missions have been provided by AID/Washington staff from TCR, the Latin American Population Office, and AID population consultants. These consultations were provided to the Missions in South Korea, Taiwan, The Philippines, Thailand, Nepal, India, Pakistan, Iran, Turkey, U.A.R., Peru, Chile, Brazil, Venezuela, Colombia, Costa Rica, Jamaica, Kenya, Uganda, and Ethiopia.

A meeting of AID's population officers from the Latin American countries was held in Puerto Rico in April 1965 in order to provide them with information on AID's expanded policies. From June 7 to 11 1965, a seminar on population dynamics was held at Johns Hopkins University School of Hygiene and Preventive Medicine for a review of existing country programs in the population field, and consultation with American universities, foundations, and private agencies (Attachment 8). AID staff attended from all 4 Regions. A booklet for distribution to all AID personnel, based on the week's discussion at the Johns Hopkins conference, is currently being prepared and will be ready for distribution this fall. An "AID Population Program Guidelines Paper," for distribution to all AID Missions, is currently in preparation and the target date for distribution is July 1965.

Funding.—For FY 1965, besides the heavy inputs of local currency used by such countries as South Korea and Taiwan for health and family planning programs, the assistance in statistics and demography provided by AID to nine countries through a participating agency service agreement with the Census Bureau of the Department of Commerce, and the time given by Mission, Regional, TCR, PC, and AID consultants, the AID Population Reference and Research Branch budgeted $1,230,000 for the present year. These central funds were allocated in large part for development of U.S. university capability in the population field in consultation, training and studies, support of international private organizations' regional population meetings, meetings of AID staff, and studies for the AID advisory committee on Economic Development. An example of an AID Mission allocation of local currency was the $54,000 released by JCRR for the development of a population training program and statistical evaluation study in Taiwan. This work is being supervised by the University of Michigan.

The activities carried on through the $1,031,000 budgeted in the past year for population studies and training by the Latin American Bureau are detailed in Attachment 9.

With the extension of AID technical assistance to direct family planning program support, it is anticipated that requests from less developed countries to AID Missions will in the next fiscal year total several million dollars. Informal discussions with the Governments of Pakistan, India, and Turkey have, for example, indicated the need and desire for USAID financial support of programs to train family planning workers in large numbers; U.S. consultants in all fields bearing on development of country-wide family planning programs; field research; program evaluation; transportation and mass communication equipment; and funds to supplement professional salaries for family planning workers.

Liaison population activities.—Communications have continued throughout the year through TCR and the Latin American Bureau. Population Office with the United Nations and member agencies, particularly the Pan American Health Organization, World Health Organization and the Economic Commission for Asia and the Far East; with American university population programs as they develop; with the Population Council, Rockefeller Foundation, Ford Founda-

tion, International Planned Parenthood Federation, Planned Parenthood-World Population, The Pathfinder Fund, and with church and other organizations, both international and domestic.

Especially since the state of the union address, AID has maintained close communications with other U.S. Government agencies in the population field. This has been particularly true of the staffs of the State Department, the U.S. Census Bureau, the Children's Bureau, the National Institute of Child Health and Human Development, National Center for Vital Statistics, the Science Advisor's Office, the Peace Corps, the Office of Economic Opportunity, and the Department of the Interior.

Summary.—The immediate impact and long term implications of world population increases are sobering and are recognized as such by our Government, by other governments of the world, and by private leaders concerned with human welfare. The problem is complex. Simple, instant solutions neither exist nor are in sight. Until recently, international activity in the field of technical assistance in family planning was undertaken only by private organizations, agencies and foundations. The past year has seen the extension of technical assistance, on request, into the field of population control programs by the World Health Organization, the United Nations, other governments, and the expansion of the assistance long offered by the Agency for International Development. It is the objective of AID to move ahead constructively in this field, with careful and deliberate consideration of all the economic, social, and human relation issues involved.

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(2) AID Policies on Population

[AID, DEPARTMENT OF STATE, MARCH 2, 1965]

1. What is the U.S. policy on population?

On January 4, 1965, President Lyndon B. Johnson said in his state of the Union message: "I will seek new ways to use our knowledge to help deal with the explosion of world population and the growing scarcity of world resources."

2. Does AID *advocate* family planning policies for developing nations?

No. AID's role is *not* that of an advocate. The U.S. opposes any effort to dictate population policies to another country.

On their own initiative over the past several years, growing numbers of less-developed countries have either instituted operating programs in the field of family planning or are considering such programs. There are major programs underway in India, Pakistan, Korea, Taiwan, Ceylon, Hong Kong and Jamaica. Pilot programs or significant action-research programs are being carried out in Thailand, the United Arab Republic and Tunisia.

3. Does AID advocate any particular method of family planning?

AID does not. It is the U.S. position that in publicly-supported health services, every family should have complete freedom of choice in accordance with its conscience with respect to what methods, if any, it uses.

4. Does AID regard the adoption of official family planning policies as a self-help condition for receiving U.S. aid?

No.

5. Does AID volunteer assistance to other nations on family planning?

No. AID assistance is provided on specific request only. The growing concern with population problems has resulted in an increasing volume of informal requests for information and assistance in relation to this problem.

Requests for assistance in this field, as in others, will be considered only if made or approved by appropriate host government authorities. Such assistance would, in any case, merely be additive to the host country's own efforts and assistance from other sources.

6. What assistance will AID provide?

AID has long given assistance in the development of health services and the training of health personnel. Asssitance has also been given in developing official statistics, including population censuses and vital statistics. In February 1965, AID provided a $400,000 grant to a Latin American research center in Santiago, Chile, Centro para el Desarrollo Economico y Social de America Latina, for studies in family size and population growth.

Since 1962 AID has encouraged the collection and analysis of population growth data and study of attitudes about family planning, but until recently requests for information and assistance in family planning have been referred to appropriate private agencies.

AID now considers requests for technical assistance including the training of family planning workers. Where appropriate, the requests will continue to be referred to private agencies.

AID will also consider requests for commodity assistance. AID will not consider requests for contraceptive devices or equipment for manufacture of contraceptives.

Items that could be provided by AID include vehicles and educational equipment for use in maternal and child health and family planning programs. We are also prepared to receive requests to assist in local currency financing of such programs.

7. What countries have already requested assistance from AID?

In addition to requests for demographic help and assistance to public health programs, AID has received indications that requests may be forthcoming from Pakistan, India, South Korea, Taiwan, and possibly other countries. These involve such items as vehicles, educational equipment, local currencies, and technical assistance.

8. How is AID organized to provide assistance?

Requests for assistance will be handled, as in any other field, on a case by case basis.

Agency headquarters has furnished AID missions with general reference materials and technical publications dealing with a wide range of subjects from demography to family planning.

The Population Reference and Research Branch, organized in the Health Service of AID's Office of Technical Cooperation and Research (TCR), serves as the AID focal point for information and coordination in the population field. Consultants have been appointed in the demographic, economic, medical, and public health aspects of the population field.

The Latin America Bureau created a Population Unit and requested each Latin American AID Mission to appoint an officer to be responsible for population matters.

Every AID mission is being instructed to assign one of its officers, as Latin America missions have done, to become familiar with the problems of population dynamics and program developments in the country and to keep the Mission Director, Country Team personnel and Washington Headquarters appropriately advised.

9. Is AID the only source available to the less-developed countries for assistance with population problems?

By no means. Substantial assistance has been made available by private institutions. Leadership has come from the Rockefeller Foundation, the Ford Foundation and the Population Council, for action research projects in Puerto Rico, India, Jamaica, Pakistan, the Republic of China on Taiwan, Korea, Tunisia, Chile and Thailand.

In addition several foreign governments offer assistance in family planning programs upon request from developing countries.

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(3) The Role of Health Programs in International Development

(By Dr. Philip R. Lee. The full text of the paper appears in part 1, Population Crisis Hearings, 1965, pp. 87–93)

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(4) Population Growth Trends in Less Developed Countries

BACKGROUND PAPER

1. *The population problem.*—In the last three years the United States Government has joined other countries and international organizations in public expressions of concern about the economic and social consequences of rapid population growth at home and abroad. The United Nations reported in August 1944 that the annual world population increase now amounts to 2.1 per cent a year, the highest yet recorded. Continuation of present trends will result in even higher rates of growth. Economists point to specific deterrent effects of rapid growth on development efforts in agricultural production, housing, urbanization, and employment. Educators emphasize the problems of providing education

for increasing numbers of children. Health personnel are concerned about the preservation of the levels of health that have already been achieved.

Present annual rates of population growth are two to three per cent a year or more in most of the countries of Asia, Africa and Latin America. In many countries, growth is resulting in a doubling of the population in less than twenty years. Per capita economic growth has been disappointedly slow over the last decade, even with considerable foreign assistance. The incomes of the majority of agricultural families are close to subsistence levels. Major segments of the population are in dependent age groups. (See Attachment 1)

In the last fifteen years, death rates have fallen swiftly. Birth rates have changed slightly, if at all, in LDCs. The steadily mounting concern with rapid population growth rates has been shared by multi-national agencies, governments, private institutions, and leaders of all religious groups.

2. *Present prospects for slowing population growth rates.*—In the last three years developments in methods of fertility control have made effective family planning attainable by people at any developmental level. Continuing research in human reproduction makes it probable that more effective and more widely acceptable means will become available in the near future. There is general agreement that family planning methods and population policy decisions are matters for individual countries and individual families to determine. Today a country which determines to reduce its birth rate through a national population program has available to it the technical resources to do so.

Using a variety of modern methods, with over half of the families electing the intra-uterine device, and with an extensive network of health services, South Korea and Taiwan hope to reduce their population growth to half its present levels in the next three to five years. The programs rely on studies and demonstrations that have been in progress for several years. The present outlook is hopeful. With the expected success of these programs, a reassessment of the outlook for fertility control and population growth in LDCs is taking place.

Even with present methods of fertility control, reduction of rates of population growth in the LDCs may be relatively slow. Some computations may serve to indicate the size of the task involved in reducing birth rates. One-sixth to one-seventh of the total population of a country with a high birth rate consists of women in the reproductive ages. From studies and experience in the last five years it is estimated that 30 to 45 per cent of the eligible women (those who are not pregnant, not lactating or sterile, and who do not want more children) will accept family planning the first year a program reaches them. There are necessary time lags between government decisions and effective programs. "It will take a year from the government authorizing decision until a field team is recruited, trained, and organized, supplied and ready for work on any substantial scale. A minimum would be 100 field workers of various levels, to cover a population of one million in cities, and 160 field workers for the same group in rural areas. It will take another year before the problems are worked out of the program, and it settles into effective and efficient operation. It will take five years of action to make a major impact on the birth rate.[1] Pakistan's most recent government fertility control plans and projections, with five years' work already providing a baseline, has a goal of preventing five million births within five years. (See Attachment 2)

As regards costs, present estimates are that with existing methods and with a network of health services already present, a mass government-sponsored fertility program, such as Korea is conducting, costs in the range of 5 to 10 cents (U.S.) per capita per year (total population). It is estimated that a program such as that in South Korea costs $10 to $20 per birth prevented. Econometric analysis indicate that with assumed hypothetical conditions, the economic return of a birth prevented is substantially greater than the cost of the prevention.[1]

3. *Present assistance available for LDCs in the population field.*—Increasing resources, particularly in research and training, are being made available by multi-national, public and private organizations. Fertility control program development assistance and support is provided chiefly by private United States resources.

(*a*) *Multi-national agencies.*—The United Nations General Assembly in 1962 unanimously adopted a resolution recommending demographic research and training assistance, but it specifically withheld recommendations for technical

[1] The material and estimates in these paragraphs appeared in a paper by Dr. Bernard Berelson, Vice President of the Population Council, September 1964, "National Family Planning Programs".

assistance in family planning. The vote was tied, 34 to 34, with 32 abstentions. The March, 1964 meeting of the ECAFE Council recommended to the U.N. General Assembly that the U.N. expand its technical assistance to include family planning programs. In a meeting on September 2–4, 1964, an *Ad Hoc* Committee of Experts appointed by the Secretary General of the United Nations to consider long-range programs of work in the field of population unanimously adopted a report that included assistance in birth control programs to countries requesting it. The specific recommendations are abstracted from the report of the Expert Committee here:[2]

"The United Nations must play a wider and more active role in population fields than it has played up to the present time—a role commensurate with the growing importance attached to population problems by Governments, especially those of developing countries, and with their increasing needs for assistance in seeking solutions.

"While the United Nations should refrain from espousing any particular policies with regard to population or attempting to promote the adoption of any such policies by Governments, it should be recognized that many Governments are now concerned with the formulation of national policies and operational programmes relating to population growth. The needs of Government for assistance in their work in this field should be taken into account in drawing up the long-range programme of work. The United Nations and its specialized agencies should expand the scope of assistance which they are prepared to give upon the request of Governments in work on all aspects of population questions, including demographic training, the collection of basic statistics, research, experimentation and national action programmes.

"Provision for expanding the scope and increasing the extent of technical assistance in population fields available to Governments of developing countries upon request should be a major feature of the long-range work programme. Assistance should be provided for work on all aspects of population questions including, *inter alia*, the formulation and execution of family welfare planning programmes and other population policy measures.

"In many countries, assistance in efforts to control fertility is now regarded as no less essential for national welfare than assistance in the control of mortality factors. The increasing responsibilities of the United Nations and the specialized agencies in population fields require a major expansion of staff and resources. The activities in research, technical assistance, training and services must be markedly increased."

This report is being considered by the Secretary General of the United Nations in current plans for more adequate staff and expanded programs in the population field.

(*b*) *Bi-national assistance other than the United States.*—A few governments, particularly Sweden, are giving limited professional support to fertility control programs at the request of the governments of Ceylon, Tunisia, Pakistan and India.

(*c*) *United States assistance programs.*—

(1) *U.S. private agencies' assistance programs.*—Thus far the Rockefeller and Ford Foundations have set aside over $30,000,000 for research, training and program support in the population field. The Population Council has established a career Technical Assistance Division; it is recruiting 25 to 30 scientists from the fields of economics, the social sciences, and medicine to be available as consultants to governments or other groups seeking assistance. Mr. Rockefeller, on September 22, 1964, before the OAS Ambassadors Population Meeting in Washington, stated: "Only government has the organization and the resources to deal effectively with the population problem on the scale required." (See Attachment 3)

Among U.S. private organizations active in the population field are the Population Reference Bureau, Planned Parenthood-World Population, Hugh Moore Fund, and Milbank Fund.

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[2] U.N. Economic and Social Council, Population Commission "Report of the *Ad Hoc* Committee of Experts on Long-Range Programme of Work in the Field of Population", pages 3 and 14, October 1, 1964. It should be noted that the Experts included two from Latin America, and one from the USSR. The Chairman was a Yugoslav.

United States industry is also currently investing in research in fertility control methods.

(2) *United States Government.*—Support of reproductive biology research has doubled in the past year through N.I.H. supported studies to over $6 million this year. This is in addition to N.I.H. career fellowship training grants and laboratory facility subsidies. In 1964 the United States made a voluntary contribution of $500,000 to the United Nations to provide support for basic research in human reproduction. In census work and demography the U.S. has for several decades, and is now, through A.I.D., financing consultation and training programs of the Bureau of the Census in the Department of Commerce, assisted countries in improving data collection. The Alliance is currently assisting in the support of the U.N. Regional Demographic Training Center (Celade) in Chile.

Through extensive technical assistance in the field of public health, through educational and training program support, development of health facilities, and through general budget support, e.g., Taiwan and South Korea, the U.S. Government through A.I.D. has indirectly paved the way for support of national fertility control programs. Informally, there have been many inquiries as to what activities A.I.D. will support.

With the development of Population Reference Units as focal points in (a) the Latin American Region in January 1964, and (b) in June, 1964 in TCR, the following steps have been taken:

(*a*) Field consultations on request by LA Population consultants with representatives of governments, church, A.I.D. missions and LA universities, and with the Ecumenical Council in Rome. The appointment of a population officer in each LA/A.I.D. mission or embassy with responsibility for liaison, coordination and information. As a result of these steps, requests for A.I.D. funding of over 100 separate actions to support population research and training in LA have been received. Budgets of $995,000 for FY 1965, and $1,200,000 for FY 1966 for LA Population Unit have received approval.

(*b*) In the Population Reference Branch of the Health Service of TCR, efforts have involved: (1) assistance to the Office of Program Coordination and the Regional Bureaus and USAIDs of the FE, NESA, and Africa by providing a focal point for coordination within the Agency and with public and private groups concerned with population problems; (2) negotiations with HEW for the establishment of population and family planning training programs for vital statisticians and nurse-midwives from LDCs; (3) organization of a seminar on population matters for A.I.D. personnel; (4) negotiations with three U.S. universities and private foundations for development of population institutes through which training, research and technical assistance to support LDCs' fertility control and population programs can be provided; (5) a research project involving the Bureau of the Census, the University of Pittsburgh, and a family planning consultant is underway, and others are being considered.

For 1965 TCR/PRRB has budgeted $1,230,000; for 1966 $1,550,000.

CHRONOLOGICAL LIST OF DEVELOPMENTS IN THE POPULATION FIELD, 1952–1964

1952: The Government of India announced a government fertility control program.

1952: The Population Council was established with the support of Rockefeller and Ford Foundation.

1959, August: The Draper Report. (The President's Committee to Study the United States Military Assistance Program.) Vol. I, p. 96: "We recommend: That, in order to meet more effectively the problems of economic development, the United States (1) assist those countries with which it is cooperating in economic aid programs, on request, in the formulation of their plans designed to deal with the problem of rapid population growth, (2) increase its assistance to local programs relating to maternal and child welfare in recognition of the immediate problem created by rapid population growth, and (3) strongly support studies and appropriate research as a part of its own Mutual Security Program, within the United Nations and elsewhere, leading to the availability of relevant information in a form most useful to individual countries in the formulation of practical programs to meet the serious challenge posed by rapidly expanding populations".

1959: The Government of Pakistan launched fertility control programs.

1960, March 22: ICA Airgram XA–758 quoted President Eisenhower's statement at News Conference of December 2, 1959: "I cannot imagine anything more emphatically a subject that is not a proper political or governmental activity . . . This government . . . will not . . . as long as I am here, have a positive political doctrine in its program that has to do with this problem of birth control. That's not our business."

1962: The Government of Turkey invited Population Council consultants to study and advise on development of fertility control programs.

1962, August 1: Current AID Manual Order on Population became effective this date. Development Manual Order 1018.2, "Special Programs and Policies: Problems of Population Growth," states: "USAID Missions have two significant roles to play in this field. . . . AID is prepared to assist census and other demographic assessment and evaluation efforts where, in the USAID's judgement, population increases will have a significant impact upon the development prospects of a country. . . . Secondly, when requested by host governments, USAIDs should recommend potential sources of information and of assistance on the ways and means of dealing with population problems. For the immediate future, reference might best be made to the United Nations, to governments with experience in the field of population control such as Sweden and Japan. and to interested private foundations such as the Population Council, Inc., Planned Parenthood, and the Ford Foundation."

1962, December 10: Richard Gardner, in a speech before the UN, stated the US Government policy of concern and urged population research, offering to "help other countries, upon request, to find potential sources of information and assistance on ways and means of dealing with population problems", and emphasizing the need for more knowledge. This speech was summarized in AIDTO A–173 of 27 December 1962.

1963, February: Establishment of the new National Institue of Child Health and Development, US Public Health Service, HEW, with responsibility for government funding and stimulation of research in reproductive biology and fertility.

1963, April 17: Report of the National Academy of Science Committee on Science and Public Policy, "The Growth of World Population", p. 2: "Other than the search for lasting peace, no problem is more urgent."

1963, April 24: President Kennedy, at a News Conference, dealt with sociobiological aspects of the problem; referring to "research in the whole area of fertility, biological studies, reproduction and all the rest", the President stated that that there are important studies at N.I.H. which should be continued. He further stated that we should know more about the whole reproductive cycle and that this informaion should be made more available to the world so that everyone could make his own judgement.

1963, May 11: AIDTO Circular A–360, remarking on the President's statement and other population developments, stated: "AID recognizes that . . . aspects of the population problem affect directly economic and social development, and the plans and prospects of aid-receiving countries. AID is therefore willing to consider requests for assistance in the form of (1) support to research activities and to the building of research institutions in the developing countries themselves which deal with statistics, demography, social science, the relationship between population trends and national development; and (2) technical assistance which aids developing countries in preparing, executing, and analyzing population censuses, and in utilizing demographic data and analyses in social and economic planning, through training of experts and technicians from the developing countries, or by making advisers available."

1963, August 10: AIDTO Circular A–44 requested information on the following points: "a) Does the country have demographic information and institutions adequate to meet the requirements for data necessary for development planning? b) If not, has it asked for assistance in institution building; if not, why not? c) If it did ask, when, and what happened to the request?"

1963, October 26: President Eisenhower declared in a *Saturday Evening Post* article: "When I was President I opposed the use of Federal funds to provide birth control information to countries we were aiding because I felt this would violate the deepest religious convictions of large groups of taxpayers. As I now look back, it may be that I was carrying that conviction too far. I still believe that as a national policy we should not make birth control programs a condition to our foreign aid, but we should tell receiving nations how population growth threatens them and what can be done about it."

1963, December 16: Address by Dr. Leona Baumgartner, head of the U.S. delegation to the UN's Asian Population Conference: "Will we continue to hold academic conferences, view the future with uncertainty veiled in gloom, or stress the inadequacy of our data? The clear, loud answer of Asian countries has been *no*. . . . In many countries (which have determined on a Family Planning program) the most urgent need is the fullest possible application of what is already known. Thus, the technology of various methods of regulating pregnancies and the statistical evaluation of Family Planning programs is well developed. . . . I suggest that we ask ECAFE to call appropriate conferences, workshops on different aspects of action programs, such as: (1) the practical problems involved in planned migration and settlement, (2) educational methods and programs in family planning, . . . (6) methodology for the development and evaluation of pilot and demonstration projects as well as large-scale operating programs, and (7) the problems of administration and organization of large-scale operating programs."

1963, December: Passage of the Foreign Assistance Act of 1963. Section 105 of this Act adds the following subsection to Section 241 of the Foreign Assistance Act of 1961: "(b) Funds made available to carry out this section may be used to conduct research into the problems of population growth."

1963, December: Address by USUN Ambassador Adlai Stevenson to Planned Parenthood/World Population: "We are always hearing predictions about future increases in population, only to discover a little later that the predictions were on the conservative side . . . There are not many areas in which governments and international organizations move creatively to lead public opinion in new directions . . . population problems provide one of the rare opportunities. . . . The limited resources of the United Nations are insufficient for this purpose. . . . Our own government . . . will help other countries, upon request, to find sources of information and assistance. . . . AID is in a position to refer requests for medical assistance in the population field to appropriate agencies of the U.S. Government, . . . to private organizations, to Universities, and to Foundations."

1964, January: AID's Latin American Bureau established its Regional Population Reference Unit. Field consultations with Latin American government, church, University, Medical, and AID Mission leaders initiated.

1964, April 17: AIDTO Circular XA–1149 sends to the Missions a list of books and references on population and family planning to be supplied by AID.

1964, April 19: Deputy Assistant Administrator William Rogers' Puerto Rico address to the International Planned Parenthood Federation, with all Latin American countries represented.

1964, May 11: AIDTO Circular LA–158 directs the appointment of a high official in each AID mission to be responsible for population programs, liaison with AID/W, and encouragement of study of population problems by host governments; emphasizing AID interest in training, research, and institution-building assistance in the population field, the Airgram quoted a statement by President Kennedy in his foreign aid message to Congress, March 22, 1961, in relation to Latin American population growth rates: "Latin America will have to double its real income in the net 30 years simply to maintain the already low standards of living".

1964, May 28: Dr. Leona Baumgartner's address to the International Conference on Population at Johns Hopkins: "Swift development of official population policy at the regional level within the United Nations system is again a response to the facts of population pressure and population growth in the (Asian) region . . . The United States Government believes that all federally supported health facilities should provide freedom of choice in family planning".

1964, May: The 88th Congress passed legislation providing funds for District of Columbia Family Planning clinics.
1964, June: Population Reference and Research Branch of TCR Health Division instituted.
1964, July: South Korea launches a massive government fertility control program based on intra-uterine devices.
1964, July: Rockefeller grant to the Population Council for development of a 30-man career consulting team, to provide technical assistance to government and private population programs.
1964, October: Meeting in New York of the UN *Ad Hoc* Committee of Population Expert. Their Report recommends to the UN General Assembly the expansion of present research, training, and technical assistance.
1964, October 4: The Medical Advisory Committee of the International Planned Parenthood Federation unanimously adopted the following resolution: "Whereas in the opinion of the Committee the effectiveness, acceptability, and safety of the intra-uterine devices have now been demonstrated, it is recommended that these devices be used by member organizations of the International Planned Parenthood Federation."
1964, October: AID receives informal requests for technical assistance in fertility control programs from India, Pakistan, South Korea, Turkey, and the United Arab Republic.
1964, November: Ex-Presidents Truman and Eisenhower accept positions as co-chairmen of the honorary sponsors' council of Planned Parenthood/World Population, Inc.
1964, November: Request by the Health Division of AID/Karachi for a decision on availability of technical assistance to aid in Pakistan's fertility control program.

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(5) National Programs To Control Population Growth

The importance of decreased fertility to most developing countries is well established.[1] The critical questions now are by what means, to what level, at what time and at what cost can the people of these countries actually lower their fertility rates. World experience in solving this problem is so limited that no one knows the answers, but persons familiar with what has been learned are sufficiently agreed on what needs to be done next to warrant greatly increased technical assistance in 1965 to meet rising demands from countries relying upon the United States Government for foreign aid.

The basic problem is the deterrent effect of high population growth rates upon the rates of economic, social and human development. Population growth is, of course, the sum of the differences between births and deaths on one hand and between in-migration and out-migration on the other. For most of the developing countries, international migration is insignificant and can be ignored. Death rates are slowly (sometimes rapidly) and steadily declining as nutrition, sanitation, education, housing and health services are improved. It follows that population growth rates will be decreased only if birth rates can be made to decline more rapidly than death rates. Yet, current efforts to lower birth rates are minuscule compared to the attack upon death and disease. National programs to lower fertility require similar elements to those of other programs in health and related fields.

They face not only the same deterrents but additional ones, because birth control does not have the same social acceptance or technological development as disease control. Health priorities of the North Atlantic countries do not apply here and should not be applied. A world-wide fertility control campaign of at least the magnitude of the world-wide malaria eradication campaign is required and is nowhere yet in sight.

A review of what developing nations have tried is best understood relative to knowledge of the major factors affecting fertility rates.[2] The range of actions that might be taken is wider than the range of actions that have been taken.

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[1] Edgar M. Hoover and Mark Perlman: Companion work paper for AID.
[2] Kingsley Davis and Judith Blake: Social Structure and Fertility: An Analytic Framework, Econ. Dev. and Cultural Change, 4: 211, 1956.

Imaginative new approaches to raise the age of women at marriage and at first birth, to make use of all kinds of direct and indirect economic incentives, to maximize the present child-spacing effect of lactation, or to provide challenging alternatives for women to the repeated production of children, for example, could contribute significantly to lower fertility.

PRESENT STATE OF CONTRACEPTIVE TECHNOLOGY

All these and all other promising avenues should be explored but the most hopeful and most actively pursued is the development and large-scale application of modern contraceptive technology. Despite disregard until very recently of research and development in reproductive processes and control by the developed nations, important new methods are becoming available and the priority for research in this field is becoming meaningful.[3]

The ideal birth control method is one which, as actually used by large numbers of people, completely prevents pregnancy, has no deleterious effect, requires no repeated thought or action or supplies and no specialized manpower, does not prevent subsequent wanted pregnancies, and is universally acceptable. How far from this ideal have been the principal birth control methods available in the world until the present decade is shown in Table 1. The condom and diaphragm and vaginal spermicides, withdrawal and rhythm, while useful supplements, as are sterilization and abortion, are not the answer. With such techniques it is remarkable that even a well-educated people, highly motivated to limit family size, as were the people of North America and Europe during the 1930's, could have achieved the low fertility rates that they did.

TABLE 1.—*Common birth control methods*

Method	Effectiveness delet. effect			Difficulties of use			Reversibility	Relative cost
	Pregnancies per 100 years	Early	Late	Repeat action	Repeat supply	Prof. hours per 100 years		
Intrauterine	1 to 3	NA	?	0	0	10 to 25	Y	1
Oral steroid	1 to 3	NA	?	D	Y	10 to 25	Y	24
Condom	5 to 15	0	0	C	Y	0	Y	6
Diaphragm/jelly	5 to 15	0	0	C	Y	10 to 15	Y	8
Aerosol foam	10 to 30	0	0	C	Y	0	Y	8
Withdrawal	10 to 30	0	0	C	0	0	Y	0
Jelly or cream	20 to 40	0	0	C	Y	0	Y	7
Foam tablet	20 to 40	0	0	C	Y	0	Y	6
Rhythm	20 to 40	0	0	C	0	0	Y	0
Sterilization	Below 1	(1)	0	0	0	NA	N	NA
Abortion		(1)	0	P	P	NA		NA

[1] Surgical.

NOTE.—D=daily, C=each coitus, P=each pregnancy, Y=yes, N=no, NA=not applicable. This is a simplified summary of data available from various sources, principally publications of Tietze, National Committee on Maternal Health; Calderone: Manual of Contraceptive Practice, Williams and Wilkins, Baltimore, 1964; Proc. Second International Conference on Intrauterine Contraceptive Devices, New York, 1964 (in prep.). Scientific field evaluations of birth control methods have been notoriously few and weak in the past, the best data being on intrauterine and oral. Data on relative acceptability are lacking. All have some acceptability worldwide. Diaphragm use has been highest in United States of America. Rhythm is the only method accepted by the Roman Catholic Church. Sterilization tends to be used by families of high parity. Abortion is legally available on a large scale in only a few countries, such as Japan and Eastern Europe.

The importance to national programs of developing countries of having simple methods of high use-effectiveness cannot be over-emphasized. Not only do they make possible an early visible dent in the birth rate [4] of populations where family planning is not yet widely accepted, but also the larger proportion of satisfied users accelerates the person to person spread of the idea that leads to wider

[3] National Academy of Sciences: The Growth of World Population. Analysis of the Problems and Recommendations for Research and Training, Publication 1091, Washington, D.C., 1963.

[4] Mindel Sheps, Amer. J. Public Health, 1963, 53 : 1031–1163.

use. Much greater efforts should be made to stimulate and support creative laboratory research that could lead to new methods and prompt, high quality field research of new methods that give promise in the laboratory. Usable immunization techniques, chemicals affecting sperm in the male, new steroids, chemicals affecting implantation of the ovum in the female and improved prediction of the time of ovulation to make the rhythm method more effective are all likely to become available in the next decade. The key fact now is that with present intrauterine and oral methods and the more effective older methods, we already have the contraceptive technology suitable for large-scale application. The immediate task is to make this technology available to the millions of people throughout the world who already want it.

PRESENT NATIONAL PROGRAMS

Few countries have yet adopted national policies on family planning and implemented them with national programs, and the experience of those few has neither been long nor fully evaluated. In particular, even the basic data on numbers of births and deaths which we take for granted do not exist in many countries where application of modern sample survey techniques to obtain precise national and regional estimates is prerequisite to knowing what the birth rate is and whether it is changing. Simplified basic information about present national programs is summarized in Table 2 and is followed by a brief summary of each.

TABLE 2.—*Present national programs*

Country	Year begun	Present population (millions)	Birth rate	Program budget		Principal foreign aid program
				U.S. (dollars) million total	U.S. (cents) per capita	
Japan	1948	97	17	[1]	[1]	
India	1956	470	45	6	1.3	FF
Pakistan	1959	105	50	1.7	1.6	PC, FF, RSG
Korea	1962	25	Over 40	.8	3.2	PC
Taiwan	1964	12	36			PC, US, AID
Turkey+	1965	30	40 to 45	1.0	3.3	PC, FF

[1] Not available.

NOTE.—This is a simplified summary of information available from various sources specified for each country in the subsequent text.
FF=Ford Foundation, PC=Population Council, RSG=Royal Swedish Government, +=Pending legislation.

Japan can properly be said to be the first nation with a national program, dating from the Eugenic Protection Law of 1943. This law permitted (1) sterilization for eugenic purposes, (2) induced abortion by designated physicians for health hazards and (3) instruction in conception control. A 1949 amendment permitted abortion for socio-economic conditions combined with possible health hazards. A 1952 amendment eliminated the requirement for a designated physician to obtain authorization from a local official committee. Coupled with the free or partially subsidized health services provided most women through government or industry, these made properly performed abortions, sterilization and contraception available to most families. The number of reported legal abortions rose rapidly over the decade, 1949–59, to approach the number of live births and the birth rate dropped from 33 to 17. Although use of contraceptives has also steadily increased, legal abortion remains the principal birth control method to date. Little administrative machinery is required beyond that already present to finance the various health services (which are largely provided by private physicians) and to finance and operate the educational and eugenic protection consultation services of health centers and hospitals throughout the country. Any estimate of program cost is difficult because

budgets of the various government funds involved do not specify this single element of care, other than a few hundred thousand dollars for Eugenic Protection Consultation services.

It should be made quite clear that the experience of Japan is unique in Asia, in that public motivation, education and technologic development were all far advanced before 1948.[5,6]

India's national program is best dated from the first appointment of a Central Family Planning Board and a Director of Family Planning in the Ministry of Health, in 1956, although funds for experimentation and development were included in the First Five Year Plan, 1951–56. The Second Five Year Plan, 1956–61, concentrated on building the organizational framework in the Ministry of Health and the states; on mass education through posters, pamphlets, films, exhibits, meetings and village leaders' camps; on extension of traditional family planning clinics; on training of health staffs in family planning; and on further research in demography, reproductive physiology and communications. About ten million dollars were allocated in contrast to the 1.3 million of the First Plan. The Third Five Year Plan, 1961–66, states that population control is "at the very center of planned development" and allocates about 57 million dollars for the program (later somewhat reduced because of the Chinese emergency). Further administrative staff and field workers are provided at central, state, district and community development block levels. Efforts are made to tie family planning administratively closer to community health services and to extend family planning education and supplies outside of the clinics into the villages, with prime reliance still on rubber condoms and vaginal foam tablets. A central Family Planning Institute was established in 1962 to coordinate and expand research and evaluation. A National Institute of Public Health Administration and Education was established in 1964 to spearhead greater training and education. A few states have also developed sizeable programs of surgical sterilization. In 1963 the program goal was stated to be the reduction of the birth rate in India to 25 births per 1000 population by 1973. During 1961–66 the Ford Foundation is providing overseas development support of about ten million dollars, including a sizeable force of American consultants. Precise estimates of the present birth rate of India or of changes since 1956 are lacking.[7,8]

Pakistan initiated a national program of family planning in 1959, just prior to beginning the Second Five Year Plan, 1960–65. The program adopted in the Second Plan was simple and similar to that of India. The program is proposed for twenty years, after which sufficient awareness, motivation and resources are anticipated to ensure continuing family planning without increased government support. The plan called for: (1) family planning added as a regular function of existing health services to 10 per cent of families of reproductive age with efforts concentrated initially in urban areas and with vaginal foam tablets and rubber condoms as principal birth control methods, (2) training of technical personnel, (3) publicity and education and (4) action research and demonstration projects assisted by American and Swedish aid. A budget of $6.4 million for 1960–65 was adopted, foreign aid of about $2.5 million was obtained from the Ford Foundation and the Royal Swedish Government, and the essential administrative units were created in health administration of the central and provincial governments. By the mid-point of the Plan, the program had fallen considerably short of its goals and serious re-evaluation was begun. The revised plan just adopted extends through the Third Plan (1965–70) and sets as its goal a 20 percent reduction in birth rate from the present 50 to 40. Intrauterine devices have been adopted as a major method following successful experience of a national cooperative study started in 1962. Administrative authority is placed with a Family Planning Commissioner, equal in rank to the Director General of Health, and from whom extends a highly decentralized separate chain

[5] Minoru Muramatsu: Some Facts About Family Planning in Japan, Pop. Prob. Research Council, Mainichi Newspapers, Tokyo, 1955.
[6] Irene B. Taeuber: The Population of Japan, Princeton Univ. Press, 1958.
[7] Lt. Col. B. I. Raina: Family Planning Programme. Report for 1962–63. Ministry of Health, New Delhi, 1963.
[8] Moye W. Freymann: Population Control in India, Marriage and Family Living, 25: 53, 1963.

of staff, tied closely to top civil officials at each level to the local (union) council. Maximum use is extended of private enterprise and of specific incentives for part-time program workers and for contraceptive users. Scarce medical resources are reserved for strictly medical functions and mobility is provided to extend them to the villages. The plan over-emphasizes conventional contraceptives, under-emphasizes training and sets impracticable goals for the first year, but is generally sound. An allocation of $63 million for 1965–70 has been made. Necessary technical assistance is being sought from several sources, including AID.[9 10 11 12]

Korea's first steps were taken in late 1961, with approval of a national policy in favor of family planning, of regulations permitting import and manufacture of contraceptives, and of a program of family planning which was rapidly implemented in 1962. The program provided for free contraceptive supplies (condoms and foam tablets), for the training of family planning workers and for the placement of one or more in each of the country's 182 health centers and all public hospitals. During 1963 and 1964 emphasis shifted to intrauterine devices. They are already being manufactured in Korea, and the rate of insertions continues to rise. The program is administered by the Ministry of Health, closely related to maternal and child health services. The current budget is about $800,000. The Population Council has been the principal source of foreign aid. Accurate knowledge of the birth rate is still lacking.[13 14]

Taiwan is actually not a country but an island province of the Republic of China. However, its special political position equates it sufficiently with some countries to warrant inclusion here. Following experience with pre-pregnancy field workers and a highly successful experimental family planning program in the provincial capital, Taichung (see ahead), a province-wide program making maximum use of intrauterine devices was initiated last year. Devices are manufactured in Hong Kong and insertions are rising rapidly. Almost $1 million have been budgeted for the proposed insertion of 600,000 devices in 5 years.[15]

Turkey has not actually launched its national program yet but appears close enough to be considered here. The First 5 Year Plan, 1963–68, includes measures of population planning and sets as a goal a decline of ten per cent in fertility every 5 years. A preliminary national survey on population has been completed and a Director of Family Planning appointed in the Ministry of Health. Implementation awaits the final stage of repeal of old Turkish laws forbidding information, importation or sale of contraceptives. Technical assistance has been largely provided by the Population Council, but is being requested also from the Ford Foundation, the Royal Swedish Government, and AID.[16 17]

INTENSIVE ACTION RESEARCH PROJECTS

Equally important as the world experience with national programs in formulating guides to action is the knowledge gained in the past decade from a variety of intensive action research projects on small populations. Further knowledge is available from a larger series of family planning surveys conducted in many countries on every continent, but it will suffice here to consider the most significant action projects. Detailed up-to-date reports on most of them are published periodically in the Population Council's Studies in Family Planning.

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[9] M. C. Balfour and Paul Harper: Report to Government of Pakistan on a National Family Planning Program, Population Council, New York, 1960.
[10] Government of Pakistan: Development Scheme: Family Planning Campaign, 1960–65, Planning Commission, Karachi, 1960.
[11] Population Council: Family Planning in Pakistan. Analysis of the First Three Years, Karachi, 1963.
[12] Enver Adil: Family Planning Scheme (revised). Government of Pakistan, Rawalpindi, 18 November 1964.
[13] M. C. Balfour et al.: Report to the Republic of Korea on the Family Planning Program of Korea, Population Council, New York, 1963.
[14] S. M. Keeny: Various 1964 Reports, Population Council East Asia Office, Taichung.
[15] Various reports from Taiwan Population Studies Center, Taiwan Provincial Department of Health.
[16] L. Corsa et al.: Report to the Republic of Turkey for a Population Planning Program, Population Council, New York, 1963.
[17] Nusret Fisek: personal report to AID, 1964.

TABLE 3.—*Intensive action research projects*

Place and country	Time	Population	University	Support
Puerto Rico	1951 to 1958	[1] 300	Puerto Rico and North Carolina	PC.
The Puerto Rican family project studied a large number of factors affecting fertility and included experimental educational programs.				
Ludhiana District, India	1953 to 1960	8,000	Harvard	RF, PC.
The India-Harvard-Ludhiana population study was designed to determine whether the population of rural India would practice a simple method of contraception sufficiently to make a significant change in fertility rates.				
Singur, India	1956 to date	7,500	All India Institute of Hygiene and P.H.	PC.
The Singur study provided education and birth control services through a health center and fieldworkers. The birth rate declined about 20 percent in 5 years in contrast to small shifts in the control area.				
Jamaica	1956 to 1961?	[1] 700	Cornell	CF, PC, NF.
The Jamaican family life project explored approaches to fertility reduction through educational techniques.				
Aluthama, Ceylon	1958 to date	7,000		RSG.
Diyagama, Ceylon	do	7,000		Do.
The Sweden-Ceylon family planning project is studying the effect of 2 pilot family planning programs. The birth rate has dropped ⅓ in Aluthama but remains unchanged in Diyagama.				
Lulliani, Pakistan	1961 to date	12,000	Johns Hopkins.	PC, FF, RF.
The medical social research project is studying the effect of an educational and service program through a rural health center, emphasizing community contacts and intrauterine devices.				
Dacca, Pakistan	do	5,000	California (Berkeley)	PC, FF.
The public health education research project is comparing male versus female, versus both channels in education and service to low-income government workers in government housing.				
Kotwali thana, Pakistan	1962 to date	6,500		PC.
The rural pilot family planning action program is part of a larger program of training and self-help for villagers by the Pakistan Academy for Rural Development.				
Taichung, Taiwan	do	300,000	Michigan	PC.
The Taichung program of prepregnancy health is studying the effectiveness of varying types, intensity and sex channels of educational programs and of the "cafeteria" choice of contraceptives through health centers, with emphasis upon intrauterine devices.				
Koyang gun, Korea	do	8,700	Yonsei	PC.
The Koyang family planning research project is studying the effect of education and service through a health center and fieldworkers.				
Tunisia	1963 to date			PC, FF.
Experimental introduction of various family planning programs in 12 of Tunisia's 14 district health centers.				
Santiago, Chile	1964 to date	100,000	Michigan	PC.
Photharam District, Thailand	do	73,000	do	Do.

[1] Sample.

DIRECTIONS FOR NATIONAL PROGRAMS

National programs to control population growth (i.e., to reduce fertility rates) require most of the same elements as other health, educational, agricultural, etc., development programs and can utilize much that has been learned in these related fields about transmitting appropriate technological advances from developed to developing areas. One critical problem in fertility control is the

minimal technological development that has occurred anywhere. Fertility control among people of the developed countries has been achieved without advanced technology and without organized programs; in fact, usually with governments and other social institutions in opposition. Those who try to give technical assistance in population control overseas need at the same time, to develop better technology at home. Indeed, we can look forward to the real possibility that superior technological development will at times take place overseas first and result in a beneficial reverse flow of ideas and practice to the developed countries. This has already occurred to a certain extent between Puerto Rico and the United States in oral contraception. Under these conditions a massive increase in research and development in the United States is essential and the charting of directions for national programs overseas can at best cover immediate steps and emphasize the necessity for exploration and experimentation with unusual need to insure that we learn as we go, worldwide. This does not mean that national programs should be mainly experimental in 1965. Quite the contrary, major effort should go into applying what we already know.

One basic condition is firmly established. All fertility control programs are based upon final determination of the number and timing of children by the individual family. All include information, education, motivation, persuasion, but none include or propose coercion. All programs thus face the formidable task of influencing millions of family decisions and making it easy for individual families to implement decisions to have fewer children.

One universal finding from the world experience just reviewed is that everywhere more families want to limit their fertility than have ready access to effective contraceptive technology. The first priority of national programs should be to make this technology available to already motivated families on a large scale. Since they tend to be the more educated living in urban areas near a country's best services, the first steps are easy. Since they tend to be large already, the immediate effect on the national birth rate will be small. The most effective contraceptive acceptable to the people should be used: those near the top of Table 1 plus sterilization and abortion in countries where they are legal and where medical resources are sufficient to perform them properly. The second stage of extending modern contraceptive technology to the present limits of a country's health services will be more difficult but entirely feasible with external technical assistance.

None of this is likely to occur, however, unless the government makes clear that the program is of highest priority. This means that the program at all levels of government is made the full-time responsibility of some of the country's most able and most trusted administrators in positions of high authority in an organization as close to the country's health administration as possible, and still be reasonably free from usual restraints to action and flexible enough to respond to change as experience warrants. It means the experience of five to ten cents per capita per year, including significant foreign exchange early. It means early and effective information and understanding from the top down to all important government officials, civic leaders and the medical profession at all levels, of the facts of the program and the reasons for it. It means special recognition and incentives and sufficient training and support for the many full-time and many more part-time (often illiterate) workers who will be required. It means taking scarce health personnel away from the care of the sick to provide those effective contraceptive methods requiring their skills. It means a sizable commitment of the mass media resources of the country. It means special efforts early for key organized groups such as teachers, soldiers and industrial employees. It means exceptions and incentives to ease the importation and manufacture of contraceptives and their subsidized distribution through regular commercial channels. It means difficult application of modern survey techniques for precise estimates of fertility rates. It means recognition from the start that knowledge in this field is more limited than in most others and that provision for experimentation to find best directions for future programs is vital.

TECHNICAL ASSISTANCE

Nor is much of this likely to occur without considerable technical assistance from outside. In no other field are the present world resources for assistance so restricted, because of past religious and political controversies about birth

control. To date, most of the response to requests for help with national programs has come from three American foundations (Population Council, Ford Foundation, Rockefeller Foundation), and the Royal Swedish Government (population seven million). They have made and will continue to make splendid contributions but do not have the resources or authority to provide the magnitude and kinds of assistance required as more and more countries press ahead toward large-scale national programs. A massive increase in such assistance must come from the United State Government and the other major bilateral and multilateral sources of foreign aid and from the appropriate international agencies.

The kinds of assistance needed are not basically different from those requested and required for other health development programs. They include for each country a five to ten year (occasionally more) commitment to providing the variety of expert technical consultants and special training essential for the development and perpetuation of a cadre of qualified and experienced nationals to run the program and the importation and local development of contraceptive technology and public information. Current activation of several new university population centers in the United States gives assurance that the technical consultants and American training resources, now in limited supply, will be ready. The foundation, while increasing their own support, have indicated that they need and welcome participation by the United States Government, too. Nothing would stimulate participation of other major developed countries and the international agencies more than knowledge of firm commitments by the United States.

The case for United States leadership in providing sizable high quality technical assistance to those countries who want help in reducing excessive population growth is today so strong as to be self-evident. Reductions of national birth rates of 10 to 20 percent in the next 5 years are feasible in countries who give their programs high internal priority and who receive prompt and effective assistance in utilizing presently available technology. No task before AID gives greater promise of achievement or is so vital to all other development objectives.

APPENDIX

The Case of Pakistan

Pakistan's national program of family planning began in 1959 with personal leadership from President Ayub Khan and strong support from his economic and health leaders and from leaders of family planning associations already at work in major cities.

Following the 1959 Government decision to develop an active program of family planning in the Ministry of Health, the Director General of Health, Brigadier M. Sharif, requested an advisory mission from the Population Council (U.S.A.). Drs. Marshall C. Balfour and Paul Harper visited Pakistan in late 1959 and by January 1960, completed a report and recommendations [1] which formed the basis of the family planning program adopted as part of the Second Five-Year Plan (1960–65).[2]

The aim of the 1960–65 Family Planning Scheme is to encourage parents to exercise birth control entirely on a voluntary basis. The birth rate was estimated to be 40–45 live births per 1,000 population per year but no program goal on reduction of birth rate was established. The program was proposed for 20 years, after which sufficient awareness, motivation and resources are anticipated to insure continuing family planning without increased government support. The program has four principal elements:

1. Family planning services and materials provided as an added regular function of existing health services to 1,200,000 families (about 10% of families of reproductive age) by July 1965, with efforts concentrated initially in urban areas and with foam tablets and condoms the principal birth control methods;

2. Family planning training of at least 1,200 technical personnel (doctors, nurses, health visitors) each year by four special provincial training institutes plus basic information to outlying personnel and village workers by two touring training teams plus American and Swedish fellowships to enable selected Pakistanis to return to key family planning posts in Pakistan;

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[1] M. C. Balfour and Paul Harper: Report and Recommendations to Government of Pakistan for a National Family Planning Program, Population Council, New York, 1960.

[2] Government of Pakistan: Development Scheme: Family Planning Campaign, 1960–65, Planning Commission, Karachi, 1960.

3. Family planning publicity and education carried out as an intensive drive by the central and provincial governments;
4. Family planning action research and demonstration projects assisted by American and Swedish aid.

To accomplish these goals, a development budget of 30.5 million rupees ($6.4 million) for 1960–65 was adopted. Foreign aid amounting to about 5.2 million rupees ($2.5 million) for 1961–64 was obtained from the Ford Foundation and the Royal Swedish Government and the essential administrative units were created in the health administrations of central and provincial governments.

By December 31, 1962, the halfway point of the Five-Year Plan, the program had fallen considerably short of its own goals. With regard to service, two-thirds of the halfway goal of 1,500 clinics in operation was met but only 165,000 families (one-quarter of the goal) were reported to have made initial visits for family planning services. The results in terms of repeat visits and contraceptives used were much lower. With regard to training of technical personnel, 313 (one-tenth of the goal) had been trained by provincial training institutes by December 31, 1962. An additional 6,500 persons had received some training from the touring teams and 32 Pakistanis had been abroad to Sweden and the United States on family planning fellowships. With regard to publicity and education, the proposed "intensive drive" did not occur, activities being limited to production and distribution of a few films, posters, pamphlets and billboards and some experimentation with the use of mobile publicity vans.

With regard to action research, a National Research Institute of Family Planning was established in the central government in 1962, but was only partially staffed. Its only research activity was a national cooperative study of plastic intrauterine coils. Two American-sponsored research projects were established early for intensive action research in small populations to identify various approaches applicable in the provincial programs. The first, called the "Medical Social Research Project," under the co-sponsorship of Johns Hopkins School of Hygiene and Public Health, was initiated in early 1961, and concentrated on what can be accomplished in conjunction with rural health centers, using Lulliani, near Lahore, the capital of West Pakistan, as the area for study. The second, called the "Public Health Education Research Project," sponsored by the University of California (Berkeley) School of Public Health, was initiated in mid-1961 and studies various educational approaches to lower-class government employees living in selected government housing areas of Dacca, capital of East Pakistan. By December 1962, they both had completed preparatory work and base line measures of population numbers and demographic characteristics of fertility and of contraceptive use, knowledge and attitudes and were initiating action programs to be supported for some time with continuing evaluation of results so that successful ideas could be applied and tested in larger programs in each province. Three Sweden-Pakistan family welfare projects were initiated in late 1961 and early 1962 to organize and supervise model clinics and to participate in the training of health personnel in conjunction with national or provincial family planning institutes in Karachi, Chittagong and Hyderabad.

President Ayub Khan concurred with recommendations during early 1963 to raise the priority given family planning in specific terms of higher administrative levels and of semi-autonomy of certain funds and personnel. A ministerial level Central Family Planning Council and similar Provincial Family Planning Boards were established in June 1963 and the Director General of Health in July 1963 endorsed intrauterine devices as a major method to be used but little else happened. In August 1964, Enver Adil, C.S.P., was named by the President to a new post of Family Planning Commissioner equal in rank to Director General of Health and was asked to prepare a new plan through the Third Five-Year Plan period, 1965–70. His plan, dated 18 November 1964, is in the final step of Government approval.

The 1965–70 Family Planning Scheme sets a goal of "reduction of the present annual birth rate from 50 per thousand to 40 per thousand and thus of the present annual (population) growth rate from (about) 30 to about 25 per thousand." It proposes to reach virtually all 20 million fertile couples in Pakistan by 1970, relying heavily on conventional contraceptives but including plans for 3 million intrauterine coil insertions and 100,000 sterilizations. It establishes a new corps of 50,000 village agents and supervisors closely tied to local and district government and makes maximum use of direct economic incentive (e.g., 50 percent

sales commission on conventional contraceptives). It limits use of scarce health personnel to service requiring their skills (e.g., coil insertions and sterilizations) and pays for them on an attractive fee-for-service basis. It includes limited public information activities to support and complement the village agent's work. The budget is increased tenfold over the Second Plan to 30 crores (300 million) rupees ($63 million) for 1965–70 or about 13 cents per capita during 1969–70.

The principal program elements and their 1965–70 budgets in crores of rupees are as follows:

A. Public information:	10.7
1. 2,000+ local FP officers, etc	(5.5)
2. 50,000+ village FP organizers	(3.5)
3. 52 district mobile publicity units	[1 2] (0.4)
4. Mass media publicity	[1 2] (1.2)
B. Conventional contraceptive distribution:	7.3
1. By 1 and 2 above with 50 percent subsidy.	
2. By private channels.	
C. Clinical contraception:	
1. 2,000 FP "doctors," 37 urban clinics, 800 part time rural clinics, etc	[1] (4.2)
2. 3,000,000 intrauterine devices	(0.2)
3. Transport (600 jeeps)	[1] (2.0)
4. 100,000 sterilizations	(0.4)
D. Administration:	
1. National	[1 2] 0.4
2. Provincial	[1 2] 0.4
3. District	1.2
4. Local	0.6
E. Training:	1.3
1. 12 provincial training institutes	[1 2] 0.7
2. Trainee costs	0.6
F. Research:	0.7
1. National Institute	[2] 0.3
2. Grants	0.4

[1] Some assistance needed from AID.
[2] Some assistance being given by FF, PC, or RSG.

Foreign aid requirements to date have been met by the combined efforts of the Ford Foundation, Population Council and Royal Swedish Government. Those efforts appear likely to continue at present or slightly higher levels but can no longer meet the total requirements. AID/Pakistan has already been informally requested to assist by providing expert technical knowledge, the mobile publicity units and jeeps, participant and other training support and counterpart fund support. Consideration is also being given to assistance in accelerating production of lady health visitors and trained midwives, to greater support of appropriate measurement of birth and fertility rates and to supplementing Swedish aid in mass media and other communications work if needed.

Attainment of the 1970 goal of a birth rate of 40 will be exceedingly difficult. The goal of "covering" all 20 million fertile couples is unrealistic. The goal of 3 million coil insertions is ambitious, but it is possible that by 1970, 15 percent of fertile couples (proportionately more in urban areas and less in rural areas) will be ready for contraception and distribution of qualified female manpower can surely be solved. One thing is certain. Without an appreciable increase in specific foreign aid, very little can be accomplished.

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(6) Population Growth

(Facts, Problems, and Strategies of Resolution, by Dr. Irene B. Taeuber, Demographic Consultant to the Agency for International Development)

The facts of population growth are now known in rough approximation for most of the less developed countries and regions. The appropriate preface to the discussion of problems and the strategy of resolution is a statement of some of

the rates of growth and the numbers of years that would be required for the populations to double if the rates continued:[1]

Area	Annual percent increase	Years to double
World	2.1	33
More developed areas	1.3	54
Europe	.8	88
Northern America	1.6	44
Oceania	1.7	41
Less developed areas	2.5	28
Mainland Middle America	3.8	18
Tropical South America	3.7	19
Southeast Asia	3.0	23
Middle south Asia	2.6	27
West Africa	3.3	21
Polynesia and Micronesia	4.0	17

The rates for the less developed areas are startling, even to those students in the field who should be immune to demographic shock.[2] Growth at high rates is pervasive, from the coral atolls of Micronesia to the rice fields of the Ganges, the delta of the Nile, and the cacao groves of Ghana. The mechanism is simple. Death rates declined, birth rates did not.

Rates of increase in specific years and the time required to double are not a sufficient basis for assessing problems as major as those of population growth. We shall therefore continue the discussion by considering the separate courses of birth and death rates and make it more incisive by limiting the illustrative computations to those for India and Pakistan. We present two estimates of future populations for each country. The first assumes a continuation of present trends, *i.e.*, that death rates decline while birth rates are stable. The second assumes that birth and death rates alike decline. The specific course of the birth rate is a reduction to half the present level between 1965 and 1995. The populations are in millions:

Year	Declining death rate, constant birth rate	Declining death rate, birth rate halved 1965–95
India:		
1960	432.7	432.7
1970	542.5	541.0
1980	694.2	661.5
1990	914.2	782.9
2000	1,233.5	908.0
Pakistan:		
1960	92.6	92.6
1970	121.0	120.6
1980	161.7	153.6
1990	222.8	188.5
2000	314.3	226.5

Continuation of the present trends would result in a trebling of the population of India by the end of the century, more than a trebling of the population of Pakistan. These estimates concern the years from 1960 to 2000. It is now 1965; trends have in fact been continuing from 1960 to 1965. Death rates have been declining; birth rates have not declined. If birth rates should now begin to decline and do so at the rate that occurred in Japan from 1930 to 1960, rates

[1] The statistics used in this note are taken directly from or based on the evaluated data and analyses of the Population Branch or the official data compiled by the Statistical Office of the United Nations.

[2] The relatively rapid growth in the United States, the U.S.S.R., and Australia and New Zealand along with Canada differs in magnitude and in kind from that in the less developed countries. This is the voluntary childbearing of highly modern people living in generally adequate if not affluent circumstances. Since the problems of internal policy are only indirectly relevant to international decisions, they are not discussed here in any detail.

would be half their present levels in 1995. The rates of population increase would decline somewhat, but the absolute increase would be enormous. Even with continually declining birth rates, the population of the subcontinent would increase from the 525 million of 1960 to 1.1 billion in the year 2000.

The hypothetical figures for India provide a frame for the evaluation of the problems of population growth, the role of population in the developmental strategies of the countries, and the feasibilities and responsibilities in international assistance, multilateral or bilateral.

It is not realistic to assume that present trends continue in India for four decades in the future, or even two decades. Populations have been dynamic and generally unpredictable components in changing economies and societies. In many of the less developed countries, including India, the levels of nutrition are such that the preservation of low death rates is unlikely unless there is rapid economic development. But if there is rapid economic development, the natural processes of change will reenforce the population programs of the governments to reduce birth rates. Hence birth rates will be likely to decline, although it is not possible to predict the rate.

The historic experience of the peoples of Europe and of Japan indicates that the halving of a birth rate in a generation of thirty years is a notable though feasible achievement. It is therefore permissible to assume for illustrative purposes that the birth rate of India is moving downward in 1965, and that it will reach half its present level in 1995. Even so, the net increase in the population of India in the forty years from 1960 to the end of the century would be almost half a billion people.

The vistas of the Indian future are stated to sharpen the focus on the problems of that future, not to predict it. Prophecies of demographic doom are not necessarily erroneous, but in the two and one-half centuries since Malthus wrote they have seldom accorded with the realities. There is no particular reason why they should do so in the next generation. Demographic continuity between the Asian past and the Asian future is neither likely nor possible. For India, as for many other countries, slow declines would be preferable to stability in the birth rate, but slow declines would not avert the hazards of population growth to economic development. For population, as for many other components in development, the patterns of the European past will serve neither as models nor as detailed guides to the Asian future.

DEVELOPMENT AND RECOGNITION OF THE PROBLEM

The implications of rapid population growth as it is now occurring are apparent, not alone for India but for other countries. Growth at two, three or even four percent a year cannot continue for any major period of time in countries already densely settled and handicapped by economic retardation, traditional societies, and limited educational levels. There is an empirical anomoly to this statement, for high birth rates and therefore the potential for high rates of growth occur only in underdeveloped countries. Modernization and high birth rates simply do not coexist. Backward economies, stable societies, and uneducated populations are not consistent with low birth rates. In fact, the level of the birth rate separates the developed and the underdeveloped nations of the contemporary world in sharp dichotomy.[3] No developed country has a birth rate above 30; no underdeveloped country has a birth rate below 30. If a country has a rate of growth of three to four percent a year, it *is* underdeveloped and therefore has major barriers to sustaining the rate of growth.

The intensity of population problems, as the rates of population growth, vary widely in the various regions. (Table 1.) In some countries, the length of time in which present rates of growth can continue is limited indeed. Increasing numbers of countries recognize population as a major problem, population growth as a critical variable in economic planning. The numbers of countries that now have or plan operational programs is increasing.

The rapidity of the movement to governmental policies, plans, and programs to reduce birth rates has been quite unexpected. Prior to the Second World War, population policies were mainly European, and they were designed to increase birth rates. In 1940 Japan adopted the only incisive population policy in its

[3] United Nations, Department of Economic and Social Affairs, Population Bulletin of the United Nations, No. 7—1963, with special reference to the situation and recent trends of fertility in the world. In press.

history—to raise the rate of population growth and so achieve 200 million Japanese to guide the Co-Prosperity Sphere!

The earlier concentration on anti-natalist policies was rational in the state of recognized knowledge of the time. Most of the nations of Europe, even the United States, faced declining populations if the movement of the birth rates continued downward. The problems of rates of population growth in Asia, Africa, and Latin America were unknown, denied, or ignored. The argument was simple and reasonably valid. High death rates largely negated high birth rates. Admittedly the potential for growth was very high if death rates should be reduced, but the experience then available indicated that death rates would decline only with comprehensive modernization. But industrialization, urbanization, and rising positions for women would lead naturally to declining birth rate. Solutions to problems of population growth were inherent in economic dynamics—in the views of the period.

The precise causes of the tumbling death rates of our times may be argued in their minutae, as may most demographic matters. The broad facts cannot be argued. Death rates dropped with almost phenomenal speed from 1947 or 1949 onward. There was coincidence if not causation with anti-malarial insecticides, antibiotics, etc. There were new technologies along with increasingly comprehensive and effective national and international organizations to achieve what was technically possible. In this field, success has been major. Effective technologies, efficient administrative organizations, and driving motivations have characterized malaria eradication and related programs. The fact that they have not yet characterized family planning programs cannot justify the conclusion that they will not do so at some future time. Some suggestions of beginning impacts may be seen in the vital rates of the East Asian countries presented in Table 3.

In summary, the perception of high death rates as problems is ancient. Scientific and technological advances have been occurring for generations, and the motivation to live is universal among normal human beings. The perception of high birth rates as problems is not ancient, for in most areas for most people numbers or the means have not been major problems until quite recently. The ancient problem was the rearing of a son to care for aged parents, venerate the ancestors, and continue the lineage; the problem of providing subsistence, training, and jobs for some three sons is only now emerging in most areas. If it is admitted that family limitation is practiced because of deep personal motivations rather than a desire to increase the per capita gross national product at some future time, then it must be admitted that strong forces impelling to limitation are only now becoming compulsions to action or the search for the means to action.

DEVELOPMENT OF ACTION PROGRAMS

The swift developments in recognition of population problems, in action programs in countries, and in international recognition of possible responsibilities for assistance are products of the altered dynamics of population growth. The problems are urgent, the timing for decisions critical. Trends as they have evolved in the last fifteen years or so may continue for fairly brief periods of time, but they cannot continue for any long periods of time. No definitions of brief and long as designations of time are offered; the variables are many, the relations indeterminate. In many areas, the length of that time is limited indeed. This fact is known in some of the countries now, suspected in others. India, Pakistan, Taiwan, Korea and Tunisia have operating government programs or firm decisions to develop them. Turkey, Thailand, Egypt, Iran—the numbers of countries that are exploring the needs and possibilities for programs are major. The theorists of Peking would label the arguments presented here as Neo-Malthusian or imperialist, but the Peoples Republic has contraception, induced abortion and sterilization in its health services and presumably is experimenting with a more radical use of sanctions than any nation has yet tried. The USSR and the Communist countries of Eastern Europe also have a range of means available and utilized in health services. If the countries with explicit population programs and those who have anti-conception programs are combined, the covered populations are a major portion of the world's total.

TRANSFORMATION: INTERNATIONAL AND THE U.S.

In the less developed countries with high rates of population growth unified programs in population dynamics to reduce both death and birth rates are re-

placing programs designed solely to reduce death rates. Population is moving from a topic of controversy to a field appropriate for planning, programs, and operations. The transformation was explicit in the decisions of the United Nations Economic Commission for Asia and the Far East to provide technical and other assistance to countries as requested. It is explicit in the United Nations mission to India; it is implicit in the resolutions, conferences, and research of the Pan American Health Organization, which is also the regional organization of the World Health Organization.

The rapid pace of international developments has been paralleled by internal movements in the United States. The Federal Council of Churches has defined responsible parenthood as a moral responsibility and recognized the planning of births as proper. The Catholic Church accepts the same tenets but differs in means permissible to its members. However, it accepts public programs provided there is a choice of means, including rhythm which alone is permissible for Catholics. The American Public Health Association was a pioneer in the open recognition of population control as a public health problem and therefore a responsibility in public health. The American Medical Association has defined birth control as a medical responsibility for doctors working in public as in private sectors. Increasingly, cities are placing birth control in health and welfare services; the Congress of the United States appropriated $25,000 as a line item for birth control in the health services of the District of Columbia.

The Government of the United States, foundations, institutions and private organizations have made contributions other than altered points of view. The stimulation and financing of research on the physiology of human reproduction by foundations and the Public Health Service are essential to the development of technologies that are essential but perhaps not sufficient for solutions to problems of population growth. Pills and the intra-uterine devices have had almost revolutionary impacts on the expectations of the less developed nations with reference to what they can achieve in operating programs. New technologies as yet unspecified may yield means truly appropriate to the people of traditional societies, whatever the cultures, ethical codes or religious beliefs.

A further and continuing contribution should be noted. This one is made in the private sector, without explicit assistance from government. It is the field study of the relations of family functioning, birth rates, social and economic characteristics, attitudes toward numbers of children, and knowledge or practice of limitation. This type of study provided some basis for specific planning.

There are also experimental studies in areas that define problems, test alternate methods, and contribute to the development of operating national programs. The role of the United States in these programs has been nongovernmental.

There are manifold activities in research, training, and technical assistance. They cannot be summarized here. The rapid increase in the number of countries concerned with population growth and the increasing intensity of operating programs have increased needs and responsibilities to the point that they can no longer be met without government participation or direct entry into the field.

Thus again the argument leads directly to the questions involved in the definition of the role of the government of the United States.

BASES AND QUESTIONS IN THE U.S. DECISION

The proper further development of the background for an assessment of the role of the United States in the resolution of the population problems of other countries would require substantial space for presentation. It could cover a list of topics somewhat as follows: *1.* What happened to birth and death rates and rates of population growth. *2.* The outlook for the future on alternate assumptions. *3.* The spectre of the increasing age groups. *4.* The interrelations with economic development and political stability. *5.* The paths to resolution in areas where birth rates have declined swiftly in recent periods, specifically, Japan, the USSR, and Eastern and Southern Europe. *6.* The dynamics in developing countries where birth rates are now declining: Taiwan; Hong Kong; Singapore and Malaya; Puerto Rico. The list could be continued. Or the further report could be organized to cover the operational questions and problems: The motivations of the people, the means that are acceptable and effective, the costs of alternate programs versus no programs, the administrative requirements for operating programs, etc.

A partial solution to the problem of background facts on population dynamics in less developed countries and population solutions in countries now developed

is given by appending two papers. One traces the dynamics of selected Asian populations for the 15 years from 1960 to 1975. The other considers the transformation in Japan, so widely considered as miracle or model but actually only a case study of one Asian country in which there was solution.

The critical questions underlying decisions as to the extent and the type of assistance to developing countries in operating population programs involve many imponderables as well as statistical facts, intricate analyses, and dynamic or stimulation models:

1. Given population growth as it is now occurring and the immense momentum of that growth, is there a contribution to economic development in the near future in the reduction of birth rates?

2. If the reduction of birth rates will so contribute, are the motivations of people and the means to realize them such that birth rates are likely to decline, given effective governmental actions in the countries?

3. Is there a reasonable basis for assuming that the plans and programs of governments and the responses of people will achieve the goals of immediate and swiftly declining birth rates? Or, phrased more conservatively, what is the outlook that involves economic advance, social change, and declining birth rates?

4. If the answer is again affirmative in general terms, what are the requirements in trained staff and what are the costs? Is the investment in population programs a wise allocation of resources in a sound strategy of development?

5. Finally, what is the role of external assistance—private, international, bilateral—in the decisions, plans and programs of governments to modify the dynamics of their own populations?

It is not the mandate here to specify the detailed development and specific activities of the United States as the transformations of the recent years and the current period continue. Rather, the questions that underlie the decisions will be noted in summary form.

THE CONTRIBUTIONS TO ECONOMIC DEVELOPMENT

The analysis of the interrelations of population and economic dynamics in the short run is complex, particularly if the question is the decline of the birth rate. The statement here is the concluding one of Ansley J. Coale's paper on population and economic development to The American Assembly conference on population, Arden House, May 21–5, 1963.[4]

"The underdeveloped areas in the world for the next fifty years or so have a choice at best between very rapid population growth and moderately rapid growth in population. Any low-income country that succeeds in initiating an immediate reduction in fertility would in the short run enjoy a reduction in the burden of child dependency that would permit a higher level of investment and more immediately productive uses of investment.

"After 25 or 30 years the advantages of reduced dependency would be enhanced by a markedly slower growth of the labor force, making it possible to achieve a faster growth in capital per worker from any given investment, and making it easier to approach the goal of productive employment for all who need it.

"In the long run, the slower growth that fertility reduction causes would reduce the overwhelming multiplication of density that continued growth implies.

"The additional gains in per capita income resulting from a 50 percent reduction in fertility occurring within 25 years would be about 40 percent in 30 years, 100 percent in 60 years, and 500 percent in 150 years, neglecting the effects of density. To postpone the reduction by 30 years is to add 64 percent to the size of the population in the long run, and to suffer a loss in potential long-range gains from the interim reduction in dependency of 40 percent. In sum, a reduction in fertility would make the process of modernization more rapid and more certain. It would accelerate the growth in income, provide more rapidly the possibility of productive employment for all adults who need jobs, make the attainment of universal education easier—and it would have the obvious and immediate effect of providing the women of low-income countries some relief from constant pregnancy, parturition and infant care."

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[4] Coale, Ansley J., "Population and economic development". Pp. 46–69 in: The American Assembly. The population dilemma. Edited by Philip M. Hauser. New York, 1963.

FIELD STUDIES: ATTITUDES, MOTIVATIONS, MEANS

The critical questions in demographic process and the population future are not what governments and press say of birth control but what intermediate operational relations there are that lead to changes in the numbers of births. There are many questions here, whether for countries with explicit population programs but no declines in birth rates or countries without population policies but with selective health permissiveness and declining birth rates. As preface to comments on the altered positions and possible actions in countries, we may note certain general relations emerging from field studies in many countries:

1. Birth limitation is an almost universal attribute of middle class urban groups in modernizing societies; practices can be stimulated in extent and in efficiency among these groups. The practices include sterilization, the oral contraceptives, and the intra-uterine devices.

2. The essential base for declines in national birth rates in densely settled agrarian areas is the deliberate limitation of births in illiterate or barely educated village populations where economic opportunities are muted and social changes are dulled, if indeed they are present.

3. The wish for smaller families than those occurring throughout the society is widespread if not universal. The wish is neither firm decision not driving motivation toward decision. Presumably women have always responded similarly to the vista of recurrent pregnancy and increasing responsibilities. At least, this would seem a permissible inference from the universality of legend and lore on the limitation practices of the people, whatever the time, the place or the society.

4. Neither conventional nor complex means of limitation have been adequate to reduce peasant birth rates, nor are they likely to be so. The condom seems the most widely relevant of the conventional means.

5. The major means involved in reducing those birth rates that have declined rapidly in the last fifteen years has been induced abortion, usually performed legally in health services or under governmental regulation to obviate the presumed harmful effects of illegal induced abortions.

6. What new means may become available is conjectural. The intra-uterine devices, now available, are a major break-through to a means that reduces decision-making to one for a period of one to several years, that is acceptable and almost completely effective for some ninety per cent of women, that is cheap in product cost, and that, given a willingness to assume balanced risks, may perhaps be inserted by para-medical personnel.

NEW FORCES IN GOVERNMENTAL DECISIONS AND ACTIONS

In countries now developed, swift declines in birth rates did not come except in contexts of advancing economic and social development and levels of educational achievement that extended far beyond literacy. Most of the world's people live in developing areas; the concentration is increasing both relatively and absolutely. The analysis of the European and other pasts cannot be utilized to develop the argument that the decline of birth rates in the developing countries must follow rather than accompany economic development. The major determinants of the actions of governments and the responses of people lie in situations that are new, not alone in the countries that are involved but in the world. Nine of the forces and developments relevant to the outlines if not the determination of the demographic future are noted here:

1. Countries that are independent, with governments and people alike dissatisfied with the low economic levels and the lethargies in development that preclude the realization of awakened anticipations.

2. Country, regional, and international concentration on an economic development that involves increasing levels of real income, improving nutrition, positive health and vitality, educational and other opportunities for children, occupational and social mobility as process or possibility, and some of the amenities that lie outside the areas of poverty deprivation.

3. Scientific and technological advances, effective internal administration, and international assistance in reducing death rates.

4. Long postponed but now productive scientific and technological work relevant to fertility control.

5. The absence of a base in administrative experience as to the organization of effective programs in the field of birth control; the inattention if not taboos toward discussion, opinion formation, and the evolution of motivations; the delayed development of technologies in fields relevant to the induction of social change at village and family levels; the barriers to international assistance in fertility control except with circumlocution and indirection; the prevalent allocation of the field as one for crusade, conversion and propaganda rather than as a proper field for appropriate concern in the core of government planning and developmental activity.

6. The increasing pressures that population growth places on families, villages, and the institutions and administrative units of the larger society, with the consequent possibility of swiftly changing milieu in assessment, attitude, and motivation with reference to operational decisions to control family size.

7. The current availability of means of limitation acceptable to and effective in at least some traditional village settings, and the probability that more acceptable and more effective means will become available as scientific and technological work continues.

8. Knowledge of the associations of population growth and developmental achievements, plans for national services in the family planning field, and the advance of administrative structures and operating facilities for the achievements of a knowledgeable population with access to means adequate to implement decisions.

9. The extension of the recognition of and priorities given to population as an appropriate field for national activities and bilateral or international cooperation.

THE DIMENSIONS OF THE DECISION

The major transformation in the population field is far advanced. The era of presupposition, emotion, debate, and persuasion has not ended, but it is ending Existing population relationships and high rates of population growth are documented realities. The problem is no longer simply the determination or the recognition of the problems of population dynamics associated with modernization.

The population dynamics of the developing countries are transitional or unstable. The words are used advisedly. Reduced death rates, high birth rates, high rates of population growth—these cannot continue indefinitely or even for substantial periods of time. The question is not change but the nature of the change and the conditions under which it occurs. There may be resolution through declining birth rates; there may be the retrogression of increasing death rates. There need be no one process of change, for the directions of population dynamics, as those of economic development, are determined largely in the decisions of the countries, the skill and efficiency with which policies are transformed into plans, plans into programs, and programs into effective operating activities that reach and motivate the people. There are major contributions in bilateral or multilateral assistance, but decisions and basic responsibilities are those of the countries. This is perhaps more true of population than of any other field, for the associations of birth rates with ethical proscription and religious values are everywhere close.

There is no necessary demographic doom in the high rates of population growth that now exist. There are no inevitable demographic solutions to problems of economic growth and human advance as they now are. It is no longer possible to avoid the evidence that there may be demographic doom in some sectors of the developing areas of the world. It is now possible, though, to point to such Asian countries as Japan where there is solution, to such Asian countries as Taiwan where economic and demographic advance are proceeding together. It is also significant that the deepest concerns over the implications of growth and the most intensive efforts to discover and implement workable solutions are those in the countries where populations are intensely in need of development, birth rates are high, and economic development itself precarious.

Whether or not demographic transitions to declining birth rates occur in the next few decades in developing countries is not a question whose answers lie solely in improved statistics, demographic analysis, or even in more effective contraceptives. Increases of the magnitude of those projected require internal

stability and international order, increasing economic productivity to sustain the increasing numbers, social change to alter traditional family aspirations and value structures, and scientific advances in fertility control somewhat comparable to those that have already occurred in mortality control.

If death rates are to decline to lower levels, there must be food, health, and sanitation in more adequate form for larger portions of the people. If birth rates are to move downward, there must be social change, altered value structures, and an integration of population with economic and social developments in the plans, projects, and programs of governments. The unsponsored transitions of industrialization, urbanization, and advancing education may occur in some areas. Some have occurred in the past; some are now occurring. For most countries, such transitions would be too limited and too late. In the past, there was evasion and procrastination in the fundamental issue of government activities to reduce birth rates along with death rates. Increasing numbers of the governments of developing countries now know that further delay may involve major hazards to the welfare if not the survival of citizens and to the internal power of the state.

This is the world context in which the decisions of the United States are being made.

TABLE 1.—*Population of the world and 8 major regions, 1920–60, and projected 1960–2000, on assumptions of continuing recent trends*

POPULATION (MILLIONS)

Area	Enumerated or estimated			Projected	
	1920	1940	1960	1980	2000
World	1,862.0	2,295.0	2,990.0	4,487.0	7,410.0
More developed areas	606.0	730.0	854.0	1,085.0	1,393.0
Europe	327.0	380.0	425.0	496.0	571.0
U.S.S.R.	155.0	195.0	214.0	295.0	402.0
Northern America	116.0	144.0	199.0	272.0	388.0
Oceania	8.5	11.1	15.7	22.0	32.5
Less developed regions	1,256.0	1,565.0	2,136.0	3,402.0	6,017.0
East Asia [1]	533.0	634.0	793.0	1,139.0	1,803.0
South Asia	470.0	610.0	858.0	1,418.0	2,598.0
Africa [1]	143.0	191.0	273.0	458.0	860.0
Latin America	90.0	130.0	212.0	387.0	756.0

INCREASE, 20-YEAR PERIODS (PERCENT)

World		23.2	30.3	50.1	65.1
More developed areas		20.5	17.0	27.0	28.4
Europe		16.2	11.8	16.7	15.1
U.S.S.R.		25.8	9.7	37.8	36.3
Northern America		24.1	38.2	36.7	14.3
Oceania		30.6	41.4	40.1	47.7
Less developed regions		24.6	36.5	59.3	76.9
East Asia		14.6	25.1	43.6	58.3
South Asia		29.8	40.6	65.3	83.2
Africa		33.6	42.9	67.8	87.8
Latin America		44.4	63.1	82.5	95.3

[1] Estimates insecure.

Source of data: United Nations. Department of Economic and Social Affairs. Provisional report on world population prospects as assessed in 1963. Tables 5–1, p. 38 and 5–3, p. 41.

TABLE 2.—*Population of the world and major regions, 1960, and projected, 1960–2000, on assumptions of declining birth and death rates* [1]

POPULATION IN MILLIONS

Area	1960	1970	1980	1990	2000
World	2,990.0	3,574.0	4,269.0	5,068.0	5,965.0
More developed areas	854.0	946.0	1,042.0	1,153.0	1,266.0
Europe	425.0	454.0	479.0	504.0	527.0
U.S.S.R.	214.0	246.0	278.0	316.0	353.0
Northern America	199.0	227.0	262.0	306.0	354.0
Oceania	15.7	18.7	22.6	27.0	31.9
Less developed areas	2,136.0	2,628.0	3,227.0	3,915.0	4,699.0
East Asia	793.0	910.0	1,038.0	1,163.0	1,284.0
South Asia	858.0	1,090.0	1,366.0	1,677.0	2,023.0
Africa	273.0	346.0	449.0	587.0	768.0
Latin America	212.0	282.0	374.0	488.0	624.0

DECADE INCREASE (PERCENT)

World	----------	19.5	19.4	18.7	17.7
More developed areas	----------	10.8	10.1	10.6	9.8
Europe	----------	6.8	5.5	5.2	4.6
U.S.S.R.	----------	15.0	13.0	13.7	11.7
Northern America	----------	14.1	15.4	16.8	15.7
Oceania	----------	19.1	20.8	19.5	18.1
Less developed areas	----------	23.0	22.8	21.3	20.0
East Asia	----------	14.8	14.1	12.0	10.4
South Asia	----------	27.0	25.3	22.8	20.6
Africa	----------	26.7	29.8	30.7	30.8
Latin America	----------	33.0	32.6	30.5	27.9

[1] Assumptions that birth rates begin continuing decline at varying dates that seem plausible, that when decline begins the rates are halved in 30 years.

Source of data: United Nations. Department of Economic and Social Affairs. Provisional report on world population prospects, as assessed in 1963. Table 5-5.

TABLE 3.—*Birth and death rates per 1,000 total population, selected countries, 1945–64 (official data, uncorrected)*

Country	1945–49	1950–54	1955–59	1960	1961	1962 [1]	1963 [1]
Birth rates:							
Mexico	44.4	44.9	45.9	46.0	45.6	45.8	45.0
Costa Rica	45.6	48.7	48.8	48.1	46.9	42.2	49.9
Chile	35.7	33.8	35.8	34.9	34.0	34.49	----------
Venezuela	38.5	43.5	44.7	45.9	45.3	42.8	----------
Ceylon	38.2	38.5	36.0	36.6	35.8	----------	----------
Malaya	40.6	44.1	44.4	40.9	41.0	40.3	----------
Singapore	46.4	45.5	42.8	38.7	36.5	35.1	----------
Hong Kong	----------	32.7	36.3	36.0	34.2	32.8	32.1
Taiwan	40.2	45.9	42.8	39.5	38.3	37.4	----------
Japan	30.1	23.7	18.2	17.2	16.9	17.0	17.2
Death rates:							
Mexico	17.8	15.4	12.5	11.5	10.8	10.8	10.4
Costa Rica	14.8	11.5	9.6	8.6	7.9	8.5	8.5
Chile	17.2	13.6	12.6	12.3	11.5	11.9	----------
Venezuela	13.5	10.3	9.0	7.5	7.1	6.7	----------
Ceylon	16.0	11.5	9.9	8.6	8.0	8.5	----------
Malaya	17.5	14.0	11.3	9.5	9.2	9.3	----------
Singapore	12.5	10.4	7.3	6.3	6.0	5.9	----------
Hong Kong	8.8	8.7	7.2	6.2	5.9	6.0	5.5
Taiwan	15.1	10.0	8.0	6.9	6.7	6.4	----------

[1] Preliminary data, usually somewhat below the definitive figures obtained later. Many of the births are incompletely reported; erratic fluctuations from year to year likely reflect registration difficulties.

Source of data: United Nations. Statistical Office. Demographic yearbook 1963, tables 1 and 23.

TABLE 4.—*Vital rates, 1960–65, and projected death rates, 1965–2000, on assumptions of continuing recent trends*

[Rates per 1,000 estimated population]

Area	Actual, 1960–65			Projected death rate			
	Births	Deaths	Natural increase	1965–70	1970–75	1975–80	1995–2000
World [1]	33.6	15.7	17.9	14.5	13.6	12.7	9.4
East Asia [2]	32.5	18.9	13.6	17.3	15.9	14.4	10.6
Mainland [3]	34.3	21.0	13.3	19.0	17.5	15.8	11.2
Japan	17.0	8.0	9.0	7.7	7.7	7.8	10.2
Other [4]	40.4	11.2	29.2	9.8	8.1	7.4	5.2
South Asia [5]	42.3	18.5	23.8	16.6	14.9	13.7	7.9
Europe	17.8	10.0	7.8	10.0	10.1	10.4	11.2
U.S.S.R.	22.1	7.2	14.9	7.1	7.1	7.3	8.7
Africa	45.5	22.5	23.0	20.9	19.5	18.1	13.1
Western	52.0	25.1	26.9	23.5	21.8	20.4	15.7
Eastern	41.7	24.0	17.7	22.7	21.6	20.4	15.8
Middle	40.0	24.7	15.3	23.5	22.0	20.9	16.2
Northern	44.1	19.2	24.9	18.5	17.2	15.3	6.9
Southern	42.8	16.2	26.6	14.5	13.2	12.8	9.4
Northern America [6]	22.6	9.2	13.4	9.4	9.4	9.2	7.9
Latin America	39.3	11.1	28.2	9.9	9.0	8.2	6.2
Temperate	26.4	9.2	17.2	9.0	8.9	8.8	8.5
Tropical, south	41.4	10.8	30.6	9.5	8.8	8.1	6.2
Middle, mainland	43.6	11.6	32.0	9.8	8.1	6.8	5.0
Caribbean	37.9	14.9	23.0	13.8	12.8	11.8	.....
Oceania [7]	25.0	10.8	14.2	10.0	9.5	9.5	9.6
Australia-New Zealand [8]	22.3	8.5	13.8	7.8	7.4	7.4	8.2
Melanesia [8]	40.0	24.7	15.3	23.5	22.0	20.9	16.2

[1] Not including areas listed in footnotes 2, 4, and 7.
[2] Not including Hong Kong, Mongolia, Macao, northern Korea, and Ryukyu Islands.
[3] Mainland China only.
[4] China: Taiwan and the Republic of Korea only.
[5] Not including Israel and Cyprus.
[6] Corresponding to immigration assumptions in original projections.
[7] Not including Polynesia and Micronesia.
[8] Assumed same as middle Africa.

Source of data: United Nations. Department of Economic and Social Affairs. Provisional report on world population prospects, as assessed in 1963. App. C, tables 1, 2, and 3.

TABLE 5.—*Birth rates and rates of natural increase, 1960–65, and projected, 1960–65 to 1995–2000, on assumptions of declining birth and death rates, world and major regions*

BIRTHS PER 1,000 POPULATION

Areas	1960–65	1965–70	1970–75	1975–80	1995–2000
World [1]	33.6	32.4	31.5	30.5	25.5
East Asia [2]	32.5	30.6	29.2	27.2	19.9
Mainland [3]	34.3	32.3	30.6	28.2	20.4
Japan	17.0	15.6	16.7	16.8	13.2
Other [4]	40.4	37.4	34.6	32.1	24.3
South Asia [5]	42.3	40.7	38.1	35.6	26.6
Europe	17.8	16.7	16.3	16.4	15.9
U.S.S.R.	22.1	19.4	19.0	19.9	19.3
Africa	45.5	45.4	45.1	44.6	40.0
Northern America [6]	22.6	21.3	22.6	23.6	22.2
Latin America	39.3	38.5	37.2	36.2	30.2
Temperate	26.4	25.5	24.4	23.5	21.0
Tropical	41.4	40.3	38.6	37.3	31.0
Middle (mainland)	43.6	42.8	41.8	40.8	32.6
Caribbean	37.9	37.4	36.0	34.7	28.3
Oceania	25.0	24.4	24.7	25.5	25.3

Footnotes at end of table.

TABLE 5.—*Birth rates and rates of natural increase, 1960–65, and projected, 1960–65 to 1995–2000, on assumptions of declining birth and death rates, world and major regions*—Continued

NATURAL INCREASE PER 1,000 POPULATION

Areas	1960–65	1965–70	1970–75	1975–80	1995–2000
World [1]	17.9	17.9	17.9	17.8	16.1
East Asia [2]	13.6	13.3	13.3	12.8	9.3
Mainland [3]	13.3	13.2	13.1	12.4	9.2
Japan	9.0	7.9	9.0	9.0	3.0
Other [4]	29.2	27.6	26.5	24.7	19.1
South Asia [5]	23.8	24.1	23.2	21.9	18.7
Europe	7.8	6.7	6.2	6.0	4.7
U.S.S.R.	14.9	12.3	11.9	12.6	10.6
Africa	23.0	24.4	25.6	26.5	26.9
Northern America [6]	13.4	11.9	13.2	14.4	14.3
Latin America	28.2	28.6	28.2	28.0	24.0
Temperate	17.2	16.5	15.5	14.7	12.5
Tropical	30.6	30.8	29.8	29.2	24.8
Middle (mainland)	32.0	33.0	33.7	34.0	27.6
Caribbean	23.0	23.6	23.2	23.9	19.9
Oceania	14.2	14.4	15.2	16.0	15.7

[1] Not including areas listed in footnotes 2 and 4.
[2] Not including Hong Kong, Mongolia, Macao, Northern Korea, and Ryukyu Islands.
[3] Mainland China only.
[4] China: Taiwan and the Republic of Korea only.
[5] Not including Israel and Cyprus.
[6] Corresponding to immigration assumptions in original projections.

Source of data: United Nations, Department of Economic and Social Affairs, "Provisional Report on World Population Prospects, as Assessed in 1963," app. C, tables 1 and 3.

Years required for populations to double at various average annual rates of increase

Average annual rate of increase (percent) :			
0.50	138.63	2.50	27.73
0.75	92.42	2.75	25.21
1	69.32	3	23.10
1.25	55.45	3.25	21.33
1.50	46.21	3.50	19.80
1.75	39.61	3.75	18.48
2	34.66	4	17.33
2.25	30.81		

(7) MEASURING THE EFFECTS OF POPULATION CONTROL ON ECONOMIC DEVELOPMENT

PAKISTAN AS A CASE STUDY

(By Edgar M. Hoover and Mark Perlman; a report prepared for the information of the Advisory Committee to the Director, AID, January, 1965, Center for Regional Economic Studies, University of Pittsburgh)

OBJECT OF THIS STUDY

The terms of reference of this report are to indicate the "impact of alternative foreseeable population trends upon economic development prospects and assistance needs of less developed countries." In it we consider the effects of varying the rate of natural increase of population on a "less-developed" country's efforts to improve its general economic well-being. Pakistan, for the period 1965–85, is the specific case examined.

In the context of that country's development constraints and plans, we have attempted to measure what difference it would make in prospects for progress if mortality and/or fertility rates were changed.

The demographic contingencies to be considered (which have been spelled out in detail in other reports to this Committee) include (1) a progressive reduction of mortality through improved environmental, medical, and nutritional conditions; and (2) a progressive reduction in fertility through government-sponsored family-planning efforts.

There are obviously many aspects of the development process that depend upon how population is growing. We have focused on evaluating the population impact in terms of selected characteristics of the national economy including aggregate and per capita income, savings, and consumption, the composition of output and employment by major productive sectors, and the degree of dependence on import of captial.

Such evaluations are basic to judgments about the desirability of programs affecting fertility or mortality and the degree of priority to be attached to them at various stages of development. They are also useful as a step toward foreseeing assistance needs in such areas as investment funds, housing and public services, and educational facilities. At the conclusion of this paper we suggest some lines on which further analysis might fruitfully be pursued.

OUTLINE OF PROCEDURE

Our task is not to appraise in any absolute sense the prospects for economic development in Pakistan, but merely to give an indication of the extent to which the course of development might be *altered by shifts in fertility and mortality rates* during the next two decades. We have drawn upon the work of the planners and economic experts for their data and estimates regarding the present and future national economy, and have constructed a "growth model" consistent with that information and what appears to be consensus regarding the main economic determinants of growth over the next 20 years. What has been lacking in previous analysis, and what we have tried to supply, is a role for the demographic factor in such an analytical scheme.

The population assumptions

Our projections model has been designed to work with alternative population projections such as the four recently prepared by the U.S. Bureau of the Census and described in a separate report to this Committee.[1]

Since these four "demographic cases" will be referred to throughout this report, it is convenient to refer to them by abbreviation:

Cf-Dm: Constant fertility and declining mortality.

Cf-Cm: Both fertility and mortality constant.

Df-Dm: Both fertility and mortality declining.

Df-Cm: Declining fertility and constant mortality.

We shall use the abbreviated designations henceforth. The cases are arranged above in descending order of rate of net population growth—Cf-Dm gives the highest projected population trend rising to 240.7 millions in 1985, and Df-Cm gives the lowest trend with 201.2 millions in 1985.

Our projections are made in sets of four, reflecting these four different demographic cases. For each *set* of projections a different combination of nondemographic assumptions (e.g., regarding the propensity to save) is adopted. Within any set, comparisons between cases serve to evaluate the impacts of fertility and mortality changes separately or in combination. For convenience we have related each of the other three cases to the *Cf-Dm* (highest population growth) case. Thus,

Cf-Cm vs. Cf-Dm shows the impact of mortality.

Df-Dm vs. Cf-Dm shows the impact of fertility.

Df-Cm vs. Cf-Dm shows the impact of both fertility and mortality.

The projected rate of economic progress (under any specified set of economic assumptions regarding parameters like the propensity to save) is inversely related to the pace of population growth in our analysis. Thus Cf-Dm, the maximum-population growth case which is used as the standard for comparisons, shows the lowest economic progress of the four in each set of projections. Cf-Cm

[1] Questions regarding the probability, efficacy, or cost of population control programs and the accuracy of population data and projections are excluded from consideration in the present report and have been covered in the other presentations to this Committee.

comes out somewhat better; Df-Dm better still; and the rather unrealistic case Df-Cm gives the highest rates of progress of the four.

Key economic factors

In order to analyze the effect of different demographic trends on the growth of the Pakistani economy, our scheme must take account of at least those main determinants of economic growth that are themselves sensitive to demographic factors. This last limitation is important. In determining the growth outlook for a country like Pakistan, it may well be that the international political and military situation, say, or new technological break-throughs or resources discovered, will be more crucial than the amount of domestic and foreign funds that can be channeled into development. But if these former factors are essentially unaffected by the Pakistani rate of population growth while the supply of funds is significantly affected by population growth, we are justified in ignoring them in the present analysis of the differential growth effect of population *per se*.

From our necessarily sketchy examination of recent analyses of Pakistani development prospects, we conclude (1) that the supply of investment funds should indeed be included as a key factor in our procedure; (2) that a substantial part of those funds will have to come from abroad; (3) that the generation of domestic funds for investment will depend on the degree to which per capita income rises; and (4) that the extent to which investment and development resources can be allocated between uses with different impacts on productivity will depend both on income levels and on the numbers of additional people to be provided for.

It is not clear that there is any very direct link between population growth and the availability of capital from abroad that needs to be incorporated in our simplified model, though indirect links certainly will exist. Our procedure handles capital-import ("external resources") in two ways, as will be described fully later:

(1) Assuming a specified trend of external resources (such as that recently envisioned in the Perspective Plan), uniform for all projections, and then working out the different trends of income growth attainable under various demographic and economic assumptions.

(2) Assuming for all projections the attainment of some specified growth target, and then working out the external resources that would be required to attain that target under the various demographic and economic assumptions.

The emphasis which the consensus seems to place on capital as the leading growth factor implies that natural-resources and labor inputs are less decisive "handles" for determining growth. From the standpoint of our problem we feel justified in ignoring both on the grounds that neither will depend substantially, in the period under consideration, on the fertility and mortality changes envisioned.

In this connection it should be noted that fertility changes (much more important than mortality in affecting the growth and structure of the population over the next 20 years) have no direct effect upon the labor force for 10 to 15 years, and that in consequence the assumed slowly widening gap between alternative projected fertility rates could hardly have a significant effect on the productive labor supply before the very end of the period here under consideration. Moreover, the consensus seems to be that, for most if not all of this period, labor should be regarded as a redundant factor in quantitative terms.

Qualitatively, of course, in terms of skills and productivity, labor input is indeed crucial to Pakistan's growth. But the rate at which productivity can be raised depends on population growth only indirectly, via effects (1) on the level of individual incomes and (2) on the supply of investment and other development funds and the extent to which these can be channeled into uses that boost productivity (such as better training, or better capital equipment) as against merely providing for additional consumers or workers at current levels of welfare or equipment.

Consequently, our procedure does not introduce manpower input as a determinant of output. It does, however, make some allowance for the indirect effects just mentioned; and also, generates projections of employment in various sectors of the economy which should be useful in any further manpower utilization studies.

Our economic growth projections

With the above considerations in mind regarding the selection of relevant variables, we constructed a computer program for projections over the period 1965–1985, using (1) the four alternative population series projected by the Bureau of the Census, (2) the most recent available estimates for initial (fiscal 1965) data on income, savings, investment, et cetera, and (3) indications from recent documents on the Perspective Plan as to reasonable "consensus" values for such variables as the marginal savings ratio, the output/capital ratio, the availability of external resources at various dates through the period, and the relation of sector growth to overall national growth.

Eight sets of four projections each were calculated, running by 2½-year intervals from 1965 through 1985 and showing G.N.P., savings, consumption, and sector breakdowns of output and non-agricultural employment to 1985.

The first step was to translate each of the four population projections into "equivalent adult consumers" by weighting children under 10 at 0.5 and women of 10 and older at 0.9. Projected G.N.P. and other magnitudes are shown in per capita and per-consumer terms as well as in aggregates.

Each set of four projections represents the four demographic cases (Cf-Dm, Cf-Cm, Df-Dm, and Df-Cm) already identified. Each set of projections involves a different selection of assumptions regarding such parameters as the marginal savings ratio, as will be described specifically later.

In addition, 16 more sets of four projections each were constructed on an alternative basis (following a suggestion from Professors Dorfman and Conrad of the Harvard Pakistan group) under which growth of the agricultural sector is viewed as the primary determinant of total growth.

The Appendix describes the construction and operation of the projections model in further detail.

WHAT THE PROJECTIONS SHOW

The 96 different 1965–1985 projections calculated for this report represent a sizeable mass of numbers, which are being separately submitted in single copy along with specifications of the computer program used. An additional full print-out copy has been sent to Professor Dorfman at Harvard. In the present report only highlights will be given, focussing on the middle and end of the 20-year period and on aggregate rather than sector-by-sector results.

Demographic impacts

Table 1 shows the levels of per-consumer G.N.P. and per-consumer consumption (G.N.P.-saving) in 1985 in eight sets of four projections each. (For comparison, the initial 1965 values of these two variables were Rs. 464 and 421 respectively.) These projections all assume the same time-series of external resources use, which is derived from a recent version of the Perspective Plan and runs as follows:

Crores per annum

Fiscal year:		Fiscal year—Continued	
1965	650	1980	240
1970	610	1985	110
1975	390		

Reading across the rows of Table 1, we see that the level reached in 1985 is in all cases strongly affected by the choice of population trends. The mortality-reduction impact is of the order of 5 percent (that is, per-consumer income or consumption in 1985 is about 5 percent lower if mortality declines than if it does not, ceteris paribus). The gain from reduced fertility is much larger—of the order of 16 percent. Comparing the various rows of the table, we see that

quite similar differentials among demographic cases appear under the various combinations of parametric assumptions that have been introduced to test the stability of the results. Some more specific attention will be given later to this question of sensitivity to the economic parameters.

In no case, however, should any significance be attached to vertical comparisons among the figures in any one column of the table. Our analysis is designed to measure only the differential effects of population trends, and (as described fully in the Appendix) procedural adjustments have been made which partly cancel out the impact of changes in an economic parameter under any given assumption about population growth.

TABLE 1.—*Comparison of 32 projections of GNP per consumer and consumption per consumer in 1985 (all figures in Rs. per annum)*

[Key: Cf-Dm—Constant fertility and declining mortality; Cf-Cm—Both fertility and mortality constant; Df-Dm—Both fertility and mortality declining; Df-Cm—Declining fertility and constant mortality]

Assumptions	GNP per consumer				Consumption per consumer			
	Cf-Dm	Cf-Cm	Df-Dm	Df-Cm	Cf-Dm	Cf-Cm	Df-Dm	Df-Cm
No autonomous GNP growth:								
Investment drain factor 0.10:								
Marginal savings ratio 0.36...	883	939	1,038	1,095	689	725	788	825
Marginal savings ratio 0.20...	685	721	785	822	598	627	678	707
Investment drain factor 0.25:								
Marginal savings ratio 0.36...	788	844	946	1,005	629	665	729	767
Marginal savings ratio 0.20...	625	662	728	766	550	580	632	662
2-percent annual autonomous GNP growth:								
Investment drain factor 0.10:								
Marginal savings ratio 0.36...	909	960	1,051	1,104	706	739	797	831
Marginal savings ratio 0.20...	754	791	857	895	653	683	735	766
Investment drain factor 0.25:								
Marginal savings ratio 0.36...	842	894	986	1,041	663	696	755	790
Marginal savings ratio 0.20...	706	744	811	850	614	645	699	730

NOTE.—Our investment drain factor does not represent the fraction of total investment that is assumed to have no effect upon the next increment to gross national product. As described more fully in the appendix, the no-growth component of investment funds is calculated as the product of (1) the investment drain factor times (2) the level of per-consumer GNP, times 3 the next 2½-years' increment to number of consumers. As a rough guide to the interpretation of the numbers, it may be useful to know that generally in our projections an investment drain factor of 0.10 implies a drain of 3 to 4 percent of total investment funds and a factor of 0.25 implies a drain of 8 to 10 percent of such funds—the exact relationship of course varies among projections and among time periods.

Table 2 measures the economic effect of alternative population trends in another way. Within each set of four projections, the growth trend of per-consumer GNP under the "least favorable" demographic case (Cf-Dm) is taken as the "target" to be matched under each of the other three demographic cases.[2]

The required external resources (per-annum levels at the middle and end [3] of the projections period) are then calculated for each case. Thus in Table 2, the costs and benefits of mortality and fertility reduction are evaluated in terms of reduced capital import. It may be noted that in every one of the eight sets of cases, the external-resources requirement actually becomes negative by 1982/3 if fertility is reduced (assuming that the same progress is made in raising per consumer income as could be made under Cf-Dm with continued external resources, still running at an annual rate of 175 crores in the Sixth Plan period).

[2] Matching of per-consumer income levels also implies (within a set of projections involving the same assumed marginal savings rate) matching of per-consumer consumption and of per-consumer saving.

[3] The latest date shown is "1982/3" because our growth projections run only to 1985 and the growth during the last 2½ years of that period is assumed dependent on external resources and saving levels at the beginning of that last 2½-year interval.

TABLE 2.—*Comparison of annual external resources requirements in 1976 and in 1982–83 under alternative fertility-mortality conditions in order to match growth of per consumer GNP with the constant fertility declining mortality case (all figures in crores per annum)*

[Cf-Dm: Constant fertility and declining mortality; Cf-Cm: Both fertility and mortality constant; Df-Dm: Both fertility and mortality declining; Df-Cm: Declining fertility and constant mortality]

Assumptions	1975				1982–83			
	Cf-Dm	Cf-Cm	Df-Dm	Df-Cm	Cf-Dm	Cf-Cm	Df-Dm	Df-Cm
No autonomous GNP growth:								
Investment drain factor 0.10:								
Marginal savings ratio 0.36..	390	311	192	127	175	−11	−205	−347
Marginal savings ratio 0.20..	390	318	209	150	175	29	−124	−236
Investment drain factor 0.25:								
Marginal savings ratio 0.36..	390	308	183	116	175	−9	−202	−344
Marginal savings ratio 0.20..	390	314	199	137	175	26	−130	−244
2 percent annual autonomous GNP growth:								
Investment drain factor 0.10:								
Marginal savings ratio 0.36..	390	287	132	47	175	−75	−334	−526
Marginal savings ratio 0.20..	390	293	149	70	175	−34	−251	−411
Investment drain factor 0.25:								
Marginal savings ratio 0.36..	390	283	122	35	175	−75	−336	−527
Marginal savings ratio 0.20..	390	289	139	56	175	−37	−258	−421

How much are the demographic impacts influenced by the choice of economic parameters?

Table 3 is designed primarily to test the sensitivity of the indicated population impacts to alterations in three economic parameters. There is a substantial range of uncertainty about the way in which savings will in fact respond to higher levels of individual income, and about the weight that ought to be attached to what we have called the "investment drain." Moreover (as has been pointed out to us by Professor Enke) we might be accused of biassing our results by attributing all growth effects to investment if in reality some growth has arisen and will arise independently of investment, through technological improvements in capital goods, qualitative improvement in manpower, or shifts in the production function. As more fully justified in the Appendix, we attempt to recognize this last consideration by letting some GNP growth be "autonomous" in half of our projections (with the assumed growth-effect of investment compensatingly reduced).

The question faced in table 3 is whether the adoption of different assumptions under any of the above heads will greatly alter the essential conclusion about the growth-impact of fertility and mortality differentials.

In table 3, we first take one initial set of projections and put the (1985) results all in terms of ratios to those of the Cf-Dm case. To illustrate: per-consumer consumption in 1985 is 14.3 percent higher under Df-Dm than it is under Cf-Dm in this initial set of projections.

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TABLE 3.—*Sensitivity of population-growth impacts to changes in assumed economic parameters*

[Evaluated in terms of 1985 figures]

	1985 population (millions)	1985 consumers (millions)	1985 aggregate (crores)		1985 per consumer (rupees)			External resources to match Cf-Dm growth (1982-83) in per consumer GNP (all figures in crores)
			GNP	Saving	GNP	Consumption	Saving	
Demographic case:								
Constant fertility and declining mortality	241	189	16,668	3,659	883	689	194	175
Both fertility and mortality constant	229	181	16,996	3,872	939	725	214	−11
Both fertility and mortality declining	211	169	17,560	4,222	1,037	788	250	−205
Declining fertility and constant mortality	201	163	17,850	4,404	1,095	825	270	−347
Ratio to constant fertility and declining mortality case:								
Both fertility and mortality constant	.950	.957	1.019	1.058	1.063	1.052	1.103	[1] −186
Both fertility and mortality declining	.875	.894	1.053	1.153	1.175	1.143	1.288	[1] −380
Declining fertility and constant mortality	.834	.862	1.070	1.203	1.240	1.197	1.391	[1] −522
CHANGES IN ABOVE RATIOS								
Minus if marginal savings ratio reduced to 20 percent:								
Both fertility and mortality constant			−0.010	−0.020	−0.010	−0.003	−0.020	[2] +40
Both fertility and mortality declining			−.026	−.052	−.029	−.010	−.059	[2] +81
Declining fertility and constant mortality			−.035	−.069	−.040	−.014	−.078	[2] +111
Minus if investment drain factor raised to 25 percent:								
Both fertility and mortality constant			+.008	+.022	+.008	+.005	+.024	[2] +2
Both fertility and mortality declining			+.022	+.061	+.025	+.017	+.067	[2] +3
Declining fertility and constant mortality			+.030	+.081	+.034	+.023	+.096	[2] +2
Minus if autonomous GNP growth is 2 percent:								
Both fertility and mortality constant			−.006	−.012	−.006	−.004	−.012	[2] −64
Both fertility and mortality declining			−.016	−.030	−.018	−.014	−.036	[2] −129
Declining fertility and constant mortality			−.021	−.041	−.025	−.020	−.045	[2] −179

[1] Absolute difference from constant fertility and declining mortality.
[2] Changes in differentials (crores).

NOTE.—Initial set of assumptions, varied as specified in stubs of table: Marginal savings ratio .36; investment drain factor .10; autonomous GNP growth 0.

Then we change each of the economic parameters and see how much that affects the various ratios. For example, the 14.3 percent fertility-reduction impact just cited would be lowered by 1 percentage point (i.e., to 13.3 percent) if we assumed a marginal savings ratio of .20 instead of .36 and left everything else the same. If we raise the investment drain factor from .10 to .25, this fertility-reduction impact would rise to 16.0 percent. If we introduce an autonomous GNP growth rate of 2 percent per annum, it would fall to 12.9 percent. None of these revisions of the impact is very large—the advantage of reduced fertility in terms of level of per-consumer GNP in 1985 remains within a range of 12.9 and 16.0 percent no matter which parameter we change. Larger changes would of course sometimes occur if we altered two or three parameters at once, but it is impracticable to explore this in full detail in this summary report. We should only note that, without exception, the reduction of the marginal savings ratio *weakens* the impact of population-growth differences, as does the introduction of an autonomous element of growth. Giving more weight to the "investment drain," by contrast, *accentuates* the impact of population-growth differences. But none of these parametric adjustments comes close to wiping out the impacts. In Table 3 we measure also the sensitivity of the calculated external-resources-saving impact. These figures run in terms of absolute differences rather than ratios. Again, the sensitivity is quite moderate in relation to the initial "demographic impacts." It is noteworthy that the effects of parameter change are not all in the same direction here as in the case of the per-consumer GNP test. Introduction of an autonomous growth rate *accentuates* the external-resources-saving impact of population, while reducing the marginal savings ratio *weakens* that impact, and raising the "investment drain factor" scarcely affects it at all.

Sector projections

We shall not take space in this report to present the results of projections of output and employment by specific sectors of the economy. Time did not permit any attempt to feed back these results into a deeper analysis of population impacts, but we believe the sector projections should be of substantial use to any further work on the development of the economy under various conditions. They are a step, for example, toward stipulation of consistent relationships between investment, domestic levels of activity in the investment-goods manufacturing industries, and imports of such goods. They could also be useful in foreseeing the manpower supply/demand balance and indicated shifts of manpower and resources between sectors.

The construction of the sector projections is fully described in the Appendix, and the results are presented in complete detail in the tabular printout delivered to the Committee.

Projections assuming agricultural growth exogenous

It was suggested to us by Professors Dorfman and Conrad at Harvard that as a supplementary exercise we might develop and use an alternative projections model in which agriculture is assigned a dominant role in determining the pace of development, rather than merely being derived from overall growth in total and per capita income.

The construction of this model is described more fully in the Appendix. Here it is sufficient to say that we used two alternative assumed trends of agricultural output growth over the 20-year period: 6 percent and 4 percent per annum. From these we derived alternative trends of gross national product, by simply inverting the relationship which in our sector-breakdown calculation had been used to derive agricultural growth from population and GNP growth. Then from the projected levels of G.N.P. (under each of the various assumptions regarding population growth and the key economic parameters) we derived domestic savings and the "investment drain," and finally the amounts of external resources needed to support the projected growth of G.N.P. in each case.

With this "agriculture-exogenous" approach, there were 16 sets of four projections rather than eight sets as in the initial approach—since we used two alternative rates of agricultural growth and retained all of the parametric and demographic variants of the initial approach. A copy of the computer print-out of these 64 further projections (each of which has also included a breakdown of output and employment by non-agricultural sectors) has been given to the Committee.

It should be noted that in the agriculture-exogenous projections, the impact of demographic trends shows up *both in different levels of projected income and*

consumption and in different external-resources requirements. In evaluating the costs or benefits of fertility or mortality reduction, we have to look at the combined "income effect" and "capital-import-reduction effect"—these effects are additive, not alternative as they were in the original model that is the basis of the results shown in Tables 1, 2, and 3.

For example, we see in the first row of Table 4 that the impact of fertility reduction (Df-Dm compared with Cf-Dm) in one set of projections is to raise the 1985 per-consumer GNP by 14 percent; and that this *higher* level of income is attained with 217 crores *less* external resources use in 1982/3.

Here as in the earlier sets of projections (Tables 1, 2, 3), the fertility impact is roughly three times the size of the mortality impact, and is in all cases favorable in terms of the improvement of income and consumption levels.

In regard to sensitivity of the population impacts to choice of economic-parameter assumptions, we note that in this agriculture-exogenous model the projected levels of GNP in the aggregate and per consumer depend solely on which of the two levels of agricultural growth and on which of the four demographic cases we assume. The impact of population trends in terms of *income* differentials among the four population cases is accordingly insensitive to variation in the other economic parameters.

In terms of consumption and savings, the choice of savings ratios does affect the population impact, but only to a very slight degree, and there is no sensitivity at all to variation in the investment drain factor or the autonomous GNP growth rate.

The measurement of the population impact in terms of external-resources differentials, on the other hand, is sensitive to all four of the economic parameters we are varying. In the first 12 of the 16 sets of projections, the "fertility impact" (next to last column in Table 4) is favorable, indicating a benefit from fertility reduction in terms of lower external resources apart from the benefit of a higher 1985 per-consumer consumption level. In the other four sets of projections, however (the last four rows of the table, where there is a fast growth of agriculture and hence of GNP, but a low propensity to save), slower population growth actually increases the external resources requirement because it means that the GNP is going up faster in relation to savings that can be generated at the low marginal rate assumed.

TABLE 4.—*Projections with agricultural growth exogenous: Comparison of results for consumption per consumer and for external resources requirement*

[Cf-Dm: Constant fertility and declining mortality; Cf-Cm: Both fertility and mortality constant; Df-Dm: Both fertility and mortality declining; Df-Cm: Declining fertility and constant mortality]

Economic parameter assumption (see key below table)				Consumption per consumer, 1985				External resources (crores 1982/3) difference from Cf-Dm			
				Cf-Dm (Rs.)	Percentage difference from Cf-Dm			Cf-Dm			
A	S	F	G		Cf-Cm	Df-Dm	Df-Cm		Cf-Cm	Df-Dm	Df-Cm
4	36	10	0	469	+5	+14	+19	147	−59	−217	−260
4	36	10	2					−179	−46	−202	−232
4	36	25	0					287	−69	−230	−292
4	36	25	2					−39	−57	−224	−264
4	20	10	0	481	+6	+17	+23	338	+9	−25	−9
4	20	10	2					12	+22	−10	+20
4	20	25	0					478	−1	−47	−41
4	20	25	2					152	11	−32	−12
6	36	10	0	745	+6	+16	+21	386	−16	−139	−139
6	36	10	2					376	+17	−80	−45
6	36	25	0					620	−34	−175	−192
6	36	25	2					611	−1	−116	−99
6	20	10	0	826	+6	+18	+24	1,562	+69	+108	+185
6	20	10	2					1,552	+103	+167	+279
6	20	25	0					1,797	+52	+72	+131
6	20	25	2					1,787	+85	+131	+225

NOTE.—Key to parameters:
A—Agricultural growth rate (percent per annum).
S—Marginal savings ratio (percent).
F—Investment drain factor (percent).
G—Autonomous GNP growth (percent per annum).

QUALIFICATIONS AND CAVEATS

As we are not Pakistani area specialists, we have accepted uncritically a variety of data and assumptions coming from what we take to be the most reliable sources. We do not presume to evaluate the consistency, feasibility, or other merits of the Pakistan development plans. Nor do we pass judgment on the population projections we have used.

Our model is a very simple one, taking into account what seems to us the economic magnitudes and relationships most clearly affected by population growth. A great many aspects of the problem have been passed over because of the limitations of our time and our knowledge.

For example, there is no consideration here of the fact that mortality and fertility rates are affected by, as well as affecting, the rate at which individual incomes and well-being rise. This feedback must of course be recognized in development planning.

Again, we have not made explicit allowance in our calculations for the costs of the public-health and other programs that would be entailed in reducing either mortality or fertility or both, as assumed in the population projections. It would not appear, however, that such programs will in any event represent any considerable fraction of the total development or investment outlays.

Nor have we made any allowance for possible effects of different rates of population growth and income levels upon labor-force participation or labor productivity. There are certainly such effects, though they are perhaps not significantly large and the direction of their net effect is somewhat conjectural. It has been argued by some that pride in large families and the dependency burden of children are important spurs to productive effort. But it has also been argued that a rising level of individual income is a more effective invigorator. The bearing and rearing of fewer children may well have an effect on the work capability of mothers. Health improvements that reduce mortality are likely at the same time to reduce morbidity, and thereby to increase manpower energy and effectiveness. Reduced number of funerals might reduce what is perhaps a significant drain on private savings. All these factors we have had to ignore.

Nor have we explicitly introduced into our model the important growth constraint that is imposed by deficiency of skills and training. There is, however, some implicit recognition of this factor built into our model. It seems reasonable to assume that, insofar as the rate of development of skills will be affected by the rate of population increase, this impact will work through the supply of investment funds in relation to the rate at which facilities have to be supplied for additions to the population. And these are relations which our model does explicitly use.

Our analytical scheme has not been sufficiently detailed to take any account of certain further constraints which might play a substantial part in shaping growth over the next two decades. Here might be mentioned the important national objective of reducing income differences between the eastern and western parts of the country; limitations on markets for Pakistani exports; the rate of urbanization of population and its implications for housing and public service requirements; shortage of qualified teachers; the need to maintain a large military defense force; and many more.

Finally, our results give a substantial range of variation in showing the economic impact of alternative mortality and fertility trends. The tables in this report adequately portray this range, which of course reflects the absence of any certainty about such matters as the savings ratio and the degree to which output growth depends on the supply of investment funds, the way in which such funds are allocated, the rate of agricultural growth, or other factors independent of overall investment. Under the circumstances, we have deemed it appropriate to provide a gamut of projection results embracing what seem to be sufficiently high and low extreme values assumed for the different economic parameters. Those more conversant with the actual planning picture in Pakistan will doubtless be able to narrow considerably the range of uncertainty of results by excluding our more far-fetched cases.

APPLICABILITY OF THIS APPROACH TO OTHER COUNTRIES

We believe that our approach has the merits of simplicity and of relying on relatively few data inputs. It should, therefore, be generally useful for planning

in similar national economies. Specifically, it suggests a measure which planners could show regarding the cost of not having a population growth control program—or of having an inadequate one, or even one of the "wrong" kind.

It should also be useful for those interested in allocating foreign aid among applicant countries. One great use might be to employ it as a rationing instrument for the allocation of the scarce public health personnel interested in, and capable of, developing local fertility clinics.

When we were asked to undertake this assignment, we were directed to identify the kind of countries for which our analysis would be applicable. It is appropriate here to identify the principal characteristics of the Pakistan situation which makes this report a possible demonstration example for other countries. We feel that what we have done is generally applicable to countries (1) receiving foreign aid, (2) willing and able to implement population control programs with regard to fertility and mortality, (3) suffering from foreign exchange shortages, (4) suffering from a population "surplus" (low real income), (5) suffering more from a shortage of development funds (external as well as internal) and an inability to maintain high rates of domestic saving than from an immediately apparent shortage of human skills relevant to operate her economy, and (6) willing and able to entertain the bold aspirations of a national economic plan. Even though we have used Pakistani data, we have abstracted from two conditions which typify that country and do not typify most other countries like her. We have not explicitly considered the effects of a bifurcated national territory, nor have we explicitly taken into account the cost to the Pakistani economy of maintaining her defense posture.

On the other hand, our approach would in general *not* be appropriate in economically advanced countries. Nor is it likely that it would have much use in an underdeveloped country which is "under-populated." It would not be particularly useful in any country having large economically important skilled industries. It would obviously have no relevance in countries where the resistance to fertility control and mortality control programs were so strong that any discussion of either was impossible. Nor would it have much use in those few areas and countries of the world where the natural increase rate is negative or close to zero.

But in the many low-income countries where foreign exchange is scarce, where investment funds have largely to come from outside, where labor is redundant and the absence of skilled manpower is low on the list of "crucials," and where the productivity of the agricultural sector is the key to immediate survival, we have confidence in the usefulness of our analytical method.

SUGGESTIONS FOR FURTHER RESEARCH

Our work has brought to light a number of questions that we can suggest for further exploration. On each of these questions, we believe the present study has provided some useful points of departure and progress toward answers.

1. Unemployment.—What is the prospect for productive absorption of the present large fraction of the labor force that is unemployed or underemployed? What sectors of the economy will play the most active part in the creation of additional job opportunities? Will employability depend increasingly on education, and decreasingly on sex? How much shift from farms to nonfarm employment do foreseeable manpower needs imply under varying assumptions about population change and progress? Our sector-by-sector projections of output and employment should be useful as material for this area of inquiry, in conjuction with analysis of the population projections by functional age groups.

2. Foreign trade and the balance of payments.—Our model (and of course others which have been developed) include consideration of consumption levels, domestic industry output by sectors, and net use of external resources. The consistent interrelation among these variables could be traced much more explicitly as affected by alternative trends of population growth.

3. Human resources investment.—An important question is how much of the nation's development funds should optimally be allocated to domestic welfare services. With how long a lag and to what degree does investment in human resources begin to affect production? To what extent, typically, does the investment in human capital rise as income rises and as populations improve their production capabilities?

4. Special manpower requirements.—Our model could be amplified to determine how many teachers and how many physicians (to cite but two examples) would

be needed at various times under alternative population and growth trends. Even more interesting are the possibilities of determining the degree to which investment in this kind of welfare activity can replace reliance upon external resources.

5. Economic benefits per prevented birth.—Our model, or a variant thereof, could fairly readily be adapted to yield estimates of the value (in terms of income and/or reduced external-resources requirements) of a birth prevented or deferred at any time in the projection period. This kind of estimate should be useful for guidance as to the scale and direction of family planning efforts in relation to the costs thereof, and in consideration of policies of fertility-control incentives under which some of the national benefits of birth prevention would be shared with cooperating parents.

APPENDIX

The analytical scheme and projections program used for generating our various projections were described in the text of this report with a bare minimum of detail.

This appendix provides more complete information on those aspects of the procedure.

The way in which the model "simulates" growth under various conditions is described below:

1. *The increase in real GNP* from each date to the next is basically a function of the level of investment at the beginning of the interval in question. Since the projections proceed by intervals of 2½ years, there is an assumed lag of GNP-increase behind investment.

The incremental output/investment ratio is *not* taken as constant. Initially for our projections the values for this ratio were derived from the investment and GNP series in the Prospective Plan—the ratio falls fairly rapidly in the earlier part of the 20-year period and then flattens out, reflecting the judgment of the authors of the Plan.

We seek in our projections to allow for the fact that some investment may be essentially geared to the welfare needs of an expanding population and not as directly related to worker productivity as would be for example, investment in irrigation works or industrial equipment. Accordingly, we assign a zero growth effect to a portion of total investment (which for convenience we can call the "Investment Drain.") We make this drain depend on (1) the level of per-consumer income, as indicative of welfare standards, and (2) the size of the next 2½-year increment of consumers, as indicative of quantitative growth of the consumer population.

Thus, our formula for Y (the gross national product) looks like this:

$$Y_{t+1}=Y_t+R_t[I_t-By_t(C_{t+1}-C_t)]$$

where R is the incremental output/investment ratio, I is gross investment, Y the level of per-consumer GNP, C the number of consumers, and B a weighting factor for the Investment Drain, to which alternative values may be assigned. In our projections we have used the alternative values of 0.10 and 0.25 for B.

2. Investment (gross) is the sum of "external resources" and domestic savings. External resources in each time period are assumed in some of our projections as will be described below; at the levels set forth in the Prospective Plan, which involve progressively lower levels through the period. In other projections, we derive external resources as a "requirement" for meeting various stipulated growth standards.

Investment in the formula previously stated is, then, broken down into two components for projection purposes:

$$I=S+E$$

where E is external resources measured as an annual rate of flow, and S is domestic saving.

3. Domestic Saving (S) is in turn derived as the number of consumers times per-consumer saving, and per-consumer saving as a linear function of per-consumer GNP. The saving formula is therefore:

$$S=C(ay-b)$$

where a is the marginal propensity to save. Alternative values for a are taken—a "high" of 36 percent corresponding closely to what the Perspective Plan assumes, and a more conservative "low" of 20 percent.

When we shift to a different value of a, we make an adjustment in b at the same time, so that the computed S for 1965 is left in conformity with current estimates. Graphically speaking this involves the pivoting of the line showing the relation of per-consumer saving to per-consumer income around that point on the line that represents the present situation. (See Note 1 below for further details.)

NOTE 1

The assumed savings function

The projections GNP and savings for the Perspective Plan very closely fit the following linear relationship:

$$S=.3614\,Y-124.7\,(Rs.),$$

where both S and Y are *per consumer*

When we decided to incorporate a different marginal savings rate as alternative to the 36% in the above fitted equation, we wanted to leave the computed per-consumer saving in 1965 *unchanged*. Taking the 1965 per consumer income as Rs. 464.75 and the 1965 per-consumer saving as Rs. 43.25 and inserting these as constants in the above formula with the marginal ratio and the intercept as variables, we have:

$$43.25=464.75a-b$$
$$\text{or } b=464.75a-43.25$$

The per-consumer savings may then be calculated as:

$$S=aY-(464.75a-43.25)$$

where a is the marginal savings ratio.

This simplifies to

$$S=a\,(Y-464.75)+43.25\,(Rs.)$$

4. The model as described so far incorporates two "adustable" features—the marginal savings ratio and the "investment drain." Acting on a suggestion from Dr. Enke, we added a third adjustable feature: an "autonomous" component of G.N.P. growth assumed to be altogether independent of investment. This feature is designed to meet the argument that an output/investment ratio based simply on historically observed or envisaged relationships between GNP growth and the level of investment implicity ascribes all growth to the enlargement of the capital stock, and none to such other factors as increased labor supply or enhancement of productivity through technical progress aside from the *quantity* of capital or labor inputs.

We are not prepared to admit that the simple output/investment-ratio model is quite as naive as the above-stated argument might imply. In the first place, our data on investment are gross rather than net—no attempt has been made to estimate the capital stock or net accretions to it. Using gross investment implicitly assigns some productivity-raising effect to "capital replacement" and thus does allow for some of the influence of technical progress via *qualitative* changes in the stock of capital. Secondly, the consensus seems to be that during the period of projection considered, manpower can be safely assumed a redundant factor—so that even if higher fertility meant a faster growth of the labor force, we could still not assign any positive GNP growth effect to that difference. In fact, of course, the difference in the projected labor force under the four demographic cases is quite small and appears late in the period.

None the less, we have introduced into our projections procedure a set of cases in which an arbitrarily-assumed GNP growth rate of 2 percent per annum is assured regardless of investment. Investment-induced GNP growth is assumed to be superimposed on that 2 percent rate. Here as in the case of the varying of the marginal savings ratio, however, it seemed to us more useful to make a counterbalancing adjustment so as to keep the projections of growth roughly the same as before—rather than simply adding 2 percent annual growth to all of them. Our reasoning on this is that if we assign some growth to non-investment factors, we should assign a *smaller* growth effect to each rupee of investment.

We do this by reducing the output/investment ratio by a multiple of the assumed annual percentage rate of autonomous GNP growth. See Note 2 below for further details. The compensation for introducing a 2 percent annual autonomous growth rate is to cut our output/investment ratio by about a quarter.

5. External resources as a requirement. All of the projections described thus far assume external resources as given, and the same for all projections. The various projections then measure how rapidly the income per-consumer (and other economic indicia) could rise with these resources.

It is equally pertinent to turn the problem around and ask what external resources would be required, under each of our sets of assumed conditions, in order to achieve a specified path of per-consumer income growth. To approach the problem in this way, we have to specify that path. This has been handled as follows:

For each of eight sets of assumptions about economic parameters, we have four "demographic cases" representing the four Census projections of population. We take the "least favorable" of these four cases (constant fertility, declining mortality) as the standard. The trend of per-consumer GNP growth achieved in that demographic case with the external resources suggested in the Perspective Plan could of course be matched under any of the three more favorable demographic cases with a smaller amount of extenral resources in each time period. How much smaller? We have calculated this, to measure the advantages of reduced fertility (and/or sustained mortality) in terms of reduced dependence on external resources and earlier attainment of the stated goal of non-dependence in that regard.

NOTE 2

Adjustment of output/investment ratio for autonomous GNP growth

The purpose of this adjustment is to scale down the growth impact attributed to investment in recognition of the fact that some growth has been attributed to factors independent of investment.

We can express this stipulation as follows, considering the rise in GNP in any 2½ year time interval:

$$RI=R^*I+YA$$

where R is the incremental output/investment ratio without any autonomous GNP growth, R* is the ratio assuming an annual autonomous growth at AY per 2½ years, Y is GNP at the beginning of the 2½-year interval, and I is the level of investment at the beginning of the interval.

The above expression yields

$$R^*=R-\left(\frac{Y}{I}\right)A$$

The value of Y/I is reasonably stable over the projections period, varying generally between 4.0 and 4.5. For our adjustment, we assign it a constant value of 4.2. This means that instead of using a simple output/investment ratio R in our projections calculation, we substitute:

$$R-4.2A$$

Since A is approximately .025 times the assumed annual percentage rate of autonomous GNP growth, an assumed 2% annual autonomous growth means A=.05 and has the effect of reducing the output/investment ratio by about a quarter.

These evaluations in terms of "external resources required to match the GNP-per-consumer growth of the constant-fertility/declining mortality case" have been carried out for all of the projections, with the eight different combinations of the marginal savings ratio, investment drain factor, and autonomous growth rate already described.

It would of course have been just as appropriate to take the most favorable rather than the least favorable demographic case as the standard, or to establish the "target" trend of per-consumer GNP by applying some time-trend of external resources other than that suggested in the Perspective Plan. That would have yielded somewhat different numbers but we see no reason to believe that it would substantially alter the character of the findings regarding the impact of fertility and mortality reductions per se on external resources requirements.

6. Projections by sectors. Each of our projections has been carried a further stage, breaking down the total gross national product by major productive sectors and translating output into employment for each sector except agriculture. These sector breakdowns are by-products of our effort in the sense that we did not attempt to have them feed back into the determination of projected overall growth.

To derive the projections of output by sectors, we used the "elasticities" shown in the April 1964 mimeographed Perspective Plan paper on "Long Term Perspectives." These sector elasticities were originally developed by Hollis Chenery ("Patterns of Industrial Growth," in *American Economic Review*, September 1960) and we understand that they have been subsequently modified and adapted more specifically to the Pakistan situation. Each one relates the percentage growth of a specific sector of the economy (starting with the base year, fiscal 1965) to the percentage growth of (1) population and (2) per capital income. Consequently the projected level of output of any sector in any year depends, in our model, on the population that the Census has projected for that year and on the GNP that we have projected for that year.

In symbols, the calculation is as follows:

$$Q_t = Q_1 \times (P_t/P_1)^{EP} \times (y_t/y_1)^{Ey}$$

where Q represents output of a particular sector, P is population, y is per capita GNP, and EP and Ey are the "Chenery elasticities" specified for that sector.

It is obvious from the form of this equation that the sector outputs thus calculated will not (except by coincidence) add exactly to the GNP total from which they are calculated. Accordingly, our calculation includes a reconciliation adjustment to make them add up. The adjustment necessary was quite small—ordinarily of the order of 1 percent.

To derive the employment projections from these sector-output projections, a further set of elasticities is used, which are presented in the same April 1964 document and stated to have been derived from an unpublished document of the European Coal and Steel Community in Luxembourg. These elasticities (in the form we have used them) relate sector employment in any year to sector output in that year as follows:

$$E_t = E_1 \times (Q_t/Q_1)^{EE}$$

where E is employment and EE is the "employment elasticity" specified for that sector.

7. Projections with agricultural growth exogenous. We have also made projections on the basis of a quite different conception of what will determine the growth of the Pakistani economy. Specifically, this alternative model starts with an arbitrarily assumed growth rate for the agricultural sector, and from that estimates the growth of GNP, savings, and so on. We have applied two alternative rates of assumed agricultural growth: 6 percent per annum and 4 percent per annum. The former is close to what is suggested in the Perspective Plan, or a shade more optimistic; the 4 percent rate is definitely more conservative than what the planners seem to envision.

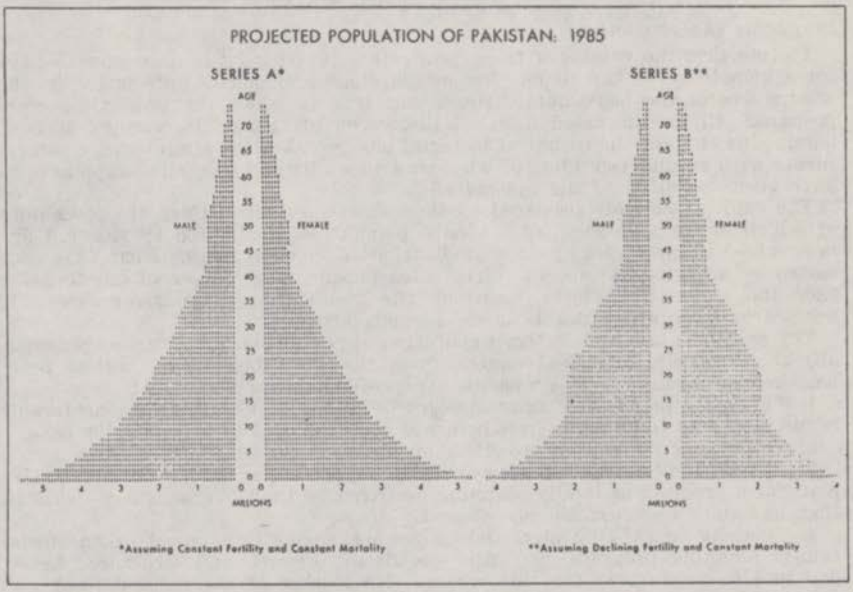
Gross national product is derived, in this model, from agricultural output (and population) by simply reversing the operation by which we derived agricultural output from GNP (and population) in getting the sector breakdowns described in Section 6 above.

From these projected levels of the GNP, we then proceed to calculate per capita and per-consumer income, consumption, and savings on the same combinations of assumptions as in the primary set of projections described earlier. There are now, however, twice as many projections (16 sets of 4 rather than 8 sets as before), because the GNP reflects two alternative agricultural growth rates. We can in each case determine the total investment requirements to support the projected growth of the GNP, and the magnitudes of domestic savings and the "investment drain." This gives us *required external resources* as a residual. For each of the 16 combinations of parametric assumptions we can make comparisons among the demographic cases, and we can appraise the sensitivity of the conclusions to variations in the parametric assumptions by looking at the 16 combinations. A summary of results of this projections procedure is shown in Table 4.

(8) Projections of the Population of Pakistan, by Age and Sex: 1965–86*

A measure of the potential impact of a family planning program

(By James W. Brackett and Donald S. Akers, Foreign Demographic Analysis Division, U.S. Department of Commerce, Bureau of the Census, June 1965)



PREFACE

This report presents projections of the population of Pakistan under alternative assumptions of an effective program of family planning and of no such program and under the alternative assumptions of constant and declining mortality. It was prepared under the auspices of the Agency for International Development as a pilot project in AID's program to study the relation between population growth and economic development.

Four sets of projections are presented:

A. Constant fertility, constant mortality.
B. Declining fertility, constant mortality.
C. Constant fertility, declining mortality.
D. Declining fertility, declining mortality.

The validity of these projections may well be questioned on two grounds: (1) the gross inadequacies in the data on which they are based and (2) the gross adjustments necessary to overcome these inadequacies. Nonetheless, they will at least indicate the magnitude of potential population growth should fertility remain at its present level and an indication of how population growth may be affected by a successful program of family planning.

The general methodology used and the problems encountered in preparing the projections are discussed in chapter I. The results of the projections are presented in chapter II. The urban population and projections of this population are presented and discussed in chapter III. Details of the procedures by which the projections were made are given in the technical appendix. Finally, the detailed tables present, for each year, 1961 to 1986, for East and West Pakistan

*This is an excerpted article. Pages 28–50, all tables, are not included in this publication.

separately, projections of the population by 5-year age groups and sex for January 1, projections of the total population on January 1 and July 1, and absolute numbers of births and deaths and birth and death rates. The decision to carry the projections to 1986 rather than to 1985 was made to provide projections of the mid–1985 population.

I. SOURCES, ASSUMPTIONS, AND METHODS

Preparing the projections

To interpret the results of these projections properly, it is necessary to have some knowledge of the underlying assumptions and some appreciation of the weaknesses of the basic data. Hence, the way in which the projections were prepared will be discussed first. A discussion of method is complex at best, but in this chapter the technical material has been kept at a minimum commensurate with an understanding of what was done; the more detailed explanations have been relegated to the appendix.

The projections were prepared by the cohort-survival method, the mechanics of which are straightforward. A base population distributed by sex and age is survived to later years by the application of survival rates. Births are estimated by applying age-specific birth rates to surviving women of childbearing age, and survived to later years by the application of survival rates. If necessary, some allowance is made for migration.

The problems involved in the preparation of population projections are generally those associated with the adequacy of the input data. Four serious problems were encountered in preparing the projections for Pakistan:

1. The latest population count appears to be deficient, so that a considerable adjustment had to be made in it before it could be used as a population base.
2. The rate of population growth is uncertain and a subject of controversy.
3. The assumption of declining fertility supposes the success of a tentative plan for a program of family planning prepared by the Government of Pakistan that has since been extensively altered.
4. There is no existing methodology for measuring the impact of an official family planning program on future population growth and structure; hence, one had to be devised for this report. No testing of the method used was attempted.

In seeking solutions to these problems, various persons with a knowledge of Pakistan were consulted. Among them were personnel of the Population Council, the Office of Population Research at Princeton University, the International Statistical Programs Office of the Bureau of the Census, the Department of State, and the Agency for International Development. Their comments were taken into account in devising methods and adjusting data.

The projections were based on the 1961 census counts adjusted for underenumeration. They were carried through by sex and single years of age, for January 1 of each year from 1961 to 1986. Separate projections were made for East Pakistan and West Pakistan and then summed to obtain figures for the entire country.

Sources of data

The two principal sources of data on the population of Pakistan are the 1961 census and the Population Growth Estimation (PGE) project. The figures from the regular registration of vital events are too deficient to be useful.

The latest census in Pakistan was taken on February 1, 1961. Censuses have been taken in the area which is now Pakistan each decade since 1871, but the problem of reassembling data to relate to the present boundaries makes historical comparisons difficult. Population growth may be measured from census data if the counts are complete, but this condition does not hold for Pakistan since there is evidence of significant underenumeration in both the 1951 and 1961 censuses.

The difficulty of obtaining adequate data on population growth in many underdeveloped countries has fostered proposals for collecting vital statistics on a sample basis. One of the first full-scale programs in this field is the Population Growth Estimation project in Pakistan. So far, the only data available from PGE are preliminary results for 1962, the first year for the project.

The population base

According to the 1961 census, Pakistan had a population of 93,831,982. However, the census is believed to have missed a substantial portion of the population. The Pakistan Planning Commission estimates the population to have been 101,500,000, thus placing the underenumeration at 7.7 million, or 7.6 percent of the population. The distribution of the population by region was as follows:

Region	Census count [1]	Estimate	Percent undercount
Pakistan	93,831,982	101,500,000	7.6
East Pakistan	50,853,721	55,300,000	8.0
West Pakistan	42,978,261	46,200,000	7.0

[1] Includes an estimate of 2,154,911 for the Frontier Region of West Pakistan.

Since the basis for assuming this amount of undercount is not known, no final evaluation of it can be made. However, our own estimate of the undercount, based on adjustments in the age-sex distribution, was 8.9 million—1.2 million higher than the Planning Commission estimate. The Planning Commission figure was accepted because it has official sanction in Pakistan and is the basis for much of that country's economic and demographic work.

Underenumeration is rarely evenly distributed among subgroups of the population. The undercount is usually greater for young children and for young adults, and in Asian populations females are more likely to be undercounted than males. If, in addition, there is much misreporting of age, the composition of the base population may be seriously distorted. It is then desirable to attempt an adjustment in the reported structure of the base population for census errors before making projections.

Distributions of the population by age and sex are available from the census for 1961 and from the preliminary results of the PGE project for 1962. The two distributions are quite similar to each other and both are quite different from the expected population if past growth had been uniform. The census rather than the PGE distribution was used as a base. Where the deviations of the reported from the expected population seem best explained in terms of counting errors, an adjustment was made in the census counts. A comparison of the enumerated and the adjusted age-sex distributions is shown in figure A–2. The adjustments are discussed in detail in the appendix.

Rate of growth

Estimates of the future growth of population must take account of the present rate of growth. For Pakistan, however, the present rate is uncertain and the subject of controversy. The available statistics imply two quite different rates of growth.

The annual rate of growth between the censuses of 1951 and 1961 was 2.1 percent. The distribution of the growth by region was as follows:

Region	1961	1951	Average annual rate of growth per 1,000 population
Pakistan	93,831,982	75,842,175	21.5
East Pakistan	50,853,721	42,062,610	19.2
West Pakistan	42,978,261	33,779,565	24.4

The rate of natural increase should be set slightly higher to allow for some out-migration from East Pakistan during the decade. If net out-migration is set rather arbitrarily at 800,000 (600,000 refugees and 200,000 young adult males

seeking employment in West Bengal),[1] the annual rate of natural increase for the decade would be 20.8 per 1,000 population for East Pakistan, 24.4 for West Pakistan, and 22.4 for Pakistan as a whole.

The preliminary results of the PGE project give much higher rates of natural increase—34 per 1,000 population for East Pakistan and 30 for West Pakistan—for 1962. These rates are the differences between the estimated birth and death rates, as follows:

Region	Birth rate	Death rate	Rate of natural increase
Pakistan	51	19	32
East Pakistan	53	19	34
West Pakistan	50	20	30

The higher rate of increase from the PGE project has been accepted as the basis for the population projections. Even though preliminary and unevaluated, the results should be more accurate than the estimates based on the census counts because the reporting was done by selected, specially trained enumerators and registrars and because of the built-in corrections for underreporting. Moreover, the estimates derived from the PGE project relate to 1962, whereas those derived from the census counts relate to the period from 1951 to 1961, during which there may have been considerable reduction in mortality.

In addition, the reasonableness of the birth and death rates resulting from the PGE project is supported by other evidence. Birth rates similar to or substantially higher than those derived from the PGE project have been estimated by Krotki, Zelnik and Khan, Ahmed, and others using a variety of methods.[2] Ahmed, for example, estimates the 1951 birth rate for all Pakistan at 60 per 1,000 population. Zelnik and Khan obtained estimates for 1961 as high as 64 per 1,000 for East Pakistan, although their rate for West Pakistan is only 48. Krotki derived a range for 1961 of from 53 to 60 per 1,000 for East Pakistan and from 47 to 54 for West Pakistan. Khan and Ziaud-Din derived the much lower estimate for West Pakistan of 44 per 1,000 for 1954. All of these estimates (except that of Khan and Ziaud-Din, which was based on surveys) rely on an analysis of the age-structure of the population from the census or the PGE project, so that their accuracy is dependent upon the validity of these sources as well as upon the representativeness of the life tables used to estimate deaths between birth and the date of the respective censuses. Variations in the birth rate of 20 to 30 percent (10 to 15 births per 1,000 population) may be obtained by changing the assumptions regarding present and past levels of mortality.

There have been fewer estimates of the death rate than of the birth rate for Pakistan so that the evidence in support of the estimated rates derived from the PGE project must be more circumstantial. Ahmed[3] estimated the 1951 death rate for all Pakistan to be 46.8 per 1,000 population. Yet the reported death rates from other Asian and Latin American countries with adequate registration systems or other means for determining the death rate range from 12 to 20. To reconcile the rate of natural increase implied by the census counts with an acceptable level of the birth rate would mean placing the death rate at 30, a level reported for only a few African countries. The rate of 19 derived from the PGE project seems more reasonable. The procedures of the PGE project make a gross underestimate of the death rate unlikely.

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[1] Based on "Migration From East Pakistan (1951–1961)," The Economic Weekly, Bombay, April 15, 1961; and Karol J. Krotki, "Population Size, Growth, and Age Distribution: Fourth Release From the 1961 Census of Pakistan," *The Pakistan Development Review*, Vol. III, No. 2, Summer 1963, p. 291.

[2] *Ibid.*, p. 300; Melvin Zelnik and Masihur Rahmen Khan, "An Estimate of the Birth Rate in East and West Pakistan," *The Pakistan Development Review*, Vol. V, No. 1, Spring 1965 (forthcoming); Mohuiddin Ahmed, "An Estimate of Pakistan's 1951 Vital Rates," *Pakistan Economic Journal*, Vol. XIII, No. 1, March 1963, p. 44; M. K. H. Khan and M. Ziaud-Din, "Crude Birth and Death Rates in the Province of West Pakistan"; and M. Ziaud-Din, "Demographic Studies in West Pakistan." The latter two papers were presented at the Conference of the International Union for the Scientific Study of Population, Vienna, 1959.

[3] Ahmed, *op. cit.*

The discussion to this point has concerned the overall rate of population increase, and the crude birth rate, death rate, and rate of natural increase. However, in projecting the population by the cohort-survival method, the crude birth and death rates cannot be used directly but must be converted into rates specific for age. This may be done by selecting schedules of age-specific rates and then successively adjusting the rates until they generate the same number of births and deaths when multiplied by the population as the crude rates do. The schedule of birth rates by age of mother used in this fashion is from the fertility model discussed in a later section of this chapter. The schedule of age-specific death rates used is a composite of rates for rural India for 1957–58 and rates from one of the United Nations model life tables (level 25).[4]

The death rates for the older ages proved to be too high to be applicable to the population of Pakistan, for they lead to incongruous results. The projections show the population of West Pakistan 75 years old and over as declining by 35 percent from 1961 to 1970, a most unlikely development. However, no change was made in the mortality rates to correct for this inconsistency in the data.

The expectation of life (in years) implied by the estimates of age-specific death rates is as follows:

Region	Male	Female
East Pakistan	48.7	52.3
West Pakistan	49.8	53.6

Life expectancy is higher in West Pakistan than in East Pakistan, according to our estimates, yet West Pakistan's crude death rate is also higher. The seeming paradox is to be explained by differences in age composition. West Pakistan has lower mortality but relatively more deaths than East Pakistan because our estimates show proportionately more older people in West Pakistan.

It is assumed in the series of projections labeled constant fertility and constant mortality that the schedules of age-specific rates remain constant. However, the crude rates may vary with a changing age composition of the population and, in fact, the crude birth rate does rise under the constant fertility assumption and the crude death rate does fall under the constant mortality assumption.

Migration

It is possible that there will be substantial movement of population between India and Pakistan. In 1964, after several years with only minor incidents, Hindus once more fled from East Pakistan to the Indian Province of West Bengal and Muslims fled in the other direction in response to communal riots. It is feared that the disturbances may continue. However, there is no way to estimate which of the two flows of population will outweigh the other. It is also possible that many young adults will leave East Pakistan to search for work in the industrial area of northeast India but that there may be a balancing movement of older men returning home. In the absence of any data indicative of the level and trend of international migration and in the absence of any clear notion as to international migration in the future, it was assumed in the projections that net migration would be zero.

The fertility model and the impact of family planning

To develop those projection series which assume declining fertility, it was necessary to make assumptions regarding the prospects for family planning and to develop some method of measuring its impact on population growth. The preliminary family planning program of August 1964 was accepted as the basis for our family planning model. This program envisioned an intensive campaign that would persuade about one quarter of the women of childbearing age to adopt some contraceptive technique, principally that of the intrauterine device (IUD), within 7 years (i.e., from 1965 through 1971). The plan has since been extensively revised, however, because it was judged to be too ambitious in its original form.

[4] Ajoy Kumar De and Ranjan Kumar Som, "Abridged Life Tables for Rural India, 1957–1958," *The Milbank Memorial Fund Quarterly*, April 1964, pp. 96–108; and United Nations, *Manuals on Methods of Estimating Populations, Manual III: Methods for Population Projections by Sex and Age*, Population Studies, No. 25, 1956, pp. 72–81.

The new plan calls for the insertion of only half as many IUD's as the original plan and relies more on conventional contraceptive techniques.

The projections assume that about one quarter of all women of childbearing age will become effective users of contraceptives by 1972 and that this proportion will not change very much thereafter. It is likely that once contraception is introduced, its adoption will continue to spread. Thus, the stricture that the series assuming declining fertility are too optimistic may apply only in the short run.

A methodology for measuring the impact of family planning on fertility levels had to be devised for this project. One important consideration in the measurement of this impact is the number of children already born to women adopting contraception. (In technical language, children ever born is known as the parity of a woman. Thus, a zero parity woman has had no child, and a one parity woman has had one child.) Those adopting contraception are likely to include a large proportion of higher parity women because they are the ones faced most immediately with the problems associated with large families. Although family planning may be highly desirable for these women, adoption of contraception by them will have less impact on population growth than its adoption by lower parity women because they are older and closer to the end of their reproductive lives. Hence, it is important in measuring the impact of contraception on fertility to allow for differentials in birth rates both by age and by parity, and our fertility model was designed to measure the interaction between contraception, parity distribution, and age-specific birth rates. This model is simple as compared with at least one theoretical model now being devised [5] and with others proposed which require complex theoretical formulations.

The model starts with a set of hypothetical fertility rates by age and parity of women, representing some kind of maximum in fertility, and a set of mortality rates by age of women. If a constant number of women are assumed to reach age 15 each year (say 100,000) and are subject from then on to the schedule of fertility and mortality rates, a stable distribution of women by age and parity will eventually be obtained. If then a proportion of the women are assumed to adopt family planning but the remaining proportion are subject to the same fertility rates as before, the number of births and their distribution by age of mother as well as the parity distribution of women will shift each year until a new equilibrium is reached. The number of births resulting divided by the number of women in the model give a schedule of age-specific rates for each year. These rates, adjusted by a constant to bring the initial rates in line with the crude birth rate, are those used in the projections under the assumption of declining fertility (see figure A–3).

Our model projects the following changes in the pattern of fertility by 1972, when the family planning program is expected to be fully implemented:

1. The proportion of women of childbearing age practicing contraception would reach 25 percent.
2. Fertility would decline by 28 percent as measured by the total fertility rate.[6] (See figure 1.)
3. For women of childbearing age, average parity would drop from 5.0 to 3.9 children. For women who have completed childbearing, it would drop from 9.8 to 7.1 children. (See table A–3.)
4. Average age of mother would drop from 30.1 years to 28.4 years.

The model is discussed in more detail in the technical appendix. It should be emphasized that the model is a theoretical construct using hypothetical rates. Its applicability to Pakistan or to any other population has not been tested.

Declining mortality

Two of the four series of projections in this report assume constant mortality and two assume declining mortality. The analysis of results presented in the next chapter is mostly in terms of constant mortality, because the more important variable is fertility, and it was simpler to emphasize the differences due to vary-

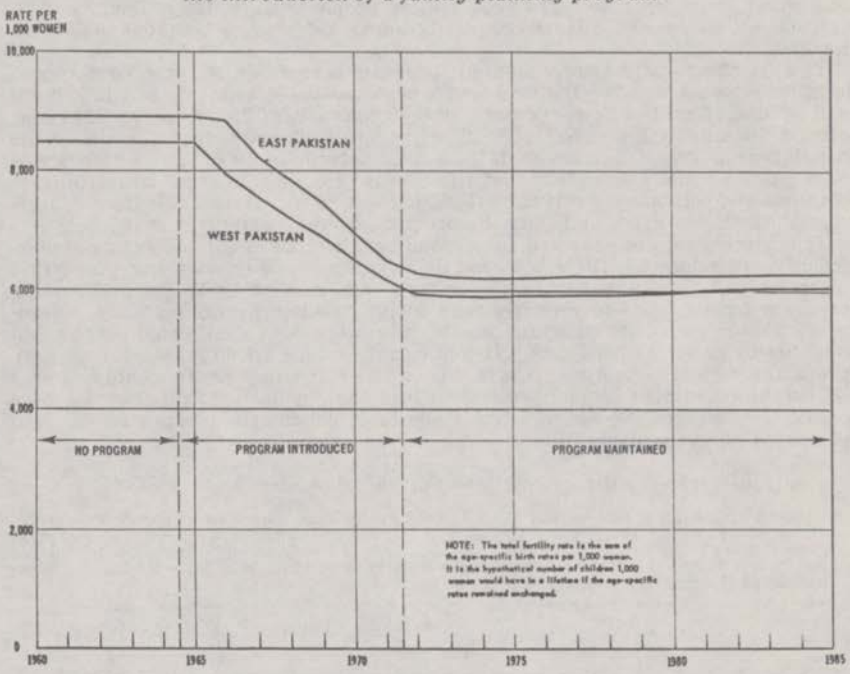
[5] Edward B. Perrin and Mindel Sheps, "Human Reproduction: A Stochatic Process," *Biometrics*, Vol. 20, No. 1, March 1964, pp. 28–45.

[6] The total fertility rate is the sum of the age-specific birth rates. It is the hypothetical number of children 1,000 women would have during their reproductive lifetimes if the age-specific rates remain unchanged.

ing the fertility assumptions if mortality were kept constant. Yet, it is quite possible that mortality will decline in Pakistan, especially if malaria is controlled.

For the two series that assume declining mortality, the expectation of life was increased to 58.8 years for males and 62.0 years for females by 1990. The ultimate values are taken from level 80 of the United Nations model life tables. This is the general level of mortality already achieved in such countries as Ceylon and Taiwan.

FIGURE 1.—*Projected total fertility rate for East and West Pakistan following the introduction of a family planning program*



II. FUTURE GROWTH OF THE POPULATION

Total population

Pakistan faces the prospect of extremely rapid population growth. It can be reasonably expected that her population will double in the next 20 years. The family planning program outlined in chapter I might reduce the growth by a fourth, but, even so, Pakistan would have seven people in 1985 for every four today. Some reduction in fertility might occur, even in the absence of a family planning program, as a result of the modernization of the country, but such reductions are likely to be gradual.

The following discussion presents four series of projections of the population of Pakistan with differing assumptions about future fertility and mortality. All four series assume that net migration will be of no consequence. The series are designated as follows:

Series A. Constant fertility, constant mortality.
Series B. Declining fertility, constant mortality.
Series C. Constant fertility, declining mortality.
Series D. Declining fertility, declining mortality.

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According to our estimates, the population of Pakistan was 115.4 million at the beginning of 1965.[7] (See table 1.) This figure is based on the assumptions that the 1961 census was undercounted by about seven million persons and that the levels of fertility and mortality estimated for 1961 has remained unchanged in the succeeding four years. The future size of the population will depend upon the future levels of fertility and mortality. If fertility and mortality remain constant at the levels assumed for 1961, as postulated for series A, the population will reach 136 million by 1970, 160 million by 1975, and almost 230 million by 1985. (See figure 2.) Thus, the population in 1985 would be double the 115 million in 1965. If the family planning program is successful, as postulated by projection series B, there will be 133 million people by 1970, 150 million by 1975, and 200 million by 1985. Thus, the population would increase by about 75 percent by 1985.

The net effect of the family planning program is represented by the differences between series A and B. If the program is successful in reducing fertility, there will be about 3 million fewer persons by 1970, about 10 million fewer by 1975, and almost 30 million fewer by 1985. The reduction amounts to 2 percent of the population in 1970, 6 percent in 1975, and 12 percent in 1985. Projection series B is based on the assumption that the family planning program will attain its maximum effectiveness by 1972 with 25 percent of all couples adopting contraception, and that after that date the program would continue at that level.

If the program does succeed in persuading a fourth of all couples to become effective planners by 1972, however, it is quite unlikely that the proportion planning will remain at that level for very long. Couples who learn about the program from friends or relatives may decide to adopt family planning. Moreover, the success of the program in attaining its present goal would serve as an impetus to an expanded effort. If additional couples are brought into the program, the rate of population growth during the 1970's and 1980's would be lower than that postulated by our projections and the population figures shown here would be too high. No attempt was made to determine the possible effect of an expanded program after 1972, however.

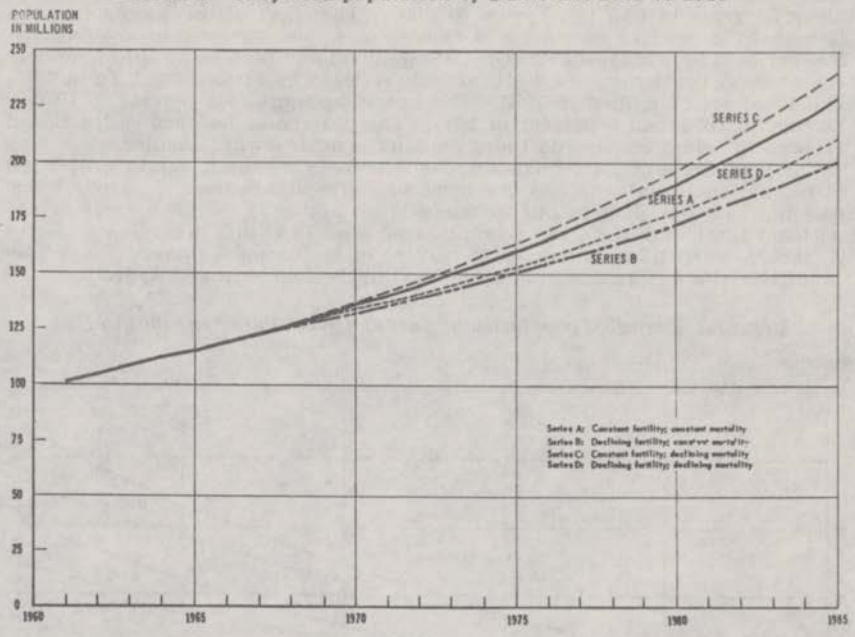
TABLE 1.—*Projected population of Pakistan, by region—1965–85*

(Population figures are in millions and relate to January 1. They have been independently rounded without adjustment to group totals. The letters A, B, C, and D denote the projection series. Series A and C assume that fertility will remain constant; series B and D assume that the family planning program will succeed in lowering fertility. Series A and B assume that mortality will remain constant; series C and D assume that mortality will decline)

Year	Pakistan				East Pakistan				West Pakistan			
	A	B	C	D	A	B	C	D	A	B	C	D
1965	115.4	115.4	115.6	115.6	63.3	63.3	63.4	63.4	52.1	52.1	52.2	52.2
1966	119.2	119.0	119.4	119.3	65.5	65.4	65.6	65.6	53.7	53.6	53.8	53.7
1967	123.1	122.6	123.5	123.0	67.7	67.5	67.9	67.7	55.4	55.1	55.6	55.3
1968	127.2	126.1	127.8	126.6	70.0	69.5	70.4	69.9	57.2	56.5	57.4	56.8
1969	131.4	129.5	132.2	130.3	72.5	71.5	72.9	72.0	59.0	58.0	59.3	58.3
1970	135.9	132.9	136.9	133.9	75.0	73.5	75.6	74.1	60.9	59.4	61.3	59.8
1971	140.5	136.3	141.8	137.5	77.6	75.4	78.4	76.1	62.9	60.9	63.4	61.4
1972	145.2	139.7	146.9	141.1	80.3	77.3	81.3	78.2	64.9	62.3	65.6	62.9
1973	150.2	143.2	152.2	145.0	83.1	79.4	84.3	80.4	67.1	63.8	67.9	64.5
1974	155.4	146.9	157.8	149.0	86.1	81.5	87.5	82.7	69.3	65.4	70.3	66.3
1975	160.8	150.8	163.7	153.3	89.2	83.7	90.9	85.2	71.6	67.1	72.8	68.1
1980	191.4	173.4	197.6	178.5	106.5	96.6	110.2	99.6	84.9	76.8	87.4	78.8
1985	229.0	201.2	240.7	210.6	127.9	112.5	134.9	118.1	101.1	88.7	105.8	92.5
PERCENT CHANGE												
1965–70	17.7	15.2	18.5	15.9	18.5	16.1	19.3	16.8	16.8	14.1	17.5	14.7
1970–75	18.3	13.4	19.6	14.5	18.9	13.9	20.2	15.0	17.6	12.9	18.7	13.8
1975–80	19.0	15.0	20.7	16.4	19.5	15.4	21.3	17.0	18.5	14.5	20.0	15.8
1980–85	19.7	16.0	21.8	18.0	20.1	16.4	22.4	18.5	19.2	15.5	21.2	17.3

[7] Projection series C and D, which assume that mortality has been declining, place the population at 115.6 million at the beginning of 1965.

FIGURE 2.—*Projected population of Pakistan: 1961 to 1985*



As the process of modernization proceeds in Pakistan, fertility levels may change, even if there is no family planning program. Pakistani women tend to marry at a rather young age, usually in their early or middle teens. Should the tradition of early marriage change, births per marriage would probably decline. The modernization process may also lead to the spread of contraceptive information through traditional channels and, even more important, to changes in the attitudes of couples toward family planning. No effort has been made in this report to measure the potential impact of such changes in fertility levels, but it seems likely that change would come gradually, if at all, and that an official family planning program constitutes the only real prospect for significantly reducing fertility in the immediate future.

In the short run, the process of modernization could actually have the effect of increasing the level of effective fertility and possibly the level of actual fertility. Improvements in prenatal care will probably reduce pregnancy wastage and thus increase the proportion of conceptions which result in viable births. Lower infant and child mortality will increase the proportion of live births surviving to adulthood. Moreover, improvements in health care and a more adequate diet for the adult population may tend to reduce fertility impairment and thus increase the likelihood of conception. Finally, there is also evidence that some couples in marginal but improving economic circumstances conclude that since their condition is improving, they can afford more children.[8]

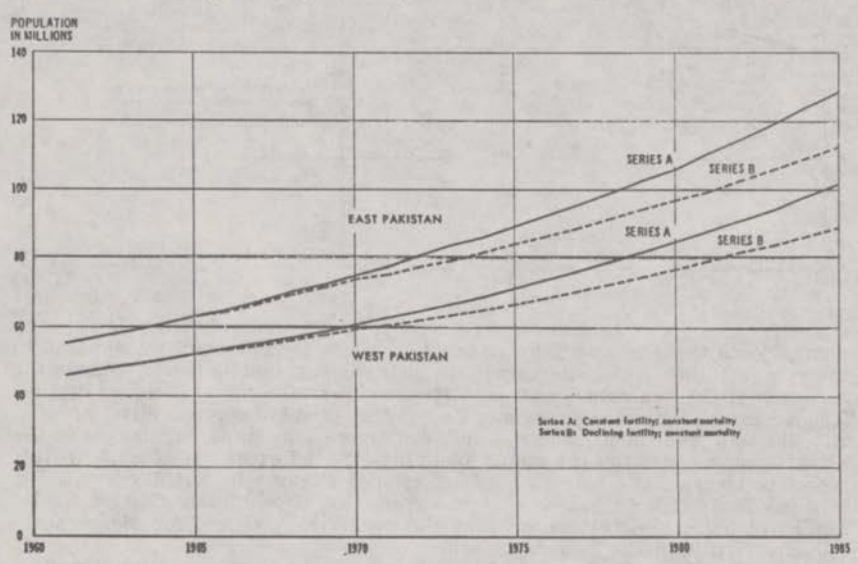
There is strong evidence that mortality in Pakistan has been declining in recent years. If the decline continues, the population will be higher than that shown for series A and B. To determine the potential effect of further declines in mortality, projection series C and D have been constructed on the assumption

[8] David M. Heer, "Economic Development and Fertility," paper contributed for the United Nations World Population Conference, Belgrade, Yugoslavia, 30 August to 10 September 1965.

that life expectancy in Pakistan will rise gradually from its estimated level of about 51 years in 1961 to 60 years by 1990. The effect of this assumption can be seen by comparing series A and C, both of which assume constant fertility. The series C projection shows about one million more persons by 1970 than does the series A projection. Series C exceeds series A by almost 3 million in 1975, and by about 12 million in 1985. The excess amounts to 1 percent in 1970, 2 percent in 1975, and 5 percent in 1985. The differences between series B and D, both of which assume declining fertility, are somewhat smaller.

The population of East Pakistan should become a slightly larger proportion of the national total whatever the trend of births and deaths. In 1965, it was 63.3 million, according to our estimates (see figure 3), or 55 percent of the national total. By 1985, the population of East Pakistan, according to series A, should reach 127.9 million, or 56 percent of the national total. The proportion living there in 1985 is almost identical in the four series of projections.

FIGURE 3.—*Projected population of East and West Pakistan: 1961 to 1985*



Projected rates of growth

The population of Pakistan is growing very rapidly, and unless fertility begins to decline, the rate of growth will increase. The series A projections, which assume constant fertility and mortality, show the rate of population growth increasing from about 32 per 1,000 population during the 1960's to about 36 per 1,000 population by the early 1980's. (See figure 4.) The rising rate of growth results from an increase in the proportion of the population in the childbearing ages (thus contributing to higher birth rates) and a decrease in the proportion at the older ages (thus contributing to lower death rates). The birth rate, according to series A, will increase from about 51 per 1,000 population in 1964 to 54 in 1985 while the death rate will decrease from 18.7 per 1,000 population in 1964 to 17.6 in 1985. (See figure 5.)

FIGURE 4.—*Projected rates of population growth for Pakistan: 1961 to 1985*

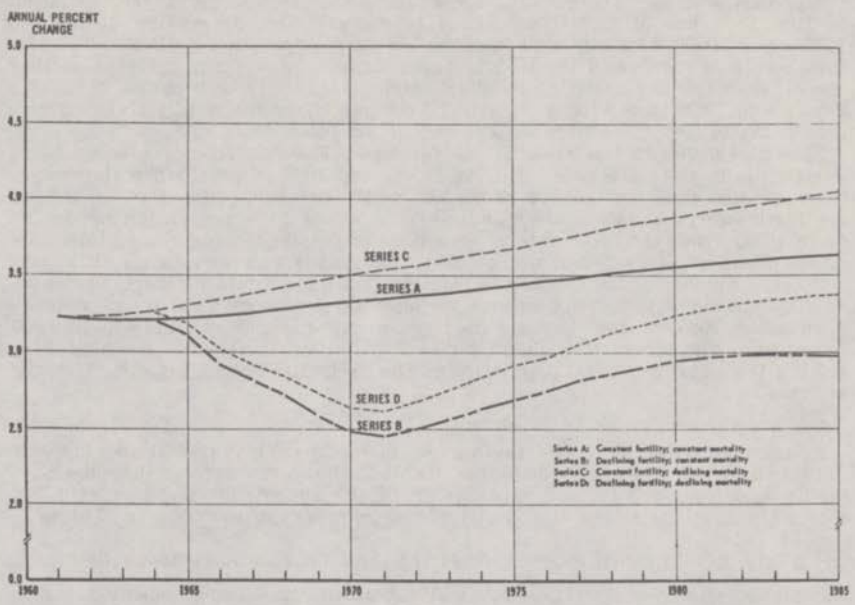
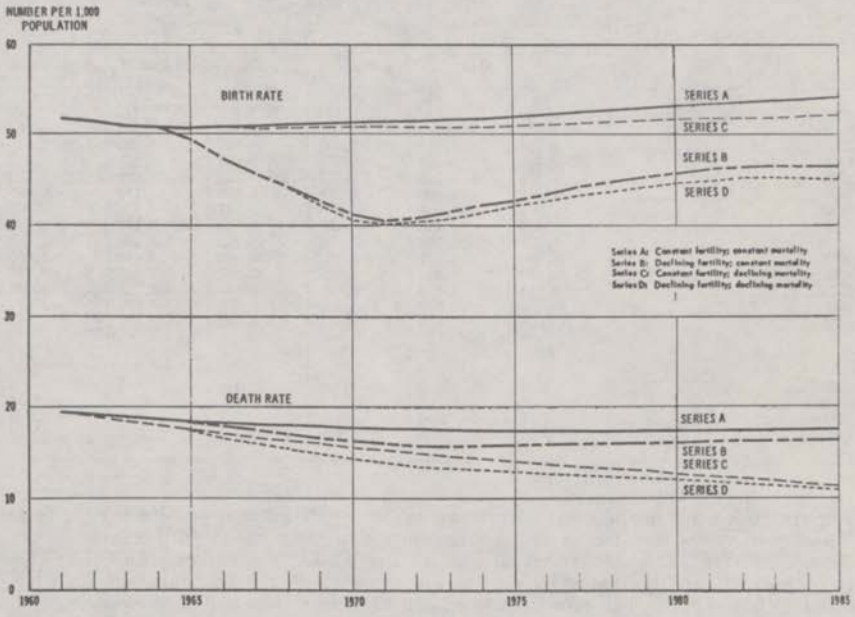


FIGURE 5.—*Projected birth and death rates for Pakistan: 1961 to 1985*



If fertility declines and mortality remains constant, as assumed for series B, the projections show the growth rate as declining from 32 per 1,000 population in 1964 to a low of 24.5 in the early 1970's, and then increasing during the 1970's and 1980's to a high of nearly 30 per 1,000 population by 1985. The rise in the rate of increase after 1971 is faster in series B than in series A so that the difference between the two sets of rates decreases from 9 points in 1971 to 6 points in 1981, thus wiping out part of the gain from the family planning program. After 1981, the difference widens a bit again.

The fluctuation in the growth rate for series B stems from a corresponding fluctuation in the birth rate. During the period 1965 to 1971, when the projections assume that the area covered by family planning clinics is expanding, the birth rate is shown as decreasing—from 50 per 1,000 population in 1965 to 41 in 1971. But, the birth rate is shown as increasing during the maintenance phase of the program when no further expansion is assumed (after 1971), because the number of women in the reproductive ages would be increasing more rapidly than the total population. So long as the large numbers of females born before 1965 continue to enter the reproductive ages, there will be an upward pressure on the birth rate. Thus, series B shows an increase in the birth rate from a low of 41 per 1,000 population in the early 1970's to a high of 47 by the mid-1980's.

Projected numbers of births

As the population increases, the number of births each year will also increase unless the level of fertility declines. Table 2 shows the projected numbers of births under alternative assumptions as to the successful implementation or the nonimplementation of the family planning program described in chapter I.

TABLE 2.—*Projected numbers of births for Pakistan, by region, 1964–85*

[Absolute numbers in thousands. Figures have been independently rounded without adjustment to group totals. Series A assumes that fertility will remain constant; series B assumes that the family planning program will succeed in lowering fertility. Both series assume that mortality will remain constant]

Year	Series A			Series B		
	Pakistan	East Pakistan	West Pakistan	Pakistan	East Pakistan	West Pakistan
1964	5,769	3,247	2,522	5,769	3,247	2,522
1965	5,950	3,354	2,596	5,802	3,333	2,469
1966	6,152	3,471	2,681	5,697	3,252	2,445
1967	6,369	3,594	2,775	5,669	3,237	2,432
1968	6,596	3,724	2,873	5,653	3,229	2,423
1969	6,833	3,859	2,974	5,596	3,180	2,416
1970	7,079	4,000	3,079	5,547	3,138	2,408
1971	7,336	4,149	3,188	5,603	3,173	2,429
1972	7,606	4,304	3,302	5,792	3,284	2,508
1973	7,890	4,467	3,422	6,020	3,416	2,605
1974	8,190	4,640	3,549	6,273	3,561	2,712
1975	8,511	4,823	3,687	6,547	3,718	2,829
1980	10,366	5,886	4,480	8,057	4,581	3,477
1985	12,616	7,180	5,436	9,468	5,405	4,064
PERCENT CHANGE						
1965–70	19.0	19.3	18.6	−4.4	−5.8	−2.5
1970–75	20.2	20.6	19.7	18.0	18.5	17.5
1975–80	21.8	22.0	21.5	23.1	23.2	22.9
1980–85	21.7	22.0	21.3	17.5	18.0	16.9

According to our estimates, about 5.8 million children were born in Pakistan during 1964—3.2 million in East Pakistan and 2.5 million in West Pakistan. These estimates are based on the assumptions that the 1961 birth rates in East and West Pakistan were 53 and 50 per 1,000, respectively, and that the hypothetical fertility rates by age of mother established to represent fertility during 1961 remained in effect during 1964. If the program is unsuccessful and if fertility does not decline for other reasons (e.g., changing age at marriage),

the number of births will increase very rapidly, as shown in series A. This series shows 6.0 million births for 1965, 7.1 million for 1970, 8.5 million for 1975, and 12.6 million for 1985. Thus, the annual number of births would double in less than 20 years.

If the family planning program postulated by series B succeeds, there will be progressively smaller numbers of births each year from 1966 through 1970. In 1970, there will be only 5.5 million births—a figure about 220,000 below that for 1964 and about 1.5 million below the series A figure for 1970. After 1970, series B shows increasing numbers of births, but the annual number falls progressively lower than in series A. By 1985, series B shows 9.5 million births, an increase of 60 percent over the 1965 figure but more than 3 million fewer births than shown in series A.

Because most of the family planning clinics scheduled to be opened in 1965 were to be in West Pakistan, the series B projections show a more rapid decline in the annual numbers of births for that region. According to this series, West Pakistan will have 50,000 *fewer* births in 1965 than in 1964, whereas East Pakistan will have about 90,000 *more* births than in the previous year. After 1965, the series shows decreasing numbers of births in East Pakistan as well but not until 1967 does it show as few births as in 1964. By 1970, when the family planning program is scheduled to be operating in most of the country, the projections show 3.1 million births in East Pakistan and 2.4 million in West Pakistan, about 100,000 below the 1964 figure for each region.

Series B shows increases after 1970 for both regions with East Pakistan reaching 3.7 million births by 1975 and 5.4 million by 1985 and West Pakistan reaching 2.8 million and 4.1 million for the same years, respectively. Thus, if the family planning program is successful, there will be in East Pakistan almost 0.9 million fewer births in 1970, 1.1 million fewer births in 1975, and 1.8 million fewer births in 1985. For West Pakistan, the series B projections show about 0.7 million fewer births in 1970, 0.9 million fewer births in 1975, and 1.4 million fewer births in 1985 than does series A.

Age composition

Pakistan has a very young population. Half of her people are less than 16.4 years old, according to our estimate. By contrast, the median age in the United States is 28.3 years. The series A projection shows the median age as dropping slightly, from 16.4 years in 1965 to 15.9 years in 1985. The series B projection, however, shows the median age as rising to 16.8 years by 1970 and to 18.8 years by 1985.

The changing composition of Pakistan's population may best be understood by a visual presentation. The population pyramids shown in figures 6 and 7 illustrate graphically the prospective changes in the age-sex composition of the population of East and West Pakistan, respectively. Because all pyramids shown in these two figures were plotted on a common scale, they may be compared between regions and by time period.

The single pyramid for 1965 in each figure shows the current age-sex structure as established for this report. The two pyramids for 1975 show the projected population for series A and B. The dark outline figure is for series A, which assumes that fertility will remain constant; the shaded figure is for series B, which assumes that the family planning program will succeed in lowering fertility. Both assume that mortality will remain constant.

The four pyramids for 1985 provide a pictorial representation of the results of all four projection series. The two dark outline figures assume constant fertility; the two shaded figures assume declining fertility. The two figures on the left assume constant mortality; those on the right assume declining mortality. Thus, the effect of varying the mortality assumptions can be seen by comparing the two dark outline figures or the two shaded figures; the effect of varying the fertility assumption can be seen by comparing the dark outline figures with the corresponding shaded figures. The population pyramids shown on the cover of this report give the projected population of all of Pakistan for 1985 assuming constant and declining fertility. These pyramids, however, are plotted on a different scale from those presented in figures 6 and 7.

FIGURE 6.—*Projected population of East Pakistan, by age and sex: 1965, 1975, and 1985*

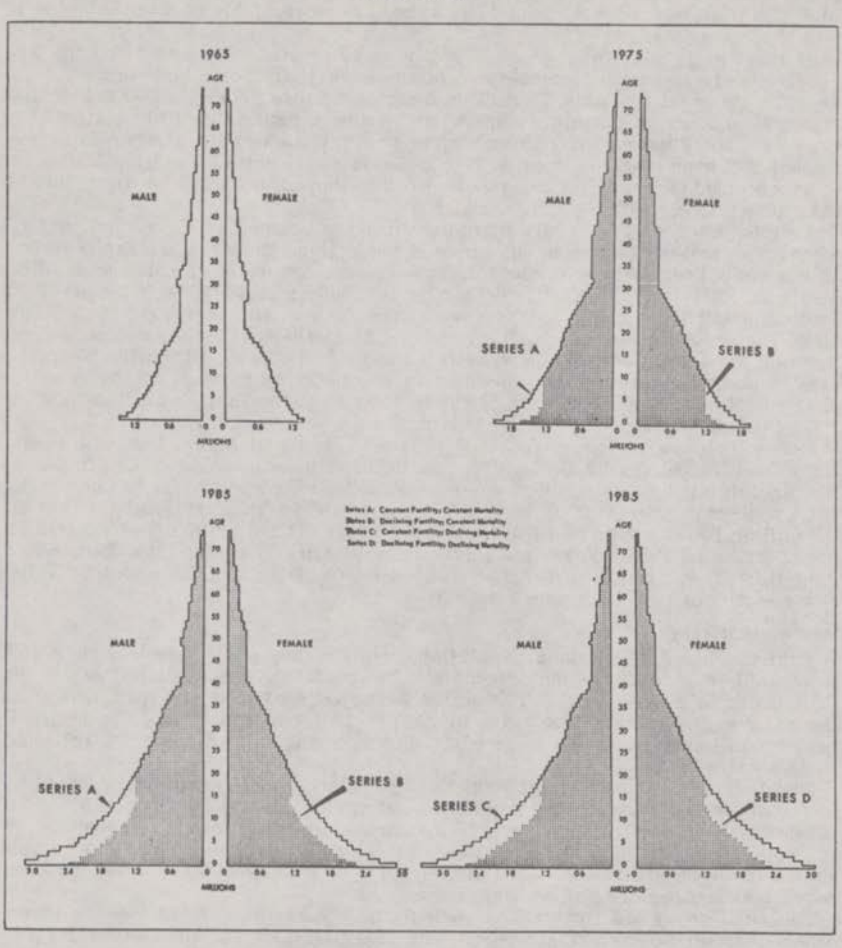
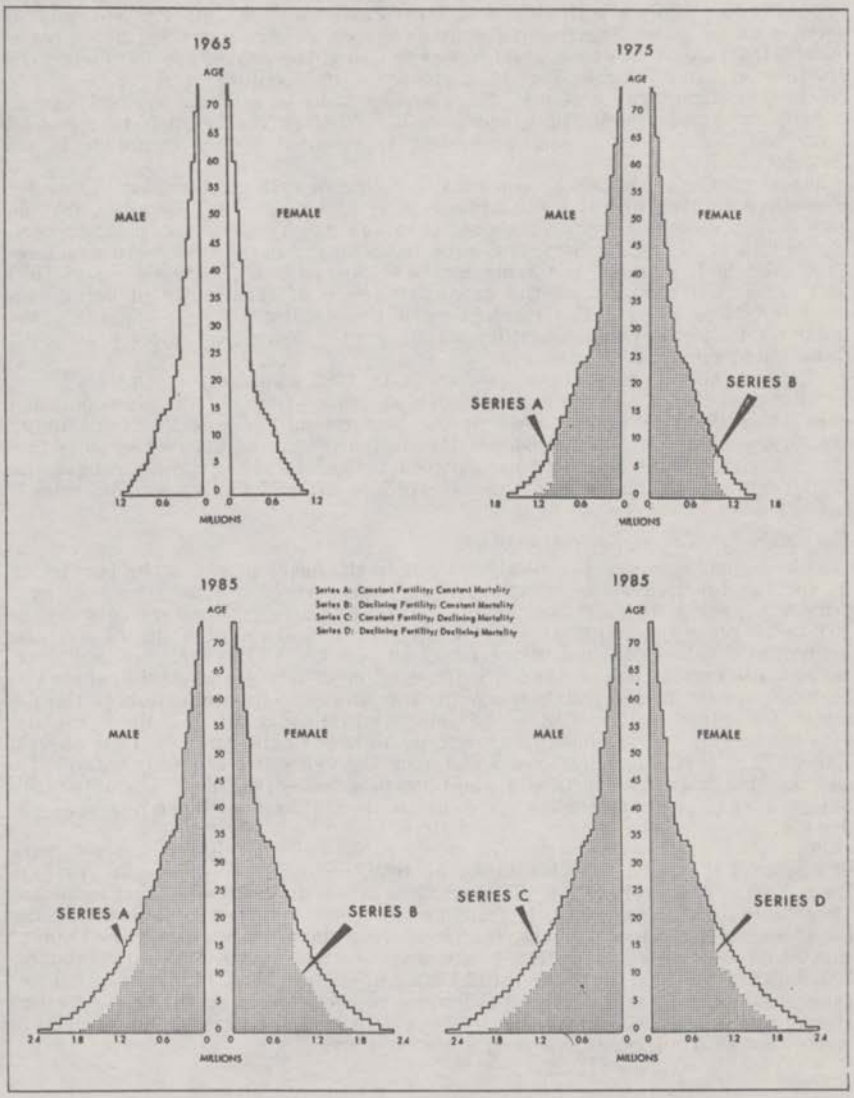


FIGURE 7.—*Projected population of West Pakistan, by age and sex: 1965, 1975, and 1985*



The present structure of the population of Pakistan as established for this report is typical of a high fertility population with an expanding base, that is, a population whose birth rate is substantially higher than its death rate. The pyramids for 1965 for both East and West Pakistan show rather broad, sloping bases for ages under 20 years and more or less equal bars above age 20. A population structure of this type could have resulted if the rate of population growth accelerated after World War II in response to declining death rates. The population structure presented here, however, is largely an artifact of the adjustments made in the 1961 census data. Whether the age-sex structures of East and West Pakistan are accurately represented by the pyramids is not known.

The pyramids for series A (constant fertility) in 1975 display a much broader base than in 1965 and the sloping begins at about age 30. However, for the series B projections, which assume that the family planning program will succeed in reducing fertility, the bars from about age 3 to age 10 are foreshortened and of about the same length. Persons 3 to 10 years old in 1975 will have been born during the expansion phase of the family planning program (1965 to 1971). The resumption of the sloping for ages under 3 years indicates that even though fertility stabilizes at a lower level, more babies will be born and survive each year.

Each of the two pyramids for series A in 1985 displays a substantially expanded base and a slope for ages under 40 years—that is, for the population born after World War II. Each of the two pyramids for series B (declining fertility, constant mortality) shows the flattened bars at ages 13 to 20, representing survivors of persons born between 1965 and 1971. The largest populations postulated by the projections are represented by the pyramids for series C in the lower right of the two figures.

Population in functional age groups

This section discusses prospective trends in the development of the population in various functional age groups. The groups covered are the preschool ages (under 6 years), primary school ages (6 to 10 years), secondary school ages (11 to 15 years), working ages (15 to 64 years), and the older population (65 years and over). Although the economy and culture of Pakistan are less structured with respect to age than are those of most western countries, the numbers of persons in these various age groups do give some indication of the demand for educational facilities, of the potential work force, and of the dependent population. Two series are shown for each of the functional age groups. Except for the population 65 years and over, the two series are designed to show the possible impact of a family planning program. In order to simplify the analysis, only the series assuming constant mortality are shown for ages under 65.

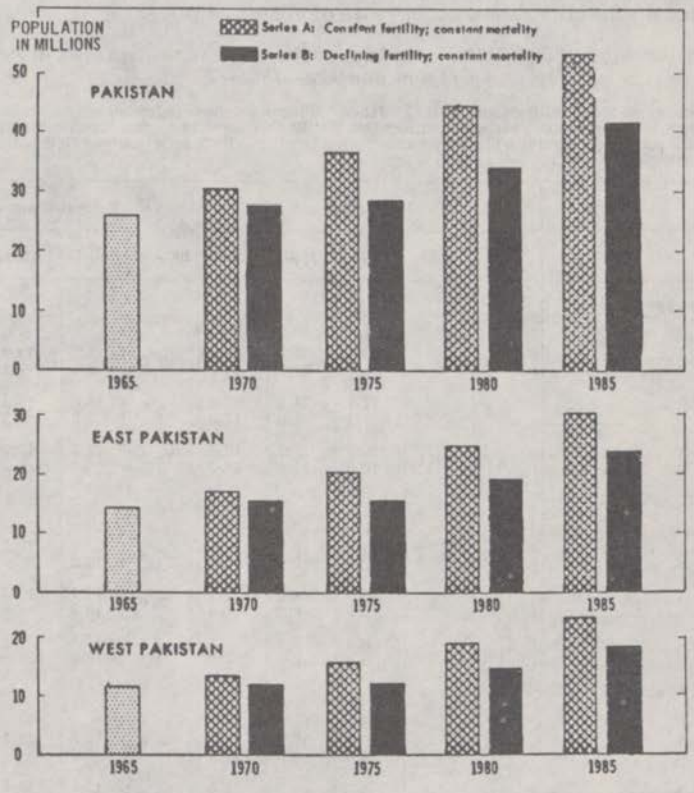
Population of Preschool Age.—There were 26.3 million children under 6 years of age in Pakistan at the beginning of 1965, according to our estimates. Of these, 14.6 million were in East Pakistan and 11.6 million were in West Pakistan. (See table 3 and figure 8.) If fertility and mortality remain constant at the levels assumed for recent years, the projections show a doubling of the population of preschool age by 1985. The figures are 53.9 million for all Pakistan; 30.5 million for East Pakistan; and 23.5 million for West Pakistan. If, however, the family planning program operates in the manner postulated by projection series B, the size of the preschool group will increase by about 60 percent—from 26.3 million in 1965 to 41.6 million in 1985.

TABLE 3.—*Projected population of preschool age (under 6 years) in Pakistan, by region—1965–85*

[Population figures are in millions and relate to Jan. 1. They have been independently rounded without adjustment to group totals. Series A assumes that fertility will remain constant; series B assumes that the family planning program will succeed in lowering fertility. Both series assume that mortality will remain constant]

Year	Pakistan		East Pakistan		West Pakistan	
	Series A	Series B	Series A	Series B	Series A	Series B
1965	26.3	26.3	14.6	14.6	11.6	11.6
1970	30.7	27.8	17.2	15.8	13.5	12.0
1975	36.7	28.4	20.6	16.0	16.0	12.4
1980	44.3	34.2	25.0	19.4	19.3	14.9
1985	53.9	41.6	30.5	23.5	23.5	18.0
PERCENT CHANGE						
1965–70	17.0	5.8	17.8	7.7	16.0	3.6
1970–75	19.3	2.2	19.7	1.7	18.9	2.8
1975–80	20.9	20.6	21.2	20.9	20.4	20.3
1980–85	21.8	21.4	22.0	21.6	21.5	21.0

FIGURE 8.—*Projected population of preschool age (under 6 years) in Pakistan, by region: 1965 to 1985*



The family planning program does not affect the rate of growth equally throughout the 20-year projection period. As the data in table 3 show, the family planning model yields an increase of about 6 percent between 1965 and

1970 as compared with 17 percent for the constant fertility model. During the period 1970 to 1975, the planning model shows an increase of only 2.2 percent as compared with 19.3 percent for the constant fertility model. Between 1975 and 1985, however, the rates of change for the two models are not significantly different, with both showing increases of about 46 percent for the 10-year period. The absolute increase for the family planning model, on the other hand, is considerably less than that for the constant fertility model—13 million and 17 million, respectively.

Population of School Age.—The school system in Pakistan is organized on a 10-grade plan. The 10 grades, in turn, are usually divided into the primary grades 1 through 5, and the secondary grades, 6 through 10. The legal age at which a child may enter the first grade is 6 years. Students who enter at that age and progress normally through the system should be ready for secondary school at age 11 and should complete the 10th grade by age 15. Thus, 6 to 10 years may be thought of as the primary school ages and 11 to 15 years as the secondary school ages.

At the beginning of 1965, our estimates show 16.6 million children of primary school age—9.3 million in East Pakistan and 7.3 million in West Pakistan. (See table 4 and figure 9.) Between 1965 and 1970, the projections show an increase of more than one-fifth—to 20.1 million for the country as a whole and to 11.1 million and 8.9 million for the East and West wings, respectively.

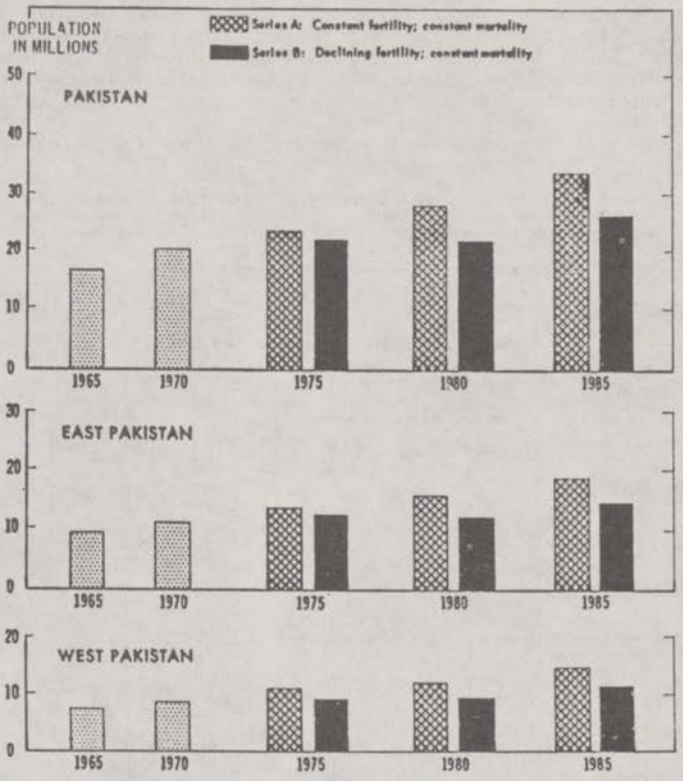
The family planning program cannot have an impact on the primary school ages until after 1970 when children born in 1965 will reach school age. If conditions hold as assumed in the series B projections, there will be an increase of only 8 percent in the number of children 6 to 10 years old between 1970 and 1975 and no increase at all between 1975 and 1980. Between 1980 and 1985, however, the series B projections show an increase of almost 20 percent.

TABLE 4.—*Projected population of primary school age (6 to 10 years) in Pakistan, by region and sex—1965–85*

[Population figures are in millions and relate to Jan. 1. They have been independently rounded without adjustment to group totals. Series A assumes that fertility will remain constant; series B assumes that the family planning program will succeed in lowering fertility. Both series assume that mortality will remain constant]

Region, sex, and series	Population					Percent change			
	1965	1970	1975	1980	1985	1965–70	1970–75	1975–80	1980–85
PAKISTAN									
Both sexes:									
Series A	16.6	20.1	23.4	27.9	33.7	21.0	16.7	19.2	20.7
Series B			21.7	21.7	26.0		8.1	−.1	19.8
Male:									
Series A	8.4	10.2	11.9	14.2	17.2	21.3	16.8	19.2	20.7
Series B			11.1	11.0	13.2		8.2	−.1	19.8
Female:									
Series A	8.2	9.8	11.5	13.7	16.5	20.8	16.5	19.2	20.7
Series B			10.6	10.6	12.7		8.0	−.1	19.8
EAST PAKISTAN									
Both sexes:									
Series A	9.3	11.1	13.1	15.7	18.9	20.4	17.6	19.5	21.0
Series B			12.3	12.2	14.6		10.2	−.6	20.1
Male:									
Series A	4.7	5.7	6.7	8.0	9.7	20.6	17.7	19.5	21.0
Series B			6.3	6.2	7.5		10.3	−.6	20.1
Female:									
Series A	4.6	5.5	6.4	7.7	9.3	20.1	17.5	19.5	21.0
Series B			6.0	6.0	7.2		10.0	−.6	20.1
WEST PAKISTAN									
Both sexes:									
Series A	7.3	8.9	10.3	12.2	14.7	21.9	15.5	18.7	20.3
Series B			9.4	9.5	11.3		5.5	.6	19.5
Male:									
Series A	3.7	4.5	5.3	6.2	7.5	22.1	15.7	18.7	20.3
Series B			4.8	4.8	5.8		5.7	.6	19.5
Female:									
Series A	3.6	4.4	5.1	6.0	7.2	21.6	15.4	18.7	20.3
Series B			4.6	4.6	5.5		5.4	.6	19.5

FIGURE 9.—*Projected population of primary school age (6 to 10 years) in Pakistan, by region: 1965 to 1985*



Because the projections assume that during its early phases the family planning program will be expanded more rapidly in West Pakistan, the series B projections show the number of children 6 to 10 years old in East Pakistan increasing at nearly twice the rate as in West Pakistan between 1970 and 1975. After 1975, however, the rates of change for the two regions are not significantly different.

If fertility remains constant, as assumed for series A, there will be a doubling of the population of primary school age by 1985 as compared with an increase of about 60 percent for the family planning model (series B). The series B projection shows nearly 8 million fewer children 6 to 10 years old in 1985 than does the series A projection.

At the beginning of 1965, there were an estimated 13.9 million children of secondary school age in Pakistan—7.8 million in East Pakistan and 6.1 million in West Pakistan. (See table 5 and figure 10.) The projections show 16.3 million by 1970 and 19.7 million by 1975. The series B projections show an increase rate between 1975 and 1980 only half that for series A and no change in the number during the last five years of the projection period—1980 to 1985. There are 6 million fewer secondary school age children in 1985 shown in the series B projections than in the series A projections.

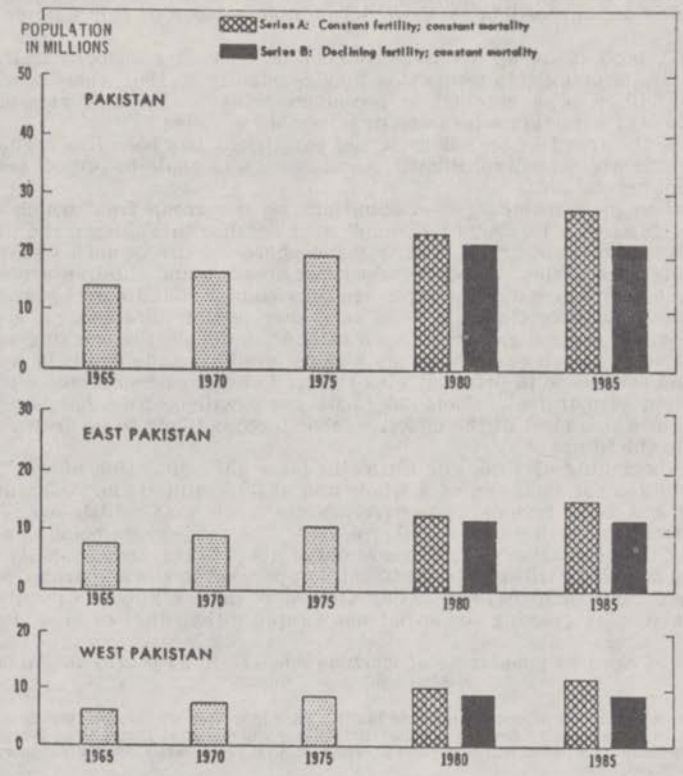
In 1961, there were, according to official statistics, 5.3 million children enrolled in primary school—3.4 million in East Pakistan and 1.9 million in West Pakistan. Our estimates show 14.8 million children 6 to 10 years old in 1961, or 2.8 children of primary school age per pupil in grades 1 to 4. East Pakistan fared somewhat better than West Pakistan. Our estimates for 1961 show 8.2 million children 6 to 10 years old in the Eastern region, or 2.4 children per primary school pupil, and 6.5 million children of primary school age in the Western region, or 3.4 per primary school pupil.

TABLE 5.—*Projected population of secondary school age (11 to 15 years) in Pakistan, by region and sex—1965–85*

[Population figures are in millions and relate to January 1. They have been independently rounded without adjustment to group totals. Series A assumes that fertility will remain constant; series B assumes that the family planning program will succeed in lowering fertility. Both series assume that mortality will remain constant]

Region, sex, and series	Population					Percent change			
	1965	1970	1975	1980	1985	1965–70	1970–75	1975–80	1980–85
PAKISTAN									
Both sexes:									
Series A	13.9	16.3	19.7	23.0	27.4	16.8	21.0	16.7	19.2
Series B				21.3	21.3			8.1	−.1
Male:									
Series A	7.1	8.3	10.0	11.7	14.0	16.5	21.3	16.8	19.2
Series B				10.9	10.9			8.3	−.1
Female:									
Series A	6.8	8.0	9.7	11.3	13.4	17.2	20.8	16.5	19.2
Series B				10.5	10.4			8.0	−.1
EAST PAKISTAN									
Both sexes:									
Series A	7.8	9.1	10.9	12.9	15.4	16.4	20.3	17.6	19.5
Series B				12.1	12.0			10.2	−.6
Male:									
Series A	4.0	4.6	5.6	6.6	7.8	16.1	20.6	17.7	19.5
Series B				6.1	6.1			10.3	−.6
Female:									
Series A	3.8	4.5	5.4	6.3	7.5	16.8	20.1	17.5	19.5
Series B				5.9	5.9			10.1	−.6
WEST PAKISTAN									
Both sexes:									
Series A	6.1	7.2	8.8	10.1	12.0	17.4	21.9	15.5	18.7
Series B				9.3	9.3			5.6	.6
Male:									
Series A	3.1	3.7	4.5	5.2	6.1	17.0	22.1	15.7	18.7
Series B				4.7	4.7			5.7	.6
Female:									
Series A	3.0	3.5	4.3	5.0	5.9	17.7	21.6	15.4	18.7
Series B				4.5	4.6			5.4	.6

FIGURE 10.—*Projected population of secondary school age (10 to 15 years) in Pakistan, by region: 1965 to 1985*



Between 1958 and 1961, primary school enrollment increased by about 300,000 annually. If the annual increase continued, enrollment in 1965 should have amounted to 6.5 million of the primary school-age population of 16.6 million. These figures imply that there should be 2.6 children per pupil in 1965.

In 1960, about 3.8 million boys were enrolled in the primary grades. Although enrollment data for 1961 do not include figures for boys and girls separately, if the proportion male reported for 1960 and earlier years held for 1961, some 4.0 million boys would have been enrolled. Our estimates show 7.5 million boys 6 to 10 years old, or 1.9 school-age boys per male pupil.

Boys comprise about 72 percent of the primary school enrollment in East Pakistan and about 80 percent in West Pakistan. In 1961, an estimated 2.5 million boys were enrolled in the Eastern region and 1.5 million in the Western region. Our estimates for 1961 show 4.2 million boys age 6 to 10 years in East Pakistan, or 1.7 boys of school age per male pupil. For West Pakistan, our estimates show 3.3 million primary school-age boys, or 2.2 boys of school age per male pupil.

If, in 1965, three-fourths of the estimated 6.5 million primary school-age pupils in Pakistan are boys, 4.9 million boys would be enrolled. Our estimates place the number of boys 6 to 10 years old in 1965 at 8.4 million, or about 1.7 times the number of male pupils.

Enrollment in secondary school in 1961 is reported to have been 1.6 million—about 0.6 million in East Pakistan and 1.0 million in West Pakistan. Our esti-

mates place the population of secondary school age at 10.7 million, or 6.7 times secondary school enrollment. For East Pakistan, the estimates show 6.1 million persons of secondary school age, or about 10 per secondary school pupil. For West Pakistan, the estimates show 4.6 million persons of this age, or 4.6 per pupil.

In 1960, boys made up about 85 percent of secondary school enrollment in Pakistan. Assuming this proportion applies equally to 1961, there would have been 1.3 million boys enrolled in secondary school. Our estimates show 5.5 million boys of secondary school age, or 4.2 per boy enrolled.

Because the trend in secondary school enrollment has been less regular than that for primary school enrollment, no attempt was made to project secondary enrollment beyond 1961.

Population of Working Age.—Delimiting the age group from which most of the labor force will be drawn is complicated because in Pakistan the demarcation between the nonworking and working phases of life is not as sharp as in most western countries. Especially in rural areas, young children are assigned chores at a very young age and often are fully employed at 10 or 11 years. Also, older persons may continue to work until they become disabled. A good case could be made for using a broad span of ages to denote the working ages, say from age 10 or 11 to age 69, but such a range would include pupils in secondary school and even some in primary school as well as older persons whose economic contribution is marginal. Thus, 15 to 64 years will be used here as the age range from which most of the effective labor force is likely to be drawn at present and in the future.

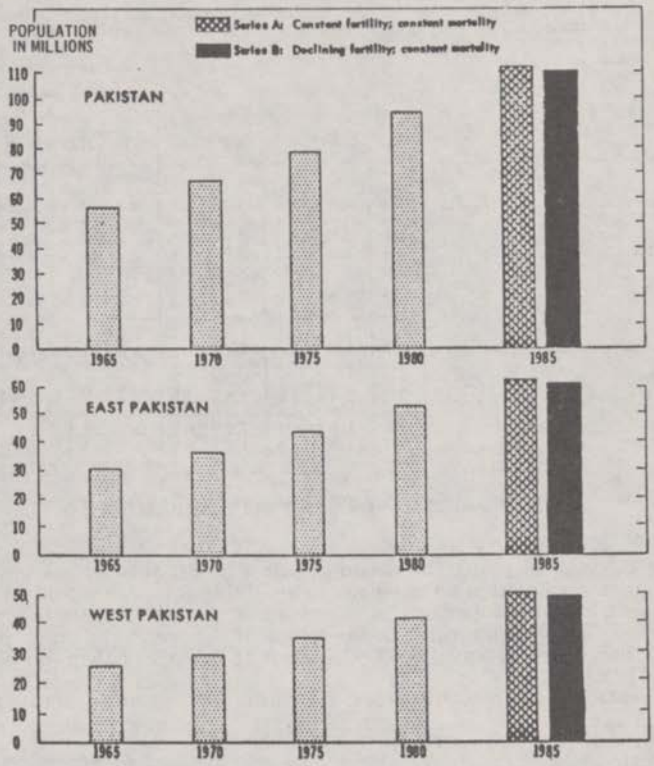
At the beginning of 1965, our estimates place the population of working age at 56.3 million for Pakistan as a whole and at 30.8 million and 25.5 million for the East and West regions, respectively. Males comprise a little over one-half of this group. (See table 6 and figure 11.) The projections point to a steady growth of the population 15 to 64 years old of about 3.5 percent annually at least to 1980 when there will be almost 95 million persons in the age group, or about 70 percent more than in 1965. They also show the working-age population of East Pakistan as growing somewhat more rapidly than that of West Pakistan.

TABLE 6.—*Projected population of working age (15 to 64 years) in Pakistan, by region and sex—1965–85*

[Population figures are in millions and relate to Jan. 1. They have been independently rounded without adjustment to group totals. Series A assumes that fertility will remain constant; series B assumes that the family planning program will succeed in lowering fertility. Both series assume that mortality will remain constant]

Region, sex, and series	Population					Percent change			
	1965	1970	1975	1980	1985	1965–70	1970–75	1975–80	1980–85
Pakistan:									
Both sexes:									
Series A	56.3	67.0	79.5	94.8	112.7	19.0	18.6	19.3	18.9
Series B					110.1				16.2
Male:									
Series A	29.2	34.6	40.8	48.6	57.6	18.5	18.1	19.0	18.7
Series B					56.3				16.0
East Pakistan:									
Both sexes:									
Series A	30.8	36.9	43.9	52.9	62.6	19.7	19.1	19.6	19.3
Series B					61.3				16.8
Male:									
Series A	16.0	19.0	22.6	26.7	32.0	19.2	18.6	19.2	19.0
Series B					31.4				16.5
West Pakistan:									
Both sexes:									
Series A	25.5	30.2	35.5	42.3	50.1	18.1	17.9	18.9	18.5
Series B					48.8				15.5
Male:									
Series A	13.2	15.5	18.2	21.6	25.6	17.6	17.4	18.6	18.3
Series B					24.9				15.2

FIGURE 11.—*Projected population of working age (15 to 64 years) in Pakistan, by region : 1965 to 1985*



The success or failure of the family planning program will not influence the size of the working-age population until after 1980 when persons born during 1965 reach age 15. The series B (declining fertility) projections point to an increase of about 16 percent in this group between 1980 and 1985 whereas the series A (constant fertility) projections point to an increase of almost 19 percent.

Older Population.—As indicated in the previous section, the demarcation between the working and nonworking phases of life in Pakistan is less sharply drawn than in most western countries. However, if the working ages are defined as terminating at age 64 years, then the ages 65 years and over must be defined as the "retirement" ages. Since our projections of the older population are the least valid of all, the trends in the series will not be discussed. The projections for West Pakistan show declines in the numbers of older persons during the early years of the projection period. (See table 7.) This trend is unrealistic and indicates that our estimates of the older population in 1961 are inconsistent with the mortality rates used and with our estimates of the numbers of persons reaching age 65. Thus, when death rates for age 65 years and over are applied to the numbers of persons in that age range, the resulting number of deaths is larger than the number of persons reaching age 65.

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TABLE 7.—*Projected population 65 years and over in Pakistan, by region and sex—1965–85*

[Population figures are in millions and relate to Jan. 1. They have been independently rounded without adjustment to group totals. Series A assumes that mortality will remain constant; series C assumes that mortality will decline]

Region and sex	Series A					Series C				
	1965	1970	1975	1980	1985	1965	1970	1975	1980	1985
Pakistan:										
Both sexes	4.8	4.8	5.1	5.7	6.4	4.8	4.9	5.3	6.0	6.9
Male	2.0	2.0	2.2	2.5	2.8	2.0	2.1	2.3	2.7	3.2
Female	2.8	2.8	2.9	3.2	3.6	2.8	2.8	3.0	3.3	3.7
East Pakistan:										
Both sexes	2.3	2.3	2.6	2.9	3.4	2.3	2.3	2.7	3.1	3.6
Male	1.0	1.0	1.1	1.3	1.5	1.0	1.0	1.2	1.4	1.7
Female	1.3	1.3	1.5	1.6	1.9	1.3	1.3	1.5	1.7	1.9
West Pakistan:										
Both sexes	2.5	2.4	2.6	2.8	3.0	2.5	2.6	2.6	2.9	3.3
Male	1.0	1.0	1.1	1.2	1.3	1.0	1.1	1.1	1.3	1.5
Female	1.5	1.4	1.5	1.6	1.7	1.5	1.5	1.5	1.6	1.8

III. PROJECTIONS OF THE URBAN POPULATION

Past growth of the urban population

During the last 40 years, the urban population of Pakistan has grown much faster than the population as a whole. (See table 8.) According to the 1941 census, about 5.6 million persons, or 8 percent of the total population, resided in urban areas. By 1961, according to the census of that year, the urban population had more than doubled, reaching 12 million, or 13 percent of the total population.

TABLE 8.—*Enumerated urban population of Pakistan—1901–61*

Year	Urban population		
	Total (thousands)	Percent change	Percent of total population
1901	2,321	----------	5.1
1911	2,496	7.5	4.9
1921	2,936	17.6	5.4
1931	3,845	31.0	6.5
1941	5,552	44.4	7.9
1951 [1]	7,863	41.6	10.4
1961	12,295	56.4	13.1

[1] Excludes non-Pakistanis.

Source: Ministry of Home Affairs, Office of the Census Commissioner, *Population Census of Pakistan, 1961. Census Bulletin No. 2.- Sex, Urban-Rural, Religion, Non-Pakistanis*, Karachi, 1961, p. 14.

More than three-fourths of the urban population, although less than one-half of the total population, lived in West Pakistan in 1961. (See table 9.) The population of West Pakistan was 22 percent urban, whereas the population of East Pakistan was only 5 percent urban. Although rates of urban growth have been high in both regions, East Pakistan starts from so low a base that absolute urban growth has not been impressive. Most of the urban growth has occurred in West Pakistan.

Although these figures reflect the trend in urbanization in Pakistan, they must be qualified by a recognition of the ambiguity of the definition of urban population. The definition of what constitutes the urban population of any country is

not easily arrived at. Smaller towns and villages may have both urban and rural characteristics and thus not fall readily into either. Although large agglomerations of population engaged in trade, commerce, government, manufacturing, etc., are clearly urban, their geographic limits are often difficult to fix because persons living at their fringes may have both urban and rural characteristics.

The criteria often used to differentiate urban are function (i.e., agricultural versus nonagricultural), size, and density. Thus, centers whose populations exceed a specified minimum might be classified as urban. Smaller centers might also be so classified if a significant proportion of their population is employed in nonagricultural occupations. The limits of the town may be defined to include contiguous settlements with densities above a certain minimum.

TABLE 9.—*Enumerated total and urban population of Pakistan, by region—1951 and 1961*

[Population figures in thousands]

Year and category	Pakistan	East Pakistan	West Pakistan
1951:			
Total population	75,842	42,063	33,780
Urban population	7,863	1,844	6,019
Percent urban	10.4	4.4	17.8
1961:			
Total population	93,720	50,840	42,880
Urban population	12,295	2,641	9,654
Percent urban	13.1	5.2	22.5
Percent change, 1951-61:			
Total	23.6	20.9	26.9
Urban	56.4	43.2	60.4

Source: Ministry of Home Affairs, Office of the Census Commissioner, *Population Census of Pakistan 1961. Census Bulletin No. 2, Sex, Urban-Rural, Religion, Non-Pakistanis*, Karachi, 1961, pp. 14, 24, and 25.

Sometimes, however, the urban concept has a legal connotation which may be only generally related to the normal criteria for urban. The locality may be legally incorporated with clearly defined boundaries which exclude persons whose mode of life is essentially urban, or the boundaries of the locality may encompass large areas of farmland and a significant farm population. Moreover, localities which have declined in population or have changed in function may continue to be legally defined as urban long after they have lost their urban function.

The criteria for distinguishing the urban population in the 1961 census of Pakistan were size, occupational characteristics of the population, and form of administrative organization. Urban areas included Municipalities, Civil Lines, and Cantonments as well as "any other continuous collection of houses inhabited by not less than 5,000 persons which the Provincial Director (of the census) may decide to treat as urban for census purposes." At the discretion of the Provincial Director, collections of houses inhabited by less than 5,000 persons were also declared urban if such places displayed "pronounced urban characteristics" such as "common utilities, roads, sanitation, schools, and specially nonagricultural occupation of the people." [9]

The stated definition for the census of 1951 appears to be comparable to that used in 1961. However, no comparison of the areas actually classified as urban has been made.

Future size of the urban population

As mentioned in chapter I, the 1961 census was assumed to be undercounted by about 7.6 percent. Thus, the enumerated urban population of 12.3 million is probably also undercounted. Our analysis of data by age and sex for the urban population indicates an undercurrent of 4.6 percent for the urban component, a substantially lower figure than that for the population of the country as a whole.

[9] Ministry of Home Affairs, Office of the Census Commissioner, *Population Census of Pakistan, 1961. Census Bulletin No. 2. Sex, Urban-Rural, Religion, Non-Pakistanis*, Karachi, 1961, p. 13.

This analysis was superficial, however, and a more thorough investigation might yield quite different estimates of the undercount. Our estimates of the 1961 urban population are 12.9 million for all of Pakistan and 2.8 million and 10.1 million for the Eastern and Western regions, respectively. Thus, 12.7 percent of the 1961 population of Pakistan was estimated to have been urban. The proportions for the Eastern and Western regions are 5.1 and 21.9 percent, respectively.

Because birth and death rates for urban areas, data on rural-urban migration, and information on changes in urban territory are not available, current estimates of the urban population must be based on crude assumptions regarding changes in the proportion urban or regarding rates of overall urban increase. Our estimates are based on extrapolations of changes in the proportion urban. Thus, the urban population at the beginning of 1965 is estimated to have been 15.8 million—3.4 million in the Eastern region and 12.4 million in the Western region.

Projections of the urban population based on the extrapolation method show, for series A, 26 million by 1975 and almost 43 million by 1985, an increase of 170 percent for the period 1965 to 1985. (See table 10 for the results and the technical appendix for the method.) Series B shows 24 million by 1975 and 36 million by 1985, an increase of 130 percent during the next 20 years. Series C shows somewhat higher figures than series A, while series D shows somewhat higher figures than series B.

TABLE 10.—*Projected urban population of Pakistan, by region and sex, 1965—1975, and 1985*

Population figures are in thousands and relate to Jan. 1. They have been independently rounded without adjustment to group totals. The figures shown were obtained by applying extrapolations of the proportion urban for each age and sex group to the projected number of persons in that group for the respective series. See the appendix for an explanation of the method used]

Year and series	Both sexes			Male			Female		
	Pakistan	East Pakistan	West Pakistan	Pakistan	East Pakistan	West Pakistan	Pakistan	East Pakistan	West Pakistan
1965:									
Series A	15,761	3,378	12,383	8,616	1,953	6,663	7,145	1,425	5,720
Series C	15,779	3,382	12,397	8,626	1,955	6,671	7,153	1,427	5,726
1975:									
Series A	26,036	5,522	20,514	14,100	3,149	10,951	11,936	2,373	9,563
Series B	24,469	5,217	19,252	13,920	2,992	10,298	11,179	2,225	8,954
Series C	26,453	5,615	20,838	14,320	3,197	11,123	12,133	2,418	9,715
Series D	24,825	5,298	19,527	13,478	3,034	10,444	11,347	2,264	9,083
1985:									
Series A	42,704	8,923	33,781	22,895	4,995	17,900	19,809	3,928	15,881
Series B	36,392	6,663	29,729	20,250	4,466	15,784	16,142	2,197	13,945
Series C	44,749	9,429	35,320	24,011	5,289	18,722	20,738	4,140	16,598
Series D	39,033	8,337	30,696	21,159	4,713	16,446	17,875	3,624	14,250

* * * * * * *

TECHNICAL APPENDIX

The Population Growth Estimation Project

The Population Growth Estimation (PGE) project was organized in 1962 as a means of establishing the parameters of population growth for Pakistan. It is based on the collection of data from 24 sample areas containing 0.1 percent of the population of the country. Data on births and deaths in these sample areas are collected by a more or less conventional registration system and by quarterly surveys. The results of the registration and the surveys are matched to determine the deficiencies in each. In addition to vital statistics, the surveys also provided data on the age-sex composition of the population in the sample areas.[1]

[1] For a description of the project, see Nazmir Ahmed and Karol J. Krotki, "Simultaneous Estimations of Population Growth, The Pakistan Experience," *The Pakistan Development Review*, Vol. III, No. 1, Spring 1963, pp. 37–65.

The results so far released from this project have been clearly labeled as provisional, unevaluated, and unweighted. Nevertheless, these data were used here because they represent the only information available on current rates of population growth in East and West Pakistan.

The provisional estimates of the birth and death rates per 1,000 population for 1962 from the PGE project are as follows:

Base of rate	Birth rate		Death rate	
	East Pakistan	West Pakistan	East Pakistan	West Pakistan
Based on registration	48	42	17	16
Based on surveys	47	38	14	12
Combined and adjusted for underreporting	58	55	21	22
Adjusted for undercount of population base	53	50	19	20

Based on these data, both the registration and the surveys appear to have missed about 20 percent of the numbers of births and deaths.

Two questions might be raised about the procedure used to derive the final rates. First, how accurate is the matching? There are many problems associated with the pairing of forms for the same individual from two different files even in western countries where street addresses are likely to be fixed and name-spellings standardized. In a country where a relatively few names account for a significant proportion of the population, where spellings vary, and where house-numbering is largely an alien custom imposed by the survey or census taker, the difficulties of assuring an accurate match are compounded.[2] Little has been written on the success of studies based on matching, but it is the impression of the authors of this report that in the United States it has not been very high.

The second question is how valid are the population estimates used as denominators for deriving the birth and death rates. The population estimates obtained from the PGE project were reported to have been adjusted to take account of assumed under-enumeration. The adjustments amounted to 10 percent of the enumerated population, but the basis for making them has not been reported.

Preliminary estimates of age-specific death and birth rates were also presented among the survey results. The age-specific death rates are too erratic to be usable; for example, they show female mortality half again as high as male mortality for ages 15 to 64. The irregularity probably resulted as much from errors in the population base as from errors in the mortality data. No attempt was made to evaluate the age-specific birth rates.

Age and Sex Composition

An inspection of the age and sex distributions of the population based on the 1961 census and on the preliminary results of the PGE project indicate that there were substantial errors in both. The validity of the data was further brought into question by the account of two observers who have had field experience in Pakistan. One person who had taken a survey in several Bengali villages stated that villagers usually did not know their ages and that, when pressed, they not infrequently reported several different figures, sometimes varying by 20 years or more. Another person reported a high frequency of gross inconsistencies based on schedule matches from separate surveys of West Pakistan villages. Again, differences of 20 years or more in the ages reported for the same individual in separate surveys were found. If these conditions are typical of Pakistan as a whole, the usefulness of age data from the census and the PGE project is certainly open to question.

[2] The lesser problem of how to estimate those births and deaths missed by both the registration and the surveys is met by the Chandrasekaran-Deming procedure which estimates the proportion from a contingency table for each subarea in the sample rather than from the sample as a whole. See C. Chandrasekaran and W. Edwards Deming, "On a Method for Estimating Birth and Death Rates and the Extent of Registration," *Journal of the American Statistical Association*, Vol. 44, No. 245, March 1949, pp. 814–815.

TABLE A–1.—*Percent distribution of the population of Pakistan, by age and sex—1961–62, according to the census count and the PGE survey*

Age	Male		Female	
	Census, 1961	PGE survey, 1962	Census, 1961	PGE survey, 1962
Total, all ages	52.6	52.7	47.4	47.3
Under 5 years	8.7	8.0	8.7	8.2
5 to 9 years	9.2	8.5	8.5	7.7
10 to 14 years	5.2	6.5	4.1	5.2
15 to 19 years	4.3	4.5	4.0	3.7
20 to 24 years	3.8	3.5	3.8	3.7
25 to 29 years	4.0	4.2	3.8	4.2
30 to 34 years	3.3	3.5	3.0	3.0
35 to 39 years	3.0	2.9	2.5	2.6
40 to 44 years	2.5	2.5	2.2	2.2
45 to 49 years	2.1	2.1	1.6	1.7
50 to 54 years	2.0	1.9	1.6	1.5
55 to 59 years	1.2	1.1	.9	.8
60 to 69 years	2.0	2.0	1.5	1.6
70 years and over	1.4	1.3	1.1	1.1

On the basis of data by age and sex for 12 reportedly rural PGE sample areas, population distributions for East and West Pakistan are available. These distributions are very similar to those based on the 1961 census and this correspondence argues for the validity of both. (The census and PGE survey distributions for Pakistan as a whole are shown in table A–1.) Yet some of the characteristics of the distributions support the alternative hypothesis that they have errors in common. Among these are a surplus of males at most ages, an irregular age distribution of the type which might result if large numbers of persons report their ages in multiples of 10, and a deficiency of young children. Furthermore, the PGE distribution shows an unexplainable excess of persons at ages 25 to 29.

Strategy for adjusting data

Once it was evident that the basic data for Pakistan were too distorted to be used without adjustment, there was a choice of two basic strategies for correcting them. One alternative was to correct the data for misreporting and undercounting on the basis of an assessment of the errors involved; the other alternative was to reject the data entirely and to substitute a population model. There is a difference of opinion among demographers as to the validity of models to represent the structure of populations in underdeveloped, high fertility countries. One body of opinion contends that models are valid since these populations tend towards a predictable structure and that unexplained deviations from this structure in census data reflect reporting errors. The other body of opinion contends that models obscure the uniqueness of a population structure. Serious consideration was given to the use of a model to represent the population of Pakistan and, in fact, a model was constructed as an aid in evaluating the census and the PGE population distributions. The decision was made to correct the census data rather than to substitute a model because some of the distortions in the data, particularly the relatively small size of the cohorts born between 1941 and 1951, are probably real.

The life table

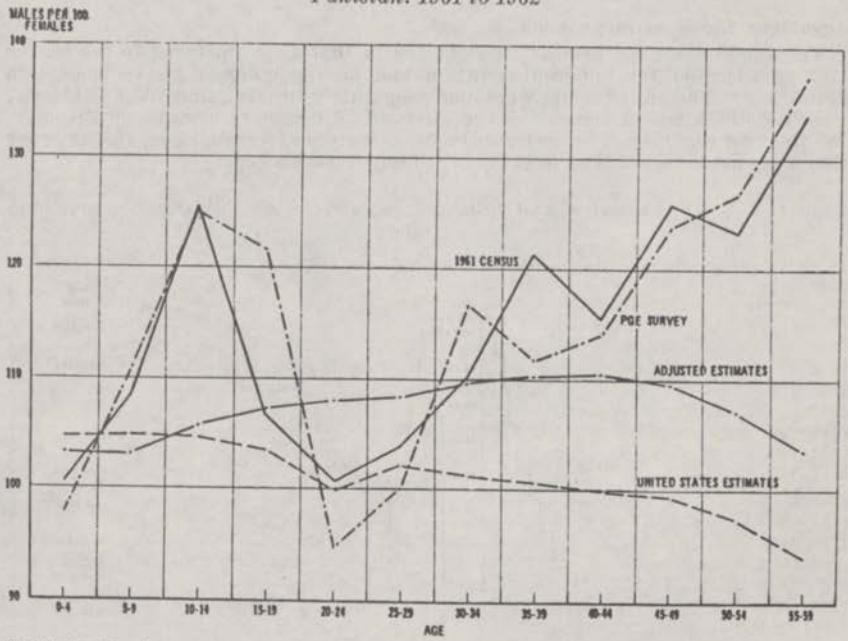
An essential tool to population analysis is the life table. It defines certain relationships in an age distribution that are the result of mortality. It also provides the survival rates by age required to make projections by the cohort-survival method.

Life tables were constructed for East and West Pakistan from the age-specific death rates given as part of the preliminary results of the PGE project, but values from these proved to be too erratic. A recently constructed life table

for rural India, based on the National Sample Survey for 1957–1958,[3] has a characteristic already postulated for Pakistan—that female mortality exceeds male mortality at ages 10 to 40. It was discovered, however, that this life table could not be reconciled with the population distribution and the estimated birth rate for Pakistan. A reconciliation required much higher mortality for young children. To obtain this, values for ages under 10 years were taken from the level 25 United Nations model life table,[4] and for ages 10 to 14, values from the United Nations and the Indian life tables were spliced. The resulting composite life table was not entirely satisfactory, however, because it yielded about one-third more deaths than that implied by the PGE death rate and thus had to be adjusted.

The life table may also be used to compute expected sex ratios (males per 100 females) by age. To do so requires an estimate of the sex ratio at birth. An estimate, based on Indian hospital records, of 106.4 male births per 100 female births was used here.[5] The life table sex ratios with only minor adjustments are shown in figure A–1 and table A–2 as "adjusted estimates." The ratios are very high by western standards because of high female mortality. The contrast may be seen by comparing the adjusted sex ratios for Pakistan with the sex ratios for adjusted estimates of the white population of the United States in 1960 (shown in figure A–1 and table A–2).

FIGURE A–1.—*Sex ratios by age for the enumerated and adjusted populations of Pakistan: 1961 to 1962*



NOTE: United States-Adjusted estimates of native white population, 1960. See Melvin Zelnick, "Errors in the 1960 Census Enumeration of Native Whites," Journal of the American Statistical Association, June 1964, p. 443, table 2.

[3] Ajoy Kumar De and Ranjan Kumar Som, "Abridged Life Tables for Rural India, 1957–1958," *Milbank Memorial Fund Quarterly*, April 1964, pp. 96–108.

[4] United Nations, *Manuals on Methods of Estimating Populations, Manual III: Methods for Population Projections by Age and Sex*, Population Studies, No. 25, 1956, pp. 72–81.

[5] K. V. Ramachandran and Vinayak A. Deshpande, "The Sex Ratio at Birth in India by Regions," *Milbank Memorial Fund Quarterly*, April 1964, pp. 84–96.

TABLE A–2.—*Males per 100 females, by age, for the enumerated and the adjusted population of Pakistan—1961–62*

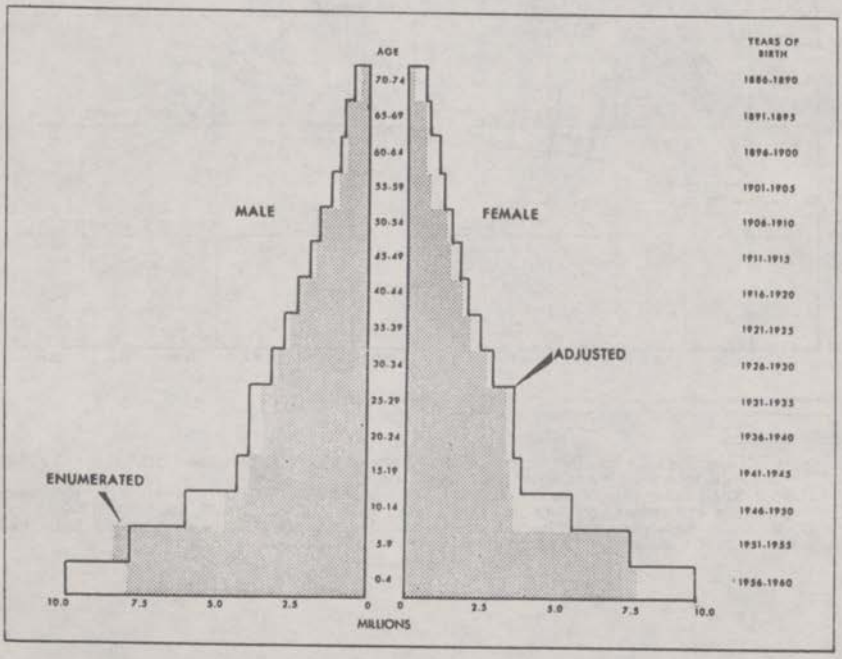
Age	Census, 1961	PGE survey, 1962	Adjusted estimates	U.S. estimates [1]
Total, all ages	111.1	111.4	103.9	99.1
Under 5 years	100.5	97.6	103.6	104.8
5 to 9 years	108.4	110.4	103.5	104.9
10 to 14 years	125.6	125.0	105.8	104.7
15 to 19 years	106.6	121.6	107.5	103.3
20 to 24 years	100.7	94.6	107.8	99.6
25 to 29 years	103.9	100.0	107.9	102.2
30 to 34 years	110.1	116.7	109.6	101.4
35 to 39 years	121.3	111.5	110.2	100.6
40 to 44 years	115.6	113.6	110.4	99.8
45 to 49 years	126.2	123.5	109.6	99.1
50 to 54 years	123.3	126.7	107.4	97.1
55 to 59 years	133.8	137.5	103.4	93.8
60 to 69 years	128.8	125.0	94.0	86.2
70 years and over	127.2	118.2	60.7	72.4

[1] Adjusted estimates of the native white population as of the 1960 census. See Melvin Zelnik, "Errors in the 1960 Census Enumeration of Native Whites," Journal of the American Statistical Association, June 1964, p. 443, table 2.

Adjusting the base population

The age and sex composition of Pakistan in 1961 as enumerated in the census and as adjusted for underenumeration and misreporting of age is shown in figure A–2. The adjustments were made separately for East and West Pakistan; however, the kinds of errors and the kinds of adjustments were much the same for the two regions. The major adjustments are as follows, given in the order they were made rather than in the order of importance:

FIGURE A–2.—*Enumerated and adjusted population of Pakistan, by age and sex: 1961*



1. The census failed to give the age and sex composition of 3,536,000 persons in the tribal areas of West Pakistan. These persons were assigned the age and sex distribution of the rural population of the Khorāsān and Balūchestān-Sīstān Provinces of Iran. These Iranian provinces are inhabited by tribal people much like those of West Pakistan.

2. At ages 40 and above, the 5-year age groups have a saw-toothed pattern, as may be observed from the percentage distribtuion by age of the census count and the PGE survey shown in table A–1. This characteristic, common to many censuses, is the result of the tendency to round ages to a multiple of 10. For males aged 40 to 69, the census counts were smoothed graphically, for males aged 70 and over, the census counts were distributed in proportion to the hypothetical population from the Indian life table.

3. The census count has a large excess of males. Overall, there are 111 males per 100 females, and for one age group (55 to 59) the ratio is 134. There are large excesses at every age except under 5 and 20 to 29 (see table A–2 and figure A–1). In the absence of a major disturbing factor such as military deaths or sex-selective emigration, the actual ratios should approach those of the life table. That they do not indicates that there had been gross underenumeration of women. To adjust for this underenumeration, the census count of the number of females except for ages 20 to 29 has been disregarded and, instead, their number, by age, was estimated on the basis of the number of enumerated males and the sex ratios from the composite life table.

4. The population counts for ages 20 to 29 are irregular and have much lower sex ratios. The deviation in the sex ratios from the pattern found at other ages might be explained by any of the following:

(*a*) More complete enumeration of young adult females;

(*b*) Misreporting of age such that many older women are counted as being 20 to 29 years old;

(*c*) Underenumeration of young adult males;

(*d*) Emigration of young adult or adolescent males during the previous decade.

It was postulated that if there had been emigration of young adult males, it was likely to have been a temporary movement from East Pakistan to the northern industrial area of India. If it is indeed temporary, the most convenient way of handling the problem is to assume that the emigrants are unenumerated residents of Pakistan and to adjust the data accordingly. A correction of 0.5 million males was made in the population of East Pakistan 18 to 32 years old to allow for underenumeration and emigration.

5. The census count shows many fewer persons at ages 10 to 14 and somewhat fewer at ages 15 to 19 than would be expected if Pakistan had had a steady rate of growth during the 20 years prior to the census. Zelnik and Khan [6] believe that the constriction at these ages are the result of errors in reporting and coverage. They cite evidence that these ages have been constricted in several censuses taken in the area which now constitutes Pakistan, as well as a study in process by Ansley Coale demonstrating a widespread undercount at these ages in many underdeveloped countries because of age misreporting. Furthermore, some enumerators may have understated age rather than complete the labor-force questions, which were asked of all residents aged 10 and over. Indeed, the number of children aged 5 to 9 appears to be unduly large when compared with women of childbearing age. It is considered more likely, however, that misreporting is only a partial explanation for the deficiency and that it is also in part the result of reduced fertility or increased infant mortality during World War II and the partition period. The proportion of the population under age 10 in 1951 was less than in 1961 or in the earlier censuses investigated by Zelnik and Khan, and the construction in the same cohort in successive censuses suggest that more than age misreporting is involved.

The age distribution from the PGE survey is also constricted at ages 10 to 19, but less so than that from the census, and the PGE distribution displays a lower proportion under age 10. It was decided, therefore, to minimize the constriction by using the PGE distribution for males under 20 years of age. Because the PGE age distribution was reported to have been based on data from 12 rural

[6] Melvin Zelnik and Masihur Rahmen Khan, "An Estimate of the Birth Rate in East and West Pakistan," *The Pakistan Development Review*, Vol. V, No. 1, Spring 1965 (forthcoming).

sample areas, however, the percentage distribution for males under 20 from the PGE survey was applied to the sum of rural males under 20 from the census. The number under 5 was further modified as in step 6 below. The absolute number of males for ages 5 to 19 from the census counts of urban areas and estimates for the tribal areas were then added. As mentioned under 3, above, the distribution for females was obtained by dividing the estimated numbers of males at each age by the life table sex ratio for that age.

6. Both the census and the PGE project appear to have undercounted the population under age 5. If the birth rate had been high and stable and the total population had been growing for the 10 years before the census, the population under age 5 would be larger than the population age 5 to 9. However, both sources show the two groups to be almost the same size. This could be so if either the birth rate had been dropping or the infant mortality rate had been rising, but neither is likely. An examination of the single-years-of-age data for ages under 10 from the census indicates that the undercount is concentrated in the first 2 years of life. The percentage distribution for males under 10 years old is a follows:

Age	East Pakistan	West Pakistan
Total under 10 years	100.0	100.0
Under 1 year	7.3	8.7
1 year	9.1	8.5
2 years	11.0	10.3
3 years	10.9	11.2
4 years	10.2	10.2
5 years	11.1	11.3
6 years	9.4	9.9
7 years	10.2	9.8
8 years	10.1	10.1
9 years	10.7	10.0

To determine the probable actual distribution of the population under age 10, an index of births from 1951 to 1960, assuming constant fertility rates, was constructed. This was done by (a) "reviving" the number of women of childbearing age to each year from 1951 to 1960, and (b) multiplying the estimated number of women in each age group by the age-specific birth rate from the fertility model. The index numbers representing births are as follows:

Year	East Pakistan	West Pakistan
1960	100.0	100.0
1959	97.9	97.9
1958	96.0	95.9
1957	94.3	94.0
1956	92.6	92.2
1955	90.8	90.4
1954	88.9	88.7
1953	87.0	87.1
1952	84.9	85.4
1951	82.8	83.7

The population under 10 years of age was then obtained as follows: (a) index numbers representing the distribution of males under 10 years old by single years of age were obtained by multiplying the index numbers representing births by appropriate survival factors for males from the United Nations model life table; (b) estimates by single years of age for males aged 5 to 9 were obtained by adjusting the index numbers for those ages to yield the number of males aged 5 to 9 years established in step 5; (c) estimates of the numbers of males under 5 years of age were obtained by applying to the index numbers representing males in that age range the adjustment factor used in (b) to derive ages 5 to 9 years (this method yields different estimates for ages under 5 years from those derived in step 5); and (d) estimates of the number of females under age 10

by single years of age were obtained by dividing the estimates for males derived in (b) and (c) by the United Nations life table sex ratios.

Estimates of the number of births for the decade may also be obtained by dividing the estimates for males in (b) and (c) by the survival factors in (a) and by dividing the estimates for females in (d) by corresponding survival factors for females. Our original calculations, using survival factors from the Indian life table generated a birth rate of 47 per 1,000 for East Pakistan and 44 per 1,000 for West Pakistan. However, by substituting survival factors from the United Nations model life table, level 25, for the survival factors from the India life table, birth rates close to those from the PGE project were obtained.

7. In order to make year-by-year projections it was necessary to distribute the adjusted data by single years of age. For ages 10 to 69, this distribution was obtained by osculatory interpolation. Single-year-of-age estimates for ages under 10 had already been obtained in step 6 and estimates for ages 70 and over in step 2.

8. Finally, the distributions were adjusted to independent estimates of the total population of East and West Pakistan, as described in chapter 1.

The fertility model

The age-specific birth rates employed in the population projections were derived from a hypothetical fertility model. This model was developed specifically for this project in order to measure the impact of the family planning program on fertility, and is described in chapter I.

Data on the distribution of women by parity in a high fertility population are limited. They are not available for Pakistan or for any neighboring country with comparably high fertility. Births by age of mother and births by parity (but not by age *and* parity) are reported for Albania, a Moslem country with somewhat lower fertility than Pakistan. Data are also available for the Hutterites, a fundamentalist sect in North America whose fertility is apparently the highest on record, and for some other high fertility populations. These data have been used together with medical data on fertility impairments and on the probabilities of conception to develop the set of hypothetical age-parity specific rates used in the model.

The rates relate to women aged 15 to 49 years, from 0 parity to 17th parity. The general guidelines for establishing the probabilities of births were: (1) that younger women of low parity are more likely to give birth than older women of higher parity; (2) that the probability that women of a given parity will give birth increases with age up to a certain age and then declines; and (3) that the average number of months between births tends to increase with parity.

The schedule of rates pertains to fecund and subfecund women only; sterile women are excluded. In this regard it was assumed that 5 percent of all women were sterile from the beginning of childbearing and that an additional 2 percent of those at each parity would not have another child because of sterility. The effect of this assumption is that 16 percent of the women in the model would be sterile by the end of childbearing. The model assumes that all fertile women will marry, that most will be married by age 15, and that virtually all fertile women will have borne their first child by age 20. Women in the model will have 9.8 children, on the average.

The family planning program

The assumption of declining fertility in this report is that a program for family planning prepared by the Government of Pakistan in August 1964 would be adopted and would prove successful. The plan called for blanketing the country with clinics over a 7-year period. The cumulative proportion of the area covered at the end of each year, by region, is as follows:

Year	East Pakistan	West Pakistan
1965	2	15
1966	20	30
1967	35	45
1968	50	60
1969	70	75
1970	90	90
1971	100	100

The plan assumed that one-half of fertile couples in the area served by clinics would accept family planning and that one-half of these would do so successfully. Because the plan did not provide guidelines as to which women would adopt family planning, it was assumed here that women with fewer than two children would not adopt contraception and that among those with two children or more the incentive to adopt contraception would be greater among higher parity women. Thus, it was assumed that 10 percent of second parity women would become effective planners, 20 percent of third parity women, etc., to 80 percent of those with nine children or more. It was also assumed that women who are desirous of family planning would visit the clinic within one year after it was established in an area and that after the first year women who move from one parity to another would adopt contraception in the same proportion as those assumed for the initial period (i.e., 10 percent for second parity, 20 percent for third parity, etc.) and that women who reverted to the nonplanning category would not elect to plan again unless they bore another child.

Of the contraceptors at each parity, 25 percent were assumed to revert to the nonplanning category annually. This pattern of entering and leaving the class of contraceptors produces the desired result, that a net of about 25 percent of all fertile couples will remain effective planners. This assumption concerning the rate of reversion to noncontraceptive status is a major modification in the official plan. It was made necessary to keep the calculations manageable. The plan relied heavily upon intrauterine devices and the length of time these devices remain in place is a crucial factor in calculating the probable effect of the plan. The plan assumes that the proportion of IUD's remaining in place after designated lapses of time will be as follows:

Years:	*Percent*	Years—Continued	*Percent*
1	75	4	25
2	50	5	10
3	33	6	None

Consequences of the family planning program

When the model is stabilized once more after the introduction of the family planning program, 25 percent of all women of childbearing age in the model are assumed to be effective users of contraceptives and another 13 percent are assumed to be sterile. Thus, the family planning model shows 38 percent of all women of childbearing age in the nonrisk population as compared with 16 percent (i.e., those which are sterile) for the nonplanning model.

The proportion who are contraceptors are shown as rising to 25 percent in the course of the 7 years of the program and remains at this level, as the following figures for East Pakistan show:

Year:	*Percent*	Year—Continued	*Percent*
1965	0.6	1971	24.4
1966	6.3	1972	25.0
1967	9.9	1973	25.2
1968	13.3	1974–78	25.4
1969	17.8	1979–83	25.3
1970	22.1	1984–85	25.2

The family planning model postulates a decline of 28 percent in the average number of live births a woman will have during her reproductive lifetime, from 9.8 births before the introduction of family planning to 7.1 births when the program is fully implemented. An equivalent measure, the total fertility rate (the sum of the age-specific birth rates), shows fertility as falling for the years in which the program is introduced and then rising slightly again, as may be seen in figure 1.

The parity and age of women bearing children fall, in line with the postulate that older women of high parity will be most prone to adopt contraception. Average parity falls from 5.0 before the introduction of the family planning program to 3.9 afterwards for all women of childbearing age and from 9.8 to 7.1 for women who have completed childbearing. (See table A–3.)

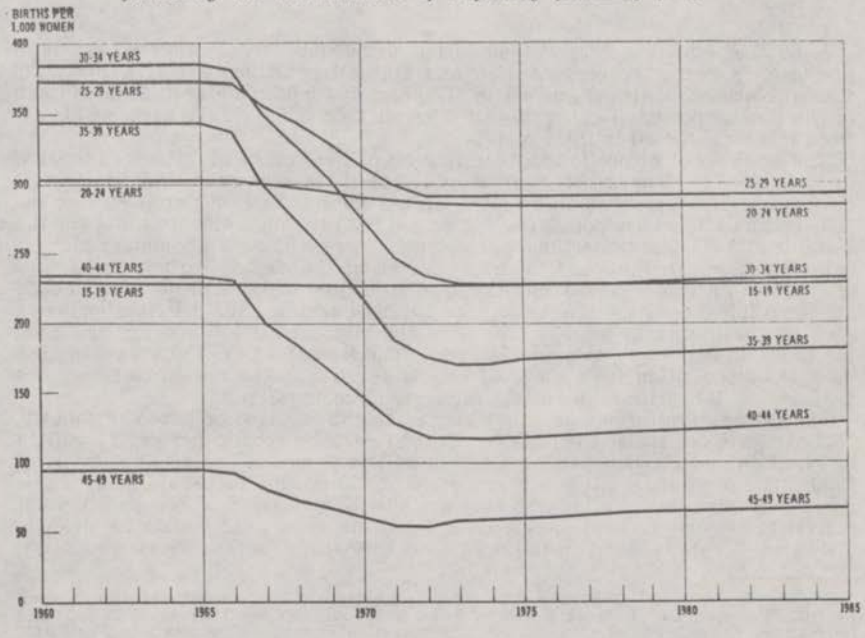
TABLE A–3.—*Parity distribution of women in Pakistan before and after the introduction of a family planning program*

Parity	Women of childbearing age		Women at the end of childbearing	
	Before	After	Before	After
Total, all levels	100.0	100.0	100.0	100.0
0	15.1	15.1	5.0	5.0
1	11.4	11.4	1.9	1.9
2	9.7	10.6	1.9	1.9
3	7.9	9.9	1.9	2.3
4	7.4	10.2	1.9	3.2
5	6.7	10.3	2.1	5.8
6	6.3	10.0	2.4	10.2
7	6.0	9.2	3.3	16.9
8	6.1	7.1	5.3	20.9
9	5.8	4.1	8.4	17.8
10	5.5	1.6	11.8	9.6
11	4.7	.4	14.6	3.5
12	3.5	.1	14.8	.9
13	2.2	(1)	11.8	.1
14 and over	1.5	(1)	13.1	(1)
Mean parity	5.0	3.9	9.8	7.1

[1] Less than 0.05 percent.

Average age of mother falls from 30.1 years before the introduction of the program to 28.4 years afterwards. Birth rates by age fall very sharply at the older ages and very little at the younger ages (see figure A–3).

FIGURE A–3.—*Projected age-specific birth rates for East Pakistan women following the introduction of a family planning program*



Theoretical formulations have demonstrated that changes in the average age at which women give birth have a marked effect on the rate of population growth.[7] The fall in the average age following the introduction of family planning, as in the model, would act as a brake on the subsequent fall in the birth rate and the rate of natural increase. There are several reasons why this is so. First, the fall in the average age reflects the fact that most of the decline in fertility would be among older women. Since there are fewer older women than younger women, there will be less a decline in the number of births than if the decline in fertility has been at the younger ages. Second, it causes a temporary bunching in the number of births and, thus, a temporary excess in the birth rate. Finally, it has a longrun effect on population growth by reducing the length of the generation, which tends to speed population growth. According to the formula offered by Coale and Tye, the change in mean age of mother would accelerate growth in Pakistan by 0.5 percent per year.

Projected urban population

One method of projecting the urban population is to assume that the proportion urban in East and West Pakistan will continue to grow at the same rate as from 1951 to 1961. During that decade, the percent urban increased by 0.7 percentage points in East Pakistan and by 4.7 percentage points in West Pakistan. It was felt, however, that some account should be taken of the impact that the change in age and sex composition might have on urban population. For example, males aged 20 to 24 in West Pakistan will increase, according to series A, from 3.7 percent of the total population in 1961 to 4.5 percent by 1975. Since this group is more heavily represented in the urban population than any other, an increase in its relative size will probably tend to accelerate urban growth. Thus, the assumed change in the proportion urban, i.e., the average annual intercensal rate, was applied to the proportion urban of each age-sex group rather than to the proportion urban for the population as a whole. Projections of the urban population, by age and sex, for the respective projection series were then obtained by multiplying the number of persons in each age-sex group in the total population by the proportion urban for that group.

Comparison with other projections

A number of other sets of population projections for Pakistan have been prepared in recent years. Mauldin and Hashmi published a set in 1959; the United Nations published one set in 1959 and another in 1964; and the Bureau of the Census prepared an unpublished set in 1963. The results of these projections are summarized in table A–4.

The two sets of projections by the Bureau of the Census and the set prepared by the United Nations in 1964 were based on the 1961 census; the Mauldin-Hashmi projections and those prepared by the United Nations in 1959 were based on the 1951 census. The base populations used for the present projections and for the Mauldin and Hashmi projections were adjusted for assumed underenumeration.

For the age distribution of the base population, the United Nations projections of 1959 used a stable population model. The United Nations projections of 1964 appear to have used a distribution obtained by averaging the distributions from each census from 1921 to 1951. Mauldin and Hashmi used a model distribution for India prepared by Coale and Hoover.[8] The Bureau of the Census set of 1963 used the distribution from the 1961 census as given. The present set used the 1961 census data with adjustments for net undercounts.

The present projections are distinctly higher than those prepared previously. The earlier sets obtained results for 1980/81 ranging from a low of 117 million by Mauldin and Hashmi to a high of 170 million from the United Nations set of 1959. The present set gives a range of from 173 million to 191 million. These figures are higher partly because they are based on a larger base population but primarily because they are based on a much higher rate of population growth. This growth rate is based on the results of the PGE project, which became avail-

[7] Ansley J. Coale and C. Y. Tye, "The Significance of Age Patterns of Fertility in High Fertility Populations," *Milbank Memorial Fund Quarterly*, October 1961, pp. 631–646; and Norman B. Ryder, "Problems of Trend Determination During a Transition in Fertility," *Milbank Memorial Fund Quarterly*, January 1956, pp. 5–21.

[8] Ansley J. Coale and Edgar M. Hoover, *Population Growth and Economic Development in Low-Income Countries*, Princeton University Press, 1958.

able only recently. The much lower rates used in earlier projections were based on an analysis of the age structure or on comparative data from other countries.

TABLE A–4.—*Alternative projections of the population of Pakistan—1970–86*

[In millions]

Source and series	1970–71	1975–76	1980–81	1985–86
Census Bureau, 1965: [1]				
Series A	135.9	160.8	191.4	229.0
Series B	132.9	150.8	173.4	201.2
Series C	136.9	163.7	197.6	240.7
Series D	133.9	153.3	178.5	210.6
Census Bureau, 1963: [1]				
Series A	114.3	129.2	151.1	178.3
Series B	113.3	126.9	146.2	169.6
Series C	112.4	124.5	141.3	160.8
Series D	111.4	122.1	139.4	152.0
United Nations, 1964: [1]				
Series A	121.0	----------	161.7	----------
Series B	121.1	----------	158.8	----------
Series C	118.6	----------	146.3	----------
Series D	120.6	136.8	153.6	----------
United Nations, 1959: [2]				
Series A	116.7	132.5	151.7	----------
Series B	125.7	154.6	169.9	----------
Series C	119.5	132.0	144.5	----------
Series D	119.5	134.5	150.8	----------
Mauldin and Hashmi: [2]				
Series I–A	110.8	124.0	140.2	160.0
Series I–B	109.0	119.7	132.0	145.4
Series I–C	107.3	115.5	123.6	131.0
Series II–A	106.8	118.3	132.2	149.0
Series II–B	105.2	114.4	124.6	135.9
Series II–C	103.5	110.5	117.2	123.0

[1] Years ending in 0 or 5.
[2] Years ending in 1 or 6.

Source: Census Bureau, 1965: Table 1. Census Bureau, 1963: Unpublished. United Nations, 1964: "Provisional Report on World Population Prospects as Assessed in 1963," 1964, p. 128. United Nations, 1959: "Future Population Estimates by Sex and Age, Report IV, The Population of Asia and the Far East, 1950–80," 1959, pp. 107–110. Mauldin and Hashmi: W. Parker Mauldin and Sultan Shah Hashmi, "Illustrative Estimates and Projections of the Population of Pakistan, 1951 to 1991," "Population Growth and Economic Development With Special Reference to Pakistan," Karachi, 1959, pp. 61–84.

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(9) PROGRAM FOR CONFERENCE ON POPULATION DYNAMICS FOR STAFF OF AGENCY FOR INTERNATIONAL DEVELOPMENT, JUNE 7–11, 1965

JOHNS HOPKINS SCHOOL OF HYGIENE AND PUBLIC HEALTH, BALTIMORE, MD.

(Conference Co-Chairmen: Dr. Leona Baumgartner, Agency for International Development, and Dean Ernest L. Stebbins, School of Hygiene and Public Health, Johns Hopkins University)

MONDAY, JUNE 7, 1965

	MORNING SESSION	
8	Registration.	
9	Welcome and announcements.	
9:15	Panel: The dilemma of development; objectives of AID and of this conference.	Irene Taeuber, Philip Lee, Robert Smith.
10:30	(Coffee break.)	
11	Economic implications	Mark Perlman.
12:45	Luncheon—Student lounge, 1st floor; discussion of economic implications.	Mark Perlman.
	AFTERNOON SESSION	
	Developments in family planning:	
2	Motivation as related to program design and implementation.	Donald Bogue.
3	(Coffee break.)	
3:20 to 5	Methods: Description; problems of each; relative effectiveness in various sociocultural groups—a preview of the future.	Sheldon Segal.
	Costs, production and procurement problems	Harry Levin.

(9) PROGRAM FOR CONFERENCE ON POPULATION DYNAMICS FOR STAFF OF AGENCY FOR INTERNATIONAL DEVELOPMENT, JUNE 7–11, 1965—Continued

TUESDAY, JUNE 8, 1965

	MORNING SESSION	
	Policies and programs in selected countries:	
8:30	Panel on India and Pakistan, Dr. Carl Taylor, Chairman; Cobb, Adelman, Raulet, AID Mission Representatives.	
10:15	(Coffee break.)	
10:30	Taiwan	Ronald Freedman.
11	Korea, Thailand	Marshall Balfour, AID mission Korea representative; AID mission Thailand representative.
12:15	Luncheon—Student lounge, 1st floor.	
	Address: The U.N. Commission to India (auditorium on 1st floor).	Dr. Leona Baumgartner.
	AFTERNOON SESSION	
2 to 3	Turkey, Egypt, and Tunisia	Parker Mauldin. AID Turkey representative; AID Tunisia representative.
3	(Coffee break.)	
3:15 to 4	Africa below the Sahara	Robert Wright, 2 AID Africa representatives.
4 to 5:30	Relevant developments in United States.	
	Panel:	
	(1) Studies of contemporary practice	Donald Bogue.
	(2) Public programs in United States	Arthur Lesser.
	(3) Public programs in Maryland, Virginia, District of Columbia.	John Whitridge.
	(4) Puerto Rico (the contribution of a voluntary agency).	Manuel Paniagua, Adaline Pendleton Satterthwaite.

WEDNESDAY, JUNE 9, 1965

8:30	Policies and programs in selected countries: Studies in Chile, Peru, and other Latin American countries.	J. Mayone Stycos, Francoise Hall; 2 Latin American mission representatives.
10:15	(Coffee break.)	
10:30	Personnel and training:	
	Demography and social science	Frank Notestein.
	Medicine and public health	Paul Harper.
12	Luncheon—Student lounge, 1st floor.	
1:30	National family planning program in a developing country—A suggested guide.	Bernard Berelson.
3	(Coffee break.)	
3:30	Group meetings (to continue Thursday morning) to discuss problems peculiar to selected regions, e.g., program development or support by AID, personnel and training, logistics, organization, methods, motivation.	

	Room	Leaders	Resource people
(1) South Asia, Middle East, and North Africa.	236	P. Mauldin, C. Taylor, AID staff.	R. Anderson, S. Segal, J. Cobb, J. Hume, T. Baker.
(2) Korea, Taiwan, Thailand, Nepal, Indonesia, Philippines.	237	AID staff, R. Freedman.	M. Balfour, J. G. Robinson.
(3) Sub-Sahara Africa		AID staff, R. Wright.	F. Rosa, R. Morgan, A. Buck, N. Dyson-Hudson.
(4) Latin America	320	AID staff, F. Hall.	A. Hellegers, M. Paniagua, L. Saunders.

6:15	Cocktails and dinner, Jubilee Room, Sheraton-Belvedere Hotel.	
	Address: The Role of Foundations in Population Research and Planning.	Oscar Harkavy, John Maier.

(9) PROGRAM FOR CONFERENCE ON POPULATION DYNAMICS FOR STAFF OF AGENCY FOR INTERNATIONAL DEVELOPMENT, JUNE 7–11, 1965—Continued

THURSDAY, JUNE 10, 1965

8:30 to 12	Group meetings	Leaders and resource people as on Wednesday afternoon.
10	Coffee in group meeting rooms	
12	Luncheon (Note: Group chairmen and rapporteurs to meet together at luncheon to prepare regional reports to conference.)	
1:30 to 2:30	Report of regional group meetings	Rapporteurs: Franz Rosa, Africa; J. C. Robinson, Far East; D. Anderson, NLSA; Benedict Duffy, Latin America.
2:30 to 5	The varying role of public health	Myron Wegman.
	Summary by social scientist	Bernard Berelson.
	Dimensions of development	Irene Taeuber.
	Summary of present population program and plans in AID	Robert Smith, AID, Washington.
	Adjournment	

FRIDAY, JUNE 11, 1965

	MORNING SESSION	
9:30	Introduction	Robert Smith.
9:45	Population programs of multilateral agencies	Richard Gardner, Deputy Assistant Secretary, Department of State.
10:15	Population and the People's Republic of China	Irene Taeuber.
10:45	Discussion "AID Population Program Guidance Paper" (draft).	
12:15	Adjournment	

ALPHABETICAL LISTING OF PARTICIPANTS—AID CONFERENCE, JUNE 7–11, 1965, BALTIMORE, MD.

Dr. Marshall Balfour, Consultant, The Population Council, New York.
Dr. Leona Baumgartner, Assistant Administrator, AID.
Dr. Donald Bogue, Professor, Department of Sociology, University of Chicago.
Dr. Willard Boynton, Senior Public Health Officer, AID/Karachi.
Henry Chuck, Health Program Coordinator, AID, Washington, D.C.
John Clay, Chief, Far East Health, AID, Washington, D.C.
Dr. Philip Cox, Prog. Officer, U.S. AID/Honduras.
Dr. John C. Cobb, Assistant Professor, Maternal and Child Health, Johns Hopkins School of Hygiene.
Lt. Col. Richard Coppedge, Surgeon, U.S.A., Center for Special Warfare, North Carolina.
Dr. Mayhew Derryberry, Health Education Advisor, AID/India.
Dr. Scott Edmonds, Health Education Advisor, U.S.O.M., Saigon.
Dr. Llyod Florio, Chief, Health Division, U.S. AID/Philippines.
Robert Fordham, Special Assistant, Office of International Affairs, HEW, Washington, D.C.
Dr. Lewis Gardella, Jr., Public Health Advisor, U.S. AID/Nicaragua.
Benjamin Gura, Special Assistant, U.S. Bureau of the Census, Washington, D.C.
Dr. Franciose Hall, Research Associate, Division of International Health, Johns Hopkins School of Hygiene.
Robert Hamer, Ass't Mission Director, U.S. Embassy, Ankara, Turkey.
Dr. Alfred Haynes, Visiting Professor, U.S. AID/India.
Dr. Harold Hudson, Hospital Administrator, AID, Washington, D.C.
Dr. Lowell R. Hughes, Johns Hopkins School of Hygiene, Baltimore, Maryland.
George Inada, Biostatistician, AID/Libya.
Dr. Paul Jehlik, Principal Rural Sociologist, U.S. Dept. of Agriculture, Washington, D.C.

Dr. Bruce Jessup, Director, Population Reference and Research Branch, AID., Washington, D.C.
Dr. Leonard Kornfeld, Technical Assistance Advisor, Office of Program Coordination, AID, Washington, D.C.
Dr. Philip R. Lee, Director, Health Services, AID, Washington, D.C.
Dr. Connie Lemonds, Hospital Administrator, AID, Washington, D.C.
Dr. Forrest Linder, Director, National Center for Health Statistics, Public Health Service, Washington, D.C.
Miss Esther E. Lipton, Nurse Midwife Con., Children's Bureau, International Unit/AID, Washington, D.C.
Charles Loughlin, Assistant Desk Officer, AID/Turkey.
Dr. Jaime Manzano, Special Assistant to Director for Program Coordination, American Embassy, Bogota, Colombia.
Dwight F. Rettie, Assistant to the Under Secretary, U.S. Dept. of the Interior, Washington, D.C.
Dr. Franz Rosa, Acting Director, National Institute of Child Health, Washington, D.C.
Dr. James Maslowski, Senior Demographer, U.S. AID/Washington, D.C.
Miss Jeanne Newman, Johns Hopkins University.
Dr. Richard C. Parsons, Public Health Administrator, AID, Washington, D.C.
Dr. Mark Perlman, Professor, University of Pittsburgh, Pittsburgh, Pennsylvania.
Mrs. Jean Pinder, Consultant, Health Ed., U.S. AID/Ghana.
Dr. Harry Raulet, Assistant Professor, Maternal and Child Health, Johns Hopkins School of Hygiene, Baltimore, Maryland.
Verl E. Roberts, International Program Development Specialist, U.S. Dept. of Labor, Washington, D.C.
Dr. J. Courtland Robinson, Assistant Prof., Yonsei University, College of Medicine, Seoul, Korea.
Dr. Jean F. Rogier, Chief Public Health Advisor, U.S. AID/Dacca, East Pakistan.
Robert Smith, Associate Assistant Administrator for Program, AID/Washington, D.C.
Dr. Ernest L. Stebbins, Dean, Johns Hopkins School of Hygiene, Baltimore, Maryland.
Dr. Irene B. Taeuber, Senior Research Demographer, Princeton University, Princeton, New Jersey.
Dr. Carl E. Taylor, Professor, Department of International Health, Johns Hopkins School of Hygiene, Baltimore, Maryland.
Dr. Robert Utzinger, Public Health Educator, U.S. AID/Washington, D.C.
Miss Beulah Washabaugh, Survey Statistician, International Statistics Programs, U.S. Bureau of the Census, Washington, D.C.
Dr. Robert Wright, Professor, Public Health Administration, Johns Hopkins School of Hygiene, Baltimore, Maryland.
Dr. George A. Wyeth, Deputy Chief, Private Investment Division, AID/Washington, D.C.
Dr. Neville Dyson-Hudson, Assistant Professor, Department of Social Relations, The Johns Hopkins University, Baltimore, Maryland.
Haldore Hanson, Representative, Ford Foundation, Karachi, West Pakistan.
Dr. Paul A. Harper, Professor, Maternal and Child Health, Johns Hopkins School of Hygiene, Baltimore, Maryland.
Dr. Andre Hellegers, Associate Professor, Gynecology and Obstetrics, The Johns Hopkins Hospital, Baltimore, Maryland.
Dr. Edvardo Arandes, Associate Professor, Obstetrics and Gynecology Department, University of Puerto Rico.
Dr. Timothy Baker, Assistant Dean, The Johns Hopkins School of Hygiene, Baltimore, Maryland.
Dr. Peter Bing, Office of Science and Technology, U.S. Government, Washington, D.C.
Dr. Harald Fredericksen, In Charge of Health and Population Research, AID, Washington, D.C.
Dr. Ronald Freeman, Professor of Sociology, University of Michigan.
Dr. Arthur Lesser, Deputy Chief, Children's Bureau, HEW, Washington, D.C.
Dr. Harry Levin, Consultant for Distribution Examiners, The Population Council, New York, New York.

Dr. Robert W. Morgan, Sociologist, Harvard School of Public Health, Boston, Massachusetts.
Dr. Manuel Paniagua, Medical Director, Puerto Rico Family Planning Association
Dr. Lyle Saunders, Program Associate, The Ford Foundation, New York, New York.
Dr. Sheldon Segal, Director, Biomedical Division, The Population Council, New York, New York.
Miss Dorothy J. Stacey, Program Director, Public Health Service, HEW, Washington, D.C.
Dr. John Whitridge, Chief, Bureau of Preventive Medicine, Maryland State Health Department.

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(10) Report on the Alliance for Progress Population Program

(By Dr. Ben Duffy, AID, June 1965)

The Population Program of AID Latin America is designed to train personnel and research the population problems of each Latin American nation from the perspectives of all facets of society—State, Church, Universities and private organizations, institutionalizing the population field.

The principal objective is the establishment of a national population policy.

The participation of AID/LA in direct action (control) programs is limited to provision of educational techniques when officially requested.

The Population Office of the Latin American Bureau was established in January 1964. Since that time the following actions have been accomplished:

1. Communications to all Missions in Latin America (March, May 1964) citing the high priority of the program, the necessity of appointing a Population Officer and offering guidelines for encouraging programs according to the concepts of the Fulbright Amendment.

2. Direct personal liaison established with Church hierarchy (Cardinals, Archbishops and their social science advisors) in six Latin American nations. Personal liaison also established with Finance, Health and Planning Ministers of seven Latin American nations (March 1964).

3. Grant to the International Planned Parenthood Federation for the Western Hemisphere Conference on Population in Puerto Rico (April 1964).

4. $100,000 grant to the U.N. Demographic Institute in Chile (CELADE) for training of 15 middle-level experts in 12 Latin American nations and the upgrading of this institution by subsidizing additional faculty for an added training year.

5. Conference with Vatican Officials at the Third Ecumenical Conference concerning population problems in relation to the Alliance for Progress (Archbishop Samore—Chief of the Latin American Section; Cardinal Cicognani, Papal Secretary of State; Vatican Representatives to U.N. agencies; and His Holiness, Pope Paul VI). Conferences with Latin American Church Hierarchy attending the Ecumenical Council (September 1964).

6. Contract ($246,000—3 years) with the University of California Demographic Program to assess, evaluate and advise Latin American nations requesting aid for institutionalizing population programs into their Governmental structure (November 1964).

7. A grant to DESAL (January 1965)—Center for Economic and Social Development of Latin America ($400,000 for 2 years) for basic studies of every aspect of family problems as related to economic and social problems primarily in rural and depressed areas, utilizing their present widespread organizational structure in practically all Latin American nations.

8. Contract ($150,000 a year for 2 years) with the Population Council for research in attitude studies, fertility patterns, and communications on family responsibilities in selected Latin American nations (May 1965).

9. Directly participated in negotiations with Church, State and Universities in Jamaica resulting in the initiation of the first population policy in the Western Hemisphere. Grant of $42,000 for a two-year program in a nationwide educational program in family planning in Jamaica (April 1965).

10. One-week course in basic demographic problem of Latin America as related to economic and social development for AID and State Department Population Officers in Latin American Missions, March 22–26, 1965, at the University of Puerto Rico.

11. A three-week course in basic demographic methods for Latin American Government officials in Ministries of Health, Economics and Planning—May 17–28, 1965 at the University of Puerto Rico.

12. Instigation of a CIAP (Inter-American Committee for the Alliance) resolution on Population (for multilateral support).

13. A grant of $30,000 to PAHO for developing a curriculum training in the medical aspects of demography at two Schools of Public Health in Latin America (April 1965).

14. Contract with Notre Dame University for demographic research, training and consultation in Colombia, Peru and Brazil—$175,000 a year for 3 years (June 1965).

15. A $30,000 equipment grant for an audio-visual center (Bogota, Colombia) for educational films in population problems awarded (May 1965).

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(11) PROGRAMME ACTIVITIES IN THE HEALTH ASPECTS OF WORLD POPULATION WHICH MIGHT BE DEVELOPED BY WHO, RESOLUTION PASSED BY 18TH WORLD HEALTH ASSEMBLY COMMITTEE ON PROGRAMME AND BUDGET, WORLD HEALTH ORGANIZATION, MAY 20, 1965

The Working Party [1] appointed by the Committee on Programme and Budget met on 20 May 1965 under the Chairmanship of Dr. J. Watt (United States of America) and decided to recommend to the Committee the adoption of the following resolution:

"The Eighteenth World Health Assembly,

"Having considered the report of the Director-General on Programme Activities in the Health Aspects of World Population which might be developed by WHO:

"Bearing in mind Article 2(1) of the Constitution which reads: 'to promote maternal and child health and welfare and to foster the ability to live harmoniously in a changing total environment';

"Noting resolution 1048 (XXXVII) adopted by the Economic and Social Council at its thirty-seventh session, August 1964;

"Believing that demographic problems require the consideration of economic, social, cultural, psychological and health factors in their proper perspective;

"Noting that the United Nations Population Commission at its thirteenth session, April 1965, attached high priority to the research and other activities in the field of fertility;

"Considering that the changes in the size and structure of the population have repercussions on health conditions;

"Recognizing that problems of human reproduction involve the family unit as well as society as a whole, and that the size of the family should be the free choice of each individual family;

"Bearing in mind that it is a matter for national administrations to decide whether and to what extent they should support the provision of information and services to their people on the health aspects of human reproduction;

"Accepting that it is not the responsibility of WHO to endorse or promote any particular population policy; and

"Noting that the scientific knowledge with regard to the biology of human reproduction and the medical aspects of fertility control is insufficient,

"1. Approves the report of the Director-General on Programme Activities in the Health Aspects of World Population which might be developed by WHO; [2]

"2. Requests the Director-General to develop further the programme proposed—

"(*a*) in the fields of reference services, studies on medical aspects of sterility and fertility control methods and health aspects of population dynamics; and

"(*b*) in the field of advisory services as outlined in Part III, paragraph 3, of his report,[2] on the understanding that such services are related, within the responsibilities of WHO, to technical advice on the health aspects of human reproduction and should not involve operational activities; and

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[1] Composed of the following delegations: Brazil, Chile, India, Iran, Iraq, Italy, Mali, Philippines, Sweden, Turkey, United Kingdom of Great Britain and Northern Ireland, United States of America, Union of Soviet Socialist Republics.

[2] Document A18/P&B/4.

"3. Requests the Director General to report to the Nineteenth World Health Assembly on the programme of WHO in the field of human reproduction."

Senator GRUENING. I now direct that my letter of March 2, 1964, to Dr. Leona Baumgartner, Assistant Administrator, Office of Human Resources and Social Development, AID, discussing advances in the population field be included in the record of this hearing.

(The letter referred to above follows:)

EXHIBIT 139

MARCH 2, 1964.

Dr. LEONA BAUMGARTNER,
Assistant Administrator, Office of Human Resources and Social Development, Agency for International Development, Department of State, Washington, D.C.

DEAR LEONA: Our meeting last Wednesday was most helpful to me, and I am pleased that you were able to give me an oral summary on the work of the Agency for International Development in various parts of the world.

Could you supply me with written information concerning the program on Taiwan where you observed that AID money had been spent for maternal and child health centers. I believe it was at this juncture in our conversation that Dr. Philip Lee described the new plastic intra-uterine coil with which I am somewhat familiar but would be interested in learning more about as soon as possible.

Your comment that you had found "indication of movement in every Asian nation" is encouraging. Would it be possible for someone in your department to brief the programs of each of the nations in memorandum form for me?

The institute in Chile, where I understand the United States has made $100,000 available for the setting up of programs in other Latin American countries, has a potential which ought to be encouraged. Could you tell me more about the programs which are planned?

The work in the foundation field, of course, will ease the world population problem. I thought the brief mention of the Rockefeller Foundation's plan to educate 30 or 40 family training officers was of great importance. Do you have specific information on that program?

I was pleased that Deputy Assistant Secretary Gardner, Mr. Leighton Van Nort, Dr. Lee and Mr. Wade Fleetwood could accompany you for the session.

The progressive work of the United States government in this area must, of necessity, move forward. I shall do what I can to implement and help.

With best wishes, I am

Cordially yours,

ERNEST GRUENING, *U.S. Senator.*

(Letter of July 6, 1964, to Senator Ernest Gruening from Dr. Leona Baumgartner, Assistant Administrator for Technical Cooperation and Research, concerning the establishing of a Population Reference and Research Branch in AID to be directed by Dr. Bruce Jessup is placed in the record at this point by direction of the chairman.)

EXHIBIT 140

DEPARTMENT OF STATE,
AGENCY FOR INTERNATIONAL DEVELOPMENT,
Washington, D.C., July 6, 1964.

HON. ERNEST GRUENING,
U.S. Senate,
Washington, D.C.

DEAR SENATOR GRUENING: Thank you very much for sending along the excellent statement on population by Congressman Fisher from the June 4 Congressional Record.

Several developments in the last few weeks may interest you. We have now established in A.I.D. a Population Reference and Research Branch and brought in Dr. Bruce Jessup to be the Director. He has already attended the Pittsburgh School of Public Health Research Meeting on Population and the London Meeting of the International Planned Parenthood Federation. The Agency had

an exhibit on population dynamics and foreign aid at the annual meeting of the American Medical Association in San Francisco last week. In addition a group of A.I.D. consultants, Public Health Service representatives, and specialists in the field met on June 25 with Dr. Philip Lee and Dr. Jessup to review recent developments and recommend areas of priority activities for the Population Reference and Research Branch.

We appreciate your continuing interest.

Sincerely yours,

JOHN F. HILLIARD,
(For LEONA BAUMGARTNER, M.D.,
Assistant Administrator for Technical Cooperation and Research).

WHAT ABOUT EARMARKING COUNTERPART FUNDS FOR FAMILY PLANNING?

Senator GRUENING. Now, I notice that you are opposed to certain pieces of legislation introduced by some of my colleagues, Senator Yarborough and Senator Tydings, earmarking or providing that certain of the counterpart funds should be used for this purpose.

Your feeling is that this is not necessary?

AID OPPOSED TO EARMARKING COUNTERPART FUNDS

Mr. BELL. Exactly, sir. I think it would be too much to say, or be too strong to say, that we oppose the legislation. The legislation does two or three different things, but the earmarking part of it we would oppose. We do not think that is sensible, we do not think it is necessary, and we think it would be administratively rather difficult and would be contrary to the sensible way to handle these local currencies that are generated from the Public Law 480 program.

Needless to say, we share the view of the gentlemen who have introduced these proposed amendments, we share their view on the urgency of the problem and on the need to get on with strong, effective American assistance to help deal with it. So we don't differ at all on the principle.

It is only on the administrative matter of earmarking that we have some difference.

Senator GRUENING. There are great sums of counterpart funds available in certain countries, and it would seem to me that you would have a concern of how these can be most effectively used.

Mr. BELL. We do, sir, and they are, in fact, being used for this purpose in Taiwan. They are, and can be used for this purpose in Korea. We would be glad to see them used for this purpose in India or Pakistan, so that I quite agree with that.

Senator GRUENING. Now, you have given some figures as to what you expect to ask for in this current budget and the coming budget. What was it—about $5 million in the coming fiscal year?

Mr. BELL. No, sir; that is the present fiscal year.

Senator GRUENING. Present fiscal year?

Mr. BELL. We expect it to be about double next year, fiscal 1967.

Senator GRUENING. Well, you, as a former Director of the Bureau of the Budget, are very knowledgeable in these matters and I take it you will ask whatever you think is usable and properly expendable in this field.

Mr. BELL. Yes, sir; that is exactly the attitude we have had. These funds, which, as you say, represent a multiplication by several times of the money we spend over a 2-year period, have been based not on any financial limitations but on our judgment, the judgment of Dr. Merrill, Dr. Moseman, and myself, our field people, our country directors, our regional assistant administrators, as to how much we can usefully apply in the time period in question. We would like to be able to spend more, but the rate at which we can usefully spend money has to be related to the development of plans and programs in these various countries which we can support.

Senator GRUENING. You feel there was a definite limit to the amount that can be applied usefully because of the novelty of this program, and because of the fact that it requires a good deal of education and so forth?

"... SIMPLE ADMINISTRATIVE PROBLEM OF ORGANIZING EFFECTIVE NATIONWIDE PROGRAMS AND GETTING THEM INTO ... APPLICATION"

Mr. BELL. My impression, sir, is that at the present time the principal limitation on the speed with which we can get action in the developing countries is not the attitude of the leaders nor our readiness to provide aid. It is the simple administrative problem of organizing effective nationwide programs and getting them into positive, concrete day-to-day application. This is a very difficult administrative, management, organizational kind of problem.

We have seen this and are seeing it today in Taiwan and Korea. While they are doing very well, they are, month-by-month encountering new kinds of problems and having to learn how to solve them. These are all being reported. We hope that as the problems are being solved in Taiwan and in Korea today, lessons will be drawn from those solutions and applied, so far as they are applicable, in India, in Pakistan, Turkey, the other countries that are now embarking on major programs.

GREAT NEED TO TRAIN FIELDWORKERS

Nevertheless, as I indicated, in Korea there are something over 2,000 fieldworkers who have had to be trained and continuously kept managed—and as they leave, some of them leave for one reason or another—new recruits have to be trained and added and that is a country, as I have said, with something over 25 million people.

In India there will be tens of thousands of people who will have to be trained, kept at work, and managed. Supplies will need to be made available to them. Their transportation and their salaries will need to be taken care of. I am not trying to exaggerate the difficulty of these matters. They are all normal types of problems that are encountered in organizing any large scale human effort. But that is the kind of problem that is a practical management problem. It seems to me, in most of the countries where we are working, such practical problems are the major limit on action at the present time.

Now, I should qualify this, Mr. Chairman. My answer has been primarily directed to conditions in Asia.

Latin America is somewhat different. There is still in Latin America a very severe problem of public policy. There is a great ferment

in Latin America. As I indicated, there are now a number of Latin American countries in which there are beginning to be quite substantial private action programs. The clinics in Chile are perhaps the most conspicuous illustration.

With very few exceptions—I think the Government of Honduras has perhaps taken the plunge—there aren't very many Latin American governments which have yet felt that they could conduct publicly supported and publicly managed efforts with public funds being used for this sort of thing.

Senator GRUENING. Because of religious sentiment?

"THE VIEWS OF THE ROMAN CATHOLIC CHURCH . . . IN A STATE OF FLUX AND UNCERTAINTY"

Mr. BELL. I think, yes, sir, religious sentiment translated into political realities. There is no religious domination of these governments, but there are political leaders who have to take account of the views of their own people, and those views are obviously affected by religious views.

Now, the views of the religious leaders in Latin America as you know, sir, are widely divergent. There are quite a few religious leaders in Latin America who have spoken out very clearly and strongly in favor of family and welfare services which would include family planning information. The views of the Roman Catholic Church are, of course, in a state of flux and uncertainty. There are many religious leaders in Latin America who have privately concurred in the kind of research and clinical activity that is going on down there. So that my own feeling about Latin America is that there is a very rapid change in the general consensus view.

OPPORTUNITIES FOR PRIVATE ACTION IN FAMILY PLANNING IN LATIN AMERICA

President Lleras Camargo, when he was here before this committee last summer, was expressing a view which is likely, probably already, the majority view, although it is not yet translated into government policies on a very wide scale, and I would expect that would not happen very quickly. But clearly there are lots of opportunities for private action in Latin America, and I think we will see a very rapid development along those lines. I would expect that our assistance in Latin America in the next few years will be primarily related to private activities rather than governmental activities for that reason.

Senator GRUENING. In other words, if some responsible clinic such as the one in Cali, for instance, were to express to you a need of more funds to extend its activity, you would feel free to consider that?

Mr. BELL. Assuming that the Government of Colombia had no objection and I would not expect the Government of Colombia to have any objection.

Senator GRUENING. You know in his last state of the Union message, the one delivered this year, the President said, "to give a new and daring direction to our foreign aid program, to make a maximum attack on hunger, disease and ignorance in those countries determined to help themselves and to help those nations trying to control population growth."

Have you had any occasion to indicate the significance of those words to the governments of any countries? In other words, what the President says, those who help themselves in this field will get more help from us.

Mr. BELL. He said that those who help themselves, those who stand on self-help programs, are the countries we want to aid.

Senator GRUENING. Self-help in the field of population control.

Mr. BELL. I am not sure that the phrasing, I don't want to argue semantics with you, Mr. Chairman, but——

Senator GRUENING. Yes.

". . . WE WANT TO HELP THOSE WHO WANT TO DO SOMETHING IN THIS FIELD"

Mr. BELL. But the policy we have taken quite deliberately and hold to, and which you referred to in your opening statement, is that because these are matters of such sensitivity, with deep emotional and indeed religious attitudes involved, we, the United States, will not urge a particular policy on any other government. We do, as we have stated many times, regard this problem as extremely important. We have joined in such statements by the United Nations. We have offered and will continue to offer assistance of all varieties, research, action, technical, capital, and so on. But we do not feel that it would be proper for the United States to, for example, set up as a condition for assistance that a country has to undertake a family planning program. That is not our view.

Senator GRUENING. Well, I would say that the President comes pretty close to suggesting that that should be our policy, that we should say to those nations that are willing to go ahead with such a population control program, "We are going to give you help" and not be enthusiastic about helping those who are lagging behind. These are matters of interpretation.

WORLD LEADERS SEE THE POPLATION PROBLEM

Mr. BELL. We certainly are saying just what you said in the first half of your sentence; namely, we want to help those who want to do something in this field. And I repeat, Mr. Chairman, it is our impression, with the qualifications I was indicating a few minutes ago about Latin America, that the leaders around the world in the developing countries do not have to be told that this is a serious problem. They know it. They see it every day in their own circumstances, and therefore what we face primarily is not a problem of persuading them they ought to be doing something about this. What we face is a problem of helping them do what they already know they need to accomplish and what they have already declared they want to accomplish.

REFERENCE TO FULBRIGHT AMENDMENT RE POPULATION AND FOREIGN AID

Senator GRUENING. Senator Fulbright, chairman of the Senate Foreign Relations Committee, has proposed an amendment to this year's foreign aid bill to authorize specifically the use of economic assistance funds for technical and other assistance for the control of population growth, and that amendment is now before the Foreign

Relations Committee. And in submitting the amendment Senator Fulbright said—

> This amendment would overcome some lingering timidity on the part of AID lawyers and administrators who embark on a serious effort to solve the underdeveloped world's most crucial problem.

Would you comment on that?

Mr. BELL. I noticed that in the record last night, Mr. Chairman. And since I have not yet commented to Senator Fulbright, perhaps I should restrict my response.

I am not aware, however—let me try to make this as colorless as I can——

Senator GRUENING. You are not aware of any lingering timidity on the part of AID officials?

Mr. BELL. I am not aware of any significant timidity on the part of myself or my colleagues on moving into this field. I would like to note that Senator Fulbright made it plain in offering that amendment that he did not consider by so doing he would be giving us any new legal authority we do not now have. It would simply be making explict that the authority that he recognized in his statement we now have. So you are quite right. What he was aiming at was the attitude of the management of the Agency for International Development which means he was aiming at me, and I will have to discuss it with him.

Senator GRUENING. Well, I think his purpose was obviously to diminish any lingering timidity, if such exists, and I hope that will be effective.

Have you any further comments before we adjourn this meeting?

Mr. BELL. No, Mr. Chairman. I am delighted to have this opportunity. We are proud of what we have been doing, and expect to do a great deal more in the future.

Senator GRUENING. Would you be kind enough to supply for the record the guidelines that you circulated in March of 1965?

Mr. BELL. Yes, we will be glad to, sir.

Senator GRUENING. And subsequently?

Mr. BELL. Right.

(The information referred to follows:)

EXHIBIT 141

AID MEMORANDUM ON POPULATION

March 2, 1965.

On January 4, 1965, President Lyndon B. Johnson said in his state of the Union message: "I will seek new ways to use our knowledge to help deal with the explosion of world population and the growing scarcity of world resources." The statement has met with wide approval domestically in the United States as indication of the continuing responsible concern of our Government for one of the most profound problems of our times. Since the concern of AID Missions is immediate and direct, this circular is intended to review recent related developments and to bring AID personnel up to date in the population field.

THE BACKGROUND

In 1964 the United Nations reported that the increase in the world's population had reached the highest rate yet recorded—an annual rate of 2.1 percent. In the less developed countries, the rates are even higher—2.5 percent annually, which would double population every 28 years. In Latin America, the figures are even more dramatic: population may be expected to double in approximately 20 years, based on a current growth of over 3 percent. All less developed coun-

tries have birth rates of more than 30 per thousand population per year, and some approach 45. All of the economically developed countries, in contrast, have birth rates of under 30 per thousand per year. Rapid population growth in the less developed countries is attributable not only to relatively high birth rates but also to the rapidly declining death rates which have accompanied economic development and the improved health and sanitary conditions. The declining death rates of the past two decades may be expected to continue, although not so dramatically.

Already in many countries, food production, employment opportunities, the development of schools and health services, and other aspects of social and economic growth are barely keeping pace with population growth.

With an average economic growth rate in the less developed countries of under 4.5 percent a year and a population growth rate of more than 2.5 percent, the per capita growth rate has been less than 2 percent.

In view of the potentially serious consequences implied by these magnitudes, it is important that AID missions assess carefully and fully all the implications of the population growth for economic and social development as well as for the AID programs.

RECENT DEVELOPMENTS

The United Nations General Assembly discussion on population problems in December 1962 included a statement of U.S. policy which indicated that the United States was concerned about the social consequences of its own population trends; the U.S. wanted to know more, and help others know more about population trends; the U.S. would oppose any effort to dictate to another country its population policies; the U.S. would help other countries, upon request, to find potential sources of information and assistance on ways and means of dealing with their population problems; and the U.S. believed there was need for additional knowledge in the field.

It has also been a U.S. position that in publicly supported health services, complete freedom of choice should be available in accordance with the conscience of the individual concerned.

The past several years have witnessed other developments in the population field which merit the attention of AID:

1. *National programs in less developed countries.*—Over the past several years, growing numbers of less developed countries have either instituted operating programs in the field of family planning or are considering such programs. There are major programs underway in India, Pakistan, Korea, Taiwan, Ceylon, Hong Kong, and Jamaica. Pilot programs or significant action-research programs are being carried out in Thailand, United Arab Republic, and Tunisia. The operating personnel in all of these programs are in medicine or public health. In most countries, the health service is the administrative, planning and operating organization for family planning. In some countries major programs are carried out primarily by private organizations with government permission and support.

2. *Assistance to National Programs.*—Several foreign governments, including the United Kingdom, offer assistance in family planning programs upon request from developing countries. The United Nations Economic Commission for Asia and the Far East (ECAFE) has called for technical assistance from the U.N. and other sources to countries in the region requesting it. Recommendations for technical assistance through United Nations organizations will be placed before the U.N. General Assembly in 1965. The Inter-American Economic and Social Council recently recommended that Latin American countries carry out studies of the relationship of population increase to economic development and social progress, and offer technical assistance for this purpose through CIAP.

3. *Technological Developments.*—Major technological advances have been made in the field of fertility regulation. Laboratory and extensive field studies, including some in the developing countries, have confirmed the effectiveness of certain hormones ("the pill") and plastic intra-uterine devices (I.U.D.) in the prevention of pregnancies. Their use in some areas has resulted in the reduction of birth rates.

4. *Attitudes on family planning.*—Attitude studies in developing countries indicate a widespread desire to limit family size and an interest in receiving family planning information. This is true in rural as well as urban areas. The reasons given are mainly economic. Valid methods are available for such studies and they have proven to be the prelude to effective family planning programs in several countries. Along with this interest in such programs, many of the

world's political, social and spiritual leaders, as well as public opinion, are increasingly recognizing the necessity of facing the many social and economic problems associated with rapid population growth.

THE ROLE OF AID

In AID, we are beginning to receive an increasing volume of informal requests for information and assistance in relation to this problem.

AID has, of course, long given assistance in the development of health services and the training of health personnel. Assistance has also been given in developing official statistics, including population censuses and vital statistics. In addition to requests in these fields, AID has had requests for technical assistance in training of family planning workers and financial assistance for the purchase of vehicles and education equipment to be used in family planning programs.

Since 1962 AID has encouraged the collection and analysis of population growth data and study of attitudes about family planning. Requests for information and assistance in family planning have been referred to appropriate private agencies.

In the past year AID missions have begun to respond directly to requests for information. AID/W furnished AID missions with general reference materials and technical publications dealing with a wide range of subjects from demography to family planning. The Population Reference and Research Branch was organized in the Health Service of the Office of Technical Cooperation and Research (TCR). It has served as the AID focal point for information and coordination in the population field. The Office of Research and Analysis has considered several population research projects and one has recently been approved by the Research Advisory Committee. The Office of Program Coordination has been working closely with TCR and the Regional Bureaus on the development of program policies. The Latin America Bureau created a Population Unit in its Institutional Development Office and requested each LA AID Mission to appoint a high official to be responsible for population matters. Consultants have been appointed in the demographic, economic, medical, and public health aspects of the population field.

At present, it is important that each AID mission assign one of its officers, as LA missions have done, to become familiar with the problems of population dynamics and program developments in the country and to keep the Mission Director, Country Team personnel and AID/W appropriately advised.

AID does not advocate any particular method of family regulation. As noted earlier, freedom of choice should be available.

Requests for assistance in this field, as in others, will continue to be considered only if made or approved by appropriate host government authorities. Such assistance would, in any case, merely be additive to the host country's own efforts and assistance from other sources.

Requests for assistance will be handled, as in any other field, on a case-by-case basis. We are prepared to entertain requests for technical assistance. Where appropriate, the requests will continue to be referred to private agencies. We are prepared to receive and consider requests for commodity assistance. AID will not consider requests for contraceptive devices or equipment for manufacture of contraceptives. Experience has made it clear that the cost of these latter items is not a stumbling block in countries that are developing effective programs. Other items could be provided by AID, such as vehicles and education equipment for use in maternal and child health and family planning programs. We are also prepared to receive requests to assist in local currency financing of such programs.

The Population Reference and Research Branch is and will continue to be the focal point for agency information on population affairs. Selected population reference material will from time to time be sent by the Branch to AID missions.

In conclusion, the immediate impact and long-term implications of world population increases are sobering and are recognized as such by our government, by other governments of the world, and by private leaders concerned with human welfare. The problem is complex. Simple, instant solutions neither exist nor are in sight. Under any circumstances, population programs must always be concerned with far more than technical services and every effort must be made to achieve social conditions favoring responsible parenthood. It is our objective to move ahead constructively, with careful and deliberate consideration of all the economic, social and human relations issues involved.

Senator GRUENING. And the subcommittee members will appreciate it if you would give us the summary of the various countries to which aid is going, to the extent that you have it, and where there is none just so state. Give us an idea of what is being done presently in the family planning field and what the prospects are, so that we can have an idea of what is going ahead.

I think we all agree that this is a very serious problem, and there seems to be on the part of most of our administrators an agreement with the President's point of view.

Mr. BELL. Right.

Senator GRUENING. Maybe not all, but we hope we can convert them in time as the rising tide of public opinion makes the obvious even more obvious.

Thank you very much.

Mr. BELL. Thank you, sir.

Senator GRUENING. I direct at this point that the article "Birth Control: The Solution to the Population Crisis Lies in Improved Methods and Universal Acceptance of the Practice" by Dr. William D. McElroy of the Johns Hopkins University, be included in the record of this hearing. Dr. McElroy is the knowledgeable Chairman of the National Academy of Sciences' Panel on Population Problems.

(The above-mentioned article follows:)

EXHIBIT 142

BIRTH CONTROL: THE SOLUTION TO THE POPULATION CRISIS LIES IN IMPROVED METHODS AND UNIVERSAL ACCEPTANCE OF THE PRACTICE

(By William D. McElroy, the Johns Hopkins magazine, Vol. XIV, No. 7, May, 1963, p. 6, ff.)

It has taken thousands of years for the world's population to reach three billion. But human numbers are increasing at the rate of 140,000 a day. At this rate, it will take only 35 years to add another three billion people. And then another 35 years for six billion people to double to twelve billion.

Amid our comforts, we are inclined to regard the statistics as only mildly distressing, and the problem as only a matter of precious-few parking spaces 35 years hence. But the "population explosion" is no vague and remote spectre. It is upon us, here and now, in every corner of the world.

* * * * * * *

In the years since World War II, the real output of the private economy rose 67 percent, but with only a 3 percent rise in man-hours. In agriculture, output rose 30 percent, but the man-hours were actually cut in half. And still, we have yet to feel the full brunt of automation and other technological forces at work on our economy, and the gap between national output and man-hours is likely to widen. Ominously, the workers under the age of twenty-five, though they comprise less than one-fifth of the labor force, now constitute more than one-third of the unemployed.

"I see no indication that the business community really wants or needs these hordes," Adolph W. Schmidt, a distinguished financier, said recently. "And, if they have no work, or have only small incomes in a highly competitive labor market, their contribution to the expected increase in national demand for the products of our economy will be nil."

But the predicament of the United States, as of the other highly industrialized nations of the world, pales in comparison with the crisis affecting the two-thirds of the human race, most of them living in utter poverty, in the underdeveloped countries of Asia, Africa, and Latin America. In these countries, where the luxury of population increases can least be afforded, the rates of increase are the highest. In some cases, they are more than double the averages for Western Europe or North America.

These high rates of population increase are not, as some are wont to believe, evidence of irresponsibility on the part of the world's least privileged people. Birth rates in feudal-agrarian societies tend to be high, but through most of human history they have been offset by high death rates caused by primitive conditions. Until recently, it was an absolute necessity among families in underdeveloped countries to produce two or three offspring in order to have one survive to maturity. In a primitive agrarian economy, where children are needed in the fields, large families are desirable. Then, too, many of the underdeveloped countries fell under the influence of older political concepts that equated population with power—a philosophy held by many of the colonial powers and still manifest, to an alarming degree, in the pronouncements of the Chinese Communists.

But now, thanks to the beneficence of science and the financial assistance of wealthier nations, death rates in the underdeveloped countries are declining precipitously. Most of this improvement has been a consequence of low-cost public health measures: insecticides, antibiotics, inexpensive water supply treatment. In many countries of Latin America, for example, the death rate has plummeted about 50 percent in the last 30 years. In Ceylon, the death rate dropped 50 percent in less than a decade. Even as birth rates remain fairly constant (and high) in the underdeveloped countries, the rapid decline in death rates causes the actual rate of population increase to rise considerably.

At the same time that population is increasing rapidly in these countries, their citizens are expecting dramatic improvements in their standards of living. Their governments, as well as the governments of wealthier nations, are committed to help them. Reflecting these ambitions, the United Nations General Assembly in 1961 set a goal for the "decade of development" for each of the underdeveloped countries: the attainment, at the end of 10 years, of an annual growth rate in gross national income of 5 percent.

The goal, seemingly modest, is, in fact, far more ambitious than realistic. Yet, even if it could be attained, its effect on standards of living would not be appreciable. Consider the experience of the past decade. The statistical income per person in the underdeveloped countries in 1950 averaged about $90 per year. In 1959, it reached slightly over $100 per person. Gross income had grown at the rate of 3 percent a year, but because there were 200 million more people to be fed in these countries, the net increase in income per person was only 1 percent—about $1 per year.

If an underdeveloped country were to attain the United Nations goal of a 5 percent rate of annual economic growth in 10 years, it would raise a present per capita income of $100 to about $123, if its rate of population growth stood at 2 percent. But, if population expansion continues at the present rate, to increase its rate of economic growth to 5 percent from, say, a current 3 percent, would require a rise in national income of about 50 percent. Even with its vast capital resources and technology, the United States required about 15 years following World War II to increase its national income by 40 percent.

The odds against this kind of "bootstrap" economic leap are overwhelming. Unless an underdeveloped country remains an insatiable sponge for foreign assistance—an impossible solution—a good part of its investment in industrialization and improvement of standards must come from its own resources. But the low-income countries find it almost impossible to steer these resources toward investment. The pressure to use all available resources for current consumption is too great. As population grows, it takes more and more investment of capital to make any appreciable change in material well-being. Furthermore, since increasing population rates have the effect of increasing the proportion of children among the total population, a larger portion of national output must be used to support a growing number of non-earning dependents. A family with many children finds it difficult to save, and a government that tries to finance industrial development out of taxes can expect less financial support from a population with many children. And, of course, much of whatever can be saved must be invested in non-revenue producing expenditures, such as schools and housing.

In Latin America, President Kennedy has indicated, "population growth is already threatening to outpace economic growth—and in some parts of the continent, living standards are actually declining." In Asia, food production per capita was 10 percent lower in the late 1950's than it had been 20 years earlier. In Egypt, where the giant Aswan Dam has become the symbol of expected deliverance from the wretched poverty of that counrty, the population

is growing by about 3 percent a year, about the same rate as the increase in gross national income. By the time the dam is in full operation in 1972, there will probably be 40 million Egyptians crowded into the country's habitable portion (smaller in area than West Virginia)—and most of them no better off than they are now. In Pakistan, salty water supplies are ruining farmland at the rate of one acre every 5 minutes. One acre feeds about two people. At the same time, the population of Pakistan is increasing at the rate of ten people every 5 minutes.

"I must be blunt," Eugene R. Black told the Economic and Social Council of the United Nations. "Population growth threatens to nullify all our efforts to raise living standards in many of the poorer countries. We are coming to a situation in which the optimist will be the man who thinks that present living standards can be maintained. The pessimist will not look even for that. Unless population growth can be restrained, we may have to abandon for this generation our hopes of economic progress in the crowded lands of Asia and the Middle East."

Mr. Black's statement reflects the thinking of a growing body of responsible leaders in government, business, religion, and the scientific community. Last fall, a group of nineteen Nobel Laureates and twenty-five business leaders, in a joint declaration, endorsed Mr. Black's warning, and added: "Clearly, the urgent, indisputable need today is for intensified action to decelerate world population growth. Population trends must become a central consideration in all national and international plans for health, economic development, and world peace."

Mr. Black, president of the World Bank, is a trustee of the Johns Hopkins University. Among the numerous voices to be raised in concern about the population problem, there are many others of distinction among the Hopkins "family." To quote a few:

Christian A. Herter, LL.D. '61, trustee emeritus of the University: "The growth of population must be regulated—not alone for the sake of individual happiness but because of the grave political implications which may follow in the wake of failure."

Alan F. Guttmacher, B.A. '19, M.D. '23, president of the Planned Parenthood Federation of America, Inc.: "Think of the unschooled hordes in Asia, Latin America, and Africa. They establish peripheral contact with the complex world of today, with its advanced knowledge and technology. Imagine the sense of bewilderment and frustration such contact engenders. In some this is followed by passive envy, in others by burning ambition, but probably in most by bitter revolt. * * * I sincerely believe that programs of economic improvement and population control applied simultaneously are basic requisites toward a rational solution. One without the other is doomed to failure, as our own government has learned through bitter experience with the terribly disappointing progress of its Alliance for Progress program in Latin America."

Harrison Brown, PH.D. '41, professor of geochemistry, California Institute of Technology: "Global family planning is an essential factor in any sensible program for resource development. Of all the problems which confront our unhappy world it is by all odds the most urgent and the most critical. Yet, ironically, it is the problem which is receiving the least attention."

Ernest Stebbins, dean of the Johns Hopkins School of Hygiene and Public Health: "Increasing population is the number one public health problem in many parts of the world. * * * Failure to attack this problem vigorously and immediately will mean increased suffering for millions of people and perhaps even world disaster."

Recently another voice of concern was added. It came from the National Academy of Sciences, representing about 600 of the outstanding scientists in this country, for whom a panel of eight biological and social scientists issued a report called The Growth of World Population. In that report, the panel, of which I was chairman, included five recommendations for swift, concerted effort by national and international agencies.

In our deliberations, one persistent fact kept coming back to us: action by those who ought to be concerned is long overdue. As James Reston of The New York Times has observed, probably never in history has so obvious and significant a problem "been so widely evaded or minimized by the governments of men."

Among Asian countries, only one nation has succeeded in a dramatic, full-scale program of family planning. Between 1947 and 1959, the birth rate in Japan—as a result of liberalized policy on legal, induced abortion and an educational

program to promote contraception—was cut in half. Its current rate of population increase is considerably below that of the United States.

But in many respect, Japan's experience is irrelevant to the problems of other Asian countries, and it is naïve to think the other countries will "evolve" a similar family pattern. Japan's modernization has been going on for a century, and the country has been an industrial nation for several decades. Education has been compulsory for about seventy-five years.

Still, the success of the Japanese experiment has helped to spur other Asian countries to take positive steps toward programs of population control. Among the countries of that region which have begun to provide assistance for voluntary birth control and to educate citizens in birth control methods are India, Pakistan, Korea, Taiwan, Ceylon, Malaya, and most recently, Thailand. The steps have been tentative and small. In India, which has the most extensive program of population control outside of Japan, the family planning clinics have contacted less than 10 percent of families of India and given contraceptive advice to less than 2 percent of them.

Some other countries outside of Asia have at least given official recognition to the problem. At a conference on economic development in Cairo last year, the representatives of 29 countries of Asia, Africa, and Latin America—not a single Western industrial nation was represented—agreed unanimously to a recommendation that "countries that suffer from the pressure of population * * * take appropriate measures to deal with their population problems."

Last December, the United Nations General Assembly passed a resolution, by vote of 69 to 0, recommending further study by U.N. agencies of the effects of population growth on the economic development of member nations. It is worthy of some note that a clause calling for U.N. technical assistance "as requested by governments, for national projects and programs dealing with the problems of population" had to be struck before the resolution was accepted. But the passage of the resolution may have marked a turning point in the policy of the United Nations, which, up to then, forbade its agencies to launch any positive, curative attack on the population problem.

The same occasion brought forth the first clear indication of a positive stand on the issue by the United States government. Speaking for the United States in support of the U.N. resolution, Richard N. Gardner of the State Department pointed out that "the United States wants to know more, and help others to know more, about population trends in less developed countries where present levels of population growth may constitute a major obstacle to the realization of goals of human economic and social development." He emphasized the "great need for additional knowledge on population matters" which the United States recognizes. Understandably, Mr. Gardner also stated that "the United States would oppose any effort to dictate to any country the means to be employed in dealing with its population problem. The population policy of any country must be determined by that country and that country alone."

These are some of the laudable accomplishments of the nations of the world, but they are meager, almost farcically inept, in the face of the monumental problem which confronts us.

Too many countries still face the issue of population growth with the evasiveness of an ostrich. Only one aid-giving country, Sweden, has made birth control assistance a part of its foreign aid program. Currently, Sweden is conducting small programs in Ceylon and Pakistan and has been asked for similar assistance by Tunisia. In three or four years, Sweden expects family planning assistance to comprise the largest item in its foreign aid effort. By U.S. standards, the current expenditures are diminutive, but the example ought to be an embarrassing one to the United States government, which has yet to demonstrate, through positive action, its recently stated policy of willingly providing assistance to other nations.

In the United States, the issue of population control has been, and remains, a sensitive one. In 1958, President Eisenhower appointed a committee of ten distinguished citizens, under the chairmanship of William D. Draper, Jr., to study the effectiveness of the military assistance program of the United States. Among other recommendations, the Draper Committee suggested that the United States "assist those countries with which it is cooperating in economic aid programs, on request, in the formulation of their plans designed to deal with the problem of rapid population growth," and give assistance "to local programs relating to maternal and child welfare." The report of the committee also recommended increased research and study to help individual countries formu-

late practical programs "to meet the serious challenge posed by rapidly expanding populations."

When the report was published late in 1959, the recommendations on population control had the predictable effect: they set aflame a long-smoldering religious controversy that involved Catholic and non-Catholic clergymen and, of course, the presidential aspirants of 1960.

The attending furor laid to rest, for the time being, all hopes of a change in U.S. policy on the question. But the Draper Report had the positive effect of bringing into the open a religious controversy too long ignored and subjected to misunderstanding through ignorance and prejudice. It also raised public interest in the whole issue of population control. As Arthur Krock of The New York Times noted, the controversy "had the immediate and invaluable effect of moving the topic from the areas of private morals and theology into the realm of public discussion of political action. This is a result which organizations and individuals concerned with the growth of population beyond national economic capacity had been unable to achieve in years of dedication."

Christian A. Herter has expressed his belief "that authentic interfaith action can and will occur. * * * The inflexible popular notion that Catholics and non-Catholics are locked in a hopeless controversy on birth control no longer fits the facts if indeed it ever did."

One of the most lucid and promising contributions to a settlement of differences has just been published. It is a book called The Time Has Come, and it was written by John Rock, a dedicated Roman Catholic who is also a leading gynecologist and one of the major contributors to the development of the oral contraceptive.

Dr. Rock finds considerable ground for agreement between Catholics and non-Catholics. "The same concepts of medical, economic, social, and family well-being which Protestants invoke in justifying family limitation are also employed by Catholics. * * * There *is* clear disagreement over how this dutiful limitation may be achieved."

To combat the popular and erroneous notion that the Catholic Church demands unlimited procreation (a notion still held by many Catholics), Dr. Rock quotes a number of Catholic theologians defending the doctrine of "responsible parenthood"—as, for example, Monsignor John A. Goodwine, who exhorts his colleagues "to acknowledge that the marriage act is a human act and, as such, is to be exercised in a reasonable manner. If cogent reasons indicate a limitation of family size, there should be no difficulty in admitting that the avoidance of pregnancy would be within the bounds of reason and morality."

To his fellow Churchmen who have opposed liberalization of laws and public policies on birth control, Dr. Rock makes a plea for tolerance and restraint:

Attempts to impose the Church's teachings by political fiat stem from an unwarranted extension of the Church's duty, as well as from a sad misunderstanding of what constitutes a democratic, pluralistic society. The Church, it seems has paid an extravagantly high price for these misconceptions.

If there are indications of a thaw in the religious controversy, there are also signs that the evasion of official Washington is less pervasive than it was at the time of the Draper Report. "But," notes Robert C. Cook, president of the Population Reference Bureau, "while discussion is much freer now, positive programs in education and research designed to solve the population problem continue to be inhibited by political considerations."

The continuing skittishness toward the issue of population control was indicated last fall when a Public Health Service report surveying current research related to birth and population control was, by order of the Surgeon General, withheld from public circulation. When news of this brought public criticism, Anthony J. Celebrezze, the new Secretary of Health, Education, and Welfare, countermanded the order and promised publication of the report by January 1, 1963. But he said the report "might be subject to misunderstanding" and therefore would be "thoroughly reviewed" by the Public Health Service. In an editorial, *The New York Times* declared: "We hope this does not mean that useful scientific information will be eliminated out of a mistaken belief that the subject is too delicate for open discussion under government auspices."

To judge by recorded opinion, a firm stand by the U.S. government has seemed overdue. According to a Gallup Poll in 1959, 72 per cent of Americans favored giving birth control assistance to those who want it. A more recent survey by the *San Francisco Chronicle* showed 84 per cent in favor of government action to provide birth control information and supplies to countries asking for them.

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Clearly, of course, the policy cannot be emboldened to the point of pressing the underdeveloped countries to adopt programs of population control as a condition of economic assistance. But a firmer stand could spur further attention to the problem where little exists now. "It is almost literally impossible to ignore the population problem in Latin America," a sociologist said recently, "although both the United States and Latin America have come as close to this as is humanly possible. The United States, so insensitive to Latin feelings in most areas in the past, has maintained a sensitivity to the assumed Latin American population values and mores which should earn the envy of every applied anthropologist."

Ironically, some foreign countries have been pressing the Uinted States to take a stronger stand. "We look to you," Ayub Khan, the president of Pakistan told an American audience in 1961, "to apply your mind and your resources to be able to combat this problem." In 1960, M. C. Chagla, then the Ambassador of India to the United States, said: "Unless government here officially steps in, the help we could expect from this country would indeed be infinitesimal. If the government gives the green signal, then India can benefit by all the scientific knowledge this country has."

Simply to give birth control programs a "green signal" is not enough. Even in developing countries which already have begun programs of population control, present measures are inadequate and must be greatly accelerated. It is clear that development funds from industrialized countries must be channeled to support these efforts.

More important, as efforts of the last 10 years have shown, programs of population control must be much better designed than they are now. The primary problem has been one of motivation: how to overcome the ignorance, superstition, and indifference which stand in the way of effective family limitation.

In India, a study of the attitudes of people in rural and urban areas disclosed than 75 per cent of the couples seemed to want to learn a method of family planning. And yet, in the state of Madras in 1959, of the 38,829 mothers who were given instruction in family planning, only 1,578—about 4 per cent—acted on the advice. In another study in an Indian village where Harvard investigators supervised an intensive educational and clinical program for two years, only 10 percent of the fertile wives actually put to use the recommended birth montrol methods. Half of the mothers refused them altogether, and most of the remaining 40 per cent were classified as "pseudo-acceptors"; they accepted the methods out of courtesy or "a wish to be helpful" to project personnel. Similar discouraging results have been found in studies throughout Asia.

Other studies have brought to light reasons for resistance to family planning. A research project in Singur, India, revealed several such factors. Many couples found the recommended methods of contraception too much bother, or expressed a general apathy toward trying a new practice. Some resisted methods which they felt would interfere with normal sexual satisfaction, and others lacked faith in the effectiveness of some methods, particularly when a village woman participating in the study became pregnant. (Most such "failures" were due to human factors, not unreliability of the contraceptive method.) Crowded living conditions and lack of privacy was another negative factor. And lastly, tradition weighed against success of the program. In rural India, high social status is accorded to the head of a large family; moreover, the prospect of children to look after the man in his old age adds to his feeling of security, both economically and emotionally.

In other cultures, other factors account for resistance to family planning. The concept of voluntary fertility control may appear to be accepted when presented by the social worker, but fail to be completely grasped or understood. Illiteracy presents a considerable barrier to effective communication. Since the decline in the death rate is not always quickly apparent, the realization that it is no longer necessary to bear several children to have some survive may take considerable time. A decline in infant mortality within the community may be viewed as an increase in births, with no appreciaton of the fact that the death rate has been reduced. Or again, the necessary joint decision between husband and wife may be difficult when sex and reproduction are not considered permissible topics of conversation.

Despite the difficulties, successful results are occasionally attained. In a 4-year program in a group of Indian villages, the personal contact by field workers—providing information, support, and supplies—apparently reduced the birth rate, albeit a modest 5 percent. In Ceylon, a similar program resulted in a 7

percent decrease in the birth rate in 3 years. A project in some Japanese villages turned a substantial proportion of couples from abortion to contraception. An informational program in Puerto Rico increased the use of contraceptive methods by more than 10 percent, and the distribution of free supplies through volunteer leaders attracted new users among those with many children.

Even the few successful projects are but miniscule attacks against a gigantic problem. But every project, whether it succeeds or fails, yields a bit more information to the still small body of knowledge on the social factors influencing population control. Each succeeding project has a better chance of success when based on the experience of the past. In Pakistan, for example, a study supported by the Pakistani government, the Population Council, the Ford Foundation, and the Rockefeller Foundation, has approached the problem of community persuasion in a careful and well considered way. Under the direction of four members of the faculty of the Johns Hopkins School of Hygiene and Public Health—Paul A. Harper, John C. Cobb, Harry M. Raulet, and Rowland V. Rider—the project was begun in 1961 in Lulliani, a village of 12,000 population in West Pakistan. A careful census of the area indicated a birth rate of about 50 per thousand population per year (twice the average for North America). Last November, the project leaders began their project of education among the townspeople. They started with a series of orientation and training courses for the leading citizens, first the men, then their wives. They also sought the support of two dozen midwives of the town, called *dias*, who were inclined to regard the campaign as a threat to their business. Enough support was won from the leaders and the *dias* to arouse the interest of other citizens, and the educational program is spreading. The government of Pakistan also supplies contraceptives to couples in the Lulliani area, and studies are being made of their acceptance and effectiveness. Particular attention is being paid to the suitability of oral contraceptives and intra-uterine plastic coils to the cultural setting.

The Lulliani project is still in progress. Like the few dozen similar projects now being conducted, it is seeking to find approaches to the population problem that are effective and economical. Clearly these experimental efforts in natural settings, using local resources, must be multiplied by hundreds, to learn more about how family planning can be implemented in societies that recognize the need for it.

Research must proceed on another front. Fertility regulation is a social problem, but it is also a technical problem. The better the contraceptive—better in ease of use, in effectiveness, in economic feasibility—the easier it is to gain widespread acceptance of family planning and to ensure success where it is practiced. The two sets of factors, the social and the bio-medical, are closely interwoven, and progress in the former cannot be achieved without more research in the latter. Because the preferences and needs among people throughout the world are diverse, the research effort must be invested in a variety of methods and procedures.

Obviously, some methods of preventing reproduction are unacceptable, particularly those which remove or destroy the organs that produce germ cells (sperm or ova). Castration, for example, is a completely effective method, but it is irreversible and cannot be regarded as acceptable under any conditions.

Surgical sterilization, which leaves intact the organs of reproduction, is being practiced in some parts of the world. The government of India has come out openly in favor of sterilization as a method of family limitation and, on a pilot basis, has begun offering thirty rupees (six dollars) as a reward for surgical sterilization to indigent parents who have at least three children.

In reply to Western critics, Indian officials have a frankly economic defense. As one of them points out, it would cost an average of one dollar per citizen in yearly taxes to supply free diaphragms to the two-thirds of the Indian population too poor to afford them. Surgical sterilization, at the desired rate of five operations per thousand people each year, would increase the per capita tax by only five cents each year. However harsh, the very unassailability of the logic of this position points up the need for perfecting a less drastic contraceptive method that is cheap as well as effective.

Short of sterilization, which by and large is irreversible, there are a variety of techniques of contraception which can be considered, in greater or lesser degree, as mechanical: diaphragms, condoms, various types of jellies, creams and foams, coitus interruptus, and periodic or total abstinence. These operate on the simple principle of physically preventing the sperm from meeting the egg. The major drawback of these methods, however, is that they are too closely

related to the sexual act itself, and hence may not provide sufficient effectiveness for the large majority of the world's people.

Again, we need to develop simpler, less demanding methods than are now available. From a biological standpoint, the chief considerations are effectiveness and safety. To be deemed effective, the technique must reduce to near zero the probability of occurrence of pregnancy after use. And the less the technique demands in the way of strong motivation, carefulness, and foresightedness, the more effective it is likely to be. Safety must be evaluated from the point of view of the physical and mental health of the user, and the effect on subsequent fertility and births when the method is discontinued. There remain, of course, the non-biological requirements as well: the acceptability of techniques in terms of the legal, moral, ethical, aesthetic, and economic standards of the culture in which they are used.

Presently, our knowledge of the human reproductive process is meager. We do know that it is an exceedingly complex process.

In mammals, the reproductive process is a sequence of steps, each depending upon the successful fulfillment of the preceding ones. There are at least thirteen distinct phases to the process, ranging from production and release of the pituitary gonad-stimulating hormones to implantation of the beginning embryo and maintenance of embryonic development.

Theoretically, at least, the reproductive process is subject to interference between each distinct phase. Interference at various points does, in fact, occur naturally and the process of reproduction does frequently fail, as evidenced by human sterility and spontaneous abortion. But these points of interference must also be considered in devising methods for voluntary regulation of fertility. Understanding of the causes of undesired sterility is closely related to the knowledge of how to induce it temporarily, and the same basic research in reproductive physiology can be applied in either direction: to inhibit fertility or to improve it.

Each of these phases of reproduction is being given attention by research scientists, but the work is not extensive and surely is not adequate to meet the mounting crisis of the world's population growth. The Public Health Service report, mentioned above, lists a total of $6 million in support of research "on reproduction related to birth and population control" by government, industry, and private foundations. But the report includes many projects which at best are tangential to the problem of birth control, and admits that much of the research effort supported by the National Institutes of Health ($2.7 million) "reflects the preoccupation of this agency with basic research on reproduction and with disease rather than with birth control as such." About one third of the N.I.H. projects listed in the report are concerned with the events which occur after fertilization, and most of these are focused on such matters as fetal wastage and maldevelopment. Unfortunately, according to John Rock, the report did not include, in its revised form, the recommendations of a group of consultants of N.I.H.—of which Dr. Rock was a member—calling for additional expenditures of $16.6 million annually for special training and a more balanced research effort.

The extent of our appalling ignorance of reproductive physiology was dramatized recently by Carl Hartman, a pioneer in the field of reproductive physiology and for many years a research associate of the Carnegie Laboratories at Johns Hopkins. From a transcript of a week-long conference of 150 distinguished investigators, Dr. Hartman distilled and published a list of 154 important unanswered questions representing "hiatuses in our knowledge of reproductive processes with particular reference to man and other mammals."

Despite the obstacles and the scientific inattention to the field, current research is perfecting at least four greatly promising methods of fertility control. Undoubtedly the best known of these methods is the use of contraceptive pills, which, when taken for twenty days beginning on the fifth day of the menstrual cycle, effectively abolish the normal ovulatory cycle and substitute an artificial anovulatory cycle—one in which no eggs are released from the ovary. In the United States, an estimated two million women are using the two varieties of these oral contraceptives now on the market, both of which are synthetic hormones. In Great Britain, women may buy the pills through the National Health Service at the nominal cost of 28 cents for a month's supply. In Egypt, Nasser's government is providing them at 46 cents a month. (Bought on prescription in the United States, the pills cost $3.50 for a month's supply.) In Puerto Rico, more than fifteen hundred women have participated in clinical

tests of the oral contraceptive, some for as long as six years. The effectiveness of the method has been striking. More investigation is needed, however, to determine any possible serious side effects from long-term ingestion of the pills. For areas of the world where illiteracy is high and the counting of days by the calendar is uncommon, the oral contraceptives would have a unique quality in their favor: they would permit women to synchronize the ovarian cycle with the readily observed cycles of the moon. But currently the cost of the pills is a barrier to their wide distribution in the poorer countries.

The second method of promise involves antizygotic agents, which appear to inhibit development of the cleaving egg (the zygote) during its transport through the oviduct. It is estimated that death of the zygote occurs spontaneously in at least one out of four instances. Certain compounds, when administered to experimental animals within three or four days after mating, have succeeded in inhibiting the development of the fertilized egg. Thus it is possible that some day the ingestion of a single pill after coitus will prevent pregnancy. If so, the pill will have important advantages over the oral contraceptives now available.

An oral contraceptive for the male is also a possibility. But research with antispermatogenic agents has had only limited success. Numerous compounds have been found which halt the formation of sperm in experimental animals, for as long as four weeks on a single dose, and which permit complete recovery of fertility when the treatment is withdrawn. Most of these compounds, unfortunately, have had unpleasant side effects, but further research and experimentation may eliminate these.

Lastly, there has been a recent revival of interest in the use of intra-uterine devices. These include rings made of stainless steel, plastic, gut, or nylon thread, and the recently developed plastic coil, which is more easily inserted into the uterus and more easily removed. The devices are inserted by a physician and may remain undisturbed for considerable time. Exactly how they work is as yet unknown, but clinical tests throughout the world have shown them to be safe and effective. What's more, they are cheap, and thus have promise in underdeveloped areas of the world.

Beyond these four methods of current promise, there are other possibilities of future promise. Attention is being directed toward compounds which can inhibit implantation of the egg in the endometrium. Secondly, it may be possible to interfere selectively with the hormones necessary for stimulating ovulation and spermatogenesis. Thirdly, it is theoretically possible to use immunological procedures, similar to vaccination against a disease, to interfere selectively with any one or all of the processes related to reproduction. It may be possible to immunize females against spermatozoa, against reception of the fertilized ovum into the endometrium, or against the development of placental tissues. In the male, a homologous sperm vaccine may cause auto-immunization to prevent sperm development. When such methods are developed, it will be possible to maintain an infertile state for any length of time simply by accepting occasional booster treatments.

In 1951, Pope Pius XII expressed the hope "that science will succeed in providing the licit [rhythm] method with a sufficiently secure basis." Greater reliability to the rhythm method is also of interest to non-Catholics, particularly in underdeveloped countries where mechanical and physiological contraceptives are not yet available on a broad scale. The difficulty, of course, is that ovulation in many women is not really rhythmic in occurrence. Even among women whose cycles approach regularity, ovulation may occur as much as six days off schedule.

John Rock points to two possible ways of perfecting the rhythm method: "by developing a cheap, simple, and accurate home test that any woman could use to predict the day of ovulation each month; or by developing an equally simple way to induce ovulation so that it could be made to occur on a selected day of each menstrual cycle."

The induction of ovulation, Dr. Rock points out, would be possible with regulary spaced injections of the pituitary hormones that evoke it. In a recent clinical test, five women were caused to ovulate in response to the injected hormones, apparently with no harmful side effects, but more research needs to be done before such drugs are available on a mass production scale.

The ability to predict ovulation, on the other hand, would allow a couple to define the fertile period accurately. Claims have been made for a chemical method and for the effectiveness of "test" papers applied to the cervix or vagina, but impartial investigators have been unable to confirm the value of these procedures. But a more reliable method may be found, perhaps using immunological procedures to determine changes in levels of the gonad-stimulating hormones.

Perfection of a simple and reliable procedure to make the rhythm method more effective will help to close the gap between Catholic and non-Catholic thinking on family planning and will open the way for an acceptable program of population control in the predominantly Catholic countries of Latin America. But as Dr. Rock points out, it must be accompanied by wider acceptance among rank-and-file Catholics of "the emerging but authoritative Catholic doctrine of responsible parenthood."

Undoubtedly, the primary task is to achieve universal acceptance of the desirability of planning and controlling family size. People throughout the world must be made aware that voluntary family planning and control of family size can provide better opportunities for them and their children.

A great part of the burden must be borne by science and technology—to provide knowledge of the reproductive processes and simple, acceptable techniques for controlling them. Only when this is done can societies make available to all people techniques which are consistent with the many differing cultural traditions of mankind and which do not interfere with the necessary privacy and fulfillment of marital life.

Recognizing these facts, the panel of scientists which prepared the National Academy of Sciences report on population growth included five specific recommendations:

1. Support of graduate and post-doctoral training in demography and in social and bio-medical sciences concerned with population problems should be increased.—Present research programs are greatly hindered by lack of manpower, both in the social scientific fields and the bio-medical fields concerned with specific aspects of the reproductive process. Universities, particularly schools of hygiene and public health, must be provided more doctoral and post-doctoral fellowships and more funds for teaching and research posts. The Johns Hopkins School of Hygiene and Public Health, for example, would like to triple the number of master's degree candidates specializing in population and fertility regulation. To do so, and to expand and improve the research effort and the curriculum, will require considerable outside support.

2. Research laboratories for scientific investigation of the biomedical aspects of human reproduction should be expanded.—The few laboratories now concerned with human reproduction should expand their facilities and mobilize more students and scholars to work our problems of human fertility. The work of these laboratories can bring public attention to the problems and stimulate additional research in other parts of the country. In this connection, the recently established National Institute for Child Health and Human Development is unquestionably a sound step forward. The scope and urgency of the problem of improving contraceptive methods demand a concentrated five-to-seven-year research effort.

3. International cooperation in studies concerned with voluntary fertility regulation and family planning is highly desirable, and the United States government should actively participate in fostering such cooperation, working in coordination with appropriate agencies of the United Nations system whenever possible, and with other inter-governmental and non-governmental organizations whenever appropriate.—The most important contribution the United States government can make is the development of new knowledge and the dissemination of this knowledge to other countries and to international agencies. In addition, there is specific need for direct assistance to countries who want to implement policies of fertility control and family planning.

4. Programs in the United States for the training of family-planning administrators should be improved and enlarged.—In all areas of the world, there is a lack of skilled administrators to carry family planning programs to the people. The United States can help immeasurably by expanding the training opportunities in schools of public health and practical "field" work under supervision of local officials.

5. An advisory committee should be established by the National Academy of Sciences for the purpose of stimulating and coordinating technical programs directed towards the solution of problems of uncontrolled growth of populations.—No one institution—government, private foundations, universities, or industry—can assume all the responsibility for progress in population control research. A committee of scientists within the National Academy of Sciences can serve as watchdog, and take the initiative in seeking ways to carry out the recommendations listed above. Since the problem is an interdisciplinary one, a committee of scientists representing a variety of fields of the natural and social

sciences could perform a valuable service in coordinating the research effort and recommending improvements.

Since the end of World War II, the wealthier nations of the world have poured billions of dollars of economic aid into the underdeveloped countries. The United States' share of this has been $62 billion; its health programs in underdeveloped countries amount to more than $84 million annually. Hardly a penny of this aid, from any country, has gone into assistance for population control.

At the same time, our National Institutes of Health are spending about three-quarters of a billion dollars annually for research projects in the control of mortality, broadly defined, and less than $3 million annually on research related to human fertility. This dollar disparity is of limited significance, since there are many causes of death and only one cause of birth.

But death control and birth control are opposite sides of the same coin. As Aldous Huxley points out, "It is self-evident that a society which practices death control must at the same time practice birth control—that the corollary of hygiene and preventive medicine is contraception."

No one resists death control. It is popular and requires little initiative on the part of the people. Fertility control, the other side of the coin, must overcome the obstacles of ignorance, weak motivation, and the persistent indifference of many of the world's leaders.

But the fulfillment of hopes of two-thirds of the world's people, the preservation of civilization's highest values, and hence the very survival of all peoples, are intimately tied to the solution of this one vexing problem, and it cannot be ignored any longer.

Senator GRUENING. Col. E. C. (Ned) Kavanagh of Washington, D.C., has sent the subcommittee a reprint of a feature story from the "Harvard Crimson." It is "Improving Quality of Life, by Limiting Its Quantity, Is Population Center Goal," by Jeffrey C. Alexander, Crimson reporter. Mr. Alexander describes the unique program now underway at Harvard's Divinity School. In his introduction, Dean Samuel H. Miller states: "There is no other theological school in the country which has an educational program directed toward issues relating to population." I direct that this article be included in the hearing record.

(The article referred to above follows:)

EXHIBIT 143

IMPROVING QUALITY OF LIFE, BY LIMITING ITS QUANTITY, IS POPULATION CENTER GOAL

(By Jeffrey C. Alexander, the Harvard Crimson, Vol. CXXXXIII, No. 34, Cambridge, Mass., Thursday, Mar. 17, 1966)

When most people think about a population studies center, they imagine gloomy Malthusian statistics and birth control pills. When Roger Revelle, director of the Harvard Center for Population Studies, thinks about population, he worries about getting more protein to India, reducing child mortality, and using the energy of the Aswan Dam to cut the birth rate in Egypt.

In the old days of demography—the study of population statistics—the experts would have considered Revelle's ideas strange and alarming: "A population center deals with improving the quality of human life; controlling the quantity of population incidental to this larger goal." But today most population experts would agree with this statement.

The population centers at Chicago and Princeton dominated the old guard of demographic study. They were limited in their activity to analyzing trends in population figures, rather than developing solutions for the problems they uncovered. But in recent years population studies have been revolutionized at new research centers, like the ones at Harvard, Michigan, and Johns Hopkins.

When the Harvard Center for Population Studies was established in October, 1964, it initiated a more ambitious program than any other center in the United States. Its membership includes engineers, divinity students, psychologists, computer experts, medical researchers, educators, economists. They study the

ethics of birth control, the physiology of the reproductive system, and the allocation of resources in poor countries to further population control.

The job of directing these diverse activities requires a man with an equally wide range of experience, and Revelle is a distinguished natural scientist as well as an experienced administrator. A former oceanographer and director of the Scripps Institute for Oceanography, he was honored by the National Academy of Sciences in 1964 for "Outstanding Contributions to Oceanography." The same year he became Dean of Research at the University of California. As science advisor to Secretary of the Interior Stuart Udall in 1962, he served as chairman of the Pakistan Project, which conducted a general review of the agricultural conditions in West Pakistan. Also, he was one of the five permanent foreign members of the Indian Commission on Education, which is now concluding its final report.

Harold A. Thomas Jr., Gordon McKay Professor of Civil and Sanitary Engineering and a member of the Center, worked with Revelle on the Pakistan Project and was instrumental in bringing him to Harvard from California. "He is such an effective director of experts," Thomas has said of Revelle, "because his genius allows him to become the second best expert on anything in a short amount of time. He is on top of everything that goes on at the Center."

Thomas himself, who is studying the relationship between resource utilization and population change in underdeveloped countries, is engaged in one of the Center's most spectacular projects. Through his research, he hopes to develop efficient computerized methods for bringing population control to underdeveloped areas.

From Thomas's viewpoint, the greatest benefit from applying computers to large socio-economic problems like overpopulation lies in their ability to consider a vast number of background factors in terms of an equally large array of alternative actions. A tremendous backlog of information on actual socio-economic conditions in different areas has to be acquired before a computer model for development can be produced. Presently, the center is operating one field station in Egypt; Thomas hopes to establish other outposts in Sweden, India, the Pacific islands, Latin America, and Africa.

The project in Egypt is sponsored by the Ford Foundation as a pilot study to determine the best use of the water from the High Aswan Dam and its subsequent effects on Egypt's population crisis. The water could be used as irrigation for expanded agriculture or as hydro-electric power for industrialization. It it were used to industrialize—the course Thomas favors—a general immigration from farms to cities would be started. Past experience has shown that populations are most amenable to birth control techniques during this period of transition. Also, Thomas said, throughout history, whenever a new water technique was introduced, a population change accompanied it.

The industry resulting from the utilization of water power can also be planned to reduce the population problem. For instance, Japan helped to stabilize its birth-rate by drawing women into the working community. Industries can thus be created that use techniques which appeal to women's special abilities. So if planners have a choice, they should build an electronics industry, which makes use of the sustained precision effort for which women have an aptitude.

The computer model which Thomas envisages would make analysis of this sort but on a fantastic scale. Even for small nations, several man-years of effort would be necessary to incorporate all the fine-grained statistics need for an effective plan. Although each nation requires a different population policy in accordance with its particular development program, the computer could easily adapt its core of "hard knowledge" gained from research in the field.

The varying factors which determine the population structures of different countries are also the subject of two research projects conducted by David MacA. Heer '50, assistant professor of Biostatistics and Demography. In the first study, Heer is concerned with the Soviet Union's demographic transition from an underdeveloped nation with high birth and death rates to an industrial society with low vital rates.

One significant fact which Heer has discovered in his research is that although birth and death rates in the USSR and the U.S. are approximately equal, total births per woman of childbearing age in Russia are somewhat lower than in the United States. This paradoxical situation occurs because there are more Russians than Americans in the prime fertility age, between 20 and 29 years old. The Great Depression drastically reduced the prime fertility age group in America today.

But there are other factors contributing to Russia's low fertility. The terrific strain of its rapid socialization is partially responsible. Although party propaganda has always encouraged a high birth rate, the use of women in the work force and the extended period of inadequate overcrowded housing have depressed the birth rate. In adidtion to these natural causes of a low rate of birth, there are, in fact, indications that a majority of the Soviet population favors birth control, either through conventional techniques or abortion. Heer believes the government legalized abortions in 1955 only because doctors were already handling a great many illegal abortions and because the flaunting of the law threatened Party morale. No matter what the party dogma says, Heer sees a definite change in the Soviet leadership's attitude toward population limitation: "It appears that they've decided it's just too expensive to raise their birth rate."

Heer has discovered other factors that mark a decline in the birth rate of a nation which are common to both Russia and the United States. They are concurrent with industrialization and improved medical techniques.

Just as the Soviet birth rate has declined since the great industrial push in the early thirties, so the United States has shown a steady decline from the 1870's to the late 1930's. Decreasing child mortality has played a major role. For example, figures reveal that the interval between births when a child lives is substantially greater than when the child dies at birth: breast nursing causes sterility for 11 months, while death at birth causes only two months of sterility.

The second factor common to both countries is the shift from dependence on the family as a source of support in old age to a reliance on support from the government. It used to be that the more children parents had, the more assistance they would receive when they could no longer support themselves. Today, measures like social security, which are part of modern industrialization, make family dependence unnecessary.

In his second project, Heer is making a statistical analysis of the social factors which differentiate fertility of nations. He has approached the problem of the effects of economic development on fertility in a unique way. Although experts have always known that economic development means a lower birth-rate, Heer claims the direct result of economic development is an increase in fertility. An example is the large increase in the American birth rate in the prosperous post World War II period.

It is only the indirect effects of development according to Heer which lead to an eventual depressing of the birth rate. Heer points to the increased cost of children in an industrial urban society where parents have to pay for the space children take up and the food they eat. In an agricultural society children may be used productively in the farm work, and there is no crucial space problem.

Other indirect effects of development are reduced child mortality, perhaps the most important single factor, and increased literacy. The latter is usually accompanied by delayed marriage and a more sensitive sophistication which leads to greater acceptance of family planning. Heer thinks that another indirect result of economic development, increasing technology, caused an eight percent decrease in the U.S. birth rate over the last year with the acceptance of oral contraceptives.

Heer is also beginning a third survey to determine the effects which reducing mortality will have on the population rate. The study centers on determining how many offspring a couple will need to assure themselves a 95 percent certainty of one surviving son when the father has reached his 65th birthday. Using a computer, the probability of having one surviving son will be determined at 24 levels of mortality, ranging from average life expectancies of 20 years to 73.9 years. The study assumes no couple can produce more than 12 children. Preliminary results reveal that population growth is greatest in the middle range of mortality. In periods of high mortality, couples will certainly produce many children, but most will not produce as many as they need to assume the survival of at least one son.

In societies where the mortality is so high that a couple must produce seven to nine sons to insure one surviving, the population growth will not achieve its maximum because the limit of children per family is 12. This also means that contraception would be useless in societies at this level, for mothers would try to have as many children as possible.

The population growth peaks at middle mortality where only five or six sons are needed. At this point, the couple would be producing close to the maximum

number of children and the ratio of birth rate to death rate will be highest at this level.

The preliminary results of the study are revolutionary because they indicate that contraception cannot curb the population rate in societies with high mortality, and that it becomes really effective only in societies of very low mortality. Thus Heer concludes that "progress in curbing the population explosion may best be brought about through further reduction in mortality," rather than increased contraception.

Still, birth control is being studied in detail in both its ethical and biological aspects, by other members of the Center. Assistant professors Ralph B. Potter and Arthur J. Dyck, both of the Divinity School, teach and do research on the relationship between ethics and population control. Dyck justifies the inclusion of ethics in population studies by pointing out that the real problem in controlling birth rates is not the acceptance of birth control techniques. This often results only in a more even spacing out of a large family, he explained. The real variable is whether people want a large or small family or, as Dyck put it "what one wants out of a family." At this level, the influence of religion becomes crucial.

The seminar Dyck and Potter are giving on religious ethics and population control exemplifies their research at the Center. It covers three areas. First, it surveys the writings and pronouncements of religious groups to determine their attitude toward family planning and the population crisis. Research thus far has revealed a subtle yet significant difference between Protestant and Catholic attitudes.

Although the Catholic Church is not opposed to the idea of family planning, it still outlaws the use of any specific techniques except the rhythm method. Also, powerful elements within the Catholic Church still are not convinced that a real population danger does exist. The only books which receive official Church sanction, Dyck noted, are those which assert that by improving techniques of utilizing resources, undeveloped countries will achieve industrialization, which will be enough by itself to halt the soaring population growth.

Juxtaposed to Catholic teaching, Protestant thought today recognizes the situation as a crisis and recommends mitigation of it through family planning. It allows the conscience of the couple to decide upon a proper birth control device.

The practical value of this part of the study will appear when the seminar determines what influence religious factors have on fertility rates. Dyck and Potter believe the effects are direct. The seminar's report on this relationship will combine a summary of the most accurate studies with some empirical research by the seminar itself. Dyck and Potter feel the seminar's study of differential fertility is unique for two reasons. First, it takes into account that the influence of a certain religion on the fertility of its followers is dependent as much upon the consistency with which it is practiced as the doctrines it teaches. Previous studies have been superficial because they have neglected the consistency factor.

A second factor which is not usually considered in studies of religion's effects is that religious attitudes often become so absorbed into a culture that aspects of the society which once resulted from religious doctrines are no longer recognized as such.

To determine whether these different religious teachings are sound becomes the final task of the seminar. The doctrines will be judged in two ways: (1) Is the position taken by the religion consistent? (2) It is morally correct? Through the seminar and in their own private research, Potter and Dyck hope to provide a sound basis for individuals to think critically about population while remaining within the context of their religion. "We are trying to lead the seminar members to explore the latent resources in their own religions which might be used to interpret * * * the problems of the sudden increase in population in recent years" Potter said.

ETHICS AND PHYSIOLOGY EXPERTS PROBE ISSUES OF BIRTH CONTROL

While Dyck and Potter concern themselves with the ethical aspects of birth control, the biological aspects are being studied by Dr. Hilton A. Salhanick, professor of Obstetrics and Gynecology. He conducts his basic research in the laboratory of human reproduction, which was established at the School of Public Health in July, 1965 as one liaison between the center, the School of Public Health, and the Medical school.

The research, which is just beginning, will concentrate on two projects. In the first, Salhanick and his associates will try to discover exactly "the mode of action" of birth control pills. "There are five million women taking them and we still don't know their basic mechanism of action," Salhanick said. It is hoped the research will lead to improvements in the pill.

The purpose of the second project is to develop a method by which a woman will be able to determine the exact time of her ovulation each month by a simple home test. At present there is no such convenient way to determine ovulation. By allowing a couple to know with certainty the exact date of ovulation, the research could lead to a method of birth control uncomplicated by use of pills and devices. Such a new method of birth control, Salhanick said, is desirable because "a large segment of people won't accept anything else and others don't have any access to the more expensive devices."

Most of the Center's projects are geared for long-range goals. But given the worldwide rapid rate of population growth, the need for action is becoming increasingly immediate. According to Thomas, the difference between instituting "moderate" birth control measures in underdeveloped countries now and 15 years from now would amount to a 25 percent difference in the population of those countries by 2025.

Senator GRUENING. We will stand adjourned until next Monday afternoon at 2 p.m.

(Whereupon, at 11:25 a.m., the subcommittee recessed, to reconvene at 2 p.m., Monday, April 11, 1966.)

POPULATION CRISIS

MONDAY, APRIL 11, 1966

U.S. SENATE,
SUBCOMMITTEE ON FOREIGN AID EXPENDITURES,
COMMITTEE ON GOVERNMENT OPERATIONS,
Washington, D.C.

The subcommittee met, pursuant to recess, at 2 p.m., in room 3302, New Senate Office Building, Senator Ernest Gruening (chairman of the subcommittee) presiding.

Present: Senator Gruening.

Also present: Herbert Beaser, chief counsel; Laura Olson, special consultant on population problems; Joseph Lippman, staff director; William J. Walsh III, professional staff member; Carole Ransom and Harriet Eklund, editors; and Mary A. Miller, clerk.

(The picture of today's witness is placed in the record at this point by direction of the chairman.)

EXHIBIT 144

The witness who testified on S. 1676 before the Subcommittee on Foreign Aid Expenditures, Monday, April 11, 1966, was the Honorable Thomas C. Mann, Under Secretary of State for Economic Affairs, Department of State, who was accompanied by Robert Adams, Special Assistant to Mr. Mann. (Pictured, left to right: The Honorable Thomas C. Mann, and his special assistant for population matters, the late Robert Adams.)

OPENING STATEMENT OF THE CHAIRMAN

Senator GRUENING. The hearing will please come to order.

Today's contributor to the population dialog on S. 1676 is the Honorable Thomas C. Mann, Under Secretary for Economic Affairs for the Department of State. He is the 92d witness to testify at these hearings which are being held by the Government Operations Subcommittee on Foreign Aid Expenditures. This hearing, the 27th, brings to a temporary suspension the hearings which will be held in the 2d session of the 89th Congress. More will be held after I return from Alaska.

The subcommittee has had an eventful past few days. Secretary Gardner of the Department of Health, Education, and Welfare, has been asked to look over his Department's report and return with a more constructive commentary and a report of his Department's work in this area. AID Administrator Bell has been asked to supply the subcommittee with a rundown of the population programs, both governmental and private, in the countries which have received or are receiving foreign aid from the United States.

NEED FOR GLOBAL KNOWLEDGE OF PRESENT AND PLANNED ACTIVITIES IN FIELD OF FAMILY PLANNING

Today, April 11, 1966, the Subcommittee on Foreign Aid Expenditures, after hearing Under Secretary Mann, will ask him to contact the embassies or missions of the United States in the nations which are not participating in our foreign aid program, asking for a report on the activities, private or governmental, of each nation in the field of family planning. The subcommittee hopes this information can be collected and made available to it no later than May 15, 1966. We need to know what other nations are doing now, and if possible what they plan to do.

"THE ONLY WAY TO SOLVE THESE PROBLEMS IS THROUGH POPULATION CONTROL"

Under Secretary Mann's distinguished career includes numerous years of service in Latin America. The population explosion in Latin America prompted former Colombian President Lleras to tell this subcommittee last year that the population increase in that part of the world is "certainly beyond the capacities of the Latin Americans to cope with it." According to President Lleras:

"Latin America is breeding misery, revolutionary pressures, famine, and many other potentially disastrous problems in proportions that exceed our imagination even in the age of thermonuclear war."

President Lleras said: "The only way to solve these problems is through population control."

The subcommittee is well aware of the signifiance of President Lleras' words.

Likewise, the subcommittee is aware of Under Secretary Mann's many statements on the subject of population. For example, in Philadelphia on December 7, 1965, Under Secretary Mann said, in part:

"In countries where populations are rapidly growing—and there are countries where present population growth rates will mean a doubling

of population every 18 or 20 years—the number of jobs must be expanded at the same rate and in the same span of time or unemployment will rise and per capita income will fall."

At the Houston, Tex., Council on World Affairs on September 23, 1964, Mr. Mann said: "* * *the Americas face a population explosion unprecedented in history."

Before the House Banking and Currency Committee on February 4, 1965, Mr. Mann said: "In many countries economic growth is barely keeping pace with population growth."

POPULATION PROBLEM IS NOT ONE OF MONEY, FOOD, OR RESOURCES ALONE

But, indeed, as Mr. Mann said in New York City on November 9, 1964, the population problem is not one of money, food, or resources alone, and decisions as to how to meet and solve the population problem must be made by each country.

The question is—How does our Federal Government properly let people in the United States and other lands know that it stands ready to help as time runs on and populations increase but do not prosper? Man is entitled to dignity and quality in his life. In too many places today dignity and quality are dreams.

Mr. Mann, we are very happy to have you here. We know about your deep interest in this problem, and your long record of distinguished public service. I will at this time make your official biography a part of the hearing record.

BIOGRAPHIC STATEMENT: THOMAS C. MANN

Thomas Clifton Mann has been Under Secretary of State for Economic Affairs since March 18, 1965.

He is a career Foreign Service officer, and has served as Assistant Secretary of State for Inter-American Affairs and as U.S. coordinator of the Alliance for Progress.

Thomas Mann's home address is Laredo, Tex., where he was born on November 11, 1912. He and his wife, Nancy, have one son, Clifton Aynesworth.

Mr. Mann served twice as Assistant Secretary of State for Inter-American Affairs, holding the office first from September 1, 1960, to March 30, 1961. His second term in the position extended from January 3, 1964, until he was named to his present position. From May 1961 to January 1964 he was Ambassador to Mexico. From September 1957 to September 1960, Tom Mann was Assistant Secretary of State for Economic Affairs.

He was graduated from Baylor University in Waco, Tex., in 1934, where he received both his B.A. and bachelor of law degrees.

From 1934 to 1952 he practiced law in Laredo, Tex.

In 1942 he joined the Foreign Service. His career has taken him to many parts of the world. He was counselor of the Embassy in Greece from August 1953 to October 1954. Mr. Mann has been Ambassador to El Salvador and has served on many embassy staffs.

We are very happy to hear from you. Will you proceed in your own way?

STATEMENT OF HON. THOMAS C. MANN, UNDER SECRETARY OF STATE FOR ECONOMIC AFFAIRS; ACCOMPANIED BY ROBERT ADAMS, SPECIAL ASSISTANT TO MR. MANN; ALEXANDER SCHNEE AND PAUL MILLER, CONGRESSIONAL LIAISON OFFICERS, DEPARTMENT OF STATE

Mr. MANN. Thank you, Mr. Chairman, and members of the subcommittee.

It is a pleasure for me to appear here to discuss with you the position of the Department of State on the population growth aspects of economic and social development programs abroad.

The Department of State, together with the Agency for International Development, has been giving increasing attention to these problems over the past 5 years. It has participated in numerous meetings, both in the international field and here at home with private organizations concerned with population growth. Its senior officers have spoken publicly on this subject and have met with many private groups to exchange views on the problem.

LONG-TERM IMPLICATIONS OF POPULATION INCREASES ARE SOBERING

In some areas the population threatens to double itself in a generation. The long-term implications of such increases in population are sobering. They are a serious challenge to us if we are to succeed in the long efforts we have been making to assist a large part of the world in its orderly economic and social development.

MANN SAYS S. 1676 SUMMARIZES POPULATION PROBLEM

The problem is summarized very well in the bill introduced by the chairman of this subcommittee and other Members of the Senate:

> (1) the application of public health measures and the introduction of modern medical life-saving and life-prolonging techniques have contributed to a doubling of the annual rate of world population growth, within the past 18 years, and may be expected to continue to increase rates of such growth in the future.
>
> (2) population growth is a vital factor in determining the extent to which economic development and political stability will prevail in any country, especially in countries which are in the early stages of economic and political development;
>
> (3) at present, because of the rapid and continued growth in population, hundreds of millions of parents are unable to provide adequately for themselves and their children;
>
> (4) those nations in which population growth is most extreme and where the problems arising from such growth are most acute are, because of economic, technical, and other considerations, also the nations least able independently to cope with such growth and the problems connected therewith. * * *

So much for the problem. What are we doing about it?

"WE HAVE . . . UNDERLINED OUR CONCERN ABOUT THE SOCIAL CONSEQUENCES OF OUR OWN POPULATION TRENDS . . ."

First, we have been active in the formulation and expression of international policies and programs on population matters. In 1962, for example, we supported a resolution in the General Assembly which endorsed United Nations encouragement and assistance to governments "in obtaining and carrying out essential studies of the demographic aspects as well as other aspects of their economic and social

development programs." We have consistently encouraged and supported United Nations activities devoted to the study of the nature and scope of population problems and their possible solutions. We have, in the United Nations and on the international scene, underlined our concern about the social consequences of our own population trends, and our interest in learning more—and helping others to learn more—about population trends in the developing countries.

MANN IS . . . KEENLY AWARE OF THE MANY COMPLEXITIES INVOLVED . . .

We have, however, also been keenly aware of the many complexities involved in the population problem and its possible solution. To the extent we can help other countries in this field, we are ready to do so, but it is essential to our foreign policy goals that there be no misunderstanding about the dimensions of our activities and intentions. Therefore, as far back as 1962, the Department of State made it clear that the United States did not—and will not—advocate any specific policy that another country might follow in approaching its population growth problems. We stated that the United States was prepared to help other countries—but only upon their request—to find possible sources of information and assistance on ways to deal with the problem.

Ambassador Stevenson set forth additional aspects of our policy in the field of international cooperation when, in a public speech in 1963, he called upon the United Nations to be prepared to extend to member countries technical assistance for surveys on attitudes toward marriage, child rearing, and family size. Ambassador Stevenson also stated that the United Nations, together with UNESCO and the World Health Organization, could advise other countries, at their request, on how best to inform their nationals about family planning, consistent with the cultural and religious values of the country concerned. We have supported the World Health Organization in a research program on fertility and human reproduction.

L.B.J.'S STATEMENT ON EXPLOSION IN WORLD POPULATION SPARKED EXPANSION OF ACTIVITIES FOR STATE DEPARTMENT AND AID

Second, we have continued to expand our own activities abroad. The guideline for the greater concentration of resources, both by the Department of State and the Agency for International Development, in our international programs is to be found in the President's statement in January 1965, when he said, "I will seek new ways to use our knowledge to help deal with the explosion in world population and the growing scarcity in world resources."

Shortly after the President's statement—early in March 1965—the Department sent an instruction to our embassies around the world to insure the closest cooperation between our embassy staffs and those of the Agency for International Development in working on population matters. We stressed to our embassies the continuing responsible concern of our Government in this field.

This is consistent with the proposal in S. 1676 concerning the transmission of data to U.S. diplomatic personnel and other mission officers so that they may be advised with respect to the problems and their duties.

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AID MISSIONS ABROAD TO BE SUPPLIED WITH FAMILY PLANNING BOOKLETS

We also informed them in this circular that our AID missions abroad were being supplied with general reference materials and technical publications dealing with a wide range of subjects, from demographic studies to family planning booklets. In each AID mission abroad there is not only a small library of reference material and technical publications but in virtually all, an officer who has been designated to coordinate mission activities in this field. This is consistent with the suggestion concerning demographic attachés in S. 1676.

S. 1676 SUGGESTION FOR COLLECTION OF FOREIGN POPULATION PROGRAM INFORMATION IS BEING FOLLOWED BY AID

Here at home, the Agency for International Development organized a Population Reference and Research Branch. This branch serves as the focal point for coordinating all AID operations around the world in this field. I am informed that AID already has good files on programs in other countries. This is consistent with the suggestion made in S. 1676 for the collection of data on all foreign population programs whether or not instituted or assisted by the United States.

Working within this AID framework are a number of consultants. They advise us on the demographic, economic, medical, and public health aspects of the population problem. But, more than that, they maintain contact and coordinate with interested U.S. and foreign private institutions and groups concerned with the population problem. Dr. Berman, for example, traveled extensively in Latin America when I was in charge of the Inter-American Bureau, where he sought out and talked with all those in the public and private sectors interested in the problem. These consultants are performing a number of the functions suggested in S. 1676.

The Bureau of Inter-American Affairs, which has merged into one organization the functions and staffs of the Department and AID with respect to Latin America, created a population unit in its Institutional Development Office. The AID geographic bureaus for the other regions also have population officers in their health units.

The Department's Office of Research and Analysis has undertaken several population research projects. We should be alert to the possibilities of using this office on additional research projects.

AID PROGRAMS TO BE INCREASED SUBSTANTIALLY

An increasing amount of AID funds has been used in support of population programs in those developing countries which have asked for our assistance, and AID programs in this field are scheduled to be increased substantially over the next few years. Mr. Bell informed this subcommittee, on April 8, of some of the principal programs AID has undertaken abroad—in the Republic of China, Turkey, Honduras, Pakistan, and in other countries. Many countries are becoming more aware of the need for action on their population problems, and a growing number are seeking advice and assistance.

MANN AGREES WITH S. 1676 ON NEED FOR POPULATION FOCAL POINT IN DEPARTMENT OF STATE

We agree with this subcommittee on the need for a focal point in the Department of State to undertake policy coordination in all our programs abroad; to insure full consideration of our foreign policy objectives, particularly those of a political nature, in the carrying out of these programs; to keep our embassies fully informed of our thoughts and plans, and where necessary, to make sure our posts abroad are giving this serious problem all the attention it deserves; and, finally, to maintain close liaison with the Department of Health, Education, and Welfare, all other U.S. Government agencies and private institutions and organizations concerned with this problem—as well as with this subcommittee.

MANN TO HAVE SPECIAL ASSISTANT FOR POPULATION MATTERS

To this end, my own office—that of Under Secretary of State for Economic Affairs—will serve as the needed focal point for policy matters and coordination.

Working under me will be a Special Assistant for Population Matters, a position comparable with that of the Special Assistants who are now in charge of such important fields in our international relationships as fisheries, food for peace, and labor. Working with me, through a Special Assistant for Population Matters, will be officers representing the bureaus in the Department, as well as the AID offices, which work on the various aspects of the problem—for example, the Bureau of International Organization Affairs, which is in charge of handling matters with the United Nations and its specialized agencies. In addition, the geographic bureaus, particularly those which cover those areas of the world in which the population problem is a serious one—Latin America, the Near East, and South Asia and the Far East—will, as I have said, designate one of their senior officers to work with my office on this subject.

"WE HAVE ALL THE LEGISLATIVE AUTHORITY WE NEED AT THIS TIME"

To sum up, Mr. Chairman, I believe that the Department has and will continue to do everything it can properly do to encourage other governments to give this problem the attention it deserves and to respond to such requests for assistance as we receive, subject only to the limitations which Mr. Bell has already described to this committee and which I will not repeat here. We have all the legislative authority we need at this time. Should the future demonstrate a need for additional legislation in this field, we shall not hesitate to ask for it.

Mr. Chairman, we have a vital national interest in this subject and are grateful for the thought you and your associates are giving it. I assure you that the Department of State fully shares your concern, and that it hopes that its increasing efforts in this field, and those of all of our official and private institutions, may soon point the way to a solution of this worldwide problem.

Senator GRUENING. Thank you very much.

Have you as yet selected your Special Assistant for Population Matters?

ROBERT ADAMS TO ASSIST UNDER SECRETARY MANN

Mr. MANN. He sits on my left—Mr. Robert Adams, who is a senior officer in Foreign Service—he has been with me in my present position, worked with me intimately in the Latin American Bureau as the Deputy Assistant Secretary at that time, and was head of the political section in Mexico City before that.

Senator GRUENING. We are very happy to welcome him to this important responsibility.

I know that you are interested in this problem. We have discussed it privately. You have made a number of very good statements on it publicly.

DO YOU THINK WE ARE DOING ENOUGH?

Do you think we are doing enough? Do you think we are moving rapidly enough and far enough in view of the great urgency of this problem, which has been so well expressed by the President of the United States, who, as you well know, has made not fewer than 20 statements since his state of the Union message of last year.

THE WORLD IS NOT MOVING FAST ENOUGH

Mr. MANN. Mr. Chairman, I am not familiar with our domestic programs. I would say that the world is not moving fast enough—especially the developing part of the world.

I would also say that I believe the U.S. Government is doing everything that it can do which will be helpful and constructive at this time.

Senator GRUENING. Well, I realize some of the limitations which have existed in the past. You expressed them in your speech to the Planned Parenthood Association in November 1964, when you said:

"Public statements by public officials on the relevance of the population increase to the political, social, and economic problems of the day have in the past been avoided. The reasons for reticence were understandable. Neither yesterday nor today do people wish to offend others by statements which might be misinterpreted as contrary to their ethical, moral, or religious convictions."

GREAT BREAKTHROUGH IN PUBLIC THINKING IS NOW APPARENT

Well, now, isn't it a fact that even since this statement was made by you, a little over a year ago, there has been a great breakthrough in public thinking—the subject is now freely discussable? I mean there is no secret about this—you might as well be frank. This was, until very recently, maybe a year or two ago, a subject that was to be avoided. Public men, especially elected officials, sought to avoid it at the peril of their political future.

But the situation has now, I think, changed to the extent that there is no inhibition, even by those who have religious scruples against a particular method, against discussion of it.

It seems to me that that has taken place. Would you agree with that?

Mr. MANN. Completely, Senator.

GRUENING PRAISES PRESIDENT JOHNSON

Senator GRUENING. Now, that is an important, a tremendously important, tremendously significant gain. It is almost an implication that there is freedom to go ahead. And no one has demonstrated that freedom more than the President of the United States.

Now, the President might have made 1 or 2 statements—but he has to date made 20, and they have been very emphatic—I needn't quote them, because I am sure you are familiar with them. He has in various ways pointed out the disparity between what a few dollars in population control would do with many more dollars in economic aid. His figure was 5 to 100. He said in his statement to the United Nations in San Francisco last July that $5 spent on population control would be as valuable as or more valuable than $100 spent in economic aid. Various people have thought that he might even amend those figures to make them not 5 to 100, but 1 to 100.

". . . CATHOLIC CHURCH HAS COME OUT CLEARLY IN FAVOR OF FAMILY PLANNING . . ."

So it seems to me that the inhibitions that you referred to a year ago last December have almost ceased to exist. We know that a Papal Commission is studying this. We don't know what they will come up with. But certainly the Catholic Church has come out clearly in favor of family planning—but with a reservation as to the methods that are to be used. Isn't that correct?

Mr. MANN. That is correct.

Senator GRUENING. Now, therefore, it seems to me that we ought to go at this with a little more vigor.

SPECIAL ASSISTANT—"AN ANONYMOUS OFFICIAL"

Now, I notice that you, as did the Secretary of HEW, shy away from the idea of an official with a title. You call him a special assistant. Well, that is a kind of anonymous official. I have no doubt of his ability. But what would be wrong with exalting this and emphasizing and dramatizing this by giving him a title of Assistant Secretary?

I think of this largely as a psychological problem.

I have no doubt that your special assistant will do everything that you ask him to do, or the Department of State thinks is proper. But it still becomes an adventure in anonymity, doesn't it?

Mr. MANN. Well, Senator, I——

Senator GRUENING. Let's be very frank about this.

I think there are two aspects to this problem. There is the aspect of meeting a fact that this is now such an urgent problem that we have to do more than say we are doing it. That was my criticism that I made of John Gardner's testimony—a man for whom I have the greatest respect and admiration—when he in effect said that we are doing what we have been doing right along.

BE FORTHRIGHT, NOT "UNDER THE TABLE," ABOUT FAMILY PLANNING

But the situation has changed between what we have been doing right along. What we have been doing right along has been under the table. We have not been free to admit it. Private conversation, the equivalent of the cloakroom conversation—we are doing this now, we are passing this out.

But if we don't come out forthrightly and say this is one of the most burning problems of the age, our foreign aid programs are being nullified and undercut by the population increase—which we know to be the case—let's do this in a big way, let's go at it as if we meant it.

IS THE DIFFERENCE ONE OF SEMANTICS?

Now, that is my only difference with the officials who are testifying, and it might be with you. Maybe this is only a semantic difference. But I think it is an important difference. If you feel that you cannot recommend this aspect of this legislation, I hope it will not be long before you do—because I think that this is a major issue.

Now, my criticism in the case of the State Department would be less than the criticism which I voiced last week of the testimony of John Gardner, because I realize—I think it is valid that unless the Government creates an equivalent position at home, it will have great embarrassment in creating it for the Foreign Service, because it would naturally be said, and understandably, "You are trying to decrease our population, but you are not taking equivalent measures at home."

And while the problem has certain different aspects domestically than it has abroad—because we are not engaged in a foreign aid program at home—still the problem is almost as pressing in a different way at home.

A BILLION PEOPLE HERE IN THE UNITED STATES IN THE COURSE OF THE LIFETIME OF PEOPLE NOW BORN

We all know that unless we do something about it, we are going to have a billion people here in the United States in the course of the lifetime of people now born, provided they live to the classical age of the psalmist. A man born in 1966 who lives to be 75 is going to see a billion people here. I have stated several times I am glad I won't be around then. It is going to be a mess. And I hope we do somthing about it.

But if we don't create an office of stature for domestic uses, it is going to be very difficult to explain to the Latin Americans and to the Asians and the Africans that we are trying merely to slow them up—but we don't want to do it for ourselves.

"LET'S TAKE OUR HAIR DOWN"—TABOO IS OVER

I can very well understand your reticence in going ahead. I think the Department of Health, Education, and Welfare should have taken the lead in this respect.

But I would like to have your reaction, frankly, to this.

Let's take our hair down. I would like to ask you—do you still feel that the inhibitions and the timidities that you voiced a year ago last December still obtain?

Mr. MANN. Senator, I don't. I believe I was one of the first officers in a relatively senior position in the Government to speak out on the population problem.

I think I have made more than 20 speeches in the last 2 years. I would even say that seldom do I discuss economic or social problems without mentioning the population problem, either on or off the record, because it obviously is a No. 1 problem in raising per capita income and raising living standards in the developing part of the world.

I think there is no disagreement at all between you and the Department of State on what the problem is, its importance, and the need to dramatize it.

As you say, the President has spoken out. I think everybody is speaking out.

And this is a rather recent phenomenon. It has taken place in the last 2 years.

I think this is, as you say, significant and very encouraging. I made a list some time ago of the number of different groups that are actively working on this problem in one continent, Latin America. I wonder if I could read those to you, because I think it shows that there is a very significant forward movement.

Senator GRUENING. I think it would be very helpful if you would put that into the record.

MORE THAN 12 GROUPS IN LATIN AMERICA NOW WORKING ON FAMILY PLANNING

Mr. MANN. In August of 1965, there was a first Pan-American Assembly on Population, which was held at Cali, Colombia. This assembly made definite recommendations to the governments in that area concerning the establishment of a national population policy in each country, and concerning the making available of family planning services to people who desire them.

I am sure you are familiar with that congress. It was the first of its kind held in this hemisphere.

Then there is an organization called CELADE, which translates into English roughly as Latin American Demographic Center, which exists in Chile, and which serves the entire area with a program for training Latin Americans in demographic problems.

Third, the Pan American Health Organization has a program for the development of research training programs in population dynamics.

Fourth, there is an organization called DESAL, which translated roughly means Center for Latin American Economic and Social Development, which also exists in Santiago, Chile. This is under the direction, according to my understanding and information, of Rev. Roger E. Vekemans, and is a center for the study of family and population problems.

Fifth, the University of California, under a contract with AID, I believe, provides technical and population consultant services on request to certain Latin American governments.

Sixth, there is a Colombian Institute of Social Development which is headed by Rev. Gustavo Perez, and it is working on the problem of audiovisual materials and the role that it can play in this field that we are talking about.

Seventh, there is a Population Council, which I believe is a U.S. organization, which is doing research and study on fertility patterns in Latin America.

Eighth, we have an American organization here, with which I am sure you are familiar—the International Planned Parenthood Federation—and this organization engages in the training of medical and paramedical personnel in family planning as an aspect of preventive medicine. It also works in the fields of education, of leadership groups on responsible parenthood, and maternal and child health.

Ninth, there is an American International Association for Economic and Social Development, and I believe that this group is now conducting a population study in Costa Rica.

Tenth, there is an organization known by its initials, IDESAC, which translated into English means Institute for Economic and Social Development in Latin America. This has its headquarters in Guatemala City. It is a private, nonprofit social science center, concerned with training and research in family planning for the Central American area.

Eleventh, there is a group called CELAP, which translated means Latin American Center of Population and Family, which has its headquarters in Santiago, and which is interested in working throughout the hemisphere.

Twelfth, there is a group called CICOP, which I understand to be an inter-American cooperative program under ecclesiastical guidance, which studies a particular technique in population control, and which has offices and people in a number of Latin American countries.

And then there is a European, I believe it to be European, organization, called FERES, which I translate roughly in English as International Federation of Institutes of Social and Socio-Religious Research. This has representatives in affiliated centers in a number of places in Latin America. It carries out studies on the use of educational media directed to the population problem.

And then, in addition to these, there are a number of private organizations—I personally know of some of them—which have been formed within, I believe, the last 12 months, Mr. Chairman, in a number of Latin American countries. They are working in cooperation with some of our private organizations here in the United States.

Senator GRUENING. Well, that is quite a gratifying list of activities.

REPRESENTATIVE ZABLOCKI QUESTIONS EXECUTIVE BRANCH'S AUTHORITY IN FAMILY PLANNING FIELD

You are aware of the fact that a Member of the House, Representative Clement Zablocki of Wisconsin, has questioned the authority of the State Department or the AID program to do these things? You had some correspondence with him. I wish you would clarify that. You mentioned certain sections—201, 211, 251.

I think it is awfully important that we resolve this doubt, so that when this matter comes up in Congress, as it will again this year, we know where we stand.

Could you be specific on the authority that Congress has given you to do this—because if you haven't it and want to do it, you certainly should seek it.

Mr. MANN. I believe this question, Mr. Chairman, was put to Mr. Bell, was it not? He is the only one in the State Department who needs such authority.

Senator GRUENING. Yes; that is right.

Mr. MANN. I know he has authority both under the Foreign Assistance Act and under two paragraphs of Public Law 480—I don't remember the exact numbers. The Food-for-Freedom bill, which is now being considered by the Congress, has a parallel provision relating to this problem.

"ARE YOU DOING EVERYTHING YOU WOULD LIKE TO DO?"

I know that Mr. Bell has told me that there is no question in his mind about our authority to do what we are doing.

Senator GRUENING. You say to do what you are doing.

Mr. MANN. Yes, sir.

Senator GRUENING. Are you doing everything you would like to do?

Mr. MANN. Well, Mr. Chairman——

Senator GRUENING. I am assuming that you share the President's views about this problem, that you are aware of its gravity, you are aware of its urgency, and that you want to do everything possible to slow down the population growth. Is that correct?

Am I interpreting your views correctly?

UNITED STATES WILL NOT DO ANY "ARM TWISTING"

Mr. MANN. Yes, sir, I recognize the problem, and we would like to do everything we can constructively do to get countries to address themselves to the problem, to develop their own programs. We are not doing any arm twisting, nor do I think we should. I think that could easily constitute intervention in somebody else's internal affairs. But we are at the service of all those who ask us for help, who decide for themselves they want it and what kind they want, subject only to the limitations that Mr. Bell talked about.

MANN DISCLAIMS DISPENSING OR MANUFACTURING CONTRACEPTIVES IS A MAJOR PART OF THE PROBLEM

We do not get into the business of dispensing contraceptives or machinery for making contraceptives. But we don't believe this is a major part of the problem.

We think we are working in the area which most needs attention right now—education and training, creating the capability of dealing with this on a meaningful scale. I think the people who are working on it, the ones that I have talked to, Mr. Chairman, believe that we are moving ahead about as fast as you could hope to get the world to move in an area which is both complex and delicate.

Senator GRUENING. Well, my question about whether we are doing enough really arose, not merely from a natural interest, but from Mr. Bell's response to my questions.

I want to say that I have the greatest admiration for Mr. Bell. I think he is an excellent and proved competent public servant. He has lasted longer than any other AID Administrator. Most of them have suffered the fate of Henry VIII's wives—they haven't lasted very long. But he has.

When I went through a list of countries in alphabetical order, he knew very little about what was going on in any of them. And while that might not have been his function, I would have assumed that in preparation for this hearing he would have informed himself a little better.

We went country after country, and I would say that in fewer than 10 percent did he know what was going on in this field. In each case he said he didn't know, he didn't know, and he would get the information.

Well, I don't criticize him for that. But I would think that in view of the urgency of this problem, the admitted urgency, and the President's mandate, I would say that this would occupy a higher priority in the consciousness of those who are authorized and entrusted with the task of administering it.

If you will read his testimony, you will see that that is the case.

Now, I am going to lead from that to a question as to what Mr. Adams' function is going to be. Is he going to work with AID, or is he going to work separately under your direction? Or how is that going to work out?

ADAMS TO COORDINATE STATE DEPARTMENT ACTION IN FAMILY PLANNING

Mr. MANN. Well, I think the operational responsibilties, in terms of the administration of the AID program, will and ought to remain under Mr. Bell's jurisdiction.

What Mr. Adams can do is to arrange for each bureau concerned in the Department of State to appoint a senior officer to examine with him the opportunities we have of moving ahead in this field, to make sure that our operations abroad are consistent with our policies, to keep our missions informed, and to make sure that they are not overlooking any possibilities of being helpful.

It seems to us this is essentially the job we can do in the Department of State as distinguished from AID.

And he, of course, will work closely with Mr. Bell and his organization, and also with, I would hope, the Department of Health, Education, and Welfare here in the United States, and would be the focal point for the State Department in talking with the various private agencies that exist around the world.

Senator GRUENING. Well, AID is essentially an adjunct of the State Department, is it not?

Mr. MANN. Not really, sir. The volume of papers and the velocity of problems these days is such that Mr. Bell runs the AID program, and must do so. It is a full-time job, and if everybody starts working on a piece of it, I think we would probably have chaos around the world.

Senator GRUENING. Well, I should imagine, I should assume that the larger spheres of overall policy—the State Department does and

would indicate to Mr. Bell that here is a country we want to help particularly. I think it has been demonstrated in the case of India, where for specific reasons, both because of their democratic outlook in Asia where there is much totalitarianism, and, because of their great population, their great need. So that I should imagine—I hope I am correct—that in a general way the State Department would give indications to AID that one country is deserving of a little special solicitude, perhaps more than some other country that is constantly kicking us in the shins and treating us very badly—I could name some of them that do that.

Mr. MANN. That is correct, Mr. Chairman.

Mr. Bell does take his policy guidance from the Secretary. As you say, he is one of the ablest and most dedicated officers I have known in my years in Government.

"COORDINATION IS VERY GOOD"

Senator GRUENING. I agree on that. I think he is a splendid public servant. He demonstrated that when he was Director of the Budget as, I think, he has ever since.

Mr. MANN. We sit together in a staff meeting every morning, precisely to do this kind of coordination with Mr. Bell and often with the Secretary, when he is available.

These coordination meetings are for the purpose of giving him policy guidance of the kind that you referred to. Coordination is very good.

I was speaking earlier about operations rather than policy guidance, which he does take, of course, from the Secretary and from the President.

Senator GRUENING. Now, I want to call your attention to one of the President's 20 statements, the one that he made in his last state of the Union address, in which he said he wants to give a new and daring direction to our foreign aid program "designed to make a maximum attack on hunger, disease, and ignorance in those countries determined to help themselves and to help those nations trying to control population growth."

Now, that spells out pretty clearly that we are going to help—we want to help those countries that want to help themselves in this field, isn't that true?

Mr. MANN. Yes, sir.

IF A COUNTRY SHOWS A REAL CONCERN ABOUT ITS POPULATION INCREASE, DOES IT GET MORE U.S. SOLICITUDE?

Senator GRUENING. In other words, if a country shows a real concern about its population increase, realizes that it is undercutting its own efforts and our efforts, that that country is going to get a little more solicitude, a little more attention, a little more sympathy than one that ignores this problem, is that correct?

Mr. MANN. I would say, generally speaking, that is correct, Mr. Chairman. I would not want to say that a country which does not have an effective family planning program would be ineligible for aid.

Certainly all of this is part of the general concept of self-help.

Senator GRUENING. That is right. In other words, a country that doesn't have a program, you could not do less for, but, on the other hand, a country that did, you would do more for.

Mr. MANN. That might be right, Senator, because in India today we would like to see the Indian Government move ahead rapidly with its own plans—they are not our plans—for addressing itself to this problem. Until they do, there still remains the possibility of famine, and the humanitarian need for countries which are in a position to help to do so.

"BUT THERE IS SUCH A THING AS PERSUASION AND EDUCATION, ISN'T THERE?"

Senator GRUENING. Well, I read this in the context of your statement that we are not going to do any arm-twisting. Well, arm-twisting sounds like a cruel performance. But there is such a thing as persuasion and education, isn't there?

Mr. MANN. Senator, I can tell you that this is a frequent topic of conversation. I don't like to quote foreign officials—I never do—but Americans and other people concerned about this problem are discussing it at the official level. And I want to say, too, as I said earlier in my prepared statement, that our consultants—some of them are very distinguished doctors—have dedicated a great part of their time and, at great personal sacrifice, have traveled through all of these countries, as part of the education process. They speak with church officials, government officials, and private people who are interested. As to the process of discussion—there is no lack of activity there. The problems are the ones that you, of course, readily appreciate, that each country must solve for itself. They involve religious and moral values.

Senator GRUENING. Of course, private enterprise in this field has been ahead of Government—various foundations, Ford Foundation, Rockefeller Foundation, others, have really pioneered in this field, and have done very important and very useful work.

The consensus as I have sensed it—people who are concerned—is that the problem is just too big for private enterprise alone to do it, and that it needs the strong support of Government. And that was most strikingly demonstrated in the conversation of former President Eisenhower from his view which he expressed as President, that this was nothing that the Government should touch—which reflects your statement that at one time people were afraid to discuss it—but now he has come around.

Even if the administration does not approve the particular provisions in Senate bill 1676, which I think represents a very minimum of Government action, we should continue with these hearings. I am confident that public sentiment will increasingly be brought to bear on the Government to do more than it is doing now. It remains to be seen what you and Mr. Adams will do, what Mr. Bell's AID program will do, and what Secretary Gardner will do.

". . . MORE COULD HAVE BEEN DONE OR COULD BE DONE RIGHT NOW . . ."

I will confess that I think that more, substantially more, could have been done or could be done right now, and the mail that I have

received just in the last 24 hours, which is quite overwhelming, indicates a very strong public response to that view.

But, I am aware of the fact that the legislation which is deemed controversial, as this was considered to be a year ago when I introduced it, seldom achieves its objectives in the first session of Congress.

We had that experience very strikingly with medicare. Medicare has been before three Congresses. At the first Congress it was very well presented by President Kennedy, but it failed. It failed in the last Congress. Now we have it. I have no doubt that this legislation or similar legislation or maybe legislation that will go further will be enacted by the Congress, if not in this Congress, by the next.

But my feeling is that this problem is so pressing and so urgent, manifestly, that Government should not hang back until, as so frequently happens, it is forced or induced by the pressure of public opinion—but will take the lead. In many issues, as you know, public sentiment is ahead of the action—not merely of the executive branch, but just as frequently of the legislative branch. I have seen that again and again. We saw that very strikingly in our statehood fight. Gallup polls were for statehood for Alaska and Hawaii long before the Congress chose to act. And I think this is a case in point.

GRUENING BELIEVES THAT MANN AND ADAMS WILL DO EVERYTHING THEY CAN

So I have not very much more to say. I have no doubt that knowing your convictions, knowing the President's views, knowing the rise in the public sentiment, knowing the urgency of the problem, that you and Mr. Adams will do everything you can.

But I feel very definitely that we have got to move further and faster. It is like the Red Queen, in "Alice Through the Looking Glass." You remember that famous illustration, where Alice says to the Red Queen, "Are we there?" "Oh, no, we are only where we started from."

Well, the same thing applies to population control. When we stop using these euphemisms of family planning and demographic problems and come out frankly with those simple, direct words, "birth control," which Secretary Gardner never mentioned—I mean he avoided them like the plague—I think then we will get down to reality, because that is what we should be after—the limitation of population, brought about by science, the great discoveries that have taken place in the last half century, when all kinds of diseases which formerly took their toll are now no longer killers in any large degree, and where this is no longer a problem of family planning—it is that, too—but it is also a problem in that it threatens the security and the welfare of all mankind.

And so I hope that the Department of State and all the other departments will move into this field.

MANN SAYS STATE DEPARTMENT REALIZES ENORMITY OF POPULATION PROBLEM

Mr. MANN. Senator, I would like to explain to you that our reluctance to go ahead with an assistant secretaryship has nothing to do with our failure to understand the need to dramatize the importance of this problem. If I might, I would like to explain the reasoning that

we had in this, so you will understand that the differences do not spring from any lack of appreciation of what the problem is or the need to do something about it.

I can say that the problems, the flow of papers into the Department, are growing geometrically, and that with improved communications the speed with which decisions are required is also growing geometrically. The result of this is, I think in everybody's opinion, that the Assistant Secretaries in charge of geographic areas are going to have to assume larger and larger responsibilities in the future.

We don't have many parts of the State Department outside of the geographic bureaus which are policymaking, simply because this is the only way in which you can administer an organization that large.

We have a legal adviser, for example, but he is an adviser. We have an intelligence section which serves all of the geographic bureaus.

We have an economic bureau—and I have been on both the geographic and functional sides—simply because a certain expertise in, for example, dividing the radio spectrum or conducting aviation negotiations or shipping matters—highly technical matters of that kind, including commodity problems—cannot be adequately dealt with by generalists.

So that I think it is fair to say that, by and large, an operational office must be either attached to the office of Mr. Rusk, Mr. Ball, or myself, or be within the geographic bureaus. And if you created a separate bureau dealing with geographic areas which was outside the line of authority and responsibility, I think it would have a very hard time in getting anything done, and for very understandable reasons.

We, therefore, thought that just as we have done with labor and with fields which are of great importance—including food for peace which involves a great deal of money—that the most effective way would be to have one person, in effect, coordinating the activities of the four or five geographic bureaus which must do the work, along with AID, rather than try to set up an organization which would be separate from AID and from those geographic bureaus.

WORLD POPULATION BECOMES AN ECONOMIC PROBLEM

Senator GRUENING. Well, I can readily understand it. I think it is quite properly placed in the realm of economics, because this is essentially in terms of world population an economic problem, because as the population increases in these countries to which we are giving aid, the population growth nullifies what we are doing. That has been very apparent.

You have pointed that out yourself on various occasions. And I think that is fairly obvious.

SUBCOMMITTEE REQUESTS INFORMATION ON FAMILY PLANNING IN EVERY COUNTRY

But I would hope that in view of the changing sentiment about this, and the increasing awareness, the urgency of the problem, it would be very helpful if, as one of Mr. Adams' first assignments, you have him make a further survey as to just what is going on in every country—not merely in the countries to which we give aid. I asked Mr. Bell about Greece, and his reply was that we no longer have an aid program there.

Well, that should not preclude our offering assistance or responding to requests for assistance from countries which do not receive aid or no longer receive it. There are a number of them that might be very glad to receive this information. As a matter of fact, they are receiving food for peace.

Mr. MANN. I agree with you, Senator, we should do that, and we will. Mr. Adams will be working closely to see what Mr. Bell has in his shop on this in the way of data and material, and I will ask him to supplement these by asking our field posts to fill in whatever gaps there are in our information, and to insure that we exercise as much imagination as we can in this area, within the limitations that we have described before.

Senator GRUENING. Another economic aspect of this problem, which is at the same time a medical aspect, is that in a great many countries, Chile was pointed out particularly, many women, when they become pregnant, resort to an abortionist, which to me is a tragic method. It is risky; it is costly.

DRAW A LINE ". . . BETWEEN CONTRACEPTION AND ACTUALLY KILLING A NASCENT BEING . . ."

Many of these women become infected, some suffer lifelong injuries, some die. And if the argument could simply be presented to those who have moral scruples—this is where the line could be drawn very distinctly between contraception and actually killing a nascent being—there would be an issue on which we might get some conversions. I don't know that that is your function or the function of anybody except those who are really concerned about this problem.

Mr. MANN. Senator, we are aware of abortion rates in some developing countries. They are higher than one might think.

Senator GRUENING. A million in the United States annually—which is a tragic solution.

Mr. MANN. I think everybody, including the church, is aware that this is a problem.

Senator GRUENING. Well, the subcommittee would appreciate it if you would give us your report on the countries with which we have relations that are not receiving aid—in other words, the fact that Mr. Bell limited himself to the countries that were receiving aid—if we could have what is happening in other countries, that are not now receiving aid, I think it would complete our picture.

Mr. MANN. We will be happy to do that, sir.

Senator GRUENING. Thank you very much.

[CHAIRMAN'S NOTE.—Following my April requests on behalf of the Subcommittee on Foreign Aid Expenditures for further information concerning family planning in the developed and developing nations, the Department of State and the Agency for International Development, assisted by several private organizations, pooled available materials. Subsequently these were formalized in the following reports submitted on October 14, 1966. The subcommittee expresses its appreciation to the Federal executive agencies involved and to the Population Reference Bureau, the Population Council, Planned Parenthood World Population, the Population Crisis Committee, and the Inter-

national Planned Parenthood Federation—Western Hemisphere Division.

The subcommittee hopes that information on the following 41 countries which is not included can be supplied at a later date. These countries are: Angola, Basutoland, Bechuanaland, Burundi, Cameroon, Central African Republic, Chad, Congo, Dahomey, Gabon, Gambia, Guinea, Ivory Coast, Libya, Madagascar, Mali, Malawi, Mauritiania, Mozambique, Niger, Rwanda, Senegal, Seychelles, Somalia, Sudan, Togo, Upper Volta, Zanzibar; Afghanistan, Bhutan, Cyprus, Iraq, Kuwait, Lebanon, Saudi Arabia, Syria, Yemen; Burma, Cambodia, Laos, and Vietnam.

The subcommittee is advised that these nations are not known to have substantial family and population planning organizations and activities. Consequently, the need to let each individual nation know that assistance in family planning is available upon request, if desired, is apparent.

Such an educational program would implement the President's remarks of January 20, 1966, at the ceremony held at the Harry S. Truman Center for the Advancement of Peace, in Independence, Mo., when he said: "* * * we will increase our efforts in the great field of human population. The hungry world cannot be fed until and unless the growth in its resources and the growth in its population come into balance. Each man and woman—and each nation—must make decisions of conscience and policy in the face of this great problem. But the position of the United States of America is clear. We will give our help and our support to nations which make their own decision to insure an effective balance between the numbers of their people and the food they have to eat. And we will push forward the frontiers of research in this important field."]

(The information above referred to follows:)

EXHIBIT 145

DEPARTMENT OF STATE,
Washington, D.C., October 14, 1966.

Hon. ERNEST GRUENING,
U.S. Senate.

DEAR MR. CHAIRMAN: In response to your request to former Under Secretary Mann and to former AID Director Bell, the Department of State and AID have prepared concise surveys of family planning activities currently existing in the principal nations of the world.

The surveys have been prepared from information available in the Department and AID and provided by the Population Reference Bureau, Population Council, Planned Parenthood-World Population, the Population Crisis Committee and the International Planned Parenthood Federation-Western Hemisphere Division. We are most grateful to these organizations for their wholehearted cooperation in supplying valuable information.

The information used in these surveys is the most authoritative available. However, this information, necessarily, has been assembled by the Department, AID, and the private organizations from many secondary sources, some in the Eastern European countries. Therefore, although its accuracy has been checked as far as possible, it cannot be assured in every detail.

Please let us know when we may be of further assistance to you and your committee.

Sincerely,

H. G. TORBERT, Jr.,
Acting Assistant Secretary for Congressional Relations.

APPENDIX

Family Planning in More Developed Countries [1]

PREFATORY NOTE

1. The following is a summary of the salient features of family planning attitudes and activities in more developed countries. No information is submitted on the United States since the subject has been extensively treated elsewhere.[2] The information is presented under five headings:

A. Statistical background, in terms of selected demographic and economic indicators;

B. Public policy, expressed in official statements on demographic issues and in legislation directly affecting family planning;

C. Family planning activities (the services and methods available), and the extent to which family planning, according to available data, is actually practiced;

D. Brief history of organized family planning movements;

E. Family planning assistance, if any, to less developed countries.

2. The birth rates in more developed countries range from 13.1 per 1,000 population (1965 figure) in Hungary to 25.1 per 1,000 population (1964 figure) in Iceland.[3] Of the 31 countries covered in this section, only 7 have a birth rate over 20 per 1,000 population. By comparison, the birth rates in less developed countries are, on the average, about 41–42 per 1,000 population.

The overall rates of population growth in more developed countries are influenced not only by levels of fertility and mortality, but also by immigration and emigration. The latter have important quantitative and qualitative implications which are beyond the scope of this summary.

3. In general, birth control in more developed countries has been, and continues to be, independent of governmental or other authoritative attitudes. Restrictive legislation, the limitations of organized family planning movements, and the lack of public availability of contraceptive information and supplies seem to have been overcome by individual recognition in these countries of the financial and psychological responsibilities for the care of children.[4]

4. Nevertheless, there is growing recognition of the need and of the demand for the continued easing of restrictions on family planning, the diffusion of information, the availability of supply and the wider use of modern means of birth control.

5. Family planning movements originated toward the end of the nineteenth century; on the whole, they did not include the provision of birth control services until after World War I. After World War II, the number of family planning organizations and their clinical activities increased.

6. At present, the basic orientation in the family planning movements in most of the more developed countries is directed toward the improvement of the health of mother and child and of the socio-economic welfare of the family. Although economic growth, a balance in the supply and demand for labor, and an improvement in levels of living are goals of these countries, national economic development is not a primary influence or objective in their organized family planning movements.

7. Family planning assistance to less developed countries is now available, on request, from the United Kingdom, Sweden, Japan, and Denmark.

8. Within the context of this summary, family allowances and other forms of social subsidies are not discussed. They are provided in all countries and, al-

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[1] The country-by-country summary of family planning activities represents a selective collation of information from secondary sources, notably: Proceedings of the International Conference on Family Planning Programs, Geneva, August 1965, sponsored by the Population Council and the Ford Foundation (contributions by D. V. Glass, K.-H. Mehlan, and Minoru Muramatsu); Hope T. Eldridge's *Population Policies: a Survey of Recent Developments*, published in 1954; published and unpublished documents of the International Planned Parenthood Federation; and pertinent documents of the United Nations. All 1965 data are preliminary. Gross national product figures were converted into dollars at official exchange rates, except for Iceland and Yugoslavia; in these countries, estimated effective exchange rates were used.

[2] Hearings before the Subcommittee on Foreign Aid Expenditures, Bill S. 1676, *Appendix*, Part 4, Washington, 1966.

[3] The birth rate for South Africa is not known.

[4] Fertility levels are not determined exclusively by the presence or absence of birth control practices. Among other factors, health and nutrition have a particularly important influence on fertility.

though varying in scope and coverage, are a pronatalist component in family formation.

AUSTRALIA

A. Year of last national census: 1961.

Population estimate, 1965 (millions)	11.4
Birth rate, 1965 (per 1,000 population)	19.6
Death rate, 1965 (per 1,000 population)	8.8
Infant mortality rate, 1965 (per 1,000 live births)	18.5
Annual average rate of population growth, 1960–65 (percent)	2.1
Number of years to double population at the above growth rate	33.0
Per capita gross national product, 1965 (dollar equivalents)	$1,857.0

B. Encouragement of immigration, an important element of the Government's population policy, is regarded as an essential condition of economic development.

There is no restrictive legislation concerning the availability or use of contraceptives, or the dissemination of birth control information. In some states, however, other social legislation (Obscene and Indecent Publication Acts, e.g.,) may interpose indirect legal barriers, particularly in regard to advertisement of contraceptive products. Non-therapeutic abortions are illegal.

C. Contraceptives can be sold only by registered pharmacists. Oral contraceptives were placed on the market in 1960.

D. Family Planning Association of Australia. Associate member of IPPF.

E. None.

AUSTRIA

A. Year of last national census: 1961.

Population estimate, 1965 (millions)	7.3
Birth rate, 1965 (per 1,000 population)	17.9
Death rate, 1965 (per 1,000 population)	13.0
Infant mortality rate, 1965 (per 1,000 live births)	28.8
Annual average rate of population growth, 1960–65 (percent)	.6
Number of years to double population at the above growth rate	117.0
Per capita gross national product, 1965 (dollar equivalents)	$1,254.0

B. The Government believes that there is no justification for an official attempt to influence the choice of parents on the size of their families. The law of 1952 legalized the prescription and the sale of contraceptives and the performance of abortions for medical reasons.

C. Birth control services are available in Vienna and given in the hospitals of some other localities. There is little private medical advice or public information on modern methods of contraception. Contraceptives are in poor supply.

D. There is no organized family planning movement.

E. None.

BELGIUM

A. Year of last national census: 1961.

Population estimate, 1965 (millions)	9.5
Birth rate, 1965 (per 1,000 population)	16.4
Death rate, 1965 (per 1,000 population)	12.1
Infant mortality rate, 1965 (per 1,000 live births)	24.1
Annual average rate of population growth, 1960–65 (percent)	.7
Number of years to double population at the above growth rate	100.0
Per capita gross national product, 1965 (dollar equivalents)	$1,735.0

B. According to an official statement, the Belgian Government has not taken, nor does it intend to take, any action designed to influence population trends.

The law prohibits the advertisement, promotion, or sale of contraceptives, or the provision of birth control information for profit. Legal abortions are permitted only on medical grounds.

C. The non-commercial character of the Belgian family planning movement enables the operation of private birth control clinics, which, so far, have been set up in Ghent, Antwerp, Brussels, Liege, and Mons. Both contraceptive information and supplies are offered. Government support, through the Ministry of Education, is given to the annual meeting on sex education organized by the

Belgian family planning association. The Belgian Government has recently created a Center for the Study of Population and the Family.

D. A formal birth control movement developed in Belgium after 1949. The National Federation (Federation Nationale Belge des Mouvements pour le Planning Familial) uniting various family planning groups, was organized in 1963. Full member of IPPF.

E. None.

BULGARIA

A. Year of last national census: 1956.

Population estimate, 1965 (millions)	8.2
Birth rate, 1965 (per 1,000 population)	15.4
Death rate, 1965 (per 1,000 population)	8.0
Infant mortality rate, 1965 (per 1,000 live births)	31.5
Annual average rate of population growth, 1960–65 (percent)	.7
Numbers of years to double population at the above growth rate	100.0
Per capita gross national product, 1965 (dollar equivalents) (1964)	$614.0

B. Abortions on liberal social grounds have been legal since 1956. In the opinion of the Government, current population trends do not adversely affect economic development.

C. The number of legal abortions has been increasing steadily since 1956. By 1963, the last year for which data are available, there were 63 terminations of pregnancies per 100 live births.

D. There is no organized family planning movement. Some individual activity has been reported.

E. None.

CANADA

A. Year of last national census: 1961.

Population estimate, 1965 (millions)	19.6
Birth rate, 1965 (per 1,000 population)	21.4
Death rate, 1965 (per 1,000 population)	7.5
Infant mortality rate, 1965 (per 1,000 live births) (1964)	24.7
Annual average rate of population growth, 1960–65 (percent)	1.8
Number of years to double population at the above growth rate	39.0
Per capita gross national product, 1965 (dollar equivalents)	$2,431.0

B. The dissemination of birth control information and the sale, advertisement or promotion of contraceptives are prohibited. Abortions are not permitted on either social or medical grounds. In 1966, a Health and Welfare Committee of the House of Commons undertook the consideration of proposed amendments to the laws on abortion and contraception. To this end, testimonies from interested individuals and organizations were presented before the Committee. In 1965, the Government of Quebec appointed a council to advise it on family legislation.

The United Church of Canada and the Anglican Church have urged the liberal revision of the criminal code dealing with contraception.

C. The philanthropic character of the Canadian birth control movement permits organized family planning activities. Family planning clinics are operating in Hamilton and Ottawa. Some birth control information is provided in a number of other cities. The Parents' Information Bureau of Kitchener, Ontario, a private organization, provides, reportedly, a non-profit family planning service through the mail. Advice from private physicians is available.

D. The Canadian Federation of Societies for Population Planning was formalized in 1964. It is a full member of IPPF.

E. None.

CZECHOSLOVAKIA

A. Year of last national census: 1961.

Population estimate, 1965 (millions)	14.2
Birth rate, 1965 (per 1,000 population)	16.4
Death rate, 1965 (per 1,000 population)	10.0
Infant mortality rate, 1965 (per 1,000 live births)	25.3
Annual average rate of population growth, 1960–65 (percent)	.7
Number of years to double population at the above growth rate	100.0
Per capita gross national product, 1965 (dollar equivalents) (1964)	$1,273.0

B. Family planning is a part of the public health service. Abortions on liberal social grounds were legalized in 1957; in 1962, more stringent regulations were introduced. Following the reinstitution of somewhat more restrictive provisions, especially in regard to first pregnancies, the number of legal abortions declined from a high of 43 per 100 live births in 1961 to 29 per 100 live births in 1964. Approval by an abortion commission is required.

Contraceptive advice is available in the gynecological departments from doctors and midwives. Some products are manufactured locally.

C. According to reports, abortions, coitus interruptus, and to some extent, condoms, are the principal means of birth control. On the whole, there is little effort to publicize family planning.

D. There is no organized family planning movement. A Commission in the Ministry of Public Health deals with family planning problems.

E. None.

DENMARK

A. Year of last national census: 1960.

Population estimate, 1965 (millions)	4.8
Birth rate, 1965 (per 1,000 population)	18.0
Death rate, 1965 (per 1,000 population)	10.1
Infant mortality rate, 1965 (per 1,000 live births) (1964)	18.7
Annual average rate of population growth, 1960–65 (percent)	.8
Number of years to double population at the above growth rate	88.0
Per capita gross national product, 1965 (dollar equivalents)	$2,102.0

B. In the opinion of the Government, current population trends do not adversely affect economic development.

Birth control is officially accepted by the Danish Government. There is no restrictive legislation on any aspect of the prevention of conception. There are regulations on advertisement and sale of contraceptives. Various private and public institutions are authorized to furnish birth control information. Family planning advice is now provided routinely as part of post-natal care. In 1956, the 1939 abortion law was revised to include socio-medical, juridical, and eugenic grounds for legal operations. A State Commission on Sexual Enlightenment was established in 1961.

C. Family planning advice is generally provided by medical practitioners. In 1956, the Danish Family Planning Association, a private institution, began to disseminate birth control information and to provide pharmacies with contraceptive supplies. A number of birth control clinics are operated both by the association and by the Maternity Aid Institute, a governmental agency. Abortions reportedly declined since 1956; however, in 1964, according to one estimate, 25 percent of pregnancies still ended in abortions. The Danish Family Planning Association places particular emphasis on sex education for young people.

D. The Danish Family Planning Association (Foreningen for Familie Planlaegning) was established in 1956. It is a full member of IPPF.

E. The Danish Government is prepared to offer family planning aid to countries requesting it.

FINLAND

A. Year of last national census: 1960.

Population estimate, 1965 (millions)	4.6
Birth rate, 1965 (per 1,000 population)	17.0
Death rate, 1965 (per 1,000 population)	9.7
Infant mortality rate, 1965 (per 1,000 live births)	17.4
Annual average rate of population growth, 1960–65 (percent)	.8
Number of years to double population at the above growth rate	88.0
Per capita gross national product, 1965 (dollar equivalents)	$1,561.0

B. The government provides financial support for the activities of the Finnish family planning association. The Lutheran Church in Finland is not in opposition to family planning. Apparently there is some pressure now for widening grounds for legal abortion. At present, abortion may be legally obtained on medical, eugenic, and psychological grounds, and the law provides for voluntary (and, in some cases, compulsory) sterilization.

C. Birth control advice and contraceptives are available through a private organization, the Finnish Population and Family Welfare League, which has

a quasi-official status. The 1950 law on abortion empowered the League to establish Social Guidance Clinics to process abortion applications. In an effort to reduce the number of abortions, six marriage clinics supply birth control advice; three perform legal abortions. Birth control advice is also furnished by gynecologists, and some municipal medical officers.

Contraceptives of all types are available through commercial sources. The 3,295 prenatal clinics, servicing over 90 percent of pregnancies, widely distribute free birth control handbooks published by the League. Attempts are made for the routine provision of contraceptive information at the post-natal examination.

D. The Finnish Population and Family Welfare League (Vaestoliitto) was organized in 1941. It is an associate member of IPPF.

E. None.

FRANCE

A. Year of last national census: 1962.

Population estimate, 1965 (millions)	48.9
Birth rate, 1965 (per 1,000 population)	17.7
Death rate, 1965 (per 1,000 population)	11.1
Infant mortality rate, 1965 (per 1,000 live births)	22.0
Annual average rate of population growth, 1960–65 (percent)	1.5
Number of years to double population at the above growth rate	47.0
Per capita gross national product, 1965 (dollar equivalents)	$1,879.0

B. The law of 1920 prohibited the promotion of birth control information and the sale or advertisement of contraceptives, other than condoms. In 1923, the penal code was modified to increase the effectiveness of the prohibition of abortions. In 1939, comprehensive welfare legislation under the title of "Family Code" was designed to increase the birth rate through economic assistance and the reaffirmation of the restrictions on birth control. Legal abortions are permitted only on medical grounds.

In 1956 an attempt to change the existing laws did not succeed. A decree of April 8, 1960, however created a Family Commission which recommended the establishment of a special group to consider modifications to the 1920 Act. Professional opinion seeks the separate consideration of abortion and birth control legislation.

The issue of family planning figured prominently in the 1965 French Presidential campaign. One of the unsuccessful candidates included the revision of the current laws in his platform. The issue elicited considerable public discussion. A bill, introduced into the Assembly to revoke the 1920 law, remains under consideration.

C. By limiting its sphere of activities to the membership, the French Family Planning Association was able to establish a birth control advisory center in 1962; the number of clinics has since grown to 85. Contraceptive advice to members is the only service permitted under the provisions of the law; the centers can inform their clients on available sources of contraceptive devices. Propagandizing of birth control is avoided. Birth control information is also available to the members of the French General Society for National Education (membership of about one million) which initiated clinical instruction in 1963.

Contraceptive supplies are received mainly by mail from abroad. Medical support is increasing. About 500 doctors (out of about 40,000), affiliated with the birth control movement, are offering contraceptive advice. A conference on contraception in 1963 attended by some 400 physicians, criticized the 1920 law as absurd and undemocratic. The President of the legislative component of the French Medical Association recently spoke in favor of modifying the 1920 law but was more reserved on the physician's role in family planning. He was also of the opinion that in any case, family planning consultations should be given in "gynecological departments of large hospital centers," rather than in nonmedical organizations.

According to available studies, among methods of contraception, coitus interruptus (solely or in combination with some other method), is in wide-spread use. Pills are legally available on prescription because they are also used in cases of infertility. Condoms, as a contraceptive rather than a prophylactic, seem to be relatively less popular in France than in some other European countries. Abortions have been estimated anywhere between 300,000 and 1,000,000.

D. The French birth control movement began under British influence around 1880. The first formal organization, the League for Human Improvement, was

founded in 1896. Its Malthusian philosophical orientation was rejected by the pronatalist National Alliance which was formed at the same time. The original birth control movement collapsed during World War II. In 1956, the French Movement for Family Planning was organized. Its membership at the end of 1965 is estimated as more than 40,000. The new movement, based on the principle of family welfare, has been described as more influential in its ability to arouse public discussion of demographic issues than its size would indicate. The activities of the organization occasionally gain the approval of municipal officials.

The French Movement for Family Planning (Mouvement Francois pour le Planning Familial) is a full member of IPPF.

E. None.

EAST GERMANY

A. Year of last national census: 1964.

Population estimate, 1955 (millions)	17.0
Birth rate, 1965 (per 1,000 population)	16.5
Death rate, 1965 (per 1,000 population)	13.4
Infant mortality rate, 1965 (per 1,000 live births)	24.5
Annual average rate of population growth, 1960–65 (percent)	
Number of years to double population at the above growth rate	
Per capita gross national produce, 1965 (dollar equivalents)	$1,500.0

B. As in all Communist countries, family planning is officially outside of the state sector, a matter of interest primarily to individual parents. In East Germany, however, state policy had to contend with strong desires for emigration.

The liberal abortion laws of 1947 was repealed in 1950. Under the pressure of spreading illegal operations, the law was "reinterpreted" in 1965, to include socio-medical and ethical indications as grounds for abortion. Approval of an abortion commission is required. Nevertheless, the state made a substantial effort to replace all abortions by methods of contraception.

C. In 1962, it was estimated that there was one abortion for ever 3.7–5.0 births. Since family planning has been formally incorporated in the public health system in 1963, advice has been generally available and contraceptives (condoms, cream, suppositories, diaphragms, and oral contraceptives) are on sale in drugstores. The family planning association provides consultative service in six centers and 50 out-patient clinics.

D. Unlike most Communist countries, the East German regime established a quasi-governmental family planning group in 1963, the Association for Marriage and the Family, which is supported by the Ministry of Public Health.

E. None.

FEDERAL REPUBLIC OF GERMANY

A. Year of last national census: 1961.

Population estimate, 1965 (millions)	59.0
Birth rate, 1965 (per 1,000 population)	17.7
Death rate, 1965 (per 1,000 population)	11.4
Infant mortality rate, 1965 (per 1,000 live births)	23.9
Annual average rate of population growth, 1960–65 (percent)	1.3
Number of years to double population at the above growth rate	54.0
Per capita gross national product, 1965 (dollar equivalents)	$1,897.0

B. The central government lends moral support to the policies of the family planning association, but does not support it financially. Some support of its activities is available through local municipal administrations.

In 1961, the restrictive birth control laws formulated in Nazi Germany were repealed. Abortions, other than therapeutic, remain illegal.

C. Six birth control clinics were established in the larger cities. West Germany is the second largest producer of contraceptives in Europe. Nevertheless, illegal abortions are quite numerous, and according to various estimates, amount to between 25–50 percent of all pregnancies. Contraceptive pills and IUD's have not been approved for general use. Contraceptive devices may be obtained by mail.

The family planning issue was discussed in a series of articles in a popular women's magazine in 1963–1964. Catholic priests in the Archdiocese of Munich have been advised through a pastoral letter to allow married couples who were using contraceptives as "a regrettable emergency" to take communion.

D. The family planning organization (Pro Familia: Deutsche Gesellschaft fur Ehe and Familie e.V.) was founded in 1952. It is a full member of IPPF.

E. None.

GREECE

A. Year of last national census: 1961.

Population estimate, 1965 (millions)	8.5
Birth rate, 1965 (per 1,000 population)	[1] 17.8
Death rate, 1965 (per 1,000 population)	[1] 7.9
Infant mortality rate, 1965 (per 1,000 live births) (1964)	[1] 35.8
Annual average rate of population growth, 1960–65 (percent)	.6
Number of years to double population at the above growth rate	117.0
Per capita gross national product, 1965 (dollar equivalents)	$653.0

[1] Incomplete coverage and/or considerable irregularity of registration.

In the opinion of the Government, current population trends do not adversely affect economic development, although some serious concern is expressed over selective emigration.

B. Abortions are illegal, except on medical grounds. There is some sentiment in favor of a pro-natalist policy.

C. Contraceptive information on modern means is generally not available. According to reports, coitus interruptus is the most frequently used method by birth controllers, with condoms in second place. There is a growing concern over maternal health and high illegal abortion rates which may eventually contribute to more general support for family planning. Some medical research in the field of birth control is being undertaken.

D. There is no organized family planning movement.

E. None.

HUNGARY

A. Year of last national census: 1960.

Population estimate, 1965 (millions)	10.1
Birth rate, 1965 (per 1,000 population)	13.1
Death rate, 1965 (per 1,000 population)	10.7
Infant mortality rate, 1965 (per 1,000 live births)	38.8
Annual average rate of population growth, 1960–65 (percent)	.2
Number of years to double population at the above growth rate (about)	350.0
Per capita gross national product, 1965 (dollar equivalents) (1964)	$870.0

B. Birth control services are part of the public health services. Legal abortions are performed on liberal social grounds since 1956. Applications are processed by a three-man commission.

C. The number of legal operations has steadily increased since the liberalization of the abortion laws in 1956. By 1964, there were 165 abortions per 100 births. The Government is concerned about the high prevalence of abortions; education of the public in contraception is to be undertaken by the Ministry of Health.

According to one estimate, about 20 to 30 percent of all couples practice contraception regularly. According to reports, contraceptives are in limited supply and of poor quality. Fifty-four percent of all applications for abortion in 1964 were necessitated by contraceptive failure. According to available reports, coitus interruptus is used by the majority of birth controllers, particularly in rural areas.

D. There is no organized birth control movement in Hungary. An independent family planning organization is under consideration.

E. None.

ICELAND

A. Year of last national census: 1950.

Population estimate, 1965 (millions)	.2
Birth rate, 1965 (per 1,000 population) (1964)	25.1
Death rate, 1965 (per 1,000 population) (1964)	6.9
Infant mortality rate, 1965 (per 1,000 live births) (1964)	17.7
Annual average rate of population growth, 1960–65 (percent)	1.8
Number of years to double population at the above growth rate	39.0
Per capita gross national product, 1965 (dollar equivalents)	$1,745.0

B. Since 1935, physicians are legally obliged to furnish family planning information on request. Abortions are permitted on medical and social grounds.

C. No clinics were established before World War II. In 1964, a family planning clinic, giving advice and selling contraceptives, was opened in Reykjavik by the Social Institute of Iceland. The family planning department of this institute is affiliated with the Church of Iceland.

D. There is no organized family planning movement.

E. None.

IRELAND

A. Year of last national census: 1961.

Population estimate, 1965 (millions)	2.9
Birth rate, 1965 (per 1,000 population)	22.2
Death rate, 1965 (per 1,000 population)	11.5
Infant mortality rate, 1965 (per 1,000 live births)	25.3
Annual average rate of population growth, 1960–65 (percent)	.2
Number of years to double population at the above growth rate (about)	350.0
Per capita gross national product, 1965 (dollar equivalents)	$982.0

B. The Government is opposed to artificial methods of population control. It is of the opinion that the solution to developmental difficulties, compounded by high rates of population growth, can be found in the "fuller development of human and economic resources and research into dissemination of information on non-artificial methods of family planning." The Government considers the country to be underpopulated and the main population problem to be the continuous decrease of the population through emigration.

The advertising, promotion, local manufacture, sale, or import of contraceptives is forbidden.

C. In 1963, a hospital in Dublin began offering birth control information based on the practice of periodic continence. In view of the relatively high fertility among married women, the comparatively low birth rate is due in a large measure to the custom of delayed marriages and relatively greater proportion of spinsters in the population.

D. There is no organized family planning movement.

E. None.

ITALY

A. Year of last national census: 1961.

Population estimate, 1965 (millions)	51.6
Birth rate, 1965 (per 1,000 population)	19.2
Death rate, 1965 (per 1,000 population)	10.0
Infant mortality rate, 1965 (per 1,000 live births)	35.6
Annual average rate of population growth, 1960–65 (percent)	.7
Number of years to double population at the above growth rate	100.0
Per capita gross national product, 1965 (dollar equivalents)	$1,028.0

B. According to an official statement, the Government has taken no direct action to influence fertility trends. It considers the phenomenon too complex for governmental action. The financial and psychological cost of child-bearing is viewed as the most effective obstacle to (excessive) procreation.

The Penal Code of 1931 prohibits advertisement and sale of contraceptives and the dissemination of birth control information. A bill to abrogate provisions in the penal code against the promotion of birth control information and to empower public health services to give family planning assistance was to be placed before the Parliament in the spring of 1966. Condoms are regarded as prophylactics and their sale is permitted. Abortions are prohibited except on medical grounds.

Since World War II, infringement of the pre-war birth control law has not been punished. In 1964 two officials of the Italian family planning association were brought to court. The ensuing litigation has led to the review of the constitutionality of the birth control law by Italy's constitutional court. No report of a decision in the case has been received.

C. The wide-spread practice of family planning in the northern part of country has been officially noted.

The family planning association operates seven birth control centers. According to some estimates, there are 800,000 to 1,000,000 illegal abortions annually, as compared with a little under one million births.

D. The Italian Association for Demographic Education was formed in 1953. IPPF membership was withdrawn in 1965. Independent family planning associations have been formed in Turin, Naples, and Rome.

E. None.

JAPAN

A. Year of last national census: 1965.

Population estimate, 1965 (millions)	98.0
Birth rate, 1965 (per 1,000 population)	18.6
Death rate, 1965 (per 1,000 population)	7.1
Infant mortality rate, 1965 (per 1,000 live births)	18.5
Annual average rate of population growth, 1960–65 (percent)	1.0
Number of years to double population at the above growth rate	70.0
Per capita gross national product, 1965 (dollar equivalents)	$857.0

B. In 1948, legislation was enacted to include health and social considerations as grounds for legal abortion. Its objectives were to minimize the harmful consequences of illegal abortions which became quite numerous after the war, and to moderate excessive population growth rates arising out of the post-war baby boom, a decline in mortality and the net repatriation of five million Japanese nationals. In 1952, the law was radically modified so that abortions were now performed at the discretion of the physician without prior evaluation by the abortion committee. Due to concern over the large demand for abortions, the Ministry of Health and Welfare introduced, at the same time, a governmental program for the promotion of family planning through general, group, and individual education. The task was assigned to personnel in the maternal and child health centers and to midwives.

After 1957, the need for governmental involvement in family planning was thought to have declined, except for the continued efforts to reduce the reliance on abortion for birth control. Since 1965, the central Government has no specific budget allocation for family planning. The future direction of official family planning programs now rest with individual local administrations.

C. The role of voluntary family planning organizations in Japan is limited. In addition to the governmental interest in the matter, private industry has made family planning education a part of its employee health services since 1953. Beginning with 1955, many other institutions initiated similar activities. Consequently, family planning organizations do not operate clinics, but concentrate on publicity and education.

The various private programs covered an estimated 410,000 families, a figure slightly exceeding the number of families served by the governmental family planning program.

The contribution of mass communication media in promoting family planning has been very extensive. It is reflective, to some degree, of the public demand and interest in the subject.

Induced abortions are declining somewhat. The use of contraceptives by Japanese wives under 50 years of age incerased from 19 percent in 1951 to 51.9 percent in 1965. The ratio of pregnancies aborted to those prevented by contraception has been estimated to be 3 : 1 in 1950 to 1 : 1 in 1961.

In 1949, the Government authorized the sale of about 60 brands of contraceptive chemicals. IUD's and pills have not yet been approved for general use.

Japan provides a rather unique example of the actual achievement of a rapid decline of the birth rate (from 34.3 in 1947 to 18.6 in 1965) by the use of family planning techniques (principally abortion).

The Population Council has contributed support for reproduction studies at 10 universities and schools in Japan, has supported research at the Institute of Public Health of Japan, and has supplied travel grants and fellowships.

D. Family Planning Federation of Japan, Inc. was founded in 1953 to coordinate the activities of various family planning groups. It is a full member of IPPF.

E. The Government is prepared to offer family planning aid to countries requesting it.

LUXEMBOURG

A. Year of last national census: 1960.

Population estimate, 1965 (millions)	.3
Birth rate, 1965 (per 1,000 population)	15.6
Death rate, 1965 (per 1,000 population)	11.8
Infant mortality rate, 1965 (per 1,000 live births)	29.2
Annual average rate of population growth, 1960–65 (percent)	1.1
Number of years to double population at the above growth rate	63.0
Per capita gross national product, 1965 (dollar equivalents)	$1,879.0

B. There are no legislative restrictions on contraceptive practices.

C. Contraceptive advice is offered by the family planning association; its principal objective, however, is the increase in the number of births. Accordingly, it supports a social and economic policy which aids the family through protective mother and child legislation and information to infertile couples. Special attention is given to education in family planning among the adult population.

D. The Family Planning Association was formed in 1965. IPPF membership is under consideration.

E. None.

THE NETHERLANDS

A. Year of last national census: 1960.

Population estimate, 1965 (millions)	12.3
Birth rate, 1965 (per 1,000 population)	19.9
Death rate, 1965 (per 1,000 population)	8.0
Infant mortality rate, 1965 (per 1,000 live births)	14.4
Annual average rate of population growth, 1960–65 (percent)	1.4
Number of years to double population at the above growth rate	50.0
Per capita gross national product, 1965 (dollar equivalents)	$1,505.0

B. There is no official policy to influence the birth rate. The advertisement or promotion of contraceptives are illegal. Sales to persons over 21 years of age are, apparently, permitted. According to reports, a bill to liberalize the provisions governing the sale of contraceptives (to include teen-age clientele) and to allow advertising of the products will be introduced in the Parliament in 1966. Earlier in 1966, the Parliament approved a fund to subsidize the distribution of family planning information by private organizations. A law of 1911 prohibits abortions on all grounds.

C. In 1931, the first medically staffed birth control clinic was established. The family planning association now operates about 40 clinics. Some family planning services are provided by other organizations. Insofar as the family planning associations serve only their membership, they do not violate the law.

According to available information, 20 to 25 percent of pregnancies are aborted.

D. The Dutch birth control movement started in the second half of the 19th century. The first organization, the Malthusian League, was established in 1872. The current family planning association, The Netherlands' Society for Sexual Reform (Nederlandse Vereniging voor Sexuele Hervorming) was established in 1946. In 1963, it had a membership of about 190,000. The Society is a full member of IPPF.

E. None.

NORWAY

A. Year of last national census: 1960.

Population estimate, 1965 (millions)	3.7
Birth rate, 1965 (per 1,000 population)	17.5
Death rate, 1965 (per 1,000 population)	9.1
Infant mortality rate, 1965 (per 1,000 live births) (1964)	16.8
Annual average rate of population growth, 1960–65 (percent)	.8
Number of years to double population at the above growth rate	88.0
Per capita gross national product, 1965 (dollar equivalents)	$1,821.0

B. Restrictive legislation on the advertisement of contraceptives is not enforced. Access to contraceptive information and supplies is not restricted. Abortions are permitted on medical and certain social grounds.

C. Before World War II, Norway had 12 birth control clinics which received grants from central and local authorities. At present, birth control services are available through the public maternal health clinics.

D. There is no organized family planning movement.

E. None.

POLAND

A. Year of last national census: 1960.

Population estimate, 1965 (millions)	31.5
Birth rate, 1965 (per 1,000 population)	17.3
Death rate, 1965 (per 1,000 population)	7.4
Infant mortality rate, 1965 (per 1,000 live births)	41.7
Annual average rate of population growth, 1960–65 (percent)	1.3
Number of years to double population at the above growth rate	54.0
Per capita gross national product, 1965 (dollar equivalents) (1964)	$764.0

B. In 1957, the abortion law was amended to permit legal operations for social reasons. In 1960, after further liberalization of the abortion provisions, a declaration of hardship by the applicant became sufficient justification for legal surgery.

C. The Association for Responsible Motherhood promotes family planning without directly involving the Government in its program of sex hygiene and education, its discouragement of abortions, and its counselling service through 2,900 consultation centers.

Despite some reported lack of interest in contraception, the rate of growth of legal and illegal abortions seem to have stabilized since the rapid increase in 1960. Thus, legal abortions per 1,000 women in reproductive ages have risen from 14 in 1955 to 65 in 1960 and to 79 in 1964. Legal abortions per 100 live births which were considered less than one in 1955, rose to 23 in 1960, and to 26 in 1964.

In the effort to reduce abortions, the Social Insurance Fund supports about 70 percent of the cost of contraceptive materials. Local production of contraceptives includes condoms, foam tablets, suppositories, creams, diaphragms, and cervical caps. In general, only condoms and tablets are available in drugstores and in the offices of the Association. It is claimed that physicians are apathetic toward contraceptives and tend to rely on abortions.

The extensive activities of the Association for Responsible Motherhood are widely publicized.

D. The Association for Responsible Motherhood was founded in 1957. The organization collaborates with the Ministry of Public Health and it is headed by the Vice-Minister of Public Health. The Association maintains its central office in Warsaw; other offices are in Krakow and in each of the 18 districts. Rural branches are in 310 counties, 150 villages. The Association is a full member of IPPF.

E. None.

PORTUGAL

A. Year of last national census: 1960.

Population estimate, 1965 (millions)	9.2
Birth rate, 1965 (per 1,000 population)	22.9
Death rate, 1965 (per 1,000 population)	10.1
Infant mortality rate, 1965 (per 1,000 live births) (1965)	69.0
Annual average rate of population growth, 1960–65 (percent)	.8
Number of years to double population at the above growth rate	88.0
Per capita gross national product, 1965 (dollar equivalents)	$421.0

B. Abortions are prohibited, except on medical grounds.

C. According to reports, some contraceptives and private medical advice are available.

D. There is no organized family planning movement.

E. None.

RUMANIA

A. Year of last national census: 1956.

Population estimate, 1965 (millions)	19.0
Birth rate, 1965 (per 1,000 population)	14.6
Death rate, 1965 (per 1,000 population)	8.6
Infant mortality rate, 1965 (per 1,000 live births) (1964)	48.6
Annual average rate of population growth, 1960–65 (percent)	.6
Number of years to double population at the above growth rate	117.0
Per capita gross national product, 1965 (dollar equivalents) (1964)	$634.0

B. Abortions on liberal social grounds have been legal since 1956. Birth control services are part of the general health services.

C. Abortions are almost the only means of birth control. Their number is considered to exceed the number of births. Women apply directly to the medical center. The processing of applications by a special abortion commission (as is the case in some other Communist countries) is omitted.

According to reports, contraception, including the "natural" means, is little known. Some educational efforts have recently been undertaken by the abortion centers. Among contraceptives, only condoms and contraceptive cream are available.

A one-child family is considered ideal.

D. There is no organized family planning movement.

E. None.

NEW ZEALAND

A. Year of last national census: 1961.

Population estimate, 1965 (millions)	2.6
Birth rate, 1965 (per 1,000 population)	22.8
Death rate, 1965 (per 1,000 population)	8.7
Infant mortality rate, 1965 (per 1,000 live births)	19.5
Annual average rate of population growth, 1960–65 (percent)	2.2
Number of years to double population at the above growth rate	32.0
Per capita gross national product, 1965 (dollar equivalents)	$1,990.0

B. The principal element in the Government's population policy is regulated immigration which is considered beneficial for New Zealand's economic development.

There is no legislative restriction on sale, advertisement, or promotion of contraceptive methods or devices. Abortions are permitted only on medical grounds.

C. According to reports, family planning is widely practiced. Contraceptive advice is available from private physicians. In addition, the family planning association operates 8 clinics, with about 5,000 regular clients. There is also a large number of persons who visit the clinics only once.

Oral contraceptives were placed on the market around 1960. Present estimates of the number of users range from 100,000 to 150,000 women.

D. The New Zealand Family Planning Association, Inc., was founded around 1940. It is slowly gaining some official approval. The Association is a full member of IPPF.

E. None.

SPAIN

A. Year of last national census: 1960.

Population estimate, 1965 (millions)	31.6
Birth rate, 1965 (per 1,000 population)	21.3
Death rate, 1965 (per 1,000 population)	8.7
Infant mortality rate, 1965 (per 1,000 live births)	37.2
Annual average rate of population growth, 1960–65 (percent)	.8
Number of years to double population at the above growth rate	88.0
Per capita gross national product, 1965 (dollar equivalents)	$650.0

B. The sale, advertisement, and promotion of contraceptives, as well as the dissemination of birth control information are prohibited. Abortions are permitted only on medical grounds.

C. There is no information on the prevalence of family planning. The evidence of relatively low fertility levels (in comparison with biological potential) suggests some form of birth control practices, (especially continence, withdrawal, or illegal abortions) in addition to other influences.

D. There is no organized family planning movement.

E. None.

SWEDEN

A. Year of last national census: 1960.

Population estimate, 1965 (millions)	7.7
Birth rate, 1965 (per 1,000 population)	15.9
Death rate, 1965 (per 1,000 population)	10.1
Infant mortality rate, 1965 (per 1,000 live births)	12.4
Annual average rate of population growth, 1960–65 (percent)	.6
Number of years to double population at the above growth rate	117.0
Per capita gross national product, 1965 (dollar equivalents)	$2,431.0

B. Following the recommendations of two Royal Population Commissions (1936 and 1941), Sweden adopted a positive, family-oriented population policy, based on the premise of "voluntary parenthood." There is no restrictive legislation concerning contraception. The 1938 abortion law, as amended in 1946 and 1963, permits legal operations on cogent medical, social, humanitarian, economic, or eugenic grounds. With the objective of further liberalizing abortion provisions, the law has been under review by an eight-member Parliamentary committee since 1965. In the opinion of the Government, current population trends do not adversely affect economic development.

C. Birth control activities are conducted principally by the National Association for Sex Education. It operates six clinics, has a substantial number of consultant doctors in different parts of the country, and offers advisory services and products through the mail. The Association is the major distributor and manufacturer of chemical contraceptives in Sweden; mechanical contraceptives are imported. The Association has 25 shops selling contraceptives and a number of authorized retailers. Since 1946, all pharmacies are required to stock contraceptives. Shops, other than those dealing in medical merchandise, must obtain a license to sell contraceptives. The devices are also obtainable in automatic dispensers at factories, barracks, and other public places.

In addition to the Association, contraceptive advice is also offered by the Maternity and Child Health Center, agencies handling abortion appliances and, to an unknown degree, by private medical practitioners.

The number of applications for legal abortions has been declining since the mid-1950's. In the early 1950's there were about 6,000 applications for abortion (to about 100,000 births) of which about 85 percent were approved. In 1960, out of 4,000 applications (to 120,000 births) a little over 60 percent were approved.[5] Illegal abortions are assumed to have declined since the 1930's; their prevalence is still thought to be relatively high.

According to a 1963 survey, birth control is extensively used. The principal means are condoms and coitus interruptus. Oral contraceptives and intrauterine devices have recently been approved for general use by the Swedish National Board of Health. Pills, obtainable on prescription, are reportedly used now by about 150,000 women, or between 8–9 percent of all women in reproductive ages.

D. The modern family planning movement in Sweden dates from 1932. In 1934 the National Association for Sex Education (Riksforbundet for Sexuell Upplysning) was founded. It is a full member of IPPF.

E. The Swedish Government was the first to offer family planning aid to less developed countries. In 1958 it started a pilot project for action and research in Ceylon. Since 1965 the Swedish project has been incorporated in the island's national family planning program. For the past four years, Sweden has been participating in the family planning program of the Government of Pakistan. Some assistance is furnished to the Government of Tunisia and in the Gaza strip.

[5] Between 1962 and 1965, U.S. nationals among abortion applicants in Sweden numbered 292 women. Of these, only 13 applications were approved by the reviewing board. (Testimony of Dr. Ulf Borell, the Swedish International Development Authority, before the Government Operations Subcommittee on Foreign Aid Expenditures.)

SWITZERLAND

A. Year of last national census: 1960.

Population estimate, 1965 (millions)	5.9
Birth rate, 1965 (per 1,000 population)	18.7
Death rate, 1965 (per 1,000 population)	9.3
Infant mortality rate, 1965 (per 1,000 live births)	19.0
Annual average rate of population growth, 1960–65 (percent)	2.2
Number of years to double population at the above growth rate	32.0
Per capita gross national product, 1965 (dollar equivalents)	$2,321.0

B. Regional independence is an important factor in the absence of national policy or programs. The grounds for legal abortion are less restrictive than in other countries of Western Europe. Sterilization is also permitted. Contraceptives are available.

C. Birth control services are principally available through private channels. Birth control clinics are attached to hospitals in Geneva and Lausanne. In Canton de Vaud, family planning services were integrated with the general health services in 1965. Some effort is reported to make family planning services more generally available in the country.

D. In 1957, the health service of Canton de Vaud (Service de la Sante Publique) became an affiliate member of IPPY. There is some local movement in Lausanne and Geneva.

E. None.

UNION OF SOVIET SOCIALIST REPUBLICS

A. Year of last national census: 1959.

Population estimate, 1965 (millions)	230.6
Birth rate, 1965 (per 1,000 population)	18.5
Death rate, 1965 (per 1,000 population)	7.3
Infant mortality rate, 1965 (per 1,000 live births)	28.0
Annual average rate of population growth, 1960–65 (percent)	1.5
Number of years to double population at the above growth rate	47.0
Per capita gross national product, 1965 (dollar equivalents)	$1,288.0

B. There is historic opposition to the use of family planning as an independent means of combatting the socio-economic causes of poverty. The stated theoretical basis of Soviet domestic policy is voluntary parenthood.

A variety of family planning methods is made available through state support, and legal abortions are performed on request. Abortions, it is claimed, were legalized in 1956 because no form of contraception was either fully effective or acceptable among various components of the population, and because of a desire on the part of the government to raise medical standards in the performance of the operations.

C. Maternal and child health centers attempt to encourage the use of both mechanical and chemical contraceptives as the "lesser of two evils" (in preference to abortion). Nevertheless, it is reported that traditional attitudes, especially in the Asiatic republics, limit the use of contraceptives. In European USSR, coitus interruptus has been a traditional method of family planning. Apparently, the pattern of abortions varies widely by republics and between urban and rural communities.

D. There is no organized family planning movement.

E. The USSR has made no effort to support family planning programs in less developed countries.

UNITED KINGDOM

A. Year of last national census: 1961.

Population estimate, 1965 (millions)	54.4
Birth rate, 1965 (per 1,000 population)	18.4
Death rate, 1965 (per 1,000 population)	11.5
Infant mortality rate, 1965 (per 1,000 live births)	19.6
Annual average rate of population growth, 1960–65 (percent)	.8
Number of years to double population at the above growth rate	88.0
Per capita gross national product, 1965 (dollar equivalents)	$1,801.0

B. The policy of the Government of the United Kingdom is to provide for the availability of contraceptive information and supply, and in this way to facilitate personal decision on family size and spacing.

There is no legislative prohibition of the sale, advertisement, or promotion of contraceptives. Since 1861, abortions have been prohibited except on medical grounds. A revised version of the abortion bill was approved in principle in the House of Lords in November 1965; final parliamentary action is awaited. In 1958, the Anglican Church declared family planning to be "a right and important factor in Christian family life."

C. The first two birth control clinics in Britain were established in 1921. By 1939, there were 71 clinics, affiliated with the Family Planning Association and, in lesser number, with the Society for Constructive Birth Control. Birth control service was also offered by some municipal clinics. In 1949, the Royal Population Commission recommended that the birth control activities of maternity and child welfare clinics should be strengthened and that the initial duty to give advice should rest with the family doctor. Nevertheless, family planning services are still, for the most part, provided by Britain's Family Planning Association. In 1964, the Association operated 455 clinics, staffed by about 1,000 doctors, 2,000 nurses, and about 3,000 voluntary social workers. In this year, about 355,000 clients (including 115,000 new ones) visited the clinics. In addition, over 100 clinics were administered by local health authorities. A practice of making house calls has been initiated by the Association.

A 1959–1960 Marriage Survey showed an increasing practice of contraception among married couples. According to the same source, condoms and coitus interruptus are the most widely used methods of family planning. IUD's have been officially approved by the Association and will probably become available in some of its clinics by the end of 1966. Contraceptives are readily available throughout the country. Oral contraceptives are available on prescription.

D. Britain was the cradle of the organized birth control movement which began in the 1860's. After World War I, the original organization (the Malthusian League, established in 1878) lost influence and eventually was replaced in 1931 by an ideologically reoriented group, the National Birth Control Association. In 1938, its name was modified to the Family Planning Association. It is a full member of IPPF.

The financial support of the Family Planning Association is derived from its membership, indirect subsidy of local authorities (in the form of nominal rent of the premises), professional fees, and profits from sales of contraceptives.

E. The British Government is prepared to offer birth control aid to requesting countries. The Minister for Foreign Affairs announced in the House of Lords in July 1964 that the United Kingdom was "prepared within our technical assistance programmes to finance visits or period of service overseas by British medical and scientific experts or experts for the organization of family planning, and also to provide the finance, the training and the research in this country for suitable people from overseas."

YUGOSLAVIA

A. Year of last national census: 1961.

Population estimate, 1965 (millions)	19.5
Birth rate, 1965 (per 1,000 population)	20.9
Death rate, 1965 (per 1,000 population)	8.7
Infant mortality rate, 1965 (per 1,000 live births)	71.5
Annual average rate of population growth, 1960–65 (percent)	1.2
Number of years to double population at the above growth rate	58.0
Per capita gross national product, 1965 (dollar equivalents)	$420.0

B. Abortions on social grounds were legalized in 1960. Applications must be approved by an abortion committee. Contraceptive advice is available as part of the public health system; it is also given routinely to applicants for abortion.

C. Since 1960, the number of legal abortions has increased while the number of illegal abortions has, reportedly, remained more stable.

Toward the end of 1965, a movement to reduce abortions by a wider reliance on contraception has been reported. Contraceptive advice is available at gynecological departments, prenatal clinics, abortion commissions, at places of employment and from general practitioners.

According to reports, coitus interruptus is the most frequently used method of birth control. Local production of some contraceptives began in 1955. A study of IUD's has been undertaken in one locality.

D. There is no organized birth control movement. Special agencies for the prevention of abortions and the encouragement of contraception have been set up by the Health Council. A Co-ordinating Committee for Family Planning was established in 1964.

E. None.

AID Assistance for Family and Population Planning Activities in Less Developed Countries [1]

AID assistance for family and population planning activities in the less developed countries has gradually increased since President Lyndon B. Johnson's State of the Union Message, January 4, 1965: "I will seek new ways to use our knowledge to help deal with the explosion of world population and the growing scarcity of world resources."

Although AID has been providing population-related assistance in less developed countries since the 1950's—primarily aimed at improvement of vital statistics, demographic analysis, and maternal and child health—its direct help for family planning programs is just beginning.

Until February, 1965, AID referred requests for family planning assistance and information to appropriate private agencies. Since then, it has formulated and promulgated a population policy—indicating that AID will provide assistance for family and population programs in the less developed countries.

The range and extent of AID activities to date in support of family and population planning programs in less developed countries is indicated by the attached country summaries.

Population Activities

LATIN AMERICA

Interest in family planning is now apparent in many Latin American countries, mainly in response to increased awareness of its importance for improving maternal and child health.

Also, government officials are becoming keenly aware of the difficulty of improving economic and social well-being in countries with excessive rates of population increase—often more than 3 percent.

At least three Latin American countries now have national family planning programs, and many others have substantial non-official family planning organizations and activities.

The Latin American Bureau of AID, by support of diverse official and voluntary organizations and activities, has catalyzed much of the current favorable family planning activity in Latin America.

Estimated AID expenditures and planned expenditures for family and population planning activities, Latin America Region:

Obligated through—	Fiscal year 1965	Fiscal year 1966	Fiscal year 1967, estimate
Country missions	$91,800	$525,000	$1,014,000
Regional projects	1,205,000	565,000	1,195,000
Total	1,296,800	1,090,000	2,209,000

ROCAP—REGIONAL OFFICE, CENTRAL AMERICA AND PANAMA

Regional family planning and population activities

A regional population program has been initiated by a private organization, the Central American Institute of Economic and Social Development (IDESAC), which has requested AID assistance in developing research training programs in each of the six Central American countries.

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[1] Data for the less-developed countries compiled by the Population Branch, AID/TCR/HS, in cooperation with the AID Regional Bureaus and private U.S. organizations.

AID assistance

IDESAC has requested help in establishing an Institute for Population and Family Planning for Central America. This request is under consideration, as is a related request from the Organization of Central American States (ODECA). ODECA has proposed AID support for a study to determine the feasibility of establishing a Central American Demographic Unit. In addition, the Superior Council for Central American Universities has proposed assistance to the Regional Institute of Statistics in developing regional facilities for training in demography and related sciences. This Institute is located at the University of Costa Rica. The Council's proposal is in process of discussion.

Fiscal year 1966	$70,000
Fiscal year 1967	117,000

Other assistance

The Latin American Center for Economic and Social Development (DESAL) provided advisory services to assist in organization of the Central American Institute for Social and Economic Development.

Assessment of current status

It is believed that regional institutions and activities can be of special value in development of population programs, training, and research in Central America.

LATIN AMERICA—REGIONAL

Family and population planning activities

Regional support and efforts for family planning and population assistance are of several kinds, involving the participation of numerous countries and several assisting agencies.

CELADE.—Important support for demographic research and training is provided region-wide by the Latin American Demographic Center (CELADE—Centro Latino-Americano de Demografia), located in Santiago, Chile. This center was organized in 1957 under an agreement between the Government of Chile and the United Nations. Its program consists of (1) teaching demography to Latin American students and promoting its teaching in other countries of the region; (2) conducting demographic research; and (3) providing technical demographic guidance to Latin American governments.

Regional Conference and Seminars.—Conferences and seminars of leaders and professional workers have contributed substantially to multi-country interest in Latin American population developments and problems.

AID assistance

AID assistance supports expansion of the staff and facilities of the Demographic Center to accommodate as many trainees as possible from Latin American countries. Also it encompasses technical and financial assistance to such countries, if requested by them, for developing local institutions to carry out research and analysis.

Fiscal year 1964	$100,000
Fiscal year 1965	-------
Fiscal year 1966	100,000
Fiscal year 1967	180,000

Conferences and Seminars: A regional training conference, sponsored by the University of Puerto Rico in 1964, was financed through AID funds. AID participants also took part in the first Pan-American Assembly on Population in Colombia in August 1965, and in a demographic seminar in Guatemala in early 1966. AID assistance is expected to be requested for financing attendance of a number of Latin American delegates to the IPPF's World Conference on Population, to be held in Chile in 1967.

Other assistance

The Population Council contributed some $290,000 in 1964–66 to Latin American regional projects in the population field, including about $133,000 for support of the work of CELADE. It provided financial support for the First Pan-American Assembly on Population, which was held under sponsorship of the Universidad del Valle and the Association of Colombian Medical Schools, in cooperation with the Population Council and the American Assembly, Colombia Uni-

versity. The Population Council's assistance included a grant in 1965 to support a program for translation, publication, and distribution of Spanish and Portuguese editions of English language books in the population field.

Assessment of current status

Activities in the above fields are laying a sound foundation for future growth of population interest and action in Latin America.

ARGENTINA

Background information:	
Last national census	1960
Population estimate, 1965 (millions)	22.4
Birth rate (live births per annum per 1,000 population)	21.7
Death rate (deaths per annum per 1,000 population)	8.1
Infant mortality rate (infant deaths per annum per 1,000 live births)	60 to 65
Annual rate of population increase, 1958–63 (percent)	1.6
Number of years to double population at present growth rate	44
Per capita gross national product, 1964 (dollar equivalents)	$541

Family and population planning activities

The International Planned Parenthood Federation reports that, "The Federation of Family Planning Centers has embarked on a program in the low-income area of Buenos Aires, a program has begun in Tucuman, and a study in abortion (incidence) has been conducted at the Rawson Hospital of Buenos Aires. There are birth control services in ten hospitals throughout Argentina * * *."

AID assistance

No AID assistance is being provided for family planning work in Argentina.

Other assistance

The IPPF has assisted the family planning organization in Argentina.

The Population Council has provided numerous grants to laboratories and universities to support research on physiology of reproduction. Recently it has supported demographic studies and provided training fellowships.

The Ford Foundation supports biomedical research in Argentina.

The Pathfinder Fund, since 1963, has subsidized salaries and supplied contraceptives for family planning work in Buenos Aires.

Assessment of current status

Little official interest but increasing private initiative and fairly low birth rate.

BOLIVIA

Background information:	
Last national census	1950
Population estimate, 1965 (millions)	3.7
Birth rate (live births per annum per 1,000 population)	41 to 45
Death rate (deaths per annum per 1,000 population)	20 to 25
Infant mortality rate (infant deaths per annum per 1,000 live births)	135 to 155
Annual rate of population increase, 1958–63 (percent)	1.4
Number of years to double population at present growth rate	50
Per capita gross national product, 1964 (dollar equivalents)	$162

Family and population planning activities

No activities in progress, so far as known.

There is little information about the population problem in Bolivia. More and better demographic data are needed.

AID assistance

None.

Other assistance

The Population Council has provided assistance with demographic studies.

Contraceptive supplies have been given by Pathfinder Fund to private groups.

Assessment of current status

Present fragmentary data indicate relatively slow growth of population, with high birth rate and high mortality rate.

BRAZIL

Background information:

Last national census	1960
Population estimate, 1965 (millions)	81.3
Birth rate (live births per annum per 1,000 population)	43 to 47
Death rate (deaths per annum per 1,000 population)	11 to 16
Infant mortality rate (infant deaths per annum per 1,000 live births)	N.A.
Annual rate of population increase, 1958–63 (percent)	3.1
Number of years to double population at present growth rate	23
Per capita gross national product, 1964 (dollar equivalents)	$175

Family and population planning activities

Official and educational interest in population matters in Brazil is being directed to improvement of knowledge respecting population movements, vital statistics, age and sex composition of the population, and related demographic considerations, especially in relation to economic development. In addition, there is interest in establishing centers for training more demographers and carrying out demographic research. Private institutions such as the Catholic University in Rio de Janeiro are planning fertility and attitude studies concerning population problems. The University of Bahia and the University of Brazil are presently conducting research in reproductive biology. The University of Sao Paulo is currently developing a demographic research training center with assistance of PAHO and AID. A National Family Planning Association has been organized. Also, field surveys on fertility and abortion have been made with support of the Population Council.

AID assistance

AID is considering provision of assistance for: (1) establishing a National Population Center in one of the major universities to conduct training and research in population work and to develop similar programs in other institutions; and (2) training a cadre of demographers and medical personnel for teaching and research in this field.

Fiscal year 1965	$13,000
Fiscal year 1966	200,000

Other assistance

International and private institutions are providing assistance for demographic studies and training, biological research, family planning attitude research, maternal and child health care, and other public health phases related to population. These institutions include PAHO's Regional Training Center at Sao Paulo University, the International Planned Parenthood Federation, the Population Council, and CELADE (Latin-American Demographic Center, Santiago, Chile). The IPPF is helping in the organization of the Family Planning Association and CELADE in conduct of demographic studies.

The Ford Foundation maintains a demographic adviser in Rio de Janeiro. It also supports biomedical research at the University of Bahia. The Population Council has contributed over $50,000 to that University's Laboratory of Physiology of Reproduction. The Council is also providing support for a Brazilian Assembly on Population, to be held at the University of Bahia in 1967 or 1968.

The Pathfinder Fund assisted family planning work in 1963–65 and supplied contraceptive materials.

Assessment of current status

Brazil's official concern with the population problem is primarily with the development of knowledge about the problem in relation to development needs. Activities in family planning, as such, are non-official.

GUYANA

Background information:

Last national census	1960
Population estimate, 1965	600,000
Birth rate (live births per annum per 1,000 population)	42.6
Death rate (deaths per annum per 1,000 population)	7.9
Infant mortality rate (infant deaths per annum per 1,000 live births)	55
Annual rate of population increase, 1958–63 (percent)	2.8
Number of years to double population at present growth rate	25
Per capita gross national product, 1964 (dollar equivalents)	$291

Family and population planning activities

None reported.

AID assistance

None.

Other assistance

The Pathfinder Fund has supplied IUD's.

Assessment of current status

Population growth rate is very high in relation to resources.

BRITISH HONDURAS

Background information:

Last national census	1962
Population estimate, 1965	100,000
Birth rate (live births per annum per 1,000 population)	46.3
Death rate (deaths per annum per 1,000 population)	8.9
Infant mortality rate (infant deaths per annum per 1,000 live births)	69.5
Annual rate of population increase, 1958–63 (percent)	3.7
Number of years to double population at present growth rate	19
Per capita gross national product, 1964 (dollar equivalents)	$360

Family and population planning activities

No organized activities reported.

AID assistance

None.

Other assistance

None known.

Assessment of current status

Very high rate of population increase points to serious problems in next few years.

CHILE

Background information:

Last national census	1960
Population estimate, 1965 (millions)	8.7
Birth rate (live births per annum per 1,000 population)	33.7
Death rate (deaths per annum per 1,000 population)	12
Infant mortality rate (infant deaths per annum per 1,000 live births)	111
Annual rate of population increase, 1958–63 (percent)	2.3
Number of years to double population at present growth rate	31
Per capita gross national product, 1964 (dollar equivalents)	$474

Family and population planning activities

Chile has the most advanced family planning program in Latin America. Concern over the sharp rise in abortions since 1937 has been instrumental in establishment of the Government-supported program. There are family planning clinics in Government hospitals and health centers serving over 150,000 women each year. A Family Planning Committee was established in the Ministry of Public Health in 1965. Catholic medical schools are cooperating in research on the rhythm method. A National Family Planning Association was organized in 1962. Chile has agreed to be host to the International Planned Parenthood Federation's World Conference in 1967. The Latin American Demographic Center (CELADE) is located in Santiage, Chile, and is serving as a regional center in demographic training.

AID assistance

AID assistance to the Latin American Demographic Center, CELADE, sponsored by the U.N. at Santiago.

Other assistance

The IPPF assists the National Family Planning Association.

The Rockefeller Foundation has appropriated $150,000 to the University of Chile, Santiago, toward the costs of a study of the feasibility and effectiveness of

family planning measures in the post partum period. (Funds available through February 1969).

The Population Council supports human reproduction research in various universities, and institutions in Chile, and provides fellowships for study abroad.

The Ford Foundation supports CELADE and biomedical research at the University of Chile.

The Pathfinder Fund has helped a research project at the University of Chile, paid a nurse's salary in the family planning program, and furnished books and contraceptives.

Assessment of current status

Action is under way with indications of further expansion as resources become available.

COLOMBIA

Background information:

Last national census	1951
Population estimate, 1965 (millions)	16.4
Birth rate (live births per annum per 1,000 population)	42–46
Death rate (deaths per annum per 1,000 population)	14–17
Infant mortality rate (infant deaths per annum per 1,000 live births	100–110
Annual rate of population increase, 1958–63 (percent)	2.2
Number of years to double population at present growth rate	32
Per capita gross national product, 1964 (dollar equivalents)	$286

Family and population planning activities

Expansion of interest in population activities is noted in selected circles. The International Planned Parenthood Federation reports it has worked closely with a committee of the Medical Schools Association of Colombia and that the universities are increasingly broadening their programs of studies in demography and family planning. A Family Planning Association is in the organizational stage. The Association of Medical Faculties is a key organization in the population field.

AID assistance

USAID/Bogotá is considering use of counterpart funds, to assist the Colombian Association of Medical Faculties in the family planning program.

Other assistance

The International Planned Parenthood Federation assists the new Family Planning Association.

The Ford Foundation and the Population Council have worked actively with interested organizations and have provided diverse kinds of assistance—especially through the Association of Medical Colleges. The Population Council has also provided fellowships for training in Colombia and abroad.

Assessment of current status

Prospect of rapid expansion of family planning activities in Colombia.

COSTA RICA

Background information:

Last national census	1963
Population estimate, 1965 (millions)	1.4
Birth rate (live births per annum per 1,000 population)	47–50
Death rate (deaths per annum per 1,000 population)	5.8
Infant mortality rate (infant deaths per annum per 1,000 live births)	86.4
Annual rate of population increase, 1958–63 (percent)	4.5
Number of years to double population at present growth rate	16
Per capita gross national product, 1964 (dollar equivalents)	$360

Family and population planning activities

Interest in the family planning problem is being stimulated by the National Family Planning Association, assisted by IPPF. The Ministry of Health has expressed interest in a health-oriented program for the accumulation of demographic and clinical data relating to population. The Ministry is considering inclusion of family planning services in the work program of mobile health clinics in rural areas. Also, it is considering plans for studies on communication of information to low income groups, particularly in rural areas. A number of studies in the population field are already under way.

AID assistance

Cooperating with the Ministry of Health, AID is financing a study on the development of population activities. This study, carried out by the American International Association for Economic and Social Development, is to develop information on the degree of public recognition of the population problem among all segments of the society. The University of Costa Rica is collaborating in the design of the project and in analysis of data. It is also planned to provide one year of demographic training to each of two persons, as part of this project, and to assist in purchase and distribution of literature for training purposes.

Fiscal year 1965	$50,000
Fiscal year 1966	47,000
Fiscal year 1967 (planned)	110,000

Other assistance

The International Planned Parenthood Federation (IPPF) is contributing to support of the National Family Planning Association. CELADE (Latin American Demographic Center sponsored by the U.N.) is conducting demographic studies in Costa Rica and is considering establishment of a branch-center at the University of Costa Rica.

The Population Council has provided fellowships to Costa Ricans. The Pathfinder Fund has supplied some contraceptive materials.

Assessment of current status

Prospects for future action in family planning seem excellent, based upon the initial progress now being noted.

DOMINICAN REPUBLIC

Background information:

Last national census	1960
Population estimate, 1965 (millions)	3.6
Birth rate (live births per annum per 1,000 population)	48–54
Death rate (deaths per annum per 1,000 population)	15–20
Infant mortality rate (infant deaths per annum per 1,000 live births)	80–100
Annual rate of population increase, 1958–63 (percent)	3.6
Number of years to double population at present growth rate	20
Per capita gross national product, 1964 (dollar equivalents)	$246

Family and population planning activities

A non-official family planning services program is being conducted in the Dominican Republic under sponsorship of Church World Service. The Republic's Government has no official program in the population field. Under the unsettled conditions of recent years, it has not been able to give attention to this phase of its development program.

AID assistance

As political conditions stabilize in the Dominican Republic, a request for assistance on demographic problems is expected. In anticipation of this, the AID Mission has outlined a proposed program providing for a full-term consultant, participant training, and limited educational and training materials for the maternal and child care program. This assistance would aim at encouraging the Government and public and private organizations to cooperate in finding desired solutions to the population problem.

Proposed:

Fiscal year 1966	$14,000
Fiscal year 1967	40,000

Other assistance

The program sponsored by the Church World Service is being assisted by the Pathfinder Fund, through provision of IUD loops for use in the program. The fund is supplying the services of a gynecologist.

The Latin American Economic and Social Institute (DESAL) has a representative in the country to encourage interest in demography and studies in family change.

Assessment of current status

Activities now under way are small in relation to population problem.

ECUADOR

Background information:	
Last national census	1962
Population estimate, 1965 (millions)	5.1
Birth rate (live births per annum per 1,000 population)	45–50
Death rate (deaths per annum per 1,000 population)	15–20
Infant mortality rate (infant deaths per annum per 1,000 live births)	94–107
Annual rate of population increase, 1958–63 (percent)	3.1
Number of years to double population at present growth rate	23
Per capita gross national product, 1964 (dollar equivalents)	$215

Family and population planning activities

Interest and activity in family planning and population work in Ecuador include recent establishment of the Ecuadorian Family Welfare Association, to disseminate information on planned parenthood; organization of the Ecuadorian Institute of Planning for Social Development (INEDES) for analysis of the effects of population growth on social and economic development; and statistical studies by the Planning Board, Government of Ecuador, relating to population problems and development. These studies of the Planning Board, including a survey of public opinion on population matters, are to be completed in 1966.

AID assistance

Following analysis of data from the above studies, it is expected that the Government of Ecuador will request assistance by AID in population program area, including help for training of population statisticians and other demographic personnel. In anticipation of this request, AID plans to provide for the services of a population consultant during FY 1967. In FY 1967, preliminary provision is made for training of two persons in demographic statistics.

Fiscal year 1966	$25,000
Fiscal year 1967	5,000

Other assistance

The International Planned Parenthood Association has assisted in organization of the Family Welfare Association. The Center for Economic and Social Development (DESAL) also has supplied assistance for organization of the Ecuadorian Institute of Planning for Social Development (INEDES).

The Population Council has supported population studies at a university, including publication of a study on the population of Quito.

Contraceptives have been donated by the Pathfinder Fund.

Assessment of current status

Little family planning activity until now in Ecuador but recent developments are encouraging.

EL SALVADOR

Background information:	
Last national census	1961
Population estimate, 1965 (millions)	2.9
Birth rate (live births per annum per 1,000 population)	46.8
Death rate (deaths per annum per 1,000 population)	10.4
Infant mortality rate (infant deaths per annum per 1,000 live births)	65.5
Annual rate of population increase, 1958–63 (percent)	3.6
Number of years to double population at present growth rate	22
Per capita gross national product, 1964 (dollar equivalents)	$280

Family and population planning activities

The Family Planning Association, given legal status in 1963, is establishing clinics in two cities and is conducting studies in population growth and incidence of abortions.

The Salvadoran Demographic Association, in cooperating with the School of Medicine in San Salvador, is conducting two family planning clinics in San Salvador and in San Miguel.

The Government and the private sector are showing increasing interest in population studies, manpower development, and problems related to population growth. The National Planning Council is establishing an Office of Human Resources for demographic research and analysis and for planning to develop the country's human resources.

AID assistance

AID has provided limited financial and other assistance for selected activities, including a short-term participant training for three demographers at the Demographic Seminar at the University of Puerto Rico in May 1965.

Fiscal year 1966	$40,000
Fiscal year 1967	45,000

Other assistance

The International Planned Parenthood Federation has assisted private physicians in founding the Salvadoran Demographic Society which provides family planning information to individuals who request it.

The Population Council provided financial assistance for a 1964 study of economic and social conditions of families in the metropolitan area of San Salvador, including attitudes of women toward family planning. The Population Council has also provided fellowships and other support.

The Pathfinder Fund has made a grant to the Demographic Association to assist its work in a government clinic. It has also supplied contraceptives.

Assessment of current status

Increasing interest in family planning among some leadership groups.

GUATEMALA

Background information:

Last national census	1964
Population estimate, 1965 (millions)	4.4
Birth rate (live births per annum per 1,000 population)	47.7
Death rate (deaths per annum per 1,000 population)	17.2
Infant mortality rate (infant deaths per annum per 1,000 live births)	42.8
Annual rate of population increase, 1958–63 (percent)	3.2
Number of years to double population at present growth rate	22
Per capita gross national product, 1964 (dollar equivalents)	$310

Family and population planning activities

A National Family Planning Association, founded in 1962, is operating four family planning clinics, two in Guatemala City, one in Quezaltenango, and one in Eacuntda. One of those in Guatemala City is operating in conjunction with the Social Security Hospital. The Family Planning Association's family planning services are scheduled for sharp expansion in 1966–67.

AID assistance

No direct assistance for family planning in Guatemala.

Other assistance

The International Planned Parenthood Federation provides assistance to the National Family Planning Association.

The Population Council has provided assistance with demographic studies. Contraceptives have been donated by the Pathfinder Fund.

Assessment of current status

Interest in population problem is limited but growing.

HAITI

Background information:

Last national census	1950
Population estimate, 1965 (millions)	4.7
Birth rate (live births per annum per 1,000 population)	(1)
Death rate (deaths per annum per 1,000 population)	(1)
Infant mortality rate (infant deaths per annum per 1,000 live births)	(1)
Annual rate of population increase, 1958–63 (percent)	2.3
Number of years to double population at present growth rate	31
Per capita gross national product, 1964 (dollar equivalents)	$73

[1] Not available.

Family and population planning activities

No activities reported or known. Demographic data and vital statistics information are sketchy.

AID assistance

No direct assistance to Haiti in the population field.

Other assistance

The Population Council has provided fellowships for advanced study of family planning. The Pathfinder Fund has donated contraceptives.

Assessment of current status

Development of population policy and program would require acquisition of factual and statistical knowledge of the population problem as an initial step.

HONDURAS

Background information:

Last national census	1961
Population estimate, 1965 (millions)	2.2
Birth rate (live births per annum per 1,000 population)	45–50
Death rate (deaths per annum per 1,000 population)	15–20
Infant mortality rate (infant deaths per annum per 1,000 live births)	47–60
Annual rate of population increase, 1958–63 (percent)	3.2
Number of years to double population at present growth rate	22
Per capita gross national product, 1964 (dollar equivalents)	$215

Family and population planning activities

Honduras is conducting a nation-wide family planning program, with a full-time director of family planning under the Ministry of Health. The program was sparked by the Family Planning Association in 1961 and its first clinic was opened in 1963. The Ministry's facilities available now for family planning services include 67 Government health centers, three hospitals, and mobile health units which reach some 47 communities in rural areas.

AID assistance

In FY 1966, AID provided $29,000 to help support expansion of family planning services by supplementing the program's costs for personnel, travel, and training, and its costs for printing of educational and training materials. The FY 1967 program proposes additional support for program expansion, principally through supplements to salaries of added personnel, provision of additional mobile health units and equipment, and training abroad in family planning and demography for Honduran participants. In addition, the International Planned Parenthood Federation will conduct, under AID contract, a regional seminar on family planning education for personnel from Central American countries.

Fiscal year 1966	$29,000
Fiscal year 1967	100,000

Other assistance

The International Planned Parenthood Federation provided assistance for establishment of the Honduran Family Planning Association.

The Population Council has provided technical and material assistance for family planning programs.

The Pathfinder Fund has donated contraceptive materials.

Assessment of current status

The program is in the early development stage.

JAMAICA

Background information:

Last national census	1960
Population estimate, 1965 (millions)	1.8
Birth rate (live births per annum per 1,000 population)	39.9
Death rate (deaths per annum per 1,000 population)	7.8
Infant mortality rate (infant deaths per annum per 1,000 live births)	39.4
Annual rate of population increase, 1958–63 (percent)	1.8
Number of years to double population at present growth rate	39
Per capita gross national product, 1964 (dollar equivalents)	$443

Family planning and population activities

Under leadership of the Family Planning Association, Jamaica is conducting an active family planning program. The Ministry of Health has supported the

FPA program since 1964. Progress in family planning work has led to a reported steady decline in the birth rate over the last five years. The Government of Jamaica also is launching its own educational family planning program in addition to that conducted by the Family Planning Association. There are about 35 family planning centers in the country, plus two mobile units serving rural areas.

AID assistance

AID assistance for developing an educational program in family planning was extended in 1965 through a contract with the Jamaica Family Planning Association, approved by the Government of Jamaica. Two mobile audiovisual units financed by AID are utilized in the educational program. Also, a project agreement is being negotiated with the Government of Jamaica to help support expanded activities, family planning administration improvements, and a cancer detection campaign (Papanicolaou smear). Participant training in statistics, cytology, and family planning is provided.

Fiscal year 1966	$115,000
Fiscal year 1967 (planned)	151,000

Other assistance

The International Planned Parenthood Federation assists the Jamaica Family Planning Association which supports family planning clinics.

The Population Council has provided assistance to the Government of Jamaica for support of a study of post partum patients, has contributed to the JFPA for sponsorship of a population seminar, has provided over $53,000 to the University College of the West Indies for a census research program, and has helped in other ways to support population research.

The Ford Foundation has provided support for demographic research at the University of the West Indies.

Contraceptives have been given by the Pathfinder Fund to private groups.

Assessment of current status

The reported decline in the birth rate is a notable achievement. It is currently estimated that about 1,000 IUD's per month are being accepted by Jamaican women at public and private facilities.

MEXICO

Background information:

Last national census	1960
Population estimate, 1965 (millions)	40.9
Birth rate (live births per annum per 1,000 population)	45.4
Death rate (deaths per annum per 1,000 population)	10.3
Infant mortality rate (infant deaths per annum per 1,000 live births)	66.3
Annual rate of population increase, 1958–63 (percent)	3.2
Number of years to double population at present growth rate	22
Per capita gross national product, 1964 (dollar equivalents)	$427

Family planning and population activities

Mexico's very high birth rate and rapidly decreasing infant mortality rate is leading toward a serious population problem within the next few years. A Family Planning Association was established in Mexico City in 1958. Its clinics in the city and surrounding rural areas, and in Chihuahua, reported serving 27,000 patient-visitors in 1964. Recently, a new association has been formed to develop family planning services on a nationwide scale. Its first clinic was placed in a woman's hospital of the Ministry of Health in Mexico City.

AID assistance

None.

Other assistance

The International Planned Parenthood Federation has assisted the formation of the two associations named above.

The Population Council has contributed toward medical and demographic studies related to family planning.

The Ford Foundation has provided a grant for social research on family planning attitudes at IMES, grants for pilot family planning projects and reproduction research at teaching hospitals, and support for demographic research at the College of Mexico.

The Pathfinder Fund has made a grant to the IUD program and has supplied contraceptives.

Assessment of current status

Limited family planning activities.

NICARAGUA

Background information:

Last national census	1963
Population estimate, 1965 (millions)	1.6
Birth rate (live births per annum per 1,000 population)	43–52
Death rate (deaths per annum per 1,000 population)	12–17
Infant mortality rate (infant deaths per annum per 1,000 live births)	75–85
Annual rate of population increase, 1958–63 (percent)	2.9
Number of years to double population at present growth rate	24
Per capita gross national product, 1964 (dollar equivalents)	$325

Family planning and population activities

None reported.

AID assistance

None.

Other assistance

The Pathfinder Fund has supplied contraceptives.

Assessment of current status

Cultural and social factors have inhibited development of program interest.

PANAMA

Background information:

Last national census	1960
Population estimate, 1965 (millions)	1.2
Birth rate (live births per annum per 1,000 population)	40.4
Death rate (deaths per annum per 1,000 population)	9–12
Infant mortality rate (infant deaths per annum per 1,000 live births)	55–65
Annual rate of population increase, 1958–63 (percent)	3.2
Number of years to double population at present growth rate	22
Per capita gross national product, 1965 (dollar equivalents)	$488

Family planning and population activities

Interest in family planning is limited but increasing. The National Family Planning Association is the principal organization in this field. A few individuals in the medical profession are supplying forthright leadership.

AID assistance

AID has assisted the Family Planning Association by furnishing a small quantity of medical instruments and office equipment.

Other assistance

The International Planned Parenthood Federation assisted in establishment of the National Family Planning Association.

The Population Council has provided fellowships. The Pathfinder Fund has donated contraceptives.

Assessment of current status

Present family planning activity is on a very small scale.

PARAGUAY

Background information:

Last national census	1962
Population estimate, 1965 (millions)	2.0
Birth rate (live births per annum per 1,000 population)	45–50
Death rate (deaths per annum per 1,000 population)	12–16
Infant mortality rate (infant deaths per annum per 1,000 live births)	110–120
Annual rate of population increase, 1958–63 (percent)	2.4
Number of years to double population at present growth rate	29
Per capita gross national product, 1965 (dollar equivalents)	$200

Family planning and population assistance

No organized population programs or activities are reported. In 1965 four physicians from Paraguay were given training at the Chile Population Training Course in reproductive biology and human fertility control.

AID assistance

The above training course in Chile was conducted by CELADE, with AID assistance.

Other assistance

Contraceptives have been donated by the Pathfinder Fund.

Assessment of current status

Cultural and social factors have inhibited consideration of the population problem.

PERU

Background information:

Last national census	1961
Population estimate, 1965 (millions)	11.7
Birth rate (live births per annum per 1,000 population)	42–48
Death rate (deaths per annum per 1,000 population)	13–18
Infant mortality rate (infant deaths per annum per 1,000 live births)	95–105
Annual rate of population increase, 1958–63 (percent)	2.8
Number of years to double population at present growth rate	25
Per capita gross national product, 1964 (dollar equivalents)	$267

Family planning and population activities

Official concern with the population problem is active. A National Center for Population and Development was established by Presidential Decree in late 1964, under a board of directors representing key branches of the Government, political parties, and professional groups. The National Center for Population and Development is the focal point for population research, population training, and for the supply of population information needed in planning and implementing development programs. The Government of Peru is providing increasing financial support for the Center.

AID Assistance

Present and projected assistance, requested by the Government of Peru, is (1) to promote programs and studies showing the relationships between population growth and national development, as a policy aid; (2) to train personnel to perform population studies and implement programs; (3) to encourage experimental and demonstration programs in connection with maternal and child care; and (4) to help in the development of programs, at request of the Government, in family planning and responsible parenthood. AID assistance, in addition to providing for short-term demographic consultants, will include office equipment for statistical work, two mobile health units the first year, and an additional mobile unit in the second year for use in maternal and child care work. Other costs will include research grants to enable Peruvians to make demographic studies. (See Notre Dame assistance below.)

Fiscal year 1966	$96,000
Fiscal year 1967	108,000

Other assistance

A Family Planning Association is being organized with financial and other help from the International Planned Parenthood Federation. The Catholic University is conducting population studies with the AID-supported assistance of Notre Dame University.

The Population Council has contributed to diverse demographic and family planning research activities. Especially notable is its grant of $159,000 in 1966 for studies on population at high altitudes, made to the Institute of High Altitude Studies, Cayetano Heredia University, Lima, Peru.

The Ford Foundation provided the nuclear funding for establishment of the National Center for Population and Development.

The Catholic University is conducting population studies with AID-supported assistance of Notre Dame University.

The Pathfinder Fund has financed production of leaflets and donated contraceptives.

Assessment of current status

Population policies and action are in the initial stages of formation and testing.

SURINAM

Background information:

Last national census	1961
Population estimate, 1965	400,000
Birth rate (live births per annum per 1,000 population)	44.5
Death rate (deaths per annum per 1,000 population)	8.2
Infant mortality rate (infant deaths per annum per 1,000 live births)	44.0
Annual rate of population increase, 1958–63 (percent)	3.6
Number of years to double population at present growth rate	19
Per capita gross national product, 1964 (dollar equivalents)	$340

Family and population planning activities

No organized activities reported.

AID assistance

None.

Other assistance

Contraceptives have been donated by the Pathfinder Fund.

Assessment of current status

Rapid rate of population increase points to serious population problem within just a few years.

TRINIDAD AND TOBAGO

Background information:

Last national census	1960
Population estimate, 1965 (millions)	1
Birth rate(live births per annum per 1,000 population)	34.5
Death rate (deaths per annum per 1,000 population)	6.2
Infant mortality rate (infant deaths per annum per live births)	39.6
Annual rate of population increase, 1958–63 (percent)	3.2
Number of years to double population at present growth rate	22
Per capita gross national product, 1964 (dollar equivalents)	$614

Family and population planning activities

The Trinidad and Tobago Family Planning Association, founded in 1956 and a member of IPPF since 1961, still awaits recognition from the government.

All contraceptives are made available at clinics in Port-of-Spain and San Fernando.

AID assistance

No direct assistance for population work in Trinidad and Tobago.

Other assistance

The Population Council has supported demographic family planning and medical research and has provided fellowships. The Pathfinder Fund has given some contraceptives.

Assessment of current status

Little family planning activity.

URUGUAY

Background information:

Last national census	1963
Population estimate, 1965 (millions)	2.7
Birth rate (live births per annum per 1,000 population)	21–25
Death rate (deaths per anum per 1,000 population)	7.9
Infant mortality rate (infant deaths per annum per 1,000 live births)	75–85
Annual rate of population increase, 1958–63 (percent)	1.2
Number of years to double population at present growth rate	58
Per capital gross national product, 1964 (dollar equivalents)	$503

Family and population planning activities

The Uruguay Family Planning Association, begun in 1961, spearheads the limited family planning movement. It operates a family planning clinic at Montevideo's Pereira Rosell Hospital, where the IUCD is reported popular. A research program is also being conducted, and a variety of community programs of family planning and sex education. Owing to Uruguay's high and increasing rate of abortions, medical and public interest in family planning has grown in recent years. Social and cultural factors may inhibit program development.

AID assistance

None.

Other assistance

The International Planned Parenthood Federation assists the Uruguay Family Planning Association.

The Population Council has supported demographic and medical research.

The Pathfinder Fund has donated some contraceptives.

Assessment of current status

With moderate birth rate, relatively low death rate except for infant mortality, and an abortion rate three times higher than the birth rate, Uruguay's annual population increase is unusually small.

VENEZUELA

Background information:

Last national census	1961
Population estimate, 1965 (millions)	8.7
Birth rate (live births per annum per 1,000 population)	45–50
Death rate (deaths per annum per 1,000 population)	10–15
Infant mortality rate (infant deaths per annum per 1,000 live births)	60–75
Annual rate of population increase, 1958–63 (percent)	3.4
Number of years to double population at present growth rate	21
Per capita gross national product, 1965 (dollar equivalents)	$797

Family planning and population activities

The Ministry of Health has set up a Population Division. The principal maternity hospital in Caracas has conducted a family planning program since 1963, and has expanded the program considerably in the last year. Physicians from other parts of the country are receiving contraceptive training there.

AID assistance

A number of fellowships for participant training in population work have been provided by AID.

Other assistance

The Population Council has supported family planning clinics, demographic and medical studies. The Pathfinder Fund has helped support a family planning nurse and has donated contraceptives.

Assessment of current status

Interest is growing slowly in sensitive atmosphere.

AFRICAN REGION

The current rapid increase in the number of African countries with voluntary family planning associations and/or official family and population planning policies and activities is largely due to the work of private agencies—especially the International Planned Parenthood Federation, Population Council, Ford Foundation, and Pathfinder Fund.

Although AID has contributed to the developing interest in family and population planning activities in Africa, mainly by support of vital statistics and public health programs, this Agency is just beginning to provide direct support for family planning in Africa.

Estimated AID expenditures and planned expenditures for family and population planning activities, Africa Region:

Expended through—	Fiscal year 1965	Fiscal year 1966	Fiscal year 1967
Country missions			[1] $22,000
Regional institutions			
U.S. institutions			
Other			
Total			22,000

[1] For participant training, IPPF Conference, Copenhagen, July 1966.

ALGERIA

Background information:

Last national census	1960
Population estimate, 1965 (millions)	12.6
Birth rate (live births per annum per 1,000 population)	45–49
Death rate (deaths per annum per 1,000 population)	-----
Infant mortality rate (infant deaths per annum per 1,000 live births)	-----
Annual rate of population increase, 1958–63 (percent)	2.2
Number of years to double population at present growth rate	32
Per capita gross national product, 1964 (dollar equivalents)	$185

Family and population planning activities

No organized family planning activities in Algeria. Legal and some traditional opposition exists. Growing interest among health workers and doctors.

AID assistance

None.

Other assistance

The Ford Foundation has provided a vital statistics advisor and survey assistance. The Ministry of Finance and Plan has recently proposed that the Ford Foundation assist a study of family planning knowledge, attitudes, and practices. Plans have been formulated for this study to be made in 1967.

The Pathfinder Fund has helped supply contraceptives.

Assessment of current status

Little organized family planning activity until now, no prospect of immediate change.

ETHIOPIA

Background information:

Last national census	None
Population estimate, 1965 (millions)	22.6
Birth rate (live births per annum per 1,000 population)	-----
Death rate (deaths per annum per 1,000 population)	-----
Infant mortality rate (infant deaths per annum per 1,000 live births)	-----
Annual rate of population increase, 1958–63 (percent)	-----
Number of years to double population at present growth rate	-----
Per capita gross national product, 1964 (dollar equivalents)	$49

Family and population planning activities

A Family Guidance Association has recently been established under the aegis of the Haile Selassie I Foundation which is offering family counseling services and which operates one clinic in Addis Ababa. The IEG has no official programs in family planning. An AID-assisted project has developed reliable estimates of birth rates, fertility rates and infant mortality in seven communities outside of Addis Ababa.

AID assistance

Since the IEG is not prepared, at this time, to support family planning as an official activity, AID assistance has been limited to a Birth and Infant Death Registration project in several villages.

The AID Population Officer has given technical guidance to the Family Guidance Association.

Other assistance

Assistance is being sought from International Planned Parenthood Federation for a continuation and expansion of the program after the first year of operation.

The Pathfinder Fund has made available the services of a field worker in organizing a Family Planning Committee (now reorganized as an Association under the Haile Selassie I Foundation). A small grant was made to support the first year's activities of the single Family Guidance Clinic and necessary supplies are provided.

The Pathfinder Fund has made a grant to the Haile Selassie Foundation for work at a family planning clinic and for renovation of an X-ray room. It has also supplied contraceptives.

The Population Council has provided fellowships for study abroad.

Assessment of current status

Little family planning activity until now but prospect for improvement.

GHANA

Background information:

Last national census	1960
Population estimate, 1965 (millions)	7.9
Birth rate (live births per annum per 1,000 population)	48–56
Death rate (deaths per annum per 1,000 population)	-----
Infant mortality rate (infant deaths per annum per 1,000 live births)	-----
Annual rate of population increase, 1958–63 (percent)	3.5
Number of years to double population at present growth rate	20
Per capita gross national product, 1964 (dollar equivalents)	$226

Family and population planning activities

A Family Planning Association has been organized and there is some family planning activity in the Advisory Center of Ghana Christian Council of Churches.

AID assistance

AID supported the attendance of five Ghanian family planning leaders at the regional IPPF conference in Copenhagen, July 1966.

Other assistance

IPPF, Population Council, Ford Foundation and Pathfinder Fund. The Population Council has given financial help for teaching and research at the University of Ghana since 1961. It extended support to the University this year toward establishment of a demographic unit in the Department of Sociology.

Assessment of current status

Little family planning activity to date, but outlook favorable for gradual increase.

KENYA

Background information:

Last national census	1962
Population estimate, 1965 (millions)	9.4
Birth rate (live births per annum per 1,000 population)	48–55
Death rate (deaths per annum per 1,000 population)	-----
Infant mortality rate (infant deaths per annum per 1,000 live births)	-----
Annual rate of population increase, 1958–63 (percent)	3.9
Number of years to double population at present growth rate	24
Per capita gross national product, 1964 (dollar equivalents)	$89

Family and population planning activities

A Family Planning Association, organized in 1961, now has 12 branches and 42 clinics. The GOK places strong emphasis on family planning and a family planning educational program will be given high priority. In 1965 four experts from the United States went to Kenya under the auspices of the Population Council at the request of Kenya to advise it on steps to reduce population growth. A major IUD program is now going forward with special training courses for government and local midwives. Family planning is also a major part of countrywide community development efforts.

Some government health centers are being used for F.P.A. clinics and in Nairobi family planning has been incorporated into the city health services. Mobile clinics are planned for extending F.P. services to rural areas. Plans have been made to include sex education in the schools.

AID assistance

AID/Africa supported the attendance of family planning leaders at the regional IPPF conference in Copenhagen, July 1966.

Other assistance

IPPF, Population Council, Ford Foundation, and Pathfinder Fund. The Population Council has supported demography teaching and research at University College, Nairobi. It maintains a resident advisor to the Ministry of Health and Housing.

Assessment of current status

A national family planning program is being organized.

LIBERIA

Background information:	
Last national census	1962
Population estimate, 1965 (millions)	1.1
Birth rate (live births per annum per 1,000 population)	-----
Death rate (deaths per annum per 1,000 population)	-----
Infant mortality rate (infant deaths per annum per 1,000 live births)	-----
Annual rate of population increase, 1958–63 (percent)	1.4
Number of years to double population at present growth rate	50
Per capita gross national product, 1964 (dollar equivalents)	$170

Family and population planning activities

A Family Planning Association has been organized, based upon the Maternity Service, and with F.P. clinics in Monrovia.

AID assistance

AID/Africa supported the attendance of family planning leaders at the regional IPPF conference in Copenhagen, July 1966.

Other assistance

None known.

Assessment of current status

Family planning activity increasing slowly.

MAURITIUS

Background information:	
Last national census	1962
Population estimate, 1965 (millions)	0.7
Birth rate (live births per annum per 1,000 population)	38.1
Death rate (deaths per annum per 1,000 population)	8.6
Infant mortality rate (infant deaths per annum per 1,000 live births)	56.7
Annual rate of population increase, 1958–63 (percent)	3.1
Number of years to double population at present growth rate	23
Per capita gross national product, 1964 (dollar equivalents)	-----

Family and population planning activities

The Mauritius Family Welfare Association, founded in 1957, has led to a government approved comprehensive family planning program under the coordination of the Minister of Health.

The Mauritius Family Welfare Association now has more than 20 branches, and clinic services are being expanded.

AID assistance

None.

Other assistance

The International Planned Parenthood Federation has provided assistance. The Pathfinder Fund has donated contraceptives.

Assessment of current status

Organizational activities presage expansion of family planning.

MOROCCO

Background information:	
Last national census	1960
Population estimate, 1965 (millions)	13.3
Birth rate (live births per annum per 1,000 population)	43–50
Death rate (deaths per annum per 1,000 population)	-----
Infant mortality rate (infant deaths per annun per 1,000 live births)	-----
Annual rate of population increase, 1958–63 (percent)	2.9
Number of years to double population at present growth rate	24
Per capita gross national product, 1964 (dollar equivalents)	$172

Family and population planning activities

No family planning association has yet been formed. Thorough analysis of 1960 census data and the example of Tunisia focused attention upon population problem of Morocco.

During 1965 the Minister of Health, who is also Director of Family Planning obtained IUD's from the Population Council and Pathfinder Fund and initiated a family planning program.

In June 1966 the Ford Foundation awarded a grant of $322,000 for family planning to the Morocco Ministry of Health. This grant will be administered by the Population Council and the MOH.

AID assistance

USAID has arranged for translation of a family planning publication into French.

Other assistance

During 1965 the Population Council provided the Ministry of Public Health with loop supplies needed in the program. The Pathfinder Fund also has donated contraceptives.

Assessment of current status

Conditions favorable for rapid increase in family planning activities.

NIGERIA

Background information:	
Last national census	1963
Population estimate, 1965 (millions)	57.2
Birth rate (live births per annum per 1,000 population)	46–53
Death rate (deaths per annum per 1,000 population)	-----
Infant mortality rate (infant deaths per annum per 1,000 live births)	-----
Annual rate of population increase, 1958–63 (percent)	1.4
Number of years to double population at present growth rate	50
Per capita gross national product, 1964 (dollar equivalents)	$225

Family and population planning activities

Organized family planning work was begun in Nigeria in 1958 by the Lagos Marriage Guidance Council and the Marital Health Clinic as an extension of the Lagos City Council's Maternal and Child Health Services. The Family Planning Council of Nigeria was set up as a national organization in 1964 with the assistance of the IPPF, and under the auspices of the National Council of Women's Societies; its main goals are the expansion of clinic facilities and eventually public and government support for a family planning program within the official health services.

Four family planning clinics have been established in Lagos, including one near the Lagos University Medical School; and an IUD pilot project has been established in Ilesha, Western Nigeria. Clinics have also been started in Abadon, Caduna, Enugu, and in a few missions in eastern Nigeria.

The Federal Office of Statistics, with U.N. assistance, is preparing to conduct a demographic survey to ascertain the rate of population growth in Nigeria.

AID assistance

AID/Africa supported the attendance of family planning leaders at the regional IPPF Conference in Copenhagen, July 1966.

Other assistance

The United Nations is assisting in the demographic survey conducted by the Federal Office of Statistics.

The Population Council is providing fellowships and assistance with demographic studies.

The Ford Foundation is assisting maternal and child health and family planning activities by means of a grant to the University of Lagos.

The Pathfinder Fund has helped with expenses of the Family Planning Council and has given contraceptives.

Assessment of current status

Little family planning activity until now, prospect for gradual improvement.

RHODESIA

Background information:

Last national census	1962
Population estimate, 1965 (millions)	4.3
Birth rate (live births per annum per 1,000 population)	46–52
Death rate (deaths per annum per 1,000 population)	-----
Infant mortality rate (infant deaths per annum per 1,000 live births)	-----
Annual rate of population increase, 1958–63 (percent)	3.3
Number of years to double population at present growth rate	21
Per capita gross national product, 1964 (dollar equivalents)	$219

Family and population planning activities

A Family Planning Association has been formed with branches in several cities. It now receives some government support and in Bulawayo, where family planning has been incorporated into the Health Service, IUDs are being inserted.

AID assistance

AID/Africa supported the attendance of several family planning leaders at the regional IPPF conference in Copenhagen, July 1966.

Other assistance

The Pathfinder Fund has paid for a special nurse for the Family Planning Association at Salisbury and has furnished contraceptives.

Assessment of current status

Little family planning activity to date.

SIERRA LEONE

Background information:

Last national census	1963
Population estimate, 1965 (millions)	2.2
Birth rate (live births per anum per 1,000 population)	----
Death rate (deaths per annum per 1,000 population)	----
Infant mortality rate (infant deaths per annum per 1,000 live births)	----
Annual rate of population increase, 1958–63 (percent)	----
Number of years to double population at present growth rate	----
Per capita gross national product, 1964 (dollar equivalents)	$115

Family and population planning activities

A Family Planning Association has been organized and is extending its activities. A few family planning clinics are operating in Freetown.

AID assistance

Through the Bureau of the Census, AID has provided technical assistance to the Central Statistical Office in Sierra Leone since 1961.

AID/Africa supported the attendance of family planning leaders at the regional IPPF conference in Copenhagen, July 1966.

Other assistance

The Pathfinder Fund has supported nurses for the FPA clinic and supplied contraceptives.

Assessment of current status

Little family planning activity to date.

SOUTH AFRICA

Background information:

Last national census	1960
Population estimate, 1965 (millions)	17.9
Birth rate (live births per annum per 1,000 population)	----
Death rate (deaths per annum per 1,000 population)	----
Infant mortality rate (infant deaths per annum per 1,000 live births)	----
Annual rate of population increase, 1958–63 (percent)	2.4
Number of years to double population at present growth rate	29
Per capita gross national product, 1964 (dollar equivalents)	$499

Family and population planning activities

The National Council for Maternal and Family Welfare, with support from national and municipal governments, coordinates the activities of the five family planning associations—which operate about 120 clinics. Oral contraceptives are now widely used.

AID assistance

None.

Other assistance

The Population Council has provided fellowship assistance. Travel fund assistance has been supplied the FPA by the Pathfinder Fund. It has also given contraceptives.

Assessment of current status

Family planning activities progressing favorably.

TANZANIA

Background information:

Last national census	1958
Population estimate, 1965 (millions)	10.6
Birth rate (live births per anum per 1,000 population)	----
Death rate (deaths per annum per 1,000 population)	----
Infant mortality rate (infant deaths per annum per 1,000 live births)	----
Annual rate of population increase, 1958–63 (percent)	1.9
Number of years to double population at present growth rate	37
Per capita gross national product, 1964 (dollar equivalents)	$73

Family and population planning activities

A Family Planning Association has been organized in Dar-Es-Salaam, and several family planning clinics are operating inside and outside that city.

AID assistance

None.

Other assistance

The IPPF made a grant in 1966. The Pathfinder Fund started support in 1963 which continued until the IPPF grant was made. The Fund has supplied contraceptives.

Assessment of current status

Little family planning to date, but signs of awakening.

TUNISIA

Background information:

Last national census	1966
Population estimate, 1965 (millions)	4.7
Birth rate (live births per annum per 1,000 population)	44–47
Death rate (deaths per annum per 1,000 population)	-----
Infant mortality rate (infant deaths per annum per 1,000 live births)	-----
Annual rate of population increase, 1958–63 (percent)	2.2
Number of years to double population at present growth rate	33
Per capita gross national product, 1964 (dollar equivalents)	$175

Family and population planning activities

Legal restrictions against family planning were repealed in 1961, and the government launched a nation-wide family planning program. President Habib Bourguiba stated: "The people must become aware of the population problem . . . we must cut down the birth rate."

Discussions on family planning between the Government of Tunisia, the Ford Foundation and the Population Council commenced in 1962; a Preliminary Phase (participant training and surveys) of an Experimental Program was begun in 1963; and the Operational Phase (IUD clinics in hospitals and maternal and child health centers) commenced in June 1964. During the Experimental Phase of the program, completed by April 1966, a total of 27,817 women attended the family planning clinics and 18,522 received first insertions of Lippes Loops. An action program is being undertaken, the goal of which is to provide family planning assistance to between 30 and 40 percent of Tunisia's women of childbearing age over a 3-year period.

"All" gynecologists and surgeons in Tunisia have received training in intrauterine contraception. Fifty-nine hospitals and health centers are currently offering IUD services.

AID assistance

AID has provided some advisory guidance and communications media assistance.

Other assistance

The Ford Foundation and Population Council supported the experimental family planning program which began in May 1963, and are assisting in the development of the national program. The Ford Foundation is continuing its support of the program for another two-year period, with a second grant of $324,400. Advisory services are provided by the Ford Foundation through the Population Council. The Population Council has contributed over $700,000 to the Ministry of Health and Public Affairs since 1963 to assist in establishing a national family planning program. It has also given support for the Demographic Center of the University of Tunis.

Assessment of current status

With assistance from the Ford Foundation and Population Council, Tunisia has developed the most effective family planning program in Africa.

Late note.—President Bourguiba recently announced a pro-natalist policy, urging increased reproduction.

UGANDA

Background information:

Last national census	1959
Population estimate, 1965 (millions)	7.6
Birth rate (live births per annum per 1,000 population)	42–48
Death rate (deaths per annum per 1,000 population)	-----
Infant mortality rate (infant deaths per annum per 1,000 live births)	-----
Annual rate of population increase, 1958–63 (percent)	2.5
Number of years to double population at present growth rate	28
Per capita gross national product, 1964 (dollar equivalents)	$74

Family and population planning activities

The Family Planning Association is a member of the International Planned Parenthood Federation. A new office and clinic has opened in Kampala. The use of intrauterine devices is being developed.

There is no government support for the program but some municipal health centers incorporate family planning, and the Family Planning Association is affiliated with the official National Council of Social Services.

The Family Planning Association plans to extend activities from Kampala clinics to rural areas. Medical students at Makere University receive instruction in family planning.

AID assistance

None.

Other assistance

The Kampala Family Planning Association was founded by the Pathfinder Fund in 1956.

The Population Council has provided fellowships in demography and technical assistance.

Assessment of current status

Little family planning activity until now; prospect of gradual improvement.

ZAMBIA

Background information:

Last national census	1963
Population estimate, 1965 (millions)	3.7
Birth rate (live births per annum per 1,000 population)	49–54
Death rate (deaths per annum per 1,000 population)	-----
Infant mortality rate (infant deaths per annum per 1,000 live births)	-----
Annual rate of population increase, 1958–63 (percent)	2.8
Number of years to double population at present growth rate	25
Per capita gross national product, 1964 (dollar equivalents)	$159

Family and population planning activities

A local family planning association has functioned at Lusaka, without government support.

AID assistance

None.

Other assistance

The Population Council has provided fellowship assistance.

Assessment of current status

Little organized family planning activity until now.

Listed below are African countries not known to have substantial family and population planning organizations and activities:

Angola
Basutoland
Bechuanaland
Burundi
Cameroon
Central African Republic
Chad
Congo
Dahomey
Gabon
Gambia
Guinea
Ivory Coast
Libya
Madagascar
Mali
Malawi
Mauritania
Mozambique
Niger
Rwanda
Senegal
Seychelles
Somalia
Sudan
Togo
Upper Volta
Zanzibar

NEAR EAST SOUTH ASIA

In this geographic region, where population pressure is most intense and the balance between population and food resources most precarious, the governments of Ceylon, India, Iran, Nepal, Pakistan, Turkey, and the U.A.R. have formulated national family planning programs. But implementation of these programs is impeded by illiteracy, poverty, lack of contraceptive materials, and primitive transportation and communication facilities.

A maximal cooperative effort by many nations will be required to implement the massive family planning programs now planned with sufficient speed to remove the shadow of impending mass starvation from the South Asian Continent.

The ability of AID to effectively engage its resources for family and population planning activities in the NESA Region has been improved recently by increments in personnel: a full-time population officer in the Regional Bureau and a team of six population experts in USAID/New Delhi.

Estimated AID expenditures and planned expenditures for family and population planning activities, Near East South Asia:

Expended through—	Fiscal year 1965	Fiscal year 1966	Fiscal year 1967
Country missions	$10,000	$510,000	$4,287,000
Regional institutions			
U.S. institutions			
Other			
Total	10,000	510,000	4,287,000

CEYLON

Background information:

Last national census	1963
Population estimate, 1965 (millions)	11.2
Birth rate (live births per annum per 1,000 population)	35.8
Death rate (deaths per annum per 1,000 population)	8.5
Infant mortality rate (infant deaths per annum per 1,000 live births)	53–64
Annual rate of population increase, 1958–63 (percent)	2.5
Number of years to double population at present growth rate	27
Per capita gross national product, 1964 (dollar equivalents)	$144

Family and population planning activities

The first birth control clinic in Ceylon was opened in 1937, and the national Family Planning Association was founded in 1953.

The Government of Ceylon has subsidized the work of the Family Planning Association since 1954, and Sweden has given increasing assistance since 1958, especially for a pilot project.

This pilot project, in 3 rural areas, has been directed by a joint committee of the Director of Public Health Services, a representative of the Family Planning Association, and the Swedish director of the project.

Organized family planning activities on Tea Estates, begun in 1954, has been extended to more than 500 estates; and the birth rate on subscribing estates has fallen from 38.1 in 1954 to 29.8 in 1963.

Both oral contraceptives and IUD's are now widely used, in addition to other methods, and in 1965 the Ceylon Government launched an extensive family planning program in close collaboration with the Family Planning Association.

AID assistance

None.

Other assistance

The International Planned Parenthood Federation has provided support.

The Swedish Government has provided substantial assistance, especially for a pilot study.

The Population Council has provided assistance for studies of fertility trends and public attitudes toward family planning. It has also contributed to the Faculty of Medicine, University of Ceylon, for family planning studies. It is currently supporting one demographic fellow.

The Pathfinder Fund has assisted the IUD project and donated contraceptives.

Assessment of current status

The combination of pilot experience, and cooperative programming by the Government of Ceylon and the Family Planning Association presage rapid expansion of family planning activities in Ceylon.

INDIA

Background information:

Last national census	1960
Population estimate, 1965 (millions)	482.5
Birth rate (live births per annum per 1,000 population)	40–43
Death rate (deaths per annum per 1,000 population)	21–23
Infant mortality rate (infant deaths per annum per 1,000 live births)	139–146
Annual rate of population increase, 1958–63 (percent)	2.3
Number of years to double population at present growth rate	31
Per capita gross national product, 1964 (dollar equivalents)	$81

Family and population planning activities

The Indian Government established the organizational framework for a family planning program by the creation of a Department of Family Planning under the Ministry of Health and Family Planning. Implementation of services is being accomplished through over 8,000 rural and urban family welfare planning centers, medical institutions, and over 5,000 voluntary contraceptive depot holders. Contraceptive methods offered include IUD's (about 1 million inserted), sterilization (almost 1.5 million performed) and condoms. Condoms are manufactured by one factory in Madras and IUD's by a factory at Kanpur. Education of the public for family planning is through exhibits, posters, leaflets, films, and display advertisements. Training of instructors and key personnel is at three centers, and of line medical and paramedical personnel at 19 centers. Research in demography communications, and physiology of reproduction is being conducted in 24 centers. Evaluation of the program is administered through six regional offices. The estimated GOI expenditure for family planning in 1965–66 is Rs. 109,663,000 (equivalent to $15.7 million).

AID assistance

A survey team headed by Dr. Malcolm Merrill, TCR/HS was sponsored in January 1965. Dr. Leona Baumgartner, formerly AA/TCR, was a member of a U.N. survey team which visited India between February and April 1965. In addition, training in vital statistics for three Indian officials was arranged in 1966. AID has supplied 32 vehicles for program use.

At present, USAID/New Delhi has a six-member team of technical consultants to help evaluate and implement the family planning program.

Other assistance

The Ford Foundation has contributed over 9 million dollars to family planning development in India, including $2,500,000 for research in reproductive biology. It maintains a team of consultants in India for this program.

The Population Council provided key equipment and guidance for setting up the IUD factory in India and contributed over $200,000 to the program in the form of loops and inserters. The Council has provided support since 1957 for the U.N. Demographic Teaching and Research Center at Bombay. Also it has given much other aid for research and has provided numerous fellowships. The U.N. and the World Bank have made surveys at the request of the Indian Government. The Peace Corps will provide 60 volunteers to assist in training, informational, and organizational aspects of the program.

The Pathfinder Fund has assisted the program with services, grants, and contraceptives.

Assessment of current status

The massive nature of the family planning organization in India is unmatched anywhere. Optimistic, targets have been set and considerable efforts are being made but current accomplishment is lagging far behind planned targets. With the establishment of an AID team in India, USAID should be in a more favorable position to assist the Indian family planning program.

IRAN

Background information:

Last national census	1956
Population estimate, 1965 (millions)	23.4
Birth rate (live births per annum per 1,000 population)	42–48
Death rate (deaths per annum per 1,000 population)	23–27
Infant mortality rate (infant deaths per annum per 1,000 live births)	
Annual rate of population increase, 1958–63 (per cent)	2.4
Number of years to double population at present growth rate	29
Per capita gross national product, 1964 (dollar equivalents)	$220

Family and population planning activities

A Family Planning Committee recently organized, gives contraceptive help in government maternal and child health centers. In 1965, the Minister of Health announced inclusion of family planning as an official part of the government's maternal and child health services.

The Iranian Society of Obstetrics and Gynecology sponsored the first Regional Conference on Family Planning in the Middle East, held in Shiraz on April 16–18, 1966. Approximately 100 Iranian physicians and specialists, and 150 participants from India, Pakistan, Turkey, Israel, USSR, the Arab countries, Europe and the United States attended.

AID assistance

From FY 1956 through FY 1962, AID, through the Bureau of Census, provided advisory services to the Government of Iran in planning, carrying out and evaluating the results of the first national census of population.

In the fall of 1965, AID provided the services of short-term consultants to help Iran prepare for the forthcoming 1966 census of population. Five full-time advisors and short-term advisors as required will help in the further planning and carrying out of the census.

Other assistance

The International Planned Parenthood Federation has provided assistance to the Family Planning Committee.

The Population Council and Pathfinder Fund have sent representatives to Iran from time to time to discuss the establishment of family planning clinics.

At request of the Government of Iran, the Population Council in 1966 submitted to it a proposed scheme for a national family planning program. The Council recently assisted the Institute for Social Studies and Research in preparing and publishing a demographic dictionary in Persia. Also it has given assistance for family planning studies, provided the services of a consultant, and aided the faculties of medicine at two universities.

The Pathfinder Fund has helped supply contraceptives.

Assessment of current status

Prospect for increasing family planning activity as a component of maternal and child health care. Little desire to limit total population increase.

ISRAEL

Background information:

Last national census	1961
Population estimate, 1965 (millions)	2.6
Birth rate (live births per annum per 1,000 population)	25.7
Death rate (deaths per annum per 1,000 population)	6.3
Infant mortality rate (infant deaths per annum per 1,000 live births)	28.2
Annual rate of population increase, 1958–63 (per cent)	3.5
Number of years to double population at present growth rate	20
Per capita gross national product, 1964 (dollar equivalents)	$1,111

Family and population planning activities

A Family Planning Association was only recently founded (1966), but the birth rate and other considerations indicate that largely effective family planning has been achieved by individual initiative, in advance of organized programs.

AID assistance

None.

Other assistance

The IPPF is assisting the Family Planning Association.

The Population Council is providing assistance for medical research, demographic analysis, and fellowships training. The Weisman Institute has received close to $3 million from the Council for studies in the biology of reproduction.

The Pathfinder Fund has helped supply contraceptives.

Assessment of current assets

Effective family planning by private initiative; formal government programs beginning.

JORDAN

Background information:

Last national census	1961
Population estimate, 1965 (millions)	2.0
Birth rate (live births per annum per 1000 population)	44–47
Death rate (deaths per annum per 1000 population)	-----
Infant mortality rate (infant deaths per annum per 1000 live births)	-----
Annual rate of population increase, 1958–63 (per cent)	2.9
Number of years to double population at present growth rate	24
Per capita gross national product, 1964 (dollar equivalents)	$199

Family and population planning activities

The Jordan Family Planning Association was established in 1963, with the assistance of the IPPF. The Government of Jordan now supports the Jordan Family Planning Association and family planning clinics are operating in several principal cities.

AID assistance

None.

Other assistance

The Pathfinder Fund has helped with contraceptive supplies.

Assessment of current status

Signs of awakening interest.

NEPAL

Background information:

Last national census	1961
Population estimate, 1966 (millions)	11.0
Birth rate (live births per annum per 1,000 population)	45–53
Death rate (deaths per annum per 1,000 population)	-----
Infant mortality rate (infant deaths per annum per 1,000 live births)	260
Annual rate of population increase, 1965 (percent)	2.5
Number of years to double population at present growth rate	44
Per capita gross national product, 1964 (dollar equivalents)	$70

Family and population planning activities

In the organizational framework, family planning is included in the Maternal and Child Health Section within the Directorate of Health Services, Implementation of services will be through existing maternal and child health centers with plans for 8 urban centers and possible rural mobile units. Contraceptive methods which are being considered are IUD's, condoms and sterilization. A massive campaign for education of the public regarding IUD's is planned for the near future. Training for assistant midwives and public health nurses is currently being conducted. Expenditures for fiscal year 1967 of up to 5 lakh rupees are being considered by the Government of Nepal.

AID assistance

AID sponsored a study tour of the Korean Family Planning program by 10 key Nepalese public health and economic planning personnel in April, 1966. In addition, AID has provided consultation to the Government of Nepal in the formulation of a family planning program.

Currently, AID plans to assign a junior officer trainee to help coordinate family planning activities. Recently, U.S. AID has received a Government of Nepal request for U.S. support in training, technical assistance, consultative services, transportation, equipment and supplies.

Other assistance

The International Planned Parenthood Federation provides assistance to the Family Planning Association of Nepal. The Population Council has given advisory assistance and is considering supplying material support (IUD's, inserters).

The Pathfinder Fund has given contraceptive supplies.

Assessment of current status

The Government of Nepal now has official interest in, as well as the beginning organization structure for, a family planning program. A recent request for U.S. AID assistance for 1967 will probably lead to a definite action program shortly.

PAKISTAN

Background information:

Last national census	1961
Population estimate, 1965 (millions)	115
Birth rate (live births per annum per 1,000 population)	48–53
Death rate (deaths per annum per 1,000 population)	20
Infant mortality rate (infant deaths per annum per 1,000 live births)	-----
Annual rate of population increase, 1958–63 (percent)	2.8
Number of years to double population at present growth rate	25
Per capita gross national product, 1964 (dollar equivalents)	$87

Family and population planning activities

In Pakistan, the family planning organizational framework is headed by the Health Minister and reaches down through village dais, family planning organizers and agents in contraception. Implementation of services has begun in 33 of 52 districts, and is being accomplished through existing medical facilities. Contraceptive methods include foaming tablets, Dura Foam, condoms, IUD's (over 200,000 inserted to date), and sterilization. IUD's are manufactured in Pakistan, but not condoms which are currently obtained from Sweden. Education of the public is primarily aimed at "face to face" personal persuasion, but group discussions, mass meetings, local entertainers and audio-visual units are utilized also. Long and short term training of personnel has been established and it is reported that almost 70% of medical and 90% of non-medical personnel have been placed. Research and evaluation are coordinated through the government's National Research Institute for Family Planning in Karachi, with a separate evaluation and research unit in East and West Pakistan. Expenditures for the period 1965–70 are expected to be Rs 286 million.

AID assistance

Commodity loan financing of vehicles and mass media equipment valued at $500,000 was provided by AID in FY 1966. Participant training for one nurse midwife, 2 women physicians, one statistician and one communications official is being arranged in 1966. A project proposal for the organization of a 5-man advisory team and participant training for 90 allied professional personnel is being considered.

Other assistance

Ford Foundation has contributed $2,750,000 for research and training, mostly through grants to the Population Council, Johns Hopkins University, and the University of California. The Swedish Government has supported pilot family planning clinics, established 2 centers for design and production of communications media materials, set up scholarships and supplied condoms. UNICEF has provided 108 vehicles. The Population Council has supplied two research advisors, as well as financial and advisory assistance to the Population Growth Estimate Study. Great Britain, Johns Hopkins University and the University of California have contributed to conferences which helped formulate the Family Planning Scheme for Pakistan.

The Population Council has given over $300,000 to the Pakistan Institute of Development Economics in support of population conferences, research, and the services of a demographic adviser. It has also assisted the Ministry of Health, Labor, and Welfare in pilot projects and has aided development of the National Research Institute of Family Planning. The Council has given support to the Population Growth Estimate Study and to the Pakistan Academy for Rural Development, supported research at universities, and provided fellowships.

Pathfinder Fund has contributed some contraceptive supplies.

Assessment of current status

While ambitious targets have not been completely achieved, the family planning program has made a good start. Supplies of contraceptives are expected to become adequate but personnel shortages will persist. A good indicator of the program's acceptability has been the demand for subsidized contraceptives from districts where there are no official family planning activities.

TURKEY

Background information:

Last national census	1965
Population estimate, 1965 (millions)	31.4
Birth rate (live births per annum per 1,000 population)	43–48
Death rate (deaths per annum per 1,000 population)	
Infant mortality rate (infant deaths per annum per 1000 live births)	160–170
Annual rate of population increase, 1958–63 (per cent)	2.9
Number of years to double population at present growth rate	24
Per capita gross national product, 1964 (dollar equivalents)	$233

Family and population planning activities

Turkey enacted strict anti-birth control legislation during the 1920's, to offset manpower losses from war and disease, and the continued high birth rate (@ 48 per thousand) coupled with a precipitous decline in the death rate after World War II, resulted in rapid population increase, increased poverty, and abortions.

Beginning in 1962 the GOT directed activities toward rescinding the anti-birth control law, which was repealed in 1964. Since then the GOT, with IPPF and the Population Council support, has initiated an extensive national family planning program.

The organizational framework is based upon a General Directorate of Population Planning within the Ministry of Health and Social Assistance, established in 1965. Implementation of services will be through the existing facilities (including 543 National Health Units) and Personnel of the Ministry of Health. Both oral contraceptive pills and IUD's have been officially approved as contraceptive methods. Manufacture of IUD's is being planned with the Population Council. Education of the public has included radio publicity, indoctrination of military personnel and emphasis on human reproduction courses in middle and high school. A central family planning organization is responsible for training of personnel, who in this case are members of the existing Public Health Service. Research and evaluation are also directed by this central organization. In 1966 expenditures of 6,699,373 TL have been authorized by the Turkish Government for the Family Planning Directorate.

AID assistance

A survey team was sponsored in July 1965. Statisticians were provided for the 1965 Turkish Census and 1966 Demographic Survey. Participant training for four nurse midwives and one statistician was arranged in 1966. An agreement authorizing the use of USAID trust funds for the purchase of 50 vehicles was signed in 1966. A $3.6 million loan agreement for vehicle and parts, and support of audio-visual education has been fully negotiated. Consultations with the Turkish Ministry of Health regarding the possible use of local currency for physician incentive payments are currently under way.

Other assistance

The International Planned Parenthood Federation and the Pathfinder Fund have provided assistance.

The Population Council has assisted the Turkish Government in preparing the family planning program. In addition, this agency has imported IUD's and molds for their production. Technical and commodity assistance is also being requested from the Swedish Government.

The Pathfinder Fund has helped with some contraceptive supplies.

Assessment of current states

Recent elections in Turkey resulted in some personnel changes among the family planning administrative staff. The organizational structure of the program appears sound, but training of personnel is not complete.

UNITED ARAB REPUBLIC

Background information:

Last national census	1960
Population estimate, 1965 (millions)	29.6
Birth rate (live births per anum per 1,000 population)	41–44
Death rate (deaths per anum per 1,000 population)	17–19
Infant mortality rate (infant deaths per annum per 1,000 live births)	139
Annual rate of population increase, 1958–63 (percent)	2.5
Number of years to double population at present growth rate	28
Per capita gross national product, 1964 (dollar equivalents)	

Family and population planning activities

In 1965 the National Assembly, after several days of debate, decided that: contraceptives should be manufactured within the country and made available free of charge; a campaign should be started to inform the public of the need for birth control; and the public should be informed that Islam presents no moral or theological barriers to family planning.

A strong organizational framework has been created, with authority beginning in a supraministerial "Supreme Council for Family Planning," directly under the Prime Minister. Implementation of services is through existing government health centers and health units (in rural areas, these now number about 2,000). Pills are the major contraceptive method but IUD's are also offered. Oral contraceptives have been imported but IUD's are manufactured locally. Training of medical and paramedical personnel is conducted through the medical schools. Research in demography, family planning and reproductive physiology is also centered in the medical schools. A central evaluation agency is proposed, but pilot projects are currently monitored by their sponsors.

AID assistance

A consultant team was sponsored by AID in January 1966. Negotiations are in progress to determine the nature and extent of further U.S. AID support.

Other assistance

The International Planned Parenthood Federation has supported the Egyptian Association for Population Studies.

The Ford Foundation has supplied consultants, training abroad, equipment and supplies, as well as supported research and medical education. The Population Council has helped support the North African Demographic Centre in Cairo since 1963, in addition to assisting various demographic and medical studies. With the Ford Foundation, it has recently provided vehicles for use in the U.A.R.'s family planning program and has supplied materials for manufacture of loops (IUD's).

The Pathfinder Fund has helped with expenses of the Joint Committee for Family Planning, a grant to the Coptic Hospital, and with contraceptive supplies.

Assessment of current status

The Egyptian family planning activities are characterized by good organizational structure and enthusiasm among personnel. The program is not yet in high gear and is still relying too much on the oral contraceptive method. In addition, some administrative problems with assisting agencies have apparently caused delays.

Listed below are Near East South Asian countries not known to have substantial family and population planning organizations and activities:

Afghanistan
Bhutan
Cyprus
Iraq
Kuwait
Lebanon
Saudi Arabia
Syria
Yemen

FAR EAST

Japan has provided an outstanding example of how a country can combine birth control with rapid economic development.

An effective birth control program, based mainly upon ready access to abortion, was implemented in Japan before effective oral contraception and improved IUCD's were generally available.

Now South Korea, Taiwan, Hong Kong, Singapore, and other Far Eastern nations are attempting to emulate Japan's remarkable population control—economic improvement feat by widespread application of the improved contraceptive methods.

Estimated AID expenditures and planned expenditures for family and population planning activities, Far East Region:

Expended through—	Fiscal year 1965	Fiscal year 1966	Fiscal year 1967
Country missions	+$300,000	+$320,000	+$300,000
Regional institutions			100,000
U.S. institutions			
Other		40,000	65,000
Total	+300,000	+360,000	+465,000

FAR EAST REGION

The United Nations reports that:

"The activities for Asia and the Far East have been expanded along the lines recommended by the Economic Commission for Asia and the Far East (ECAFE), by increasing the number of United Nations regional demographic experts in the fields of demographic training, research, population policies and information services, including clearing-house activities. These activities have been gathering momentum as the number of requests from Governments in the region increases. In March of this year, ECAFE convened a Working Group on Administrative Aspects of Family Planning Programmes, with financial assistance from the Population Council of New York. The meeting was organized to serve the needs of the ECAFE countries which are engaged in the administration of family planning programmes. As set forth in the Working Group's report, the meeting heard statements from various experts regarding problems at the national level. The group discussed how to set targets in family planning programmes and how to cope with administrative difficulties in implementing the programmes in terms of budget, timetables and programming arrangements. Finally, extensive discussions were held on problems related to evaluation of family planning programmes in relation to action and its effectiveness. The services to be rendered by ECAFE with respect to dissemination and exchange of knowledge and experience in this field were stressed as a means of regional cooperation among Governments."

Programs are already underway in Korea, Taiwan, and Hong Kong. During the past year significant development has been carried out in Thailand with the assistance mainly from the Population Council. In Korea, Thailand, Taiwan, and the Philippines, almost all U.S. assistance has been from the Population Council, the International Planned Parenthood Federation and other U.S. and international organizations and foundations (e.g., the Ford Foundation). In selected areas, American missionary groups have provided assistance. The United Nations Economic Commission for Asia and the Far East (ECAFE) has called for technical assistance through the U.N. and other sources to countries in the region requesting it.

Population has been one of the main themes of regional and international meetings, of organizations such as ECAFE, the Colombo Plan, and most recently the Pacific Science Congress of the Pacific Science Association. Asians attending these conferences have expressed great concern about the problems of overpopulation and family planning. The Governments of Indonesia and South Vietnam have recently indicated interest in receiving advisory services. Vietnam has requested assistance to develop a pilot family planning project in Saigon. Responding to both requests, AID has helped arrange for the Population Council to provide assistance directly to the two governments or to family planning organizations.

During the past year the Far East Health Branch has been represented at various planning meetings sponsored by the Population Division of the United Nations.

AID has been requested to assist in development of a proposed regional population institute to be located at Bangkok under the aegis of ECAFE. Programs of the ECAFE Population Institute will encompass the entire range of disciplines

within the broad subject of Population and Family Planning. They will improve the curricula of the region's medical schools in reproductive physiology, provide midwifery training for personnel of the region, sponsor pilot projects in population research, and provide demographic training.

AID is considering expansion of its support of programs in population and family planning through a proposed institutional contract. Under contract, the institution would sponsor research studies, pilot projects, consultation on problems of research design, data collection and analysis, regional conferences and seminars and workshops, and would provide fellowships and travel grants within the region, especially in Korea, Vietnam, Thailand, the Philippines, and Indonesia.

INDONESIA

Background information:

Last national census	1961
Population estimate, 1965 (millions)	104.6
Birth rate (live births per annum per 1,000 population)	43–48
Death rate (deaths per annum per 1,000 population)	19–23
Infant mortality rate (infant deaths per annum per 1,000 live births)	120–155
Annual rate of population increase, 1958–63 (percent)	2.3
Number of years to double population at present growth rate	31
Per capita gross national product, 1964	$80

Family and population planning activities

Family planning is available at some government health clinics and other welfare centers, and voluntary family planning groups work sporadically within a national effort.

During 1966 the GOI requested consultation through the AID Representative and from the Population Council.

AID assistance

Information available on request.

Other assistance

The Population Council has supplied loops and inserting devices for the Family Planning Clinics Project in Djakarta and is helping support reproduction studies at the University of Indonesia.

The Pathfinder Fund has helped with contraceptive supplies.

Assessment of current status

Signs of increasing official and non-official interest in family planning.

HONG KONG

Background information:

Last national census	1961
Population estimate, 1965 (millions)	3.8
Birth rate (live births per annum per 1,000 population)	27
Death rate (deaths per annum per 1,000 population)	4.9
Infant mortality rate (infant deaths per annum per 1,000 live births)	26.4
Annual rate of population increase, 1958–63 (percent)	4.7
Number of years to double population at present growth rate	15
Per capita gross national product, 1964	$392

Family and population planning activities

Following a visit by Margaret Sanger, this Crown Colony in 1936 began family planning clinics in government-supported hospitals.

Cooperation between the Hong Kong Family Planning Association and the government has continued: recently, the government has contributed approximately 55 percent of the budget of the private family planning organization.

In addition to the clinics, the association conducts a home-visiting program to provide information and contraceptives to those who are unable to get to a clinic. Free contraceptives are provided to those unable to pay for them.

Attendance at the present 53 clinics is rising. IUDs are manufactured locally, and the birth rate has declined from 37.1 per thousand in 1960 to 27 in 1965.

AID assistance

None.

Other assistance

The Hong Kong Family Planning Association was one of the original IPPF members when the Federation was founded in 1952, and continues to receive IPPF support.

The Population Council has supplied technical and other assistance.

The Pathfinder Fund has helped supply funds for family planning and has donated some contraceptive supplies.

Assessment of current status

Birth rate falling but immigration maintaining very high population growth rate.

MALAYSIA

Background information:	
Last national census	1959–60
Population estimate, 1965 (millions)	9.4
Birth rate (live births per annum per 1,000 population)	39–44
Death rate (deaths per annum per 1,000 population)	8.9
Infant mortality rate (infant deaths per annum per 1,000 live births)	56–65
Annual rate of population increase, 1958–63 (percent)	3.2
Number of years to double population at present growth rate	22
Per capita gross national product, 1964 (dollar equivalents)	$290

Family and population planning activities

"The Federation of Family Planning Associations, Federation of Malaya was formed in 1958 as the central coordinating body for the then existing State Planning Associations, and as a national organization through which liaison could be established with the Government and the IPPF."

The Federation of Family Planning Associations was stimulated to greater activity in 1961 by the IPPF and Pathfinder Fund representatives, and became a member of IPPF.

Since the Federation of Malaysia came into being in 1963, a National Family Planning Board has been established with representation from the government, family planning associations, trade unions, chambers of commerce and religious and medical organizations.

The Government aims to integrate family planning into its Rural Health Development program.

The voluntary family planning association will continue to operate clinics and play an important role in the total family planning program.

AID assistance

None.

Other assistance

The IPPF and Pathfinder Fund have provided assistance as indicated above.

The Population Council has provided technical assistance, fellowship training, and material aid.

The Ford Foundation is providing assistance for the National Family Planning Program through the University of Michigan.

Assessment of current status

Well advanced family planning program.

PHILIPPINES

Background information:	
Last national census	1960
Population estimate, 1965 (millions)	32.3
Birth rate (live births per annum per 1,000 population)	44 to 50
Death rate (deaths per annum per 1,000 population)	----------
Infant mortality rate (infant deaths per annum per 1,000 live births)	----------
Annual rate of population increase, 1958–63 (percent)	3.2
Number of years to double population at present growth rate	22
Per capita gross national product, 1964	$136

Family and population planning activities

The Philippines now has a nation-wide family planning program under non-governmental direction but with significant governmental, medical and Roman Catholic backing. The Family Planning Association, created in 1965, now operates 4 family planning clinics in Manila, 2 in Quezon City, and one each in Pasay City, Caloocan City, and Dumaquete City. Three of the Manila City health centers offer family planning services and the Manila Health Department and the Family Planning Association have a training project open to the staff of the 40 city health centers.

AID assistance

AID has provided no material assistance but the Chief of the Health Division of USAID/Manila has played an active catalytic role.

Other assistance

The Population Council helped the Manila Department of Health finance training and materials for an experimental project in family planning; helped Silliman University to undertake studies of family planning knowledge, attitudes, and practices and develop a research-action program in one Province. The Council is maintaining a consultant at this University. In addition, its aid to the University of the Philippines has totaled $111,600 since 1961.

The International Planned Parenthood Federation is providing considerable assistance.

The Pathfinder Fund has helped finance family planning work and given contraceptive supplies.

The Ford Foundation is supporting the Institute of Population Studies at the University of the Philippines.

Assessment of current status

Changing religious and political climate with increasing family planning activity.

SINGAPORE

Background information:	
Last national census	1957
Population estimate, 1965 (millions)	1.9
Birth rate (live births per annum per 1,000 population)	33.2
Death rate (deaths per annum per 1,000 population)	5.8
Infant mortality rate (infant deaths per annum per 1,000 live births)	29.3
Annual rate of population increase, 1958–63 (percent)	3.2
Number of years to double population at present growth rate	22
Per capita gross national product, 1964	$453

Family and population planning activities

The Singapore Family Planning Association was founded in 1949, and in 1955 received its first government support, a grant for $85,000. In January 1966, as part of a 5-year plan to bring family planning services to all of its 300,000 married women between the ages of 15 and 44 years the government began to take over 26 clinics previously operated by the Family Planning Association in government centers. Birth rates have decreased from 40.3 per thousand in 1959 to 32 in 1965.

AID assistance

None.

Other assistance

The International Planned Parenthood Federation provides support for family planning clinics and for the maintenance of the East Asian Training Institute.

The Ford Foundation has provided support to the Singapore Family Planning Association and the Economic Research Center at the University of Singapore.

The Population Council in 1965 helped support a family planning study by the University of Singapore. The Council has provided IUD loops and inserting devices to the Ministry of Health.

The Pathfinder Fund has helped supply contraceptives.

Assessment of current status

Considerable current family planning activity and favorable trend.

SOUTH KOREA

Background information:

Last national census	1960
Population estimate, 1965 (millions)	28.4
Birth rate (live births per annum per 1,000 population)	40 to 45
Death rate (deaths per annum per 1,000 population)	12 to 16
Infant mortality rate (infant deaths per annum per 1,000 live births)	
Annual rate of population increase, 1958–63 (percent)	2.8
Number of years to double population at present growth rate	25
Per capita gross national product, 1964 (dollar equivalents)	$118

Family and population planning activities

Korea's national family planning program was initiated by a voluntary association which received a first grant of $6,000 from the IPPF in 1961.

Since 1963 the Korean Government has included a family planning program in its budget—also supported by the IPPF, Ford Foundation, and the Population Council.

The Ministry of Health and Social Affairs operates about 190 health centers throughout the country and employs over 2,000 workers in the family planning field.

Through 1965, 345,000 women had received IUD's; during May 1966, 45,000 IUD insertions were performed—making it likely that the goal of 400,000 IUD insertions during 1966 will be attained.

AID assistance

The Korean Government has made several specific requests for assistance from the United States. To date, AID assistance consists of—

(1) AID-generated local currencies which support a substantial portion of the Korean Government budget which includes family planning as a line item. In FY 1966 the Korean Government has allotted 423.1 million WON (about U.S.—$1.6 million) for the program.

(2) Ten vehicles from U.S. excess property to be used as mobile clinics (these do not require AID dollar funding).

(3) Financing for a trip by Korean officials to observe family planning activities in Hong Kong, Taiwan, and Japan (funds were provided from the Far East Regional program funds).

Other assistance

IPPF, Ford Foundation, Pathfinder Fund, and the Population Council. The Population Council has provided massive help. It has supplied a consultant and resident adviser to the Bureau of Statistics, Economic Planning Board; assisted Seoul University in developing a demographic program and a center for population training and research. Since 1962 the Council has contributed over $800,000 to the Planned Parenthood Federation of Korea for studies and program support. It has provided many travel grants and fellowships.

Assessment of current status

Considerable current family planning activity and trend of events favorable.

TAIWAN

Background information:

Last national census	1956
Population estimate, 1965 (millions)	12.4
Birth rate (live births per annum per 1,000 population)	32.7
Death rate (deaths per annum per 1,000 population)	5.5
Infant mortality rate (infant deaths per annum per 1,000 live births	
Annual rate of population increase, 1958–63 (percent)	2.7
Number of years to double population at present growth rate	24
Per capita gross national product, 1964 (dollar equivalents)	

Family and population planning activities

A Family Planning Association was established on Taiwan a decade ago, but it is only during the last 5 years that much progress has been achieved.

The Executive Yuan has recently approved a long-range plan for manpower development that officially advocates a family planning program to reduce population growth to 2 percent per year. The Taiwan program has resulted from initial pilot projects partially financed by the Population Council. The current program is financed by the Council and the Joint Commission for Rural Reconstruction (JCRR), a semi-autonomous agency in Taiwan. An island-wide program has been in effect since 1965, and the birth rate has declined to 32.7 in 1965.

The Taiwan Population Studies Center, established in 1961 to study population problems, now assumes primary responsibility for the evaluation of the family planning program.

Lippes Loops are being manufactured in Taiwan.

In 1965, when the target was 100,000 loop insertions, 99,253 insertions were performed.

For 1966 the target is 120,000 loop insertions, and recently about 10,000 insertions have been performed each month.

AID assistance

AID's economic assistance to Taiwan was terminated in 1965, and no AID dollar funds or technicians have been provided for the population program. However, the family planning program has been and will be financed in part by AID-generated local currency which has now been placed in a Special Fund in control of Chinese officials. For the years 1965–1970, the equivalent of U.S. $1.5 million has been reserved from this Fund for health and family planning clinics.

Other assistance

The Population Council and the Ford Foundation, especially through the University of Michigan, have contributed substantially to family planning activities on Taiwan. In addition to supporting reproduction studies, the Population Council has contributed about $600,000 to the Joint Commission on Rural Rehabilitation for help in family research, training, and evaluation. It has recently supported a medical follow-up study on use of the IUD loop.

The Pathfinder Fund has helped with travel costs of the FPA.

Assessment of current status

Expanding family planning activities are now having a discernible effect upon the birth rate.

THAILAND

Background information:

Last national census	1960
Population estimate, 1965 (millions)	30.6
Birth rate (live births per annum per 1,000 population)	42–48
Death rate (deaths per annum per 1,000 population)	19–21
Infant mortality rate (infant deaths per annum per 1,000 live births)	-----
Annual rate of population increases, 1958–63 (percent)	3
Number of years to double population at present growth rate	24
Per capita gross national product, 1964	$126

Family and population planning activities

The Family Planning Association in Thailand, organized in 1958, is receiving growing suport from the government.

Following a population seminar in Bangkok in March 1963, the National Research Council submitted a proposal to the Prime Minister to establish a National Population Program. In 1964 the Prime Minister set up a National Family Health Research Committee, which launched a family planning demonstration project in a rural district of 70,000 people.

Family planning clinics are now widely distributed and many thousands of women are using the pill or IUDs.

AID assistance

AID provided the services of a demographic advisor for a year, 1965–66; and USAID personnel have contributed to the recent surge of official and nonofficial interest in family planning.

Other assistance

The International Planned Parenthood Federation provides support through the Family Planning Association. The Pathfinder Fund has helped.

The Population Council has helped support a family planning project since 1964, under auspices of the National Research Council. In 1966 it gave $50,000 to support a Demographic Research and Training Center at Chulalongkorn University. It recently contributed $65,000 to the Ministry of Public Health for the family planning program.

Assessment of current status

Increasing official and non-official family planning activity.

Listed below are Far Eastern countries not known to have substantial family and population planning organizations and activities:

Burma	Laos
Cambodia	Viet Nam

Senator GRUENING. I now direct that a speech given by Mr. Mann at the Planned Parenthood annual banquet in November 1964, as well as excerpts from four of his other speeches be included in the record of this hearing.

(The speech and excerpts mentioned above follow:)

EXHIBIT 146

POPULATION GROWTH AND THE ALLIANCE FOR PROGRESS

(Address by the Honorable Thomas C. Mann, then Assistant Secretary of State for Inter-American Affairs, and U.S. Coordinator, Alliance for Progress, before persons attending the Planned Parenthood World Population banquet, in New York City, November 9, 1964)

In August of 1961 the nations represented at Punta del Este, Uruguay, united in the most noble of all alliances dedicated to one overriding purpose: the improvement of the condition of human life.

In the few short years following the formation of this Alliance For Progress, the accomplishments of our hemisphere have been notable. Possibly one of our most significant achievements has been in increased comprehension throughout the hemisphere of our complex problems in all of their aspects and a better mobilization of our efforts and talents in the search for their solutions.

There is a growing realization that one of the important factors affecting our efforts to improve the conditions of human life throughout the world—to increase each individual's income—is the rapid expansion of population. Reliable demographers now estimate that in this year the population of the world will increase by some 63 million persons—each born with the same right to food, shelter, education, employment and with the same special and economic needs that so many in the world today do not adequately possess.

Nearly every part of the world is affected. Here in the United States, for example, our population growth rate is said to be at 1.6 percent this year. Because our population has been increasing for sometime, more than a million additional people will be looking for jobs this year in our country alone.

In Latin America the demographers say that the annual population increase is somewhere near 3 percent per annum. It is predicted that, if this average is maintained, the population of the area, which now stands at about 200 million, will reach about 600 million in 35 years. To use a different span of time, the population of Latin America will have increased in this century from some 69 millions to some 600 millions.

This arithmetic has a direct and important bearing on the ability of the American states to achieve the Alliance For Progress goal that the increase in the income of every man, woman and child in the hemisphere "should be not less than 2.5 percent per capita per year."

With high rates of population growth, it is obvious that the only way the Alliance goal can be achieved is with commensurate high rates of economic growth. This means that production must grow at a rate of 5½ percent to 6 percent a year in Latin America. Unless it does, we cannot achieve social justice.

But the problem is even more complex than that. Latin America is a developing area. The composition of the population is quite different from that in the United States. For example, about one-fourth of the population is less than ten years old. A large portion of the population therefore contributes little to production; rather it is essentially a consumer. This means that the working force has a heavier burden to bear. Because a higher percentage of production must be consumed on the necessities of life, there is less available to invest in farms and factories that are needed to increase production. This is truly one of the dilemmas of the Alliance: how can we best achieve adequate levels of production so essential to social justice and political stability and at the same time meet the desire of the people that production be distributed immediately so that it can be consumed.

Allow me to illustrate the dimensions of the job ahead of us in this hemisphere:

In 1960 a United Nations study estimated that the existing housing deficit in Latin America was about 40 million units. If the population trebles in the next 35 years, this figure will obviously also grow geometrically.

Another illustration: we are having difficulties today overcoming a very high illiteracy rate. In the next decades we face an even more difficult task in building the classrooms and training the teachers who will be needed to care for an additional 400 million people.

Again: if some cities in Latin America are currently growing in population at the rate of 14 percent per annum obviously we shall have even a larger task of providing the transportation, streets, electricity, sewage, market facilities and all the other things that the urban dweller needs.

Another factor is the relationship between population growth and the availability of natural resources. It is a fact that water supplies are becoming scarce in some areas not only for irrigation in the production of food and fiber but also for human consumption. The lack of arable land is today a problem with some countries having over 300 people per square mile.

Of more immediate concern is the urgent need to increase the production of food. I recently saw figures which indicate that the annual production of grain in Central and South America has remained virtually the same over the past six years. The failure to increase food production in the face of rapid population growth has required several countries to import such basic items as corn and rice, spending scarce foreign exchange earnings which are badly needed to finance industrialization programs and infrastructure. Despite costly imports, insufficient production has resulted in a decline in individual consumption of grain in recent years.

In speaking of the dimensions of the problem I do not wish to predict, like Malthus, that man is outgrowing his environment. Whether or not mankind will find it possible eventually to accommodate to soaring populations I do not pretend to know. I only make this suggestion: in the decades immediately ahead of us, the rate of population growth will have a direct effect on the aspirations of peoples in this hemisphere for a rapid improvement in their standards of living. To the extent that these aspirations are frustrated, additional strains and stresses are placed on the political, economic and social fabrics of the hemisphere.

Public statements by public officials of the relevance of the population increase to the political, social and economic problems of our day have, in the past, been avoided.

The reasons for reticence were understandable: Neither yesterday nor today do people wish to offend others by statements which might be misinterpreted as contrary to their ethical, moral or religious convictions.

Today nearly everyone agrees that the study of the population problem is desirable. And, in consequence, progress is now being made in broadening our understanding of the problem in all of its aspects. As Pope Paul VI recently said:

"The question is being subjected to study, as wide and profound as possible, as grave and honest as it must be on a subject of such importance. It is under study which, we may say, we hope will be concluded with the cooperation of many and outstanding experts."

Discussions on the topic have been held by the National Council of Churches of Christ and by the Rabbinical Assembly. Universities, professional associations and foundations have held symposiums and devoted funds and personnel to the questions of population.

67-785 O—66—pt. 4——19

The effect of this public discussion has been salutary in focusing the attention of governments and the public on the implications of population growth. About one year ago the Foreign Assistance Act under which we administer our part of the Alliance was amended to provide that: "Funds made available to carry out this section (development research) may be used to conduct research into the problems of population growth."

Under the terms of this legislation, the Latin American bureaus of the Department of State and Agency for International Development are giving the question of population growth careful and serious consideration. All U.S. Missions in the hemisphere have been advised of the importance attached to the population issue and we are consulting with foreign governments and with responsible private, church and educational institutions.

We have provided funds for the Latin American Science Board of the National Academy of Sciences which has organized a committee on population composed of eminent sociologists, economists, social psychologists, demographers, political scientists and physicians. This committee serves to assist our staff in its work through consultation and advice.

In addition, we are considering requests from several Latin American organizations interested in the problem of financing demographic training and research in such crucial matters as attitudes about family size and family responsibility. We will be working with several organizations and universities here in the United States which will be helping us to study and define the problem more clearly.

But I should add that the more we have reflected upon the issue of population growth, and its effect on the economic and social development goals of the Alliance For Progress, the more we are impressed with its complexity. The issue is not simply one of money. It is, at least in Latin America, rather a problem of innumerable facets: the extent to which national planning agencies are equipped and prepared to study the demography of their own countries; the extent to which ministries of education can program long-term investments in the light of population growth projections; the extent to which ministries of health are attentive to the matter; the attitudes and aspirations of the campesinos, the slum dwellers, the middle class; the extent to which the religious, civic and community groups of the nation are involved—and, beyond all else, the desires and the hopes and the decisions of individuals and families in whose hands rest the final responsibility.

In short, though our role can be a significant one, the decisions must be made by each country. We can work with—and we are prepared to work with—institutions and groups both in the United States and in Latin America. We can offer a helping hand in training and research in demography and the exchange of information to government institutions, church interests and private organizations. But as we do this, we are fully aware that much will depend on the private initiative of the organizations in this hemisphere, including those which are represented here tonight.

I venture to express the hope that out of all the research, the training of demographers, the exchange of information and the careful examination of the ethical, moral and religious aspects of the population growth, will come a clearer understanding of its relationship to social, economic and political progress in this hemisphere. And I venture the additional hope that from such a deeper understanding will evolve a consensus of the peoples of the continent about how it can be reconciled with our ideals of dignity and a fuller life for every person.

(Excerpt from the speech by the Hon. Thomas C. Mann, Assistant Secretary of State for Inter-American Affairs before the Senate Foreign Relations Committee on "Increasing the Resources of the Fund for Special Operations of the Inter-American Development Bank," February 8, 1965)

. . . In many countries economic growth is barely keeping pace with population growth.

(Also before the House Banking and Currency Committee, February 4, 1965.)

(Excerpt from the speech of the Honorable Thomas C. Mann, Assistant Secretary of State for Inter-American Affairs, before the Washington Institute of Foreign Affairs, Washington, D.C., May 13, 1964)

The population of Latin America will, say the demographers, double in about 20 years. This is a fact of outstanding importance.

It means that jobs and food production must be increased at an extraordinary rate or unemployment and hunger will increase. It means that educational and health and all the other facilities required by civilized man today in our age of rising expectations must be built at the same rapid rate. It means that governments must also promptly provide additional infrastructure required by their growing agriculture and industry. Never in our history have political and economic systems been required to meet so many needs in such a short period of time.

If nations are to meet this challenge, their economies must obviously have very large amounts of capital for development.

* * * * * * *

If this hemisphere is to achieve and maintain the high and sustained rate of economic growth so urgently needed to meet rising expectations and to keep pace with the population increase, the role and responsibilities of domestic private capital in the development process needs to be better understood.

(Excerpt from the speech of the Hon. Thomas C. Mann, Assistant Secretary of State for Inter-American Affairs, before the Houston Council on World Affairs, Houston, Tex., September 23, 1964)

* * * * * * *

Twenty-one free and sovereign nations exist in Middle and South America with a population and a land mass greater than our own.

* * * * * * *

Not only do these contrasts exist in an age of rising expectations, but the Americas face a population explosion unprecedented in history. There are now 200 million Latin Americans. If present trends continue, this number will double in the next two decades.

A high and sustained rate of economic growth in all of Middle and South America is not therefore merely a desirable goal. It is an imperative. Each country must, for example, rapidly expand production of food that its people consume or there will be hunger. Each nation must rapidly increase the number of job opportunities or there will be rising unemployment.

(Excerpt from the speech of the Honorable Thomas C. Mann, Assistant Secretary of State for Inter-American Affairs, before the International Council of B'nai B'rith, Washington, D.C., November 4, 1964)

* * * * * * *

. . . Only an adequate rate of economic growth can provide the number of new jobs and the additional food required by growing populations.

Senator GRUENING. I will at this time place in the hearing record other pertinent information about the population crisis. This includes a letter sent to the subcommittee on June 18, 1965, by Ambassador Douglas MacArthur II with certain attachments; an address by the Honorable James Roosevelt, Deputy United States Representative on the Economic and Social Council, United States Mission to the United Nations; and an excerpt from the book "A Thousand Days" by Arthur M. Schlesinger, Jr.

EXHIBIT 147

(Letter to the Chairman from the Assistant Secretary of State for Congressional Relations discussing organizational procedures instituted by the Department of State to assure coordination and dissemination upon request of information on birth control—received June 18, 1965.)

DEPARTMENT OF STATE,
Washington, D.C.

Hon. ERNEST GRUENING,
Chairman, Subcommittee on Foreign Aid Expenditures,
U.S. Senate.

DEAR MR. CHAIRMAN: This is to acknowledge your letter of June 4 requesting information on organizational procedures instituted by the Department of State to assure coordination and dissemination upon request of information on birth control. I understand that you have addressed a similar letter to the Administrator of the Agency for International Development, which has primary responsibility for foreign assistance activities in the population field. On March 6, 1965, the Department of State specifically instructed United States Ambassadors to extend full cooperation to AID Mission Directors in carrying out AID population program activities, which include responding to requests for information in the field of family planning.

For several years now the Department has had, working under the supervision of Assistant Secretary Cleveland, an Officer in Charge of Population Affairs in the Office of International Economic and Social Affairs, with responsibility for initiating policy recommendations relating to the foreign policy implications of world population trends, maintaining close liaison with AID and with the regional and functional bureaus of the Department and with the domestic departments and agencies concerned with population matters, and making appropriate recommendations for coordinated Department policies in the population field.

A number of other officers are also concerned with population problems. The Department has a research demographer in the Office of Research in Economics and Science. The joint State/AID Bureau of Inter-American Affairs/Latin American Affairs has a full time consultant and another part time consultant on population problems assigned to the Office of Institutional Development, and substantial attention is devoted to population matters in the Department's other regional bureaus which deal with less developed countries. The Scientific Attachés located in American embassies abroad are prepared, under the direction of the Director of International Scientific and Technological Affairs, to facilitate the exchange of scientific information relating to population problems and means for dealing with them.

United States Delegations to the United Nations and to the World Health Organization have made increasingly successful efforts to encourage these organizations to extend more effective assistance, on request, to member countries seeking help in connection with their family planning programs.

This background information is in the nature of a preliminary response to your inquiry. We are assembling more detailed data on job descriptions of relevant officers which we hope to be able to submit to you in the near future. If in the meanwhile I can be of any further assistance, please do not hesitate to call on me.

Sincerely yours,

DOUGLAS MACARTHUR II,
Assistant Secretary for Congressional Relations
(For the Secretary of State).

DEPARTMENT OF STATE INTERNATIONAL SCIENTIFIC AND TECHNOLOGICAL AFFAIRS

U.S. scientific attachés in U.S. missions abroad and their regional responsibilities

Embassy	Scientific attaché and deputy	Regional responsibilities
Europe:		
Bern	Dr. Henri Bader	International scientific activities at Geneva.
Bonn	Dr. William W. Williams, (vacant).	Netherlands and Austria.
London	Dr. William W. Greulich, Dr. Warren B. Cheston.	Ireland.
Moscow	Glenn E. Schweitzer, (science reporting officer).	
Paris	Dr. Edgar L. Piret, Dr. Alan G. Mencher.	Belgium, Spain, and Portugal.
Rome	Dr. Walter Ramberg, Michael G. Kelakos.	Greece.
Stockholm	Dr. Sverre Petterssen, John A. Collins.	Finland, Norway, Denmark, and Iceland.
U.S. Regional Office, NATO-OECD, Paris.	Dr. M. Carl Walske, Jr.	European science activities related to NATO and OECD science programs.
Latin America:		
Buenos Aires	Dr. Frederick W. Brown	Paraguay, Uruguay, and Chile.
Rio de Janeiro	Dr. Andre C. Simonpietri	Columbia, Venezuela, Bolivia, Peru, and Ecuador.
Far East:		
Canberra	Dr. Paul A. Siple	New Zealand.
Tokyo	Dr. Carl Tolman, Dr. Joseph P. Leahy.	Korea, Philippines, Hong Kong, and Taiwan.
Near East and south Asia:		
Cairo	Dr. John C. Clark	Lebanon, Syrian Arab Republic, and Iraq.
Karachi	John M. Tinker	Iran and Turkey.
New Delhi	Dr. Donald L. Fuller	Ceylon.
Tel Aviv	Dr. Robert T. Webber	

FUNCTIONS OF SCIENTIFIC ATTACHÉS

Scientific Attachés are usually appointed to selected Embassies abroad to provide the Ambassador with substantive support on matters concerned with science and technology. The interaction of such factors underlie many of the important political developments which face or concern the United States in our international relationships. These Embassies are located in countries where science and technology represent an important segment of society; where such matters play an important role in the political, economic and social life of the country; and where such activities influence the formulation of national policies. In addition, the countries to which the Attachés are assigned often are involved in developments concerning science and technology which are of high interest and concern to the U.S. scientific and technological community and which should be incorporated into the decision-making process at the Embassy and within the Department of State.

Scientific Attachés are also assigned to areas of the world where the degree of technical sophistication may be less, but the Attaché nevertheless has a role of play in the development of, or in the carrying-out, of U.S. foreign policies. The high esteem and prestige of American science and technology in the world, plus the ability of science and technology to communicate internationally and broaden areas of understanding, make the Scientific Attaché's function valuable to the total mission in such areas.

Within this general outline the Scientific Attaché is assigned the following duties and responsibilities:

1. Participates in the development of policy by bringing to bear on the problems confronting the Mission to which he is assigned the perspective and insights of a scientist through evaluation and guidance on the scientific and technical aspects of such problems.

2. Recommends areas of activity in the scientific and technical fields which will assist the Embassy in its conduct of U.S. relations in that country. Such recommendations include analysis of the technical implications involved; possible actions for broadening the area of associations of the Embassy which can con-

tribute to international understanding; interpretation and evaluation of the interaction of science and technology with local political, economic, military and commercial developments in that country; and providing assistance in the correct and adequate presentation of U.S. scientific and technological developments and interests. Help to identify areas of bilateral cooperation in the fields of science and technology which can contribute to closer association and collaboration.

3. Coordinates the activities of the technical representatives of other U.S. agencies at the Embassies on U.S. scientific and technological programs and activities in that country in order to provide them with adequate foreign policy guidance and to ensure their full participation in the objectives of the U.S. Mission. The Attaché and the other agency representatives work as a science team so as to make a maximum contribution to the mission of the post and to the objectives of U.S. science.

4. Serves as point of liaison with, and provides foreign policy advice and guidance to U.S. scientific missions in the country of assignment and visiting U.S. scientists. Arranges appropriate briefings and visits with Embassy personnel.

5. Studies in depth and prepares analytical and evaluative reports on significant scientific and technological developments, and on the organization or administration of science. Provides reports required by standard reporting requirements, ad hoc requests from the Department of State or those prompted by his own awareness for matters which should be the concern of the Department and the scientific agencies of the Government.

6. Represents the Ambassador to the foreign scientific community as a means for broadening the area of association for the Embassy, for explaining U.S. policies, for encouraging broader areas of cooperation and exchange in scientific and technological information and activities and to explore ways of developing meaningful dialogue which can contribute to understanding between that country and the United States. This involves visits to universities, scientific institutes and laboratories, and with individual scientists and technologists in the discussion of mutual problems and concerns.

7. Represents the Ambassador, the Department, and other agencies at scientific and technological meetings, conferences, ceremonies and similar activities. Arranges the Ambassador's participation where appropriate and assists in the preparation of statements to be given before such scientific groups.

8. Analyzes and reports on scientific and technological developments in nearby countries, when so assigned. Maintains liaison and working relationships with Foreign Service Officers at such posts who are assigned continuing responsibility for scientific and technological matters. Provides them with technical advice and guidance as necessary.

In this relationship with the science liaison officers, the Attaché with his scientific background and prestige provides an entree to governmental and scientific leaders for the liaison officer; serves as an intermediary and assists in establishing key contacts. This arrangement allows the liaison officer to serve as a point of contact for the scientists; to cultivate these associations and to be in a position to provide assistance and continuity.

(Letter received July 14, 1965)

DEPARTMENT OF STATE,
Washington, D.C.

Hon. ERNEST GRUENING,
Chairman, Subcommittee on Foreign Aid Expenditures,
U.S. Senate.

DEAR MR. CHAIRMAN: In reference to your letter of June 4, 1965 and our reply of June 17, 1965, I am enclosing titles and job descriptions of the individuals charged with the responsibility of supervising the carrying out of procedures concerning population control.

If I can be of any further assistance, please do not hesitate to let me know.

Sincerely,

DOUGLAS MACARTHUR II,
Assistant Secretary for Congressional Relations
(For the Secretary of State).

Optional Form 8
Feb. 1958
U. S. CIVIL SERVICE COMMISSION
Chapter P2, Federal Personnel Manual
5008-108

POSITION DESCRIPTION

1. Check one: Dept'l ☒ Field ☐
2. Official headquarters: Washington, D.C.
3. Reason for submission: (a) If this position replaces another (i. e., a change of duties in an existing position), identify such position by title, allocation (service, series, grade), and position number
4. Agency position No. S-29035
5. C. S. C. certification No. 135.20
6. Date of certification 7/8/65
7. Date received from C. S. C.

8. CLASSIFICATION ACTION — (b) Other (specify) Partially in lieu of GS-130-14-S-22738

ALLOCATION BY	CLASS TITLE OF POSITION	CLASS: Service	Series	Grade	INITIALS	DATE
a. Civil Service Commission						
b. Department, agency, or establishment						
c. Bureau	Foreign Affairs Officer	GS	130	14		
d. Field office						
e. Recommended by initiating office						

9. Organizational title of position (if any): Officer-in-Charge, FAO and Population Affairs
10. Name of employee (If vacancy, specify V-1, 2, 3, or 4): Leighton van Nort
11. Department, agency, or establishment: Department of State
a. First subdivision: Bureau of International Organization Affairs
b. Second subdivision: Office of International Economic and Social Affairs
c. Third subdivision: FAO and Population Affairs
d. Fourth subdivision:
e. Fifth subdivision:

12. This is a complete and accurate description of the duties and responsibilities of my position
(Signature of employee) (Date)

13. This is a complete and accurate description of the duties and responsibilities of this position
(Signature of immediate supervisor) (Date)
Title:

14. Certification by head of bureau, division, field office, or designated representative
(Signature) (Date)
Title: Acting Executive Director - IO

15. Certification by department, agency, or establishment
(Signature) (Date)
Title: Administrative Officer - IO

16. Description of duties and responsibilities

This position is in the Office of International Economic and Social Affairs of the Bureau of International Organization Affairs of the Department of State. The Office of International Economic and Social Affairs (OES) exercises responsibility for the Department in formulation and coordination of U.S. policies in those intergovernmental agencies of the UN system concerned with economic and social subjects. It also exercises Departmental responsibility for social, health, human rights, freedom of information, population matters, and for Antarctic affairs.

The incumbent serves as Officer in Charge of Population and Food and Agriculture Organization Affairs and is responsible under the guidance of the Director of the Office (FSO-130-2-S-23990) for formulating foreign policy relating to population problems and to the Food and Agriculture Organization (FAO) and the World Food Program (WFP). He has primary responsibility within the Department of State for all aspects of U.S. foreign policy relating to population problems and for all aspects of U.S. relations with the FAO and the WFP.

Skills Code 107

If more space is required, use the other side and additional pages size 8 x 10½

GPO 1960—O-540820

Specifically, his duties are as follows:

In connection with responsibilities in population field:

(1) Incumbent maintains close relations with the Assistant Administrator of AID for Technical Cooperation and Research and other AID officials responsible for population matters, the regional bureaus of the Department of State, the Office of International Scientific and Technological Affairs of the Department of State, the Assistant Director of the Bureau of the Census for Demographic Fields, and the Department of Health, Education and Welfare.

(2) He initiates policy recommendations relating to the foreign policy implications for world population trends and makes appropriate recommendations for coordinated Departmental policies in the population field.

(3) He prepares briefing material for use by the Assistant Secretary and other key Departmental officials in hearings on population matters.

(4) He drafts speeches for delivery by the Assistant Secretary, or Deputy Assistant Secretary, on population matters, and often delivers speeches to public audiences.

In connection with responsibilities on FAO and WFP matters the incumbent maintains close relations with the Assistant Secretary of Agriculture for International Affairs, the Assistant Administrator of AID for Material Resources, and the Director of Food for Peace. He prepares position papers on FAO and WFP matters, after careful negotiation with interested officials in the Government. He attends FAO conferences as Adviser to the U.S. Representative, and prepares summaries and briefings.

DEPARTMENT OF STATE,
BUREAU OF INTELLIGENCE AND RESEARCH,
OFFICE OF RESEARCH IN ECONOMICS AND SCIENCE,
Washington, D.C.

POSITION DESCRIPTION

Intelligence Research Specialist—Population

Conducts intelligence research in the area of population problems and developments, in support of Departmental activities. In particular—

(*a*) Plans and executes research projects involving critical analysis, evaluation, interpretation, and coordination of world-wide demographic data.

(*b*) Evaluates the reliability and the significance of intelligence materials.

(*c*) Develops studies and estimates requested by the Directors of the Bureau and Office, policy-making officials of the Department and officials of other agencies.

(*d*) Collaborates with analysts of other offices in planning and organizing studies or reports on specialized problems.

(*e*) Reviews for content reports prepared by other INR analysts which are concerned with demographic problems, as required.

(*f*) Recommends preparation of studies on, or in anticipation of, important developments.

(*g*) Is consultant to officers within the Bureau and of other bureaus on world-wide demographic problems.

(*h*) As required, represents the Office or Bureau on Departmental and inter-departmental committees and working groups.

(*i*) Maintains contact with representatives of other Government and private agencies to develop new sources of information.

Description of duties of Edgar F. Berman, M.D., Consultant in Population Activities: To provide leadership to the Latin American Bureau in developing population policy and program in Latin America; stimulate mission interest and through them develop national interest and national policy in population matters; promote a more effective dialogue between high level government, academic and ecclesiastic leadership in the development of a positive Latin American policy in the population field.

Description of duties of Dr. Benedict J. Duffy (Expert): Provides scientific advice in planning for the development and evaluation of population research and training programs, developing, participating in, correlating data and evaluating, from the point of view of a physician with broad experience in teaching and public health practice, the population planning research program which the Bureau will be carrying out; advises on the relationship of population growth to the cultural, economic, and social structure in the developing countries and serves on ad hoc committees for discussion of population problems, and act as professional liaison with other recognized leaders in the population planning field. Coordinates the work of the Population Staff.

EXHIBIT 148

U.S. PRESENTS VIEWS ON POPULATION GROWTH AND ECONOMIC DEVELOPMENT

(Statement by James Roosevelt,[1] Deputy U.S. Representative on the Economic and Social Council, U.S. Missions to the U.N.; from the official weekly record of United States Foreign Policy, the Department of State Bulletin, Vol. LIV, No. 1388, January 31, 1966, pps. 175–178)

Although much worthwhile research remains to be done, and although much demographic information remains to be gathered concerning the precise interrelationships in given circumstances between population changes and economic development, the general facts of the exploding world population are well known. The time interval required for the world's population to double itself has telescoped at an alarming rate. We have doubled in number since 1900, when the world's population was approximately 1.5 billion, and today we have a world population of 3 billion. According to projections of the Secretariat, we may have 6 billion people by the end of the century. I might add, parenthetically, that the report of the Committee on Population of the United States National Citizens Commission on International Cooperation has just reported to the President of the United States that if present world trends continue, the century-end figure will be more than 7 billion.

Moreover, it is not only a question of absolute numbers but also one of the *rate* of growth. The world's annual rate of growth in 1945 was 1 percent. Today it is about 2 percent, and some experts have told us that the rate is expected to go even higher. These projections of the world's population present problems of enormous magnitude and potentially disastrous consequences, and we must, as President Johnson said this year at San Francisco, "face forthrightly the multiplying problems of our multiplying populations and seek the answers to this most profound challenge to the future of all the world."[2]

Most of the attention regarding the effects of population growth has been focused on the circumstances in developing countries, where the overall average annual increase is slightly more than 2.5 percent and where for some countries the growth rate has reached 3 percent. In the developing regions as a whole, food production has bearly kept pace with the population increase. At Belgrade,[3] the Director General of the Food and Agriculture Organization pointed out that per capita world food production had failed to rise appreciably for almost 7 years. Other experts pointed out that during the 1960's food production in the developing regions of the world had increased less rapidly than population, and thus per capita food output was actually declining. If the trend continues, the outlook is grim indeed and the threat of starvation in some countries is a very real one.

But avoiding starvation is not the only, nor even the principal, reason for concern about population increases. The problem is one of diverting resources which could otherwise be used for capital formation. The difficulty is one of finding sufficient savings, after expending resources just to meet current consumption needs of an expanding population, to invest in order to insure a reasonable rate of progress toward modernization and a higher standard of living based on sustaining economic growth.

As we all know, the goal of a 5 percent annual growth rate in the developing countries has not been reached in all developing countries. Even if this goal, in terms of gross national product, is reached, the prospect is that population growth would greatly dilute its impact on individual levels of welfare.

It is in the developing countries that the situation is most critical, and it is there that population growth threatens to frustrate the aspiration for economic and social development. The problem is not, however, limited to those countries.

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[1] Made in Committee II (Economic and Financial) on Dec. 15 (U.S. delegation press release 4751).

[2] Bulletin of July 19, 1965, p. 98.

[3] The 2d U.N. World Population Conference was held at Belgrade, Yugoslavia, Aug. 30–Sept. 10, 1965.

In the United States, with a population growth rate of about 1.5 percent a year, prospects are that our population will grow from its present 190 million to 300 million by the end of the century. A recent report by the National Academy of Sciences has revealed a variety of problems which even this relatively modest rate is causing—especially among the poor and the uneducated. The problems involve maternal health, infant mortality and morbidity, family life, housing, opportunities for education, employment, and a better standard of living. The growing population adds to strains on our society in the form of air and water pollution, transportation difficulties, overcrowding in urban areas, the depletion of national resources, and the destruction of recreation areas and open space.

My country's efforts to create a Great Society are complicated not only for these reasons but because of the relatively faster increase in that portion of the population which is at the lower end of the economic scale. Parents in the less fortunate economic group have nearly twice as many children as those in the most fortunate bracket. The relatively high birth rate in poor families is not only an important contributing cause in their poverty—it actually tends to perpetuate the circumstances and condemns them to life in conditions of relative economic and cultural deprivation.

I have touched on the problems caused by population growth in my country only to indicate that the problem of population growth and its economic effects is not confined to the developing countries. And if the magnitude of problems faced by my country, with its relatively low annual birth rate and high per capita income, is immense, what must be the problems of a country with an annual population growth of 3 percent and a per capita income of $100?

I do not believe, however, that we can judge the success of our response in meeting the challenge of population growth only with demographic facts and measurements of the standards of living of peoples. There is more to life than existence and mere freedom from hunger. The goals of national and international society should not only be higher standards of living for all peoples, regardless of the number of people in the world, but, more importantly, should be the satisfaction of the political, cultural, and spiritual needs which are fundamental to all men. It is against these goals that we must measure our efforts, and it is within the context of these goals that we should view the increasing world population and devise appropriate population policies. Against the general background of what I have said, I would like to sketch out the policy views of my Government on this subject of population growth and economic development.

First, we are concerned about the economic and social consequences of our own population trends and are devoting considerable attention, publicly and privately, to the present and probable future demographic facts of domestic life.

Second, we seek more information about population trends and circumstances in the developing countries, not only as a guide to the formation of our own policies but in order to help others to know more. We consider this particularly important in those nations where present population levels and rates of growth may constitute major obstacles to the realization of desired economic and social development aspirations.

Third, we oppose any effort to dictate to any country the means employed or the policies devised to deal with its population problems.

Fourth, while we do not advocate specific policies with reference to population growth in other countries, we are prepared to actively help such countries, at their request, in their efforts to deal with the problems involved. The Agency for International Development has extended its assistance beyond statistical, demographic, and public health fields, to the direct support of family planning programs. I think it would be appropriate to mention that the Agency for International Development missions will, in accordance with a policy message directed to them last March, now respond positively to requests for technical, financial, and commodity assistance in support of family planning programs. In that message emphasis was put on the following points:

Each AID mission assigned one officer to bceome familiar with the population dynamics and program developments in the country to which he is posted. It is this officer's responsibility to keep both the United States mission in that country and the Agency for International Development headquarters in Washington appropriately advised.

The Agency for International Development does not advocate any particular method of family regulation. Freedom of choice in this matter should be available in any program for which technical assistance is requested.

Requests for assistance in this field, as in other fields, will be considered only if they are made or approved by the appropriate authorities of the requesting government.

The Agency for International Development is prepared to entertain requests for technical, commodity, and local currency assistance in support of family planning programs.

The Agency for International Development will not consider requests for contraceptive devices or equipment for the manufacture of contraceptives, since experience has made it clear that the cost of these items is not a stumbling block in countries which are developing effective programs.

As a result of this facet of United States policy, the Agency for International Development is at the moment considering the first request for such assistance. The Government of Turkey has requested a $3.5 million low-interest loan to buy 14,000 vehicles and educational equipment. This is to be used to further its family planning program in rural areas. I am confident the request is now receiving most sympathetic consideration.

Fifth, as a matter of general United States policy, we believe that there remains a need for increased knowledge on population matters. We are quite encouraged with indications at the Belgrade conference of the substantially increased body of demographic information available to the international community and the growing number of experts in this field. We hope these indications augur well for further and increasingly precise data.

Sixth, we feel that the United Nations and its affiliated organizations have a role to play in the population field. My Government has consistently supported expansion of the United Nations role in assisting countries at their request in action programs dealing with population problems. We believe that member governments should be able to obtain from the United Nations and its agencies such assistance as they need and request.

Mr. Chairman, this subject was given thorough consideration at the 39th session of the Economic and Social Council, and it was on the basis of those deliberations that the Council passed Resolution 1084. Even more detailed examination was made at the recent conference at Belgrade. Under the crowded schedule of this committee, we would have considered it perhaps more appropriate to have a resolution merely noting the Economic and Social Council's resolution and the Secretary-General's report on the Belgrade conference. Nevertheless, Mr. Chairman, my delegation supports this draft resolution and its most able introducer, the distinguished representative of India, because, as you may judge from what I have said, there are no important differences between my Government's policies with regard to population growth and economic development and the draft resolution. We will therefore vote in favor of it.[4]

EXHIBIT 149

EXCERPT CONCERNING POPULATION FROM "A THOUSAND DAYS"

(By Arthur M. Schlesinger, Jr., Houghton-Mifflin Co., Boston, Mass., 1965, pp. 600–604)

DEVELOPMENT VERSUS POPULATION

The struggle for economic growth encountered more than the well-advertised obstacles of ignorance, disease, corruption and inertia. Even when countries had the will to reshape attitudes and institutions there was still the constant threat that population would increase faster than output, producing a decline in per capita income and therefore in the savings available for capital formation. Indeed, this threat actually became more acute as nations began to modernize. Improvements in sanitation and public health—from the boiling of water and the swatting of flies to penicillin and DDT—often neutralized the old Malthusian checks before economic growth could take up the slack.

In Venezuela, for example, from 1957 to 1963 the gross national product, according to the UN, grew at a rate of 4.5 per cent, but population grew at a rate

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[4] A proposal to postpone consideration of the agenda item on "Population growth and economic development" until the 21st session of the General Assembly was adopted in Committee II on Dec. 15 and in plenary session on Dec. 20.

of 3.8 per cent, reducing the net gain in per capita income to .7 per cent; in Uganda, the figures were 3.4 and 2.5 per cent, leaving the per capita gain at .9 per cent.[1] "Like a thief in the night," said Asoka Mehta of the Indian Planning Commission, "population growth can rob us of all that we achieve, day after day, in economic growth." One AID economist calculated that in certain countries every dollar invested in birth control would be 200 times as productive as the same dollar invested in foreign aid.

This problem had nagged the consciousness of foreign aid people for some time. In the very long run, industrialization and affluence might bring down the birth rate (though even this was not certain; the United States, after a period of decline in the thirties, now had as high a rate of population growth as India); but in the short run the situation seemed to require a more specific and purposeful attack. In 1959 one of the recurrent blue-ribbon reviews of aid policy, this one chaired by General William H. Draper, courageously recommended that the United States assist birth control programs in developing countries. When the Draper report provoked a strong counterstatement by the Roman Catholic bishops, President Eisenhower quickly said, "This government will not . . . as long as I am here, have a positive political doctrine in its program that has to do with birth control. That's not our business."[2] An ICA directive promptly banned birth control assistance or even consultation.

The election in 1960 of a Roman Catholic President might have been supposed to place population control even further outside the realm of public policy. The President-elect's interregnum task force on economic aid hardly mentioned the problem in its report. When one of its consultants, Richard N. Gardner of Columbia, soon to become Harlan Cleveland's Deputy Assistant Secretary for International Organization Affairs, pointed this out, his intervention only produced pitying smiles from those who assumed the question closed in the Kennedy years.

Actually Kennedy had long been concerned about the implications of population growth for economic development. In 1959, for example, John Cowles made a speech on the population problem, arguing that "unless we want to see the conditions that exist in India and in Egypt spread over the rest of the world, the scientists must find some method of simple, inexpensive and effective fertility control"; and Kennedy inserted it in the *Congressional Record* as "a challenging panorama of the developments abroad which will shape our foreign policy during the next decades." Asked on Meet the Press early in 1960 what he proposed to do about countries where people were multiplying faster than production, Kennedy replied that the solution was "for the United States and other powers to help them get ahead of their population increase. If they make a judgment that they want to limit their population under those conditions, that is a judgment they should make, and economic assistance which we give permits them to make that judgment, if that is their choice." In his first foreign aid message, he noted that "in Latin America, for example, population growth is already threatening to outpace economic growth."

In the summer of 1961 George McGhee confronted the State Department's Policy Planning Council with the problem. One result was a cautious paper saying in effect that the problem was real and that, while the United States could not come out for population control, it ought to do something, though no one was ready to say what. Another result was the designation of Robert W. Barnett as the Department's population adviser. Over the next year Barnett pressed the problem in the Department, with occasional public speeches defining the issues and arguing for government support of demographic research.

In the autumn of 1962 Sweden laid before the UN General Assembly a resolution calling on the Secretary-General to conduct an inquiry on population problems. This meant that, for the first time, the General Assembly would debate population policy. Richard Gardner, whose concern was unabated, volunteered to handle the topic for the U.S. Mission. He thereupon drafted a speech welcoming the Swedish initiative and declaring it "absolutely essential that we be concerned with population trends." American policy, as Gardner went on to state it, opposed "any effort to dictate to any country the means to be employed in dealing with its population problem"; but at the same time "the United States believes that obstacles should not be placed in the way of other governments

[1] I am conscious of the spurious precision of such figures and of all statistics from developing countries (indeed, from developed countries as well); see Oskar Morgenstern, *On the Accuracy of Economic Observations* (2nd edition; Princeton, 1963).

[2] Eisenhower abandoned this position in later years.

which, in the light of their own economic needs and cultural and religious values, seek solutions to their population problems." Gardner then said that the United States would "upon request" help other countries "to find potential sources of information and assistance on ways and means of dealing with population problems." He also affirmed on behalf of his government the need for additional knowledge on these matters, including "more facts about alternative methods of family planning."

Gardner first submitted his draft to Dean Rusk, who made no objections, and then to Ralph Dungan. Dungan, a thoughtful Catholic of the John XXIII school, was the White House liaison with the dignitaries of the Church and the resident expert on Catholic doctrine. He was, in addition, a man of wisdom and experience. He had, I think, a certain skepticism about the birth control zealots in the United States; the organized movement had for him a little too much the aspect of a crusade of white Anglo-Saxon Protestants determined to stop non-WASPs from propagating lest the WASPs be overwhelmed. (Kennedy may have had the same feeling; as he once put it, most people think "that it is other people's families that provide the population explosion.") On the other hand, Dungan had a realistic understanding of population issues; and he gave the speech prompt White House clearance.

A few days later the United States voted for the Swedish resolution in the General Assembly, balking only at a section calling for UN "technical assistance" on population problems; we abstained here because the UN already had all the authority it needed to give its members technical assistance and the inclusion of this superfluous language might raise fears that the UN was about to go into the business of distributing contraceptive devices. This action took place, however, during the New York newspaper strike of the winter of 1962–63, and no one seemed to notice it. The State Department quietly circulated the Gardner statement to foreign governments, and AID soon adopted it as a directive, superseding the Eisenhower ban against action on population questions. This activity slowly awakened public interest. In April 1963 someone asked Kennedy at a press conference whether he thought the United States should supply funds for international birth control studies. The President replied: "If your question is: Can we do more, should we know more about the whole reproduction cycle, and should this information be made more available to the world so that everyone can make their own judgment, I would think that it would be a matter which we could certainly support."

Kennedy's statement represented a significant revolution in the attitude of the American government. He affirmed two principles: freedom of research on population matters and freedom of every nation to use the resulting knowledge in determining its own policy. In handling the question this way, he dispelled all doubt, if any remained, about the capacity of a Catholic President to decide public issues on their merits. Actually, with the growing reappraisal within the Church itself, the policy provoked little criticism among his co-religionists. Catholic concern seemed now to narrow to the relatively small point—and one on which they received reassurance—that the government should not ship out contraceptives. The Kennedy years thus further strengthened the American attack on world poverty by preparing the means to keep population growth from nullifying the development effort.

Senator GRUENING. I have nothing further. I want to thank you very much for coming, Mr. Mann. I am confident of your interest in this problem. I hope that actions will correspond with words and that we may really move constructively ahead.

Mr. MANN. Thank you, sir. Always a pleasure to see you.

Senator GRUENING. Thank you.

(Whereupon, at 3 p.m., the subcommittee recessed, subject to the call of the Chair.)

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