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PRESIDENT CLAUSEN
ITINERARY FILES

Mexico 1984 (3)

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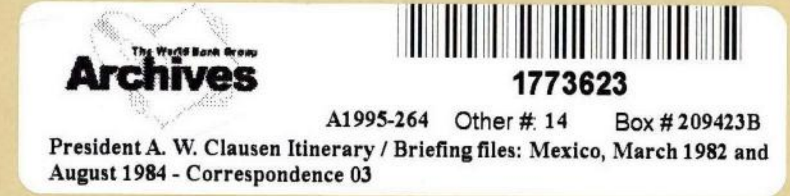

THURS. AUG. 9

Visit to Family Planning Clinic in Mexico

Thursday, August 9th

Since the Government of Mexico is hosting the World Population Conference and strongly supporting family planning, we propose that Mr. and Mrs. Clausen visit health and family planning programs in neighborhoods of Mexico City between the hours of roughly 11:00 am - 4:00 pm on August 9th. This would be a private visit, with no press or other hoopla, to permit Mr. and Mrs. Clausen to see how family planning programs work and talk to clinic staff and clients from the neighborhood.

We will start from the Hotel Camino Real about noon.

1) A government-run hospital with a voluntary sterilization program (run by the Social Security Administration);

2) A typical family planning clinic serving the outskirts of the city where poor rural migrants come;

3) A community-based "outreach" program where women bring family planning and health care door to door, in a rural area just outside the city. (This illustrates a fairly new approach getting dramatic results around the world as it is tried.)

We will return to the hotel about 4:00 pm. Our Mexican colleagues have dry-run this visit so that it will go smoothly. We should all wear casual clothes.

We have consulted with Sr. Geronimo Martinez-Garcia, Secretary General of Mexico's National Population Council (CONAPO) and a close associate of Sr. Manuel Bartlett, Minister of Interior and Chairman of the Population Conference for Mexico. Sr. Martinez is enthusiastic about our proposal and helped plan the visit. (We are coordinating with Mr. Jose-Luis Flores, Director of International Operations in the Finance Ministry, who is the Bank's usual contact there.)

Sr. Martinez will provide an appropriate escort to explain the family planning program and help translate as Mr. and Mrs. Clausen talk with health workers and clients from the neighborhood. We have also invited Sra. Guadalupe de la Vega, the articulate and experienced leader of Mexico's private family planning programs (which serve the poor particularly in the Northern cities). Mr. North and Mrs. Herz will accompany.

MEDIA & STATEMENT TO PRESS

STATEMENT TO THE PRESS

I am very pleased to be back in Mexico to attend the United Nations International Conference on Population and have another opportunity to meet with your authorities.

I would like to congratulate President de la Madrid and his government for the firmness and foresight with which the Government has been confronting a difficult period and implementing the stabilization program following the crisis of 1982.

We feel that the Government is on the right course and should be encouraged to continue present policies until financial stability is reestablished, which is necessary for recovery of economic growth and improved living standards.

The World Bank has a long relationship with Mexico, which dates back to 1949. In the past 35 years, the Bank has made 83 loans to Mexico, totalling over $7.3 billion. In the past fiscal year, which ended last June, we approved three loans for a total of $576.3 million, as a part of our continuous support for Mexico's development efforts.

Two of these loans, one of $200 million for a major highway rehabilitation project, and another of $300 million to improve agricultural productivity and production, were signed today. We hope they will make a positive contribution to the recovery of the Mexican economy.

After two years of economic contraction in Mexico we are beginning to see some early signs of recovery, but the road ahead is long and difficult. In support of the Government's stabilization and development plans, we are prepared to expand our assistance and help stimulate the flow of capital to Mexico.

DECLARACION A LA PRENSA

Me complace mucho estar de nuevo en México, esta vez para asistir a la Conferencia Internacional sobre Población, y tener otra oportunidad de reunirme con las autoridades de este país.

Deseo felicitar al Presidente de México, Excmo. Sr. de la Madrid, y a su Gobierno por la firmeza y visión con que vienen haciendo frente a un difícil período y poniendo en vigor el programa de estabilización, a continuación de la crisis de 1982.

Estimamos que el Gobierno mexicano está en el buen camino y que se le debe alentar a continuar aplicando las políticas actuales hasta lograr el restablecimiento de la estabilidad financiera, que se necesita para recuperar el crecimiento económico y mejorar los niveles de vida.

El Banco Mundial tiene relaciones con México que datan de 1949. En los últimos 35 años el Banco ha otorgado 83 préstamos a México, por un monto total que asciende a más de US$7.300 millones. En el último ejercicio económico, que finalizó el pasado mes de junio, aprobamos la concesión de tres préstamos, por un total de US$576,3 millones, como parte de nuestro apoyo continuo a los esfuerzos de desarrollo de México.

Dos de estos préstamos, uno de US$200 millones para un importante proyecto de rehabilitación de carreteras y el otro de US$300 millones para mejorar la productividad y la producción agrícolas, se han firmado hoy. Esperamos que hagan una contribución positiva a la recuperación de la economía mexicana.

Tras dos años de contracción económica, comenzamos a vislumbrar en México algunos indicios de recuperación, pero el camino que queda por recorrer es largo y difícil. Con objeto de apoyar los planes de estabilización y desarrollo del Gobierno mexicano, estamos dispuestos a ampliar nuestra asistencia y contribuir a estimular los flujos de capital hacia México.

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MEXICO

INFORMATION MEDIA

The Mexican information media comprises one of the largest networks in Latin America and among the developing countries. They include over 600 periodicals -- with an estimated circulation of more than 23 million copies -- and a network of over 750 radio stations and over 100 television stations commanding audiences of more than 50 million and 30 million respectively.

The press remains the most influential medium in the country, but radio is now commanding a wider audience. Television has grown in importance, particularly in recent years.

The current economic crisis and recession has affected mostly the printed media. Several newspapers have closed or reduced their editions due to financial difficulties, but the Mexican print media remains very diversified for Western standards.

Print Media

Mexico City still has about 11 national newspapers with 2 or even three separate editions each, for a total of about 25 daily publications.

The most influential newspapers are Excelsior, El Universal, Novedades, Uno mas Uno, and El Sol. Other important newspapers in Mexico City are La Prensa, El Heraldo, El Dia, El Nacional, Ovaciones, and Esto.

Owned since the 1920's by a cooperative of its employees, Excelsior is still the most influential and best known Mexican newspaper outside the country. It has been able to go through the recession without many problems and still maintains one of the largest group of foreign correspondents of any newspaper in the Latin America region.

The largest newspaper organization in the country is still El Sol de Mexico, which was acquired in 1976 by the then President Luis Echeverria. Uno mas Uno is a small-circulation but influential newspaper that reflects a nationalists, leftist orientation, very critical of the IMF and of the World Bank.

Uno mas Uno was created as a result of a division among the staff of Excelsior in 1976. Recently his influence has diminished, and

is being now affected by the recent separation of an important group of editors and writers, of a more radical leftist leaning. This group is in the process of establishing a new daily, under the name of La Jornada, which is expected to be published in late August.

The only financial daily is El Financiero, which began to be published about three years ago. Since then, El Financiero has acquired a reputation of a serious, independent newspaper that gives a lot of attention to economic and financial issues.

There is also a daily newspaper in English, The News, published by the Novedades group, an important editorial conglomerate which represents the Monterrey interests and that also owns the Televisa television network.

The largest circulation newspapers in Mexico City are Esto and Ovaciones, both sports-oriented, with close to 400,000 copies each. The other dailies, including Excelsior, are in the range of 150,000 to 350,000, with the exception of Uno mas Uno, which has only around 50,000 copies.

Among the news magazines, Proceso is the most important. Born also as a result of the division in Excelsior in 1976, Proceso has earned a reputation of being an independent, investigative, although sometimes sensationalistic, publication. Both Uno mas Uno and Proceso have become outlets for anti-establishment opinions in Mexico.

Another important magazine is Siempre, the traditional political publication.

Radio and Television

The largest radio networks are Radiodifusoras Unidas Mexicanas (RUMSA), Radio Programas de Mexico (RPM), and Radio Cadena Nacional (RCN). The most important commercial radio stations are XEQ, XEW, and XEX, and the cultural stations are Radio Universitaria, of the Universidad Nacional Autonoma de Mexico, and Radio Educacion of the Secretary of Public Education.

Televisa, a private monopoly, controls most of the commercial stations in Mexico. It has four channels in Mexico City, and four networks with about one hundred television stations all over the country. Televisa is owned by the O'Farril family (of the Novedades conglomerate) and relatives of former President Miguel Aleman. Televisa has also participation in the Spanish International Network (SIN), the Spanish-language network in the United States with over 200 stations in the United States.

Mexico City has another commercial station, Channel 13, and one cultural station, Channel 11, the last one operated by the Instituto Politecnico Nacional.

The most widely listed news program in the Mexican television is Televisa's 24 Horas. Under the direction of Jacobo Zabludowsky, 24 Horas is an evening news program broadcasted nationally and reproduced throughout the SIN network in the United States.

August 2, 1984
Information and Public Affairs

GENERAL BRIEFING
ON POPULATION

THE WORLD BANK/INTERNATIONAL FINANCE CORPORATION

OFFICE MEMORANDUM

DATE July 25, 1984

TO Distribution

FROM Nancy Birdsall, CPDRM

EXTENSION 60176

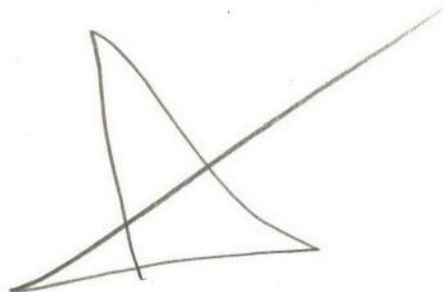
SUBJECT My Hotel in Mexico City

This is to inform you that I will be staying at the Galeria Plaza hotel (rather than the Camino Real) in Mexico City, should I need to be reached. It is in the same chain as the Camino Real. I will arrive the afternoon of August 6, to participate in the planned press briefing at 5 p.m. August 6, and depart the afternoon of August 8, after the briefing on WDR for members of delegations.

Distribution

Mr. Clausen
Mr. North
Ms. Herz
Mr. Gamarra
Mr. Ranganathan
Mr. Schebeck
Ms. Husain
Mr. Denning
Mr. McGreevey

NBirdsall:gjc



RECEIVED
1984 JUL 26 PM 3:44
OFFICE OF THE PRESIDENT

THE WORLD BANK/INTERNATIONAL FINANCE CORPORATION

OFFICE MEMORANDUM

DATE: July 19, 1984

TO: Distribution Below

FROM: Barbara Herz, PHNPR *Barbara Herz*

EXTENSION: 61584

SUBJECT: U.S. Population Policy Statement

Attached is the final version of the U.S. population policy statement to be given in Mexico. (Former Senator James Buckley is expected to head the U.S. delegation.)

The statement permits continued U.S. funding for family planning but strengthens the ten-year prohibition on funding for abortion (see page 9). This calls into question continued U.S. support for IPPF, which now receives about one-fourth of its roughly $50 million ODA budget from the United States. (IPPF provides less than 1% of its funds for abortion-related programs of national family planning associations in a few countries where abortion is legal.)

Attachments

Distribution List:

Mr. John D. North, Director, PHN
Dr. K. Kanagaratnam, PHN
Dr. A. Measham, PHN
Mr. A. Berg, PHN
Mr. E. Schebeck, PHND1
Ms. I. Husain, PHND2
Mr. S. Denning, PHND3

cc: Mr. S.J. Burki, IRDDR
Mr. A. Shakow, IRDDR
Mr. J.W. Stanton, VPE
Ms. J. Maguire, IPAPA

For: Mr. Clausen
Per Your Request: 8/3/84
Bill Stanton

BHerz:lcj

JWC 7/12/84

POLICY STATEMENT: INTERNATIONAL CONFERENCE ON POPULATION

Introduction

For many years, the United States has supported, and helped to finance, programs of family planning, particularly in developing countries. This Administration has continued that support but has placed it within a policy context different from that of the past. It is sufficiently evident that the current exponential growth in global population cannot continue indefinitely. There is no question of the ultimate need to achieve a condition of population equilibrium. The differences that do exist concern the choice of strategies and methods for the achievement of that goal. The experience of the last two decades not only makes possible but requires a sharper focus for our population policy. It requires a more refined approach to problems which appear today in quite a different light than they did twenty years ago.

First and most important, population growth is, of itself, a neutral phenomenon. It is not necessarily good or ill. It becomes an asset or a problem only in conjunction with other factors, such as economic policy, social constraints, need for manpower, and so forth. The relationship between

population growth and economic development is not necessarily a negative one. More people do not necessarily mean less growth. Indeed, in the economic history of many nations, population growth has been an essential element in economic progress.

Before the advent of governmental population programs, several factors had combined to create an unprecedented surge in population over most of the world. Although population levels in many industrialized nations had reached or were approaching equilibrium in the period before the Second World War, the baby boom that followed in its wake resulted in a dramatic, but temporary, population "tilt" toward youth. The disproportionate number of infants, children, teenagers, and eventually young adults did strain the social infrastructure of schools, health facilities, law enforcement and so forth. However, it also helped sustain strong economic growth, despite occasionally counterproductive government policies.

Among the developing nations, a coincidental population increase was caused by entirely different factors. A tremendous expansion of health services -- from simple inoculations to sophisticated surgery -- saved millions of lives every year. Emergency relief, facilitated by modern

transport, helped millions to survive flood, famine, and drought. The sharing of technology, the teaching of agriculture and engineering, and improvements in educational standards generally, all helped to reduce mortality rates, especially infant mortality, and to lengthen life spans.

This demonstrated not poor planning or bad policy but human progress in a new era of international assistance, technological advance, and human compassion. The population boom was a challenge; it need not have been a crisis. Seen in its broader context, it required a measured, modulated response. It provoked an overreaction by some, largely because it coincided with two negative factors which, together, hindered families and nations in adapting to their changing circumstances.

The first of these factors was governmental control of economies, a development which effectively constrained economic growth. The post-war experience consistently demonstrated that, as economic decision-making was concentrated in the hands of planners and public officials, the ability of average men and women to work towards a better future was impaired, and sometimes crippled. In many cases, agriculture was devastated by government price fixing that wiped out rewards for labor. Job creation in infant

industries was hampered by confiscatory taxes. Personal industry and thrift were penalized, while dependence upon the state was encouraged. Political considerations made it difficult for an economy to adjust to changes in supply and demand or to disruptions in world trade and finance. Under such circumstances, population growth changed from an asset in the development of economic potential to a peril.

One of the consequences of this "economic statism" was that it disrupted the natural mechanism for slowing population growth in problem areas. The world's more affluent nations have reached a population equilibrium without compulsion and, in most cases, even before it was government policy to achieve it. The controlling factor in these cases has been the adjustment, by individual families, of reproductive behavior to economic opportunity and aspiration. Historically, as opportunities and the standard of living rise, the birth rate falls. In many countries, economic freedom has led to economically rational behavior.

That pattern might be well under way in many nations where population growth is today a problem, if counterproductive government policies had not disrupted economic incentives, rewards, and advancement. In this regard, localized crises of population growth are, in part, evidence of too much

government control and planning, rather than too little.

The second factor that turned the population boom into a crisis was confined to the western world. It was an outbreak of an anti-intellectualism, which attacked science, technology, and the very concept of material progress. Joined to a commendable and long overdue concern for the environment, it was more a reflection of anxiety about unsettled times and an uncertain future. In its disregard of human experience and scientific sophistication, it was not unlike other waves of cultural anxiety that have swept through western civilization during times of social stress and scientific exploration.

The combination of these two factors -- counterproductive economic policies in poor and struggling nations, and a pessimism among the more advanced -- led to a demographic overreaction in the 1960's and 1970's. Scientific forecasts were required to compete with unsound, extremist scenarios, and too many governments pursued population control measures without sound economic policies that create the rise in living standards historically associated with decline in fertility rates. This approach has not worked, primarily because it has focused on a symptom and neglected the underlying ailments. For the last three years, this

Administration has sought to reverse that approach. We recognize that, in some cases, immediate population pressures may require short-term efforts to ameliorate them. But population control programs alone cannot substitute for the economic reforms that put a society on the road toward growth and, as an aftereffect, toward slower population increase as well.

Nor can population control substitute for the rapid and responsible development of natural resources. In commenting on the Global 2000 report, this Administration in 1981 disagreed with its call "for more governmental supervision and control," stating that:

> "Historically, that has tended to restrict the availability of resources and to hamper the development of technology, rather than to assist it. Recognizing the seriousness of environmental and economic problems, and their relationship to social and political pressures, especially in the developing nations, the Administration places a priority upon technological advance and economic expansion, which hold out the hope of prosperity and stability of a rapidly changing world. That

> hope can be realized, of course, only to the extent that government's response to problems, whether economic or ecological, respects and enhances individual freedom, which makes true progress possible and worthwhile."

Those principles underlie this country's approach to the International Conference on Population to be held in Mexico City in August.

Policy Objectives

The world's rapid population growth is a recent phenomenon. Only several decades ago, the population of developing countries was relatively stable, the result of a balance between high fertility and high mortality. There are now 4.5 billion people in the world, and six billion are projected by the year 2000. Such rapid growth places tremendous pressures on governments without concomitant economic growth.

The International Conference on Population offers the U.S. an
opportunity to strengthen the international consensus on the interrelationships between economic development and population which has emerged since the last such conference

in Bucharest in 1974. Our primary objective will be to encourage developing countries to adopt sound economic policies and, where appropriate, population policies consistent with respect for human dignity and family values. As President Reagan stated, in his message to the Mexico City Conference:

> "We believe population programs can and must be truly voluntary, cognizant of the rights and responsibilities of individuals and families, and respectful of religious and cultural values. When they are, such programs can make an important contribution to economic and social development, to the health of mothers and children, and to the stability of the family and of society."

U.S. support for family planning programs is based on respect for human life, enhancement of human dignity, and strengthening of the family. Attempts to use abortion, involuntary sterilization, or other coercive measures in family planning must be shunned, whether exercised against families within a society or against nations within the family of man.

The United Nations Declaration of the Rights of the Child (1959) calls for legal protection for children before birth as well as after birth. In keeping with this obligation, the United States does not consider abortion an acceptable element of family planning programs and will no longer contribute to those of which it is a part. Accordingly, when dealing with nations which support abortion with funds not provided by the United States Government, the United States will contribute to such nations through segregated accounts which cannot be used for abortion. Moreover, the United States will no longer contribute to separate non-governmental organizations which perform or actively promote abortion as a method of family planning in other nations. With regard to the United Nations Fund for Population Activities (UNFPA), the U.S. will insist that no part of its contribution be used for abortion. The U.S. will also call for concrete assurances that the UNFPA is not engaged in, or does not provide funding for, abortion or coercive family planning programs; if such assurances are not forthcoming, the U.S. will redirect the amount of its contribution to other, non-UNFPA family planning programs.

In addition, when efforts to lower population growth are deemed advisable, U.S. policy considers it imperative that such efforts respect the religious beliefs and culture of

each society, and the right of couples to determine the size of their own families. Accordingly, the U.S. will not provide family planning funds to any nation which engages in forcible coercion to achieve population growth objectives.

U.S. Government authorities will immediately begin negotiations to implement the above policies with the appropriate governments and organizations.

It is time to put additional emphasis upon those root problems which frequently exacerbate population pressures, but which have too often been given scant attention. By focusing upon real remedies for underdeveloped economies, the International Conference on Population can reduce demographic issues to their proper place. It is an important place, but not the controlling one. It requires our continuing attention within the broader context of economic growth and of the economic freedom that is its prerequisite.

Population, Development, and Economic Policies

Conservative projections indicate that, in the sixty years from 1950 to 2010, many Third World countries will

experience four, five or even sixfold increases in the size of their populations. Even under the assumption of gradual declines in birth rates, the unusually high proportion of youth in the Third World means that the annual population growth in many of these countries will continue to increase for the next several decades.

Sound economic policies and a market economy are of fundamental importance to the process of economic development. Rising standards of living contributed in a major way to the demographic transition from high to low rates of population growth which occurred in the U.S. and other industrialized countries over the last century.

The current situation of many developing countries, however, differs in certain ways from conditions in 19th century Europe and the U.S. The rates and dimensions of population growth are much higher now, the pressures on land, water, and resources are greater, the safety-valve of migration is more restricted, and, perhaps most important, time is not on their side because of the momentum of demographic change.

Rapid population growth compounds already serious problems faced by both public and private sectors in accomodating changing social and economic demands. It diverts resources

from needed investment, and increases the costs and difficulties of economic development. Slowing population growth is not a panacea for the problems of social and economic development. It is not offered as a substitute for sound and comprehensive development policies. Without other development efforts and sound economic policies which encourage a vital private sector, it cannot solve problems of hunger, unemployment, crowding or social disorder.

Population assistance is an ingredient of a comprehensive program that focuses on the root causes of development failures. The U.S. program as a whole, including population assistance, lays the basis for well grounded, step-by-step initiatives to improve the well-being of people in developing countries and to make their own efforts, particularly through expanded private sector initiatives, a key building block of development programs.

Fortunately, a broad international consensus has emerged since the 1974 Bucharest World Population Conference that economic development and population policies are mutually reinforcing.

By helping developing countries slow their population growth through support for effective voluntary family planning

programs, in conjunction with sound economic policies, U.S. population assistance contributes to stronger saving and investment rates, speeds the development of effective markets and related employment opportunities, reduces the potential resource requirements of programs to improve the health and education of the people, and hastens the achievement of each country's graduation from the need for external assistance.

The United States will continue its longstanding commitment to development assistance, of which population programs are a part. We recognize the importance of providing our assistance within the cultural, economic and political context of the countries we are assisting, and in keeping with our own values.

Health and Humanitarian Concerns

Perhaps the most poignant consequence of rapid population growth is its effect on the health of mothers and children. Especially in poor countries, the health and nutrition status of women and children is linked to family size. Maternal and infant mortality rises with the number of births and with births

too closely spaced. In countries as different as Turkey, Peru, and Nepal, a child born less than two years after its sibling is twice as likely to die before it reaches the age of five, than if there were an interval of at least four years between the births. Complications of pregnancy are more frequent among women who are very young or near the end of their reproductive years. In societies with widespread malnutrition and inadequate health conditions, these problems are reinforced; numerous and closely spaced births lead to even greater malnutrition of mothers and infants.

It is an unfortunate reality that in many countries, abortion is used as a means of terminating unwanted pregnancies. This is unnecessary and repugnant; voluntary family assistance programs can provide a humane alternative to abortion for couples who wish to regulate the size of their family, and evidence from some developing countries indicates a decline in abortion as such services become available.

The basic objective of all U.S. assistance, including population programs, is the betterment of the human condition-- improving the quality of life of mothers and children, of families, and of communities for generations to come. For we recognize that <u>people</u> are the ultimate resource--but this means happy and healthy children, growing up with education, finding productive work as young adults,

and able to develop their full mental and physical potential.

U.S. aid is designed to promote economic progress in developing countries through encouraging sound economic policies and freeing of individual initiative. Thus, the U.S. supports a broad range of activities in various sectors, including agriculture, private enterprise, science and technology, health, population, and education. Population assistance amounts to about ten percent of total development assistance.

Technology as a Key to Development

The transfer, adaptation, and improvement of modern know-how is central to U.S. development assistance. People with greater know-how are people better able to improve their lives. Population assistance ensures that a wide range of modern demographic technology is made available to developing countries and that technological improvements critical for successful development receive support.

The efficient collection, processing, and analysis of data derived from census, survey, and vital statistics programs

contributes to better planning in both the public and private sectors.

The U.S. at Mexico City

In conjunction with the above statements of policy, the following principles should be drawn upon to guide the U.S. delegation at the International Conference on Population:

1. Respect for human life is basic, and any attempt to use abortion, involuntary sterilization, or other coercive measures in family planning must be rejected.

2. Population policies and programs should be fully integrated into, and reinforce, appropriate, market-oriented development policies; their objective should be clearly seen as an improvement in the human condition, and not merely an exercise in limiting births.

3. Access to family education and services needs to be broadened, especially in the context of maternal/child health programs, in order to enable couples to exercise responsible parenthood.

Consistent with values and customs, the U.S. favors offering couples a variety of medically approved methods.

4. Though population factors merit serious consideration in development strategy, they are not a substitute for sound economic policies which liberate individual initiative through the market mechanism.

5. There should be higher international priority for biomedical research into safer and better methods of fertility regulation, especially natural family planning, and for operations research into more effective service delivery and program management.

6. Issues of migration should be handled in ways consistent with both human rights and national sovereignty.

7. The U.S., in cooperation with other concerned countries, should resist intrusion of polemical or non-germane issues into Conference deliberations.

8-3-84

This briefing material was based on the U.S report that has been subsequently revised but not yet distributed. John North, in contact with US AID, has learned that the revisions have made the original report somewhat more internally consistent but they have not changed the basic thrust of the arguments.

When North gets hold of the revised report and has a chance to review it, he will brief you in Mexico if he feels it is necessary.

Roy

I. WHITE HOUSE DRAFT POSITION PAPER FOR THE MEXICO CITY CONFERENCE AND THE BANK'S WORLD DEVELOPMENT REPORT

II. BANK POLICY AND PRACTICE ON ABORTION

I. White House Paper and WDR

1. Although moderated in the course of redrafting, the theme still runs through the White House position paper that rapid population growth does not necessarily hamper development. However, it does acknowledge that present growth rates of population in the world and especially in the developing countries cannot continue indefinitely. It shares with the World Development Report the view that the present high growth rates are mainly a result of the rapid decline of mortality experienced after World War II as a consequence of better health services, better education and better communications and transportation.

2. The White House paper asserts that had it not been for "governmental control of economies" and "an outbreak of anti-intellectualism, which attacked science, technology, and the very concept of material progress" in the western world, fertility would have been reduced in parallel to the reduction in mortality, and we would not have reached the high rates of population growth now occuring in the developing world. These imply in turn, that had it not been for those two factors, economic development would have been very rapid and, consequently, fertility would have also been reduced very rapidly.

3. The WDR shares with the White House paper the view that economic development contributed to the reduction in fertility. Low levels of education and labor force participation of women, and continuing general poverty contribute to high levels of fertility. However, while admitting that economic development could have gone faster in the past, WDR does not subscribe to the assertions quoted above.

4. Major differences between the two documents also appear in the policy prescriptions to solve the problem. The position of the White House paper appears to be simply that elimination of government control and of antiintellectualism and, in very special circumstances, the provision of family planning services, is an adequate policy response. The position of the WDR is that both economic development and family planning services are necessary. WDR confirms that family planning services have been shown to be effective and they should be almost doubled inmediately and quadrupled by the year 2000.

5. In terms of practical interventions, the White House paper does not give a role to society in the determination of the level of fertility desired. It leaves family size to private decision and expects the needs of society and the individual to be balanced because individuals by their own actions will achieve the optimum social good. The WDR, on the other hand, clearly establishes a role for society and hence for government; it justifies public intervention and shows how public

policy has made a difference in the past and should make a difference in the future.

6. In accepting that, at least in some cases, population programs may be necessary, the White House Paper establishes the conditions under which it will provide population assistance in the future. These conditions are based on the premise that the United States does not consider abortion to be an acceptable method of family planning. USAID has been prohibited since 1974 from funding abortion but now, if a country supports abortion, the U. S. may support its population program only through a segregated account which cannot be used for abortion. The U. S. will not in the future contribute to non-governmental organizations which perform or actually promote abortion as a method of family planning in other nations. (This position may impact especially the International Planned Parenthood Federation (IPPF) which spends less than one per cent of its budget on abortion.) The US will not allow any part of its contribution to the United Nations Fund for Population Activities (UNFPA) to be used for abortion. Moreover, it will call for assurances that the UNFPA is not engaged in, or does not provide funding for, abortion or coercive family planning programs. The position paper emphasizes that family planning programs have to be completely voluntary and non-coercive.

7. The WDR does not take a moral position in respect to strategies or methods utilized in family planning programs. It insists that each nation has the right to establish its own policy and that external agencies should respect that policy choice. It stresses that the decision to practice family planning or not has to be made by the individual or couple voluntarily, but recognises the role of incentives and disincentives. It emphasizes that there is a role for public policy not just in providing services, but also in educating the population in regard to the availability of such services, the advantages of lower fertility and the disadvantages to both individual and society of high rates of growth. Moreover, WDR recognizes that illegal abortion is a serious problem in several developing countries and that the solution is better family planning services.

8. The reluctance of the White House document to recognize the need for family planning services and for abortion implies ignorance of the socioeconomic conditions of the population in many developing countries. First, even if economic conditions were to improve very rapidly, the reduction in fertility would require family planning services whether provided by the private or the public sector. Even under optimum conditions there would be some groups in the population which would not have access to private services and on equity grounds these groups should be served by the public sector. Secondly, and in part due to the absence of access to appropriate family planning services, abortion is a serious fact of life in some developing countries. Where abortion is illegal, women look for those services underground, where abortion is practiced by unqualified people in unsanitary conditions, with high risk to health and life of the woman.

9. In summary, the positions presented in the White House paper and in the WDR are very different. They differ in the conception of the problem and its seriousness, they differ in regard to the possible solutions and consequently they differ in programmatic implications. The final point in the White House paper appears to be that today about ten per cent of total U. S. government's development assistance goes for population activities; this share could be reduced in the future. The WDR, on the other hand, recommends strongly that external assistance for population should be substantially increased.

10. The Bank position in regard to these differences before is that, unlike the White House position paper, we believe

(a) that rapid population growth is seriously hampering development in most L.D.Cs;

(b) that both development and access to family planning are needed to slow this growth;

(c) that appropriate public policies can reduce fertility and that there is an important and increasing role for government action in this area;

(d) that we should not interfere with the right of nations to decide what mix of family planning method (e.g. abortion) is appropriate, provided individual choice is available and use is voluntary (see note II below on abortion);

(e) that greatly increased resources (both developing country and external aid) should be devoted in the future to population programs.

II. Bank policy and practice on abortion

1. The Bank has no stated operating policy explicitly addressing abortion as a family planning method. We have never promoted abortion or, indeed, any individual method of contraception. We recommend that several kinds of contraceptives be made available through family planning programs so that people have a reasonable choice open to them which they can exercise voluntarily, but we leave the question of which methods are to be provided for governments to determine on the basis of their particular national economic and social circumstances.

2. Abortion is legal and publicly financed in a number of member countries -- both Part I and Part II. We have PHN projects in countries where abortion is legal, e.g. India, Korea and Tunisia, but these projects do not include funding specifically for abortion. Nonetheless, we have

constructed, equipped and trained staff for maternal and child health and family planning clinics that provide health and family planning services; such services could include abortion in countries where abortion is a stated government policy. In another case (Mauritius), in the light of the alarming number of illegal, unsafe abortions, we joined with UNFPA in recommending abortion for reasons of maternal health; we have not financed a population project there.

rather than as a family planning method

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THE WORLD BANK/INTERNATIONAL FINANCE CORPORATION

OFFICE MEMORANDUM

DATE June 27, 1984

TO Mr. Munir P. Benjenk

FROM S. Shahid Husain

EXTENSION 72283

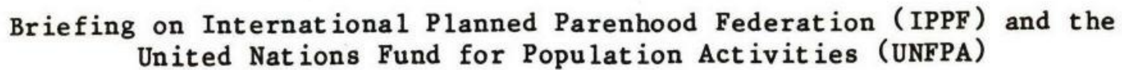
SUBJECT **World Bank Policy and Practice on Abortion**

You inquired about the Bank's policy and practice on abortion.

The Bank has not advised any government on whether or not to legalize abortion. It has not financed abortion as a part of its projects. None of the projects in the pipeline includes abortion.

cc: Messrs. Stern
Vogl
Mss. I. Husain
Birdsall

SSHusain:bce



Briefing on International Planned Parenhood Federation (IPPF) and the United Nations Fund for Population Activities (UNFPA)

I. IPPF

1. The national family planning associations that belong to the International Planned Parenthood Federation typically initiate family planning service delivery, to show that safe, effective, convenient and affordable services will be used. Recently many of these associations have sought to show that community-based "outreach" linked to available health infrastructure will work better. They also press governments to establish and extend family planning services and information and to adopt supportive policies. As governments begin to provide family planning, the associations shift focus toward hard-to-reach groups, such as youths or people, those in remote areas, or introduction of more kinds of services (currently by adding sterilization). (Sometimes -- e.g., Colombia, Hong Kong, Korea -- they still supply much of the nation's family planning services at the request of governments.) The associations provide critical continuity even during political upheaval and often set standards for cost-effectiveness. They now spend about US$90 million annually. Almost two-thirds comes from official development assistance contributed to IPPF headquarters, which then makes grants to third-world associations. Some 25 nations contribute, led up to now by the United States at US$12 million (the U.S. contribution is now imperilled by the new U.S. position on population assistance).

2. The World Bank does not contribute directly to IPPF but has financed activities of several national family planning associations in the context of Bank project funding. The current Secretary General, whom you will probably meet at Mexico, is Mr. Bradman Weerakoon, until recently a top civil servant in Sri Lanka. You will also meet his predecessor Mr. Carl Wahren, now Director of the Swedish International Development Agency.

II. UNFPA

1. The United Nations Fund for Population Activities is the principal channel for population assistance, particularly for the poorer countries of Asia and Africa. UNFPA typically assists governments in initial analysis of demographic situations, helps them design population policies, and helps them establish family planning services and information programs, typically providing training, contraceptives, equipment, and technical advice. Often it supports efforts to extend family planning along with basic maternal and child health services through "primary health care". UNFPA also supports biomedical research to improve family planning methods. Its annual program expenditures peaked at about US$137 million (all grants) in 1980 and 1981, over a third official population assistance, but fell to US$123.7 million in 1982. It is supported by over 90 countries; the United States is the leading contributor, providing about one-fourth of UNFPA's income.

2. The World Bank collaborates increasingly with UNFPA, and although the different approaches of the two agencies are not easy to combine in a formal association we are associated in many of the projects financed by the Bank. Programs and operations are reviewed jointly from time to time and joint missions (mainly on sector work and needs assessment) have been planned. Close contact is maintained between the staff of the two agencies on individual country situations. You are likely to meet the following at Mexico City:

Executive Director: Mr. Rafael Salas, Philippines
Deputy Executive Director: Mr. Heino Wittrin, FRG
Assistant Executive Director: Dr. Nafis Sadik, Pakistan

(You have already met Mr. Salas, who will be Secretary General of the World Population Conference. Dr. Sadik, the Bank's main operational contact in UNFPA, is the daughter of the late Mr. Shoiab, who was a Vice-President of the World Bank.)

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BRIEFING FOR MR. CLAUSEN ON INTERNATIONAL POPULATION CONFERENCE IN MEXICO

The United Nations has organized an International Population Conference to be held August 6-14 in Mexico City. You are scheduled to speak during the morning of August 7th. We suggest you host a lunch for donors on the 7th and attend a reception in the evening of the 7th hosted by UNFPA. On the 9th we recommend you host a breakfast for borrowers, visit one of Mexico's good family planning programs, and attend a key dinner for donors and developing countries hosted by Sweden. (We will propose precise arrangements shortly.) Most governments will send ministerial-level delegations including health specialists and people with broader development interests. We still have few names, but the heads of family planning programs in China, India, and Indonesia, among others, will attend.

The Conference comes ten years after the World Population Conference in Bucharest. It will consider what more needs to be done to implement the "World Plan of Action" adopted in Bucharest and to agree on goals for national and international action. At Bucharest debate raged over whether birth rates could be brought down most rapidly by concentrating on family planning or on development that builds demand for smaller families. Few developing countries outside Asia were enthusiastic about family planning. Since then fairly broad consensus has been reached that both family planning and development matter — and developing countries in all regions have sharply increased requests for population assistance, although sensitivity about family planning persists particularly outside Asia. (Most assistance still goes to the large Asian countries, but many African governments are initiating family planning services as part of maternal and child health care.) But population assistance from DAC countries still comes to only about $370 million annually; total population assistance (including the Bank's) approaches $500 million, less than 2% of all Official Development Assistance from DAC countries.

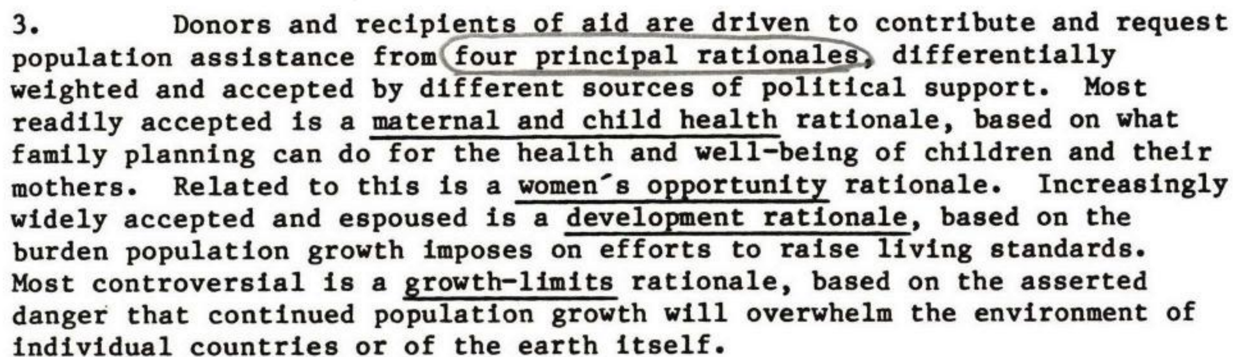
In FY83 the Bank disbursed about $40 million in population lending, though much health lending also supported family planning. More projects are being developed, however, and the Bank aims at least to double its population and related health lending in the next few years, focusing on Asia and Africa. The opportunity is there; it is a question of working with governments to develop practical projects. Government programs to extend basic maternal and child health usually include family planning care since it is itself a key health measure. We also support research on population growth and its consequences and causes.

Mexico itself has brought birth rates down fast following vigorous government support for family planning. By 1970 Mexico's population was growing at about 3.2% annually (doubling every 22 years or so), the birth rate was about 45 per 1000 inhabitants, and families averaged about six children. But development progress had brought some interest in smaller families. (By 1982 about half of Mexico's girls were in secondary school, child mortality had dropped to half its mid-1960s level, and more women were in the labor-force.) In 1973 the government passed a law integrating population into national development planning and began to strengthen government-sponsored family planning programs. It also established a high-level National Population Council. Private family planning programs and commercial efforts began to grow. Today over 40% of Mexican couples practice family planning, the birth rate has dropped to about 32 per thousand, and the population growth rate has fallen to about 2.5% a year. Families now average about 4.6 children. Much remains to be done — reportedly about one-fifth of Mexican women want no more children but lack ready access to good family planning services. And Mexico City is projected to grow from 17 million today to 31 million by the year 2000. But Mexico's experience recently is promising — and shows what can happen when development builds demand for smaller families and family planning is offered to help realize that demand. The Bank has not yet lent to Mexico for population and health. Several years ago we prepared a population project to the stage of negotiating a loan, but the Mexicans decided to carry it out on their own because of remaining sensitivity. We are doing sector work and hope to reopen a dialogue on population, which we hear informally the Mexicans would welcome. The Bank would be willing to consider financial assistance to the population sector, if officially requested by the Government, though we should be careful not to appear to be "pushing" our help in a sector where a previous Government felt that Bank financing might be counter-productive.

BRIEFING PAPER FOR MR. CLAUSEN
ON OFFICIAL DEVELOPMENT ASSISTANCE FOR POPULATION

1. "Population assistance" for family planning and other "population programs" accounts for less than two percent of all official development assistance provided by governments--about $370 million annually now (over 90% grants). It comes primarily from the United States, the Nordic countries, Japan and West Germany. Beyond this the World Bank lends for population and related health services (disbursing about $40 million annually now, though the trend is rising).

2. Official population assistance goes through three main channels: (1) the United Nations Fund for Population Activities and other U.N. agencies, (2) non-governmental organizations, notably the worldwide network of national family planning associations loosely tied together through the International Planned Parenthood Federation, and (3) bilateral programs, primarily that of the United States. The World Bank is the major additional channel. Population assistance goes to widely distributed countries in the third world. While most donors and channels try to give priority to poorer countries and regions, opportunities there may be limited, and allocations reflect opportunities as well as "need." Asia gets the bulk; special efforts are underway in Africa.



3. Donors and recipients of aid are driven to contribute and request population assistance from four principal rationales, differentially weighted and accepted by different sources of political support. Most readily accepted is a maternal and child health rationale, based on what family planning can do for the health and well-being of children and their mothers. Related to this is a women's opportunity rationale. Increasingly widely accepted and espoused is a development rationale, based on the burden population growth imposes on efforts to raise living standards. Most controversial is a growth-limits rationale, based on the asserted danger that continued population growth will overwhelm the environment of individual countries or of the earth itself.

4. Indeed, so central are these rationales, that some explanation is required to account for the minute share of development assistance that has gone to population programs. The explanation lies partly in incomplete acceptance of the rationales. Primarily, however, it lies in deep feelings and powerful political forces aroused in some countries by "birth control" methods and "population-control" programs that raise a spectre of government intrusion in the most private decisions of life. These reactions can cause ambivalence and conflict among those who influence governments and their assistance programs. Moreover, competing claims for assistance arise from the shorter term priorities in the productive sectors, such as agriculture, particularly when assistance budgets are highly constrained as they are now.

5. The same ambivalence and conflict often affect progress in family planning activities and population policies in individual countries. That progress also depends on economic and social development in a country, on

its cultural and political heritage and educational status, and on the extent to which population size and growth are obvious sources of difficulty. The current stage of population programs differs markedly from country to country and even from region to region.

6. On the whole, however, family planning in the third world has grown more popular over the past decade. Over 90% of the people in the third world live in countries where governments are trying to extend family planning for health reasons. Moreover, the governments of about two-thirds of these people seek to slow population growth as a matter of official policy and support family planning for that reason too. The commercial sector is also active, particularly in Latin America. In many developing countries a fourth to a half of fertile-age couples practice family planning, and the trend is generally rising.

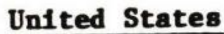
7. Evidence suggests substantial increases in family planning practice occur within a year or two after good services are extended, followed by lower fertility. Where development has generated economic and social conditions conducive to smaller families and to effective program management, family planning services are often welcomed and fertility falls rapidly (e.g., Mexico and Colombia). Community-based "outreach" is particularly effective.

8. Even where poverty persists, services offering safe and effective contraceptives conveniently and with sensitivity to culture do find considerable acceptance. Here too community-based "outreach" is key.

9. Developing countries as a whole now contribute more to their own population and family planning programs than they receive in assistance. Assistance organizations nonetheless remain critical sources of funding, technical advice and logistical support. Continuity of such assistance (policy, funding levels, mechanisms) is key to smooth operation of programs.

10. Donors remain concerned, however, that family planning programs be voluntary, safe, and culturally attuned. Several donors (notably Sweden) encourage the provision of family planning within broader maternal and child health services, to improve the appeal and the quality of family planning services. As determining appropriate balance among services is difficult when health-care budgets are tight and health care is scarce, support for more focused family planning programs also exists. Substantial research has been funded to improve contraceptive technology and to improve service delivery.

11. But no more than 40% of the people of the third world outside China have ready access to modern family planning. This level of service costs somewhat over $1 billion annually (including external aid). Associated birth rates in the third world outside China average about 37.



United States

The United States has long been the leading donor in population assistance, though its share has fallen to about 40% today. It has provided over $200 million annually in recent years including about one-fourth of UNFPA's and of IPPF's income. It is the mainstay support for other main private organizations and funds research on population issues and family planning. It provides bilateral assistance of over $70 million annually to about 20 countries, particularly Indonesia, Bangladesh, Philippines, India, and Kenya. (Other funds assist Egypt.) The future of U.S. population assistance is now in doubt. For 10 years the U.S. has been prohibited by law from supporting abortion through population assistance. The policy statement for Mexico just issued by the White House strengthens this by prohibiting U.S. funding for any private family planning programs that include abortion. This may threaten U.S. support for IPPF since it assists a very few programs where abortion is legal, although IPPF's overwhelming emphasis is on family planning that substantially reduces abortion.

Canada

Canada began providing population assistance in 1970 and supports all major fields of population assistance, emphasizing family planning as part of primary health care. In 1982, Canada provided about $12 million, including about $7 million to UNFPA, about $4 million to IPPF, and bilateral support to Bangladesh and Thailand in collaboration with the World Bank.

Denmark

Danish population assistance goes primarily through multilateral channels. In 1982, Denmark provided about $8 million, including over $4 million to UNFPA, over $1 million to IPPF, and bilateral assistance in collaboration with these organizations to Bangladesh and India.

Finland

Finland has provided population assistance since 1969. In 1982, Finland provided roughly $1 million, largely to UNFPA and bilaterally.

Federal Republic of Germany

West Germany has provided population assistance since 1969. It has gradually increased population assistance, though levels have declined as a fraction of all German assistance recently. West Germany supports a wide range of population activities. In 1982, West Germany provided roughly $22 million including some $13 million to UNFPA, $2 million to IPPF and bilateral assistance (e.g., to Bangladesh and Kenya cooperating with the Bank in Bangladesh).

Japan

Japan has provided population assistance since 1969 and has increased its assistance recently, so that Japan is now the second largest donor. Japan supports a wide range of activities (excluding abortion). In 1982, Japan provided $43 million in population assistance, including $24

million to UNFPA, $9 million to IPPF, and substantial bilateral assistance in Bangladesh, Indonesia, the Philippines, and Thailand (reflecting interest in Asia).

The Netherlands

In 1982, the Netherlands provided about $13 million in population assistance, exclusively through UNFPA and IPPF (having phased out earlier bilateral assistance).

Norway

Norway has long been a principal source of population assistance. In 1971 the Norwegian government decided to allocate about one-tenth of Norwegian development assistance to population and maternal and child health--the highest percentage of any donor. Norway supports broad range of activities. About three-fourths of Norwegian population assistance goes through multilateral channels (especially UNFPA and IPPF). Norway provided about $27 million in population assistance in 1982, including about $14 million for UNFPA, and $3 million for IPPF. It has recently assisted Bangladesh, India, and Thailand, and several other countries.

Sweden

In 1958, Sweden provided the first population assistance to the third world. Sweden now ranks fourth among population donors--though second only to Norway in population assistance per capita. Swedish population assistance has recently declined as a share of overall Swedish ODA--falling from 4.6% in 1977 to 3.4% in 1981, but is still about twice the average level. Sweden believes population programs should be seen in the context of broader social development efforts and urges integration of family planning with other kinds of maternal and child health care. It has been particularly concerned with protecting the voluntary character of family planning programs. It emphasizes the need for a broad range of family planning methods. Sweden provides most of its population multilaterally. In 1982 Sweden provided about $23 million including about $8 million for UNFPA and about $7 million to IPPF. Sweden now limits its bilateral assistance to Bangladesh and Kenya. It has cooperated in several multidonor efforts involving the Bank (e.g., in Bangladesh, in Kenya, and earlier in India).

United Kingdom

The United Kingdom has provided population assistance since 1964,though population assistance has declined as a share of total ODA. The United Kingdom emphasizes the need to slow population growth as a way to facilitate development progress and to improve health. Most of its population assistance goes through multilateral channels, but it provides some bilateral assistance to governments and to private organizations such as Save the Children, Oxfam, and churches. In 1982 it provided about $20 million, including about $5 million for UNFPA, and about $5 million for IPPF. Its principal bilateral effort recently is State of Orissa in India. It has also joined multi-donor projects led by World Bank or UNFPA in Kenya, Bangladesh and Egypt and provided assistance to such countries as Botswana, Sudan, and Sri Lanka.

BANGLADESH

Population size:	90.7 million (mid-1981)
Population Growth Rate:	2.6% (1970-81)
Contraceptive Prevalence:	19%
Bank Operations in PHN:	FY85 Health Sector Study
Bank Lending in PHN:	Pop. I - FY75 ($15.0 m) IDA
	Pop. II - FY79 ($32.0 m) IDA
	Pop. III - FY86S ($40.0 m) IDA
	Pop. IV - FY88 ($40.0 m) IDA

PHN's population strategy through FY86 derives from ten years of joint support to the Bangladesh population program through two projects in collaboration with a number of bilateral cofinanciers. The main lines of the population strategy are to promote fertility reduction by affecting both the supply and demand side of family planning. Specifically, the Bank strategy is to assist Bangladesh to:

- meet currently unmet demand for family planning services towards a national objective of achieving a 35% contraceptive prevalence rate by 1990; and

- generate additional demand for family planning services so that program momentum will continue after 1990 towards the goal of replacement level fertility by around 2005.

The strategy involves continued IDA and cofinanciers' lending support through a third population project in the FY85 pipeline centering on:

- consolidation and qualitative improvement of the family planning delivery system, particularly with respect to middle-level management and supervision;

- extension of peripheral facilities at a rate commensurate with GOB managerial capabilities;

- improved logistics and supply of medical and surgical equipment; and

- promotion of private sector involvement in family planning services delivery.

Moreover, because of the postulated relationship between women's socio-economic position and their adoption of family planning, the Bank as a whole needs systematically to seek ways of raising women's incomes and status. Increasing women's productive participation requires a multi-sectoral strategy for both Bangladesh and the Bank, to be pursued through both lending and country economic dialogue in agriculture, education, small industries and other applicable fields. PHN can serve as the catalyst for such efforts to be carried out mainly by the regional programs and projects divisions.

In health, our near-term strategy is to focus on helping the Government prioritize and strengthen MCH care as a natural adjunct to family planning services through the proposed third project. Simultaneously, we should begin sector work leading to a policy dialogue aimed at improving priorities, service delivery patterns, outreach and cost-effectiveness of the health system.

INDIA

Population:	690.2 million (mid-1981)
Population Growth Rate:	2.1% (1970 - 1981)
Contraceptive Prevalence:	32%
Bank Operations In PHN:	FY84 Pop. Sector Study
	FY85 Pop. Sector Study
Bank Lending in PHN:	Pop. I - FY72 ($21.2 m) IDA
	Pop. II - FY80 ($46.0 m) IDA
	Pop. III - FY84 ($70.0 m) IDA
	Pop. IV - FY86S ($70.0 m) IDA
	Pop. V - FY86R ($70.0 m) IDA
	Pop. VI - FY88 ($70.0 m) IDA
	Nutrition I - FY80 ($32.0 m) IDA

PHN's population strategy in India results from 12 years of Bank assistance to family planning programs through one completed project, and two under implementation. Taken together, the two latest projects cover around 7% of India's population or about 45 million people. The Bank's population policy also recognizes that India's population policy and official strategies to implement it have all the components of a sound family planning program. Apart from socio-economic factors inhibiting demand, the major constraints to improving prevalence are essentially managerial and administrative, particularly at state and district levels.

Under these circumstances, PHN's strategy is to:

- increase Bank lending for population to levels more consistent with India's absorptive capacity;

- concentrate lending on (but not necessarily confine it) to states where the Bank has knowledge and close relationships based on past support;

- broaden project content to strengthen state planning and management capabilities and appropriate national activities.

- promote a better contraceptive mix through increased emphasis on non-terminal rather than permanent methods;

- generate additional demand for family planning through more effective communications programs and community involvement; and

- support Government efforts to coordinate and expand cofinancing of the family planning program as a whole.

PHN's interim health strategy is to continue to deal with health only as it relates to population program interventions. Since health and family planning services are integrated in India, this implies a broad concern for primary health care and specific needs such as improved management, planning and communications. Concern for an effective referral service to secondary level facilities, expressed in current projects, will continue.

PAKISTAN

Population:	84.5 million (mid-1981)
Population Growth Rate:	3.0% (1970-81)
Contraceptive Prevalence:	5%
Bank Operation in PHN:	FY85 Health Sector Study
Bank Lending in PHN:	Pop. I - FY83 ($18.0 m) IDA
	Pop. II - FY87 ($20.0 m) IDA

Pakistan's annual population growth rate of around 3.0% is the highest in South Asia and poses a major constraint to economic growth. Therefore, fertility reduction is PHN's principal Pakistan objective to be pursued mainly through the current FY83 population project and one in the FY87 pipeline.

Since its inception in 1960, the family planning program in Pakistan has operated in an environment in which most of the factors generally associated with high fertility have coexisted and reinforced one another: high illiteracy, poverty, isolation, few opportunities for personal growth or employment for women, and prestige associated with a large number of sons. Administratively, the most pervasive problems have been frequent interruptions and changes in organization and program direction, a low level of commitment by the authorities, and indifference or overt resistance to family planning by health professionals in the Government system, which led to the establishment of an organizational structure fostering a single-purpose program with family planning services offered in isolation of other MCH and general health consultations. Resources have been spread too thinly to all parts of the country, irrespective of the likely public response and field staff have been selected with little regard for qualifications. Even well-conceived schemes have failed because of insufficient testing, inflexibility, and a lack of operational plans.

All of these constraints will continue to be felt to a greater or lesser extent in the implementation of the current Bank-assisted population project. The main issues will be maintenance of commitment to the program by high level authorities, the selection of capable personnel to key management positions (both in national and provincial activities), consistency through a period of at least five years in organizational arrangements for the program and the adoption of effective management approaches. The latest Population Plan is, as were some of its predecessors, well conceived; it is the extent of commitment to execution and weaknesses in management which are the key issues that must be addressed.

The FY83 project supports the institutional development and the establishment of a viable population program in Pakistan, in coordination with other donor assistance. The project consists of a national component supporting three essential sub-programs: program training (non-clinical), IEC, and population education in schools; and a regional component concentrating program efforts in 13 districts with a total of 20 million mainly urban and semi-urban population, most likely to be receptive to fertility reduction objectives. It also includes an evaluation scheme and funds for the preparation of a subsequent project. The project objectives

are to: assist the GOP in making the transition to a multi-sectoral population program; promote institutional development; and improve the program implementation process by emphasizing use of operational plans and staff training. The project's target for 1982-86 is to increase the number of current users of contraceptives from 7% to 14.5% of married women in reproductive ages, which implies a reduction of about four points in the crude birth rate in project districts by 1987.

In population, our strategy will be to:

- promote managerial and operational improvements required for successful execution of the Population Welfare Plan and identify key areas for further support under the proposed second project;

- maintain close contact with other donors to assure a consistent approach to population issues; and

- proceed with design and preparation of the proposed second population project.

In health, our strategy will be to:

- encourage the Government to undertake studies (financed through a Bank-aided technical assistance project) to deal with major organizational, managerial, financial and operational shortcomings of the health system; and

- through policy dialogue promote resolution of other key health issues which the Sixth Plan has not satisfactorily addressed, e.g., skewed deployment of resources toward urban, curative care and inappropriate pricing policies.

ETHIOPIA

Population:	32.0 million (1981 estimate)
Population Growth Rate:	2.5% (1970-81 estimate)
Contraceptive Prevalence:	n.a.
Bank Operations in PHN:	FY84 PHN Sector Review, FY84
Bank Lending in PHN:	FY88S P/H project, ($35 million/IDA)

Ethiopia's strong pronatalist tradition meant that family planning services were initially provided by voluntary agencies. Such services have been available since 1963 through the Family Guidance Association of Ethiopia (FGAE), but until recently in a limited number of clinics, and mainly in urban areas. Contraceptive prevalence is rising, mostly in towns, but the overall CPR is negligible. Demand for family planning appears to be significant, even in rural areas.

Following the Revolution, the Government's attitude toward the population issue changed. In 1979 the Government assumed responsibility for providing family planning services as part of the national MCH program. If, as is probable, the 1984 census confirms that the population is over 42m, this is likely to provide an important impetus toward development of a multisectoral population policy.

Major constraints in the population, health and nutrition sectors include an undeveloped family planning program reflecting past pronatalist policy; the legacy of an urban and curative oriented health system; limited budget, construction capacity and logistic support for expansion of health services; a shortage of skilled health and managerial staff; shortages and maldistribution of food; and the disruptive effects of war and drought.

The major challenge for the Government, having acknowledged the importance of reducing fertility, is to develop an effective population program with broad public support. Related issues include:

a. How far the Government will find it politically possible to introduce population considerations into its social and economic planning decisions;

b. the need to increase the coverage of the family planning program and to move its focus from the present concentration on child spacing based on temporary methods to an emphasis on limitation of family size;

c. whether sufficient priority will be given to family planning services as a part of integrated health services. A package of training, education and services to support family planning in this competitive context must be developed; and

d. whether and how peasant associations can be used to educate and motivate communities as yet unfamiliar with the concept and practice of family planning.

A preliminary assessment of the PHN sectors was made during the March 1983 economic mission. A detailed sector review was undertaken in April/May 1984, and it's findings will be discussed with Government in Fall of 1984. An FY88S PHN project is included in the Region's lending program, with an IDA allocation of $35 million.

SUDAN

Population: 21.6 million (1983 estimate)
Population Growth Rate: 3%
Contraceptive Prevalence: 5%
Bank Operations in PHN: The New Halfa Irrigation Project has a US$5 million health component, consisting of control measures for both malaria and schistosomiasis, and of general upgrading and extension of community health services.

The Gezira Rehabilitation Project I has a US$10 million schistosomiasis component.

Population Sector Review: FY85

Until recently, it appeared that the Government of Sudan had accepted, in principle, the need for population planning. To date, the GOS, while not formally incorporating family planning in its programs, has not actively opposed the introduction of pilot programs within the context of maternal and child health care; neither has it opposed the Sudan Family Planning Association (SFPA), nor has it restricted imports of contraceptives or prohibited information, education and communication (IEC) efforts. However, despite convening national population conferences in 1973 and again in 1983, the GOS has not yet developed a national population policy. The National Population Committee, which was set up to organize these conferences, has remained dormant.

In Sudan, it has traditionally been the view that the country's potential resources are more than ample to meet the needs of a significantly larger population. Expansion of the labor force is deemed to be a critical factor in exploiting these resources. It has been reasoned that, as socioeconomic development proceeds, a natural decline in fertility should occur, which would reduce the rate of population growth, without direct intervention. Until very recently, it seemed that this view was gradually being replaced by the realization that continued rapid population growth will retard growth and improvements in living standard due to the additional investment needed to maintain educational and health services at their current low level per capita, and to the country's inability to absorb the rapidly increasing labor force. However, in May 1984, President Nimeiry announced that the Government will introduce incentives to encourage population growth, including gold medals for mothers who have nine children or more.

The most important issue in population growth in Sudan is the lack of government commitment, a national population policy with objectives, goals, and the concomitant strategy to achieve them, all prerequisites for an effective program. Strong commitment will not come readily in view of Sudan's strong pronatalist attitude and the belief that the resource base can accommodate a much larger population.

SUDAN (Cont'd)

Constraints impeding changes in population policy include high infant mortality, low level of economic development with widespread poverty, high illiteracy, especially among women (86%), and the strong pronatalist attitudes in the country. Cultural, religious and legal pressures restrict women's activities, their marriage rights, and their property rights. Delivery of family planning and maternal and child health services requires further consolidation of the health service infrastructure--the main vehicle for services particularly in poorer rural areas. Due to relatively well-developed health services in Khartoum and in the central region, higher educational levels and less severe logistical constraints, greater progress may be anticipated in these areas if appropriate Government commitment emerges.

PHN dialogue has been limited to aspects Bank assisted health components of agriculture projects. Only recently, in view of the planned PHN sector work, have we initiated a dialogue with the Ministry of Health and the Ministry of Finance and Economic Planning, concerning the consequences of the continued rapid population growth. A population sector mission was agreed with Government for FY1985, but is now being reconsidered in view of the newly unfavorable climate for population activities in the country. The most critical issue requiring resolution before Bank assistance can be contemplated, is whether there is sufficient GOS commitment to population control and to the focusing of health care on family planning and maternal and child health. This commitment is in renewed doubt, following the recent policy announcement about incentives for population growth.

ZIMBABWE

Population:	7.5 million (1982 estimate)
Population Growth Rate:	3.2% (1970-81 estimate)
Contraceptive Prevalence:	n.a.
Bank Operations in PHN:	FY82 PHN Sector Review, FY86 Health/Population Project, (US$25 million/IBRD)

The Government does not have an explicitly stated population policy, but supports family planning (child spacing) services. Most of the child spacing (CS) services presently available are delivered by the Child Spacing and Family Planning Council (CSFPC), which was previously called the Family Planning Association, and later the Child Spacing and Fertility Association, outside of the context of MCH care. The CSFPC has had successful community-based distribution and youth advisory programs for a number of years, and the percentage of married women of reproductive age practicing contraception may now be around 15% (a high figure for sub-Saharan Africa). Since independence the Government has taken increasingly positive steps to strengthen the delivery of these services, and has assumed much of the responsibility for funding and managing the CSFPC. Indeed, the CSFPC has recently become a parastatal organization under the Ministry of Health (MOH). With financial assistance from USAID, these programs are now being further expanded, training activities are also being strengthened, a research and evaluation capability is about to be established, and an information, education and communication (IEC) unit and program are also to be set up. In addition limited MCH care is now about to be introduced into the program.

At present the Bank's lending program for Zimbabwe contains a health and population project in FY86. In preparing this project, the following principles will be followed. First, the development of family planning services will be a central part of the project. Second, the project should be complementary to ongoing health and population activities in Zimbabwe, particularly those being provided by the CSFA. Third, the project will primarily be directed to the underprivileged socio-economic groups. Fourth, particular attention will be given to overcome existing manpower constraints and improving the efficiency of existing resource utilization--for example, through focussing more on making existing facilities more functional rather than on establishing a large number of new facilities. Fifth, opportunities will be explored for possible cost savings--for instance, through improvements in the pharmaceutical system, the establishment of equipment maintenance units, and the provision of laundries at district hospitals (to eliminate the need to transport laundry over vast distances to and from Harare). And Sixth, where feasible, alternative pricing policies and additional sources of finance should be examined as part of efforts designed to improve health management and administration activities.

Using the above criteria, the recent project identification mission agreed with the Government that the proposed project would include: (i) the nationwide strengthening of MCH/Child spacing services in both rural and selected urban areas; (ii) support for the development of the peripheral health services, up to and including the district level, but with emphasis on the upgrading of existing services and decentralisation; (iii) manpower development and training activities; and (iv) strengthening of health management and administration.

Accurate cost estimates for the project are not available at this stage, but the total cost of the project could likely be about $70-80 million. The indicative allocation in the Bank's lending program is an IBRD loan of $25 million. In view of the anticipated shortfall in the loan funds compared with the likely project size (even allowing for the Government's contribution), and also bearing in mind the Government's desire for other funds to "soften" the overall terms of the external assistance, co-financing possibilities are being explored actively. In addition to the possibilities of co-financing by current donors, we also may have to consider raising the Bank's proposed loan amount.

EGYPT

Population size (mid-1982):	44.3 million
Annual population growth rate (1970-1982):	2.5%
Contraceptive prevalence (1981):	24.0%
Projected population (2000):	63.0 million
Bank operations in PHN:	Population Sector Memorandum FY85 Population I FY84 ($5 million/IDA) Population I FY71 ($25 million/IDA)

1. The high population growth rate in Egypt is a serious obstacle to social and economic development and is a major factor contributing to poor health status and the deterioration of the physical environment. In the last two decades population growth has averaged 2.6% per annum or almost as much as agricultural production, while the index of food production per capita declined during this period. Total population was estimated by CAPMAS at 47 million in April 1984, and will double in 27 years if present trends continue. Egypt's resource base is not unlimited; a decrease in the rate of population growth will have to be combined with improvements in economic policies if living standards are to be improved.

2. The Government acknowledged officially that rapid population growth was a major obstacle to development as early as 1962, but policy directives have not been translated into effective programs and as a result, Egypt's three-point reduction in fertility in the last decade is no greater than Bolivia's, a country which has no population programs. The Government's population-related measures during the 1960s included the establishment of a national family planning council under the chairmanship of the Prime Minister, a family planning association to coordinate private efforts and agencies; and the provision by the Ministry of Health of family planning services. The 1973 population policy called for a reduction of the birth rate by one point per year from 33.6 per 1000 population in 1973 to 23.6 per 1000 in 1982. Instead, the birth rate rose to about 38 after the 1973 war, then declined again. In 1982 the birth rate was estimated at 35. Government policy calls for increased educational levels, more female employment, industrialization of rural areas, reductions in infant mortality, family planning information and education and family planning services. Family planning services have been de-emphasized from the beginning and this has contributed to the ineffectiveness of the policy. High Ministry of Health officials believe that good health services must be established before family planning interventions are initiated. The Government has been unable to replicate a successful family planning project in Menoufia or to translate lessons learned there to a nationwide effort. At a national population meeting in Cairo in March 1984, President Mubarak reviewed the problems the country is facing because of the high population growth rate. He asked Egyptian leaders for specific programs which would address the population problem. A new National Population Council, which will report directly to the President, is being formed.

3. The Bank's interest in population and health in Egypt dates from 1971, when preparation of its first project was started. The project was implemented between 1973 and 1980 and contributed to expanding the basic health infrastructure. It demonstrated the feasibility of home visiting for family planning and opened the doors for continuation of Bank assistance to the Government. A second project was approved in 1978. Implementation of the hardware component was good and is practically completed. Implementation of the software components did not start until 1981 and is about two years behind original plans. A common factor behind delays in software implementation under the two projects appears to be lack of government commitment to institutional changes required to expand services and increase their efficiency. While the Bank might consider the identification of a project with the private sector Family of the Future organization, the prospects for another project with the Ministry of Health are not good.

4. The Bank should continue to seek every opportunity to stress the priority of population in economic discussions with Government. A population sector memorandum (now in yellow cover) will consolidate information and analysis of the sector and explain in more detail the Bank's sector strategy and next steps. The memorandum should be transmitted to the Government and would serve as a useful focus for future discussions.

5. Development plans should include fertility reduction as a major goal and should take into consideration the impact of different patterns of population growth on each sector and also the influence that activities in a particular sector have on fertility. Education and employment opportunities for women should receive some priority; consumption subsidies could be provided independently of family size, in order to discourage large families; and the cost of high fertility might be partly shifted from the society to the individual family. Outlets for family planning supplies have to be expanded. Pharmacies and private doctors are excellent outlets but they do not cover rural areas adequately. The possibility of distributing some contraceptives through community organizations and small variety shops should be carefully studied.

TUNISIA

Population size (mid-1982):	6.7 million
Annual population growth rate (1970-1982):	2.3%
Contraceptive prevalence (1981):	41.0%
Projected population (2000):	10.0 million
Bank operations in PHN:	Population I FY74 ($4.8 million/IBRD) Health and Pop FY81 ($12.5 million/IBRD)

1. Tunisia's population was 6.7 million in 1982. The population growth rate has been estimated at 2.8% per annum for 1966-1975 and appears to have decreased slightly to 2.5% per annum by 1982. The limited progress in reducing population growth reflects a reduction in infant mortality (from 135 to 84 per 1000 live births) emigration rates and limited progress in the expansion of family planning services. The crude birth rate has declined from 44 to 35 per thousand population and the proportion of the population of reproductive age is expected to decline in the future; this and the relatively high socio-economic level of the population augur well for further reductions in the fertility rate.

2. The Government recognized the importance of controlling population growth soon after independence. The Tunisian family planning program began in 1964, and was the first in Africa. The National Office of Family Planning and Population (ONPFP) was established in 1973 as a semi-autonomous agency under the Ministry of Health which provides services through its own facilities and those of the Ministry. The 1980 Population and Employment Survey showed that 35% of women of reproductive age practised family planning in urban areas, but only 18% in rural areas. Preliminary results from a 1983 contraceptive prevalence survey indicate that contraceptive prevalence is now around 40% of all women. The lower user rates in rural areas reflect the higher infant mortality rates, inadequate health and FP services and lower educational levels of the population (especially of women) in those areas. A more effective family planning program will require improvements in the service delivery network, including further education of physicians in family planning, stronger information efforts, and experimentation with the use of nurses and male paramedical workers in the provision of services.

3. Bank experience in health and population began in 1968, when a population specialist was included in an economic mission (at the request of the Government) to review the demographic situation and the Government's family planning efforts. This was followed by a $4.8 million loan for a project launched in 1971. The project included construction of medical and educational facilities, provision of consultants to devise a system to increase resource utilization in the FP field, and technical assistance for training, and for the evaluation of the national family planning program. The project's closing date was March 1982. The project's hardware

component was implemented, although with delays and cost overruns. Technical assistance to maximize resource use was not successful, largely due to the frequent changes in the MOH management of the program and difficulties encountered in attempts to work with the ONPFP when family planning services were moved to this new, semi-autonomous agency. The external review of the FP system was carried out as envisaged. The Government considered the project a success. The main lessons learned were the need for other approaches to FP besides postpartum contacts, the urgency of reorienting efforts towards rural areas (where the need and the potential for improvement are greatest), and the advantages of decentralizing services to facilitate implementation.

4. A second project was prepared between 1979 and 1981. It focuses on the expansion of basic health services in eight governorates and includes the improvement of management and management information systems for basic health care, the training of middle-level administrators and technicians, and support to the MOH for extending health and FP services in underserved areas of the country. Performance under the project has been generally good. Regional governorate and district level staff have been recruited, retrained and deployed; new managerial procedures have been established; technical guidelines for health programs have been issued and stability and continuity of basic health care has been ensured through separate budgeting and accountability. A third project was appraised in December 1983. It includes expansion of basic health services to nine additional governorates in the southern part of the country, the strengthening of MOH´s services at headquarters; sanitation and community participation; and manpower development. Project implementation has been scheduled for 1985; however, government budgetary constraints and an ongoing reorganization of the MOH and FP services may lead to changes in the project´s schedule.

5. Substantial experience has been gained in the health and population sectors by both the Government and the Bank; however, the problems asociated with coordination of health and family planning services continue. The recent government decision to move the family planning office (ONPFP) to a newly created Ministry of Women and the Family will require the Bank to work with an additional organization on population matters. PHN is planning jointly with Programs to expand the Bank´s macroeconomic dialogue on population, possibly by including specific population elements and staff in future economic missions. Female education and employment issues would be highlighted in planned contacts with the newly created Ministry of Women and the Family in efforts to expand population activities beyond family planning. In the health field the Bank recently carried out a preliminary sector financial analysis and is working with the Government on a series of studies on the unit cost of operations and management improvements. The Bank´s strategy for addressing population issues will have to be reviewed and revised when the Government´s reorganization of population and family planning activities has been accomplished.

BRAZIL

Population size (mid-1982): 126.8 million
Annual population growth rate (1970-1982): 2.4%
Contraceptive prevalence (1981): 25.0% - 30.0%[1]
Projected population (2000): 181.0 million
Bank operations in PHN: Nutrition I FY76 ($19 million/IBRD)
Health-NW Rondonia FY82 ($13 million/IBRD)
Second Health Project FY84 ($57.5 million/IBRD)

1. Brazil's health system reflects great regional disparities. In the large urban areas of the southeast a substantial health infrastucture is already in place which provides high-cost, hospital-based, fee-for-service care. At the other extreme, in the outlying rural areas, particularly in the Northeast, health services are rudimentary. The urban problems are being addressed by the recently approved Second Health Project, while rural disparities will be the focus of the proposed Northeast Project envisaged for Bank financing in FY86.

2. In general, infant mortality was 73 per 1000 in 1982, down from 118 per 1000 in 1960. A survey in the mid-1970s indicated that 21% of children under age 18 had at some time in their lives been severely malnourished. While levels of malnourishment are probably significantly lower today, Brazil's health indicators remain poor for countries with similar per capita incomes. Family planning delivery has occurred primarily through the private sector with the tacit approval of the Goverment. The Brazilian Family Planning Association (BEMFAM), the largest family planning education and service institution for the poor, has been in operation since the early 1970s.

3. Bank involvement with the Brazilian PHN sectors began with small interventions, in 1973, in the form of health components of integrated rural development projects. In addition to the Rondonia health project, the Bank has financed a nutrition improvement project. At present, PHN plans a series of loans for health projects broadly conditioned on continued progress in health policy reform. A sum of US$180 million allocated to three projects has been included in the FY84-88 lending program.

4. In view of official Government reticence on population issues, we keep a fairly low profile. We attended the Western Hemisphere Conference of Parliamentarians on Population and Development in Brasilia in December 1982, as well as the Brazilian Congress on Maternal/Child Protection and Family Planning held in September 1983. More recently, we have witnessed a slight change in the government's position on population issues, specifically in terms of the positive effects family planning can have on maternal and child health. Also, the Country Programs Division recently received a request for technical assistance from the Bank to assist in developing a study on implementing a national population program and a PHN team will travel to Brazil for this purpose in July 1984.

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[1]No Bank estimates are available. This estimated range is based on Brazil's average annual birth rate of 36 per 1000 during the 1980-1985 period.

COLOMBIA

Population size (mid-1982): 27.0 million
Annual population growth rate (1970-1982): 1.9%
Contraceptive prevalence (1981): 49.0%
Projected population (2000): 38.0 million
Bank operations in PHN: Appraisal for Public Health Loan for FY86 program
Nutrition I FY77 ($25 million/IBRD)

1. Beginning around 1963, Colombia experienced a rapid fertility decline, so that by the early 1980s both the crude birth rate and total fertility rate were a third lower than they were in 1960. Over the same period mortality declined by 42 percent. The rate of population growth is still above 2% per year. Preliminary evidence suggests that the decline in fertility is now slowing.

2. Despite a very active program of family planning begun by the private family planning association PROFAMILIA and later supported by the Government, the Government has not expressed interest in Bank advice and/or financial assistance in population. In December 1982, when a PHN mission explored the possibility of using Bank financing to make up an expected shortfall in UNFPA assistance, the technical levels of Government expressed interest in Bank support, but the political levels considered it too risky. When a new health minister entered office in FY84 an informal commission was convened to investigate the government's subsidy of sterilization services. These services are provided by PROFAMILIA. To date, no instance of abuse has been identified, and both private and public family planning programs continue to operate, but the political atmosphere concerning population issues remains tense.

3. The infant mortality rate was 54 per 1000 in 1982, down from 93 per 1000 in 1960. Approximately 8% of children under five years of age are still seriously malnourished, though such malnutrition has been cut in half since 1965.

4. The FY 1978-1982 Bank strategy included a lending program of 32 projects which continued a broad-based effort to support agriculture, industry, infrastructure, power, and selected coastal projects such as nutrition, water supply and sewerage, and urban development. The Bank has previously entered into various loans in Colombia which contained health components such as the National Food Program (PAN--Loan 1487-CO), the Integrated Rural Development Project (DRI I--Loan 1352-CO), and Intermediate Cities Project (ZMI--Loan 1558-CO).

5. At present, the Government expects that an integral part of financing the 1983-1986 Health Plan will be a Primary Health Care loan. The Bank's role is likely to be one of adapting the health system to the austere economic situation in which Colombia finds itself, while remedying the worst regional disparities within the resource constraints. An appraisal mission took place in June/July 1984 and a health loan is included in the FY86 lending program.

JAMAICA

Population size (mid-1982):	2.2 million
Annual population growth rate (1970-1982):	1.5%
Contraceptive prevalence (1981):	55.0%
Projected population (2000):	3.0 million
Bank operations in PHN:	Population/Health Sector Memorandum FY85 Population I FY70 ($2 million/IDA) Population II FY76 ($6.8 million/IDA)

1. Jamaica's rate of natural increase declined from approximately 3% in 1960, to just over 2% in 1980. Emigration was an important factor in easing the impact of rapid population growth in the seventies, however, it is generally thought that the scope for emigration will be much more limited in the future.

2. Health indicators in Jamaica indicate substantial improvement: Infant mortality declined from 52 per 1000 in 1960 to 10 per 1000 in 1982. The country enjoys an adequate health infrastructure, though improved efficiency of the financial and physical resources of the health care delivery system is necessary.

3. Two PHN projects were completed in Jamaica to date. The loans have been reasonably successful in establishing a model of primary health care in Cornwall County, though much less successful in achieving its population objectives due to a decline in Government commitment to the population component during project implementation.

4. In July 1983, the Government introduced a new policy on population before the Parliament and requested Bank support for implementation in the form of a Third Population and Health Project. An identification mission visited Jamaica in November 1983 and among the criteria we adopted in discussing possible Bank assistance were that 1) the main thrust of a third project be population, 2) to the extent that the project deals with health, it should be directed to improving the efficiency of the health care delivery, not expanding existing infrastructure, and 3) the project should be designed on the assumption that Government expenditures on health should not increase in real terms over their current levels. We envisioned a small loan of US$5 to 10 million.

5. The Bank received a proposal of relatively good quality before the close of the last fiscal year. However, given 1) the current difficult economic situation Jamaica; 2) the scarcity of foreign exchange; and 3) the lack of counterpart funds which already hamper execution of other Bank projects, the Region does not plan to let this project continue. A scheduled preparation mission in July 1984 was recently canceled.

MEXICO

Population size (mid-1982):	73.1 million
Annual population growth rate (1970-1982):	3.0%
Contraceptive prevalence (1981):	39.0%
Projected population (2000):	109.0 million

1. Mexico's recent demographic history is characterized by a fertility decline attributed to the enactment of Mexico's national family planning policy in 1973 and subsequent increases in family planning activity in the 1970s. Average annual population growth from 1970 to 1980 fell to 3.2% and a 1979 survey indicated a 2.5% growth rate for 1980. Average family size declined from 6.2 in 1973 to 4.6 in 1979.

2. The death rate declined from 28 per 1000 in 1940, to 12 in 1960, to 8 per 1000 in 1979. Child mortality declined from 10 per 1000 inhabitants in 1960 to 4 per 1000 inhabitants in 1982, though the 53 per 1000 infant mortality rate recorded in 1982 is the highest rate for Latin American upper-middle income countries.

3. In 1978, President Portillo's government announced a specific population growth target recommended by CONAPO of one percent by 2000 with an interim objective of 2.5% by 1982. Due to a combination of socioeconomic changes in lifestyles (e.g. increases in levels of education, health care, urbanization, and women's labor force participation), causing Mexican families to prefer fewer children (demand) and the availability of public family planning services (supply), the 1982 interim goal was met.

4. The Bank has made several attempts to assist Mexico in all three PHN sectors. The Government has apparently felt that problems in PHN sectors should be addressed internally without any overt foreign assistance. All the PIDER projects included PHN components, however, aside from building a few health posts, little PHN work was completed. In 1978, a population loan reached the green cover stage before negotiations were terminated. The proposed Bank project did serve as the basis for the Government program however, though implementation was done with internal resources and with help of UNFPA and non-governmental organizations. Sector work by the PHN Department on the population sector is planned for FY85 and FY86.

CHINA

Population size (1982):	1,008 million
Annual Population growth rate (1982):	1.5%
Contraceptive prevalence (1982):	70%
Projected population (2000):	1,196 million
Bank operations in PHN:	
Bank lending in PHN:	Rural Health and Medical Education FY84 ($85M/IDA) Health II FY86 ($85 million/IDA)

China's crude birth rate was almost halved between 1965 and 1980 and its population growth rate is now extremely low by developing country standards. However recent data indicate a reversal; the total fertility rate (family size) has reportedly increased from 2.5 in 1980 to 2.8 in 1981.

Policy objectives. Birth planning has been a major national priority in China since 1971 when the government launched a new program to promote later marriage, longer spacing between births and fewer children. China's official demographic target calls for a population of 1.2 billion by the year 2000, requiring that the total fertility rate stay below 2 for the rest of this century and that many couples have only one child.

Programs. Since 1980 China's birth planning program has promoted the one-child norm -- resulting in a program of unprecedented strength without parallel in any other country. Family planning services are widely accessible through China's extensive health services delivery system. High levels of contraceptive use are induced by a system of economic rewards to parents with one child who commit themselves to having no more, and penalties for those who have more than two children. However the very strength of the program has rendered its implementation subject to abuse by local officials, reportedly including forced abortions late in pregnancy. Indeed, the strength of current policy seems to have led to female infanticide in order that the only child be male; this practice has become sufficiently widespread to have been denounced by the Prime Minister in public speeches.

Several policy and program issues need to be addressed to maintain the current low fertility levels: (i) the lack of an extensive old-age security system to substitute for economic support provided by children, (ii) the need for appropriate education and improvements in the status of women to overcome persistent son preference, which is a strong cultural impediment to having only one child, (iii) the need to avoid coercion and improve economic incentives in order to encourage acceptance of the small family norm, and (iv) the need to improve the quality of contraceptive services.

Bank role: Early in 1984 the government approached the Bank for a project to assist the State Family Planning Commission. The Bank discouraged the government from pursuing the initiative for several reasons -- concern over

direct support for a coercive program and excesses in the Chinese program, concern over the duplication of family planning services outside the health care system, and concern over diffusing our overall China lending program. The Minister responsible for the SFPC, Mr. Wan Wei, will lead the Chinese delegation in Mexico and will visit the Bank on route. If he again requests project funding during his visit, the response will continue to be discouraging for the above reasons. Staff will stress, however, that the Bank would like to maintain a dialogue. Specifically we will invite Chines participants to EDI's December high-level policy seminar on population, we will offer to organize, in China, a seminar on WDR1984, and we would be willing to engage in extensive discussions with the SFPC concerning the treatment of population in the major economic report now being written. Moreover, PHN plans to maintain a population dialogue in the context of ongoing and planned lending operations in the health sector; a just health project (Rural Health and Medical Education) was approved by the Board in FY84 and a follow-up project is planned for FY86.

GHANA

Population size (1982):	12 million
Annual population growth rate (1982):	3.6%
Contraceptive prevalence (1979):	10.0%
Projected population (2000):	24 million
Bank operations in PHN:	Human Resources Review FY85-86
Bank lending in PHN:	Health I FY87 ($10 million/IDA)

Policy Objective: The Government of Ghana (GOG) adopted a national population policy in 1969, becoming the first West African government to recognize the adverse effects of rapid population growth on individual and social welfare. The GOG aims to achieve a population growth rate of 2.0 percent by the year 2000. Attainment of this goal would require the total fertility rate to be more than halved to a level of 3.3.

Programs: The national family planning program is executed by the Ministry of Health (MOH). Services are provided through maternal and child health clinics operated by the MOH. Additional services are delivered through non-governmental clinics in urban areas. Indirectly supportive policies include efforts to raise female education and to limit maternal benefits and child allowances after three births.

The national program has so far been unsuccessful in achieving significant increases in contraceptive use or reductions in fertility. This reflects the combination of serious constraints on both the demand and the supply side. On the demand side, World Fertility Survey data for 1979 show that only 20 percent of women wanted no more children -- reflecting high levels of desired family size. On the supply side family planning service delivery is constrained by the limited accessibility, poor management, inadequate manpower and ineffective logistics of the rural health delivery system -- which still assigns relatively low priority to family planning services.

Bank Role: The Bank's past involvement in the PHN sectors in Ghana has been limited. A PHN sector review was undertaken in 1978 and updated in 1981. Discussions on possible lending were initiated in late 1980 and components of a project were identified in June 1981. Active project preparation was then suspended, however, due to the difficult political and economic situation in the country. The Bank is again cautiously developing an active PHN work program for Ghana. A project has been proposed for FY87 to assist in instituting a stronger family planning and primary health care program, with the dual goal of strengthening the effectiveness of the national family planning program and improving health/nutrition services. In addition a comprehensive PHN sector review is scheduled for FY86/87.

INDONESIA

Population size (1982):	153 million
Annual population growth rate (1983):	2.1%
Contraceptive prevalence (1981):	46.7%
Projected population (2000):	212 million
Bank operations in PHN:	Population Program Review FY84-85 Nutrition Sector Review FY84-85 Health Administration Study FY86-87
Bank lending in PHN:	Population I FY73 ($13.2 million/IDA) Population II FY78 ($24.5 million/IBRD) Population III FY80 ($35 million/IBRD) Population IV FY85 ($50 million/IBRD) Health I FY83 ($27 million/IBRD) Health II FY85 ($50 million/IBRD) Health III FY88 ($60 million/IBRD) Health IV FY88 ($45 million/IBRD) Nutrition I FY77 ($13 million/IBRD) Nutrition II FY86 ($60 million/IBRD)

Policy Objectives: The Government of Indonesia formally adopted family planning as a national program in 1968, with the explicit objective of reducing population growth. Current demographic policy objectives are to achieve a total fertility rate of 2.7, and a population growth rate of 1.4 percent, by the year 1990.

Programs: The National Family Planning and Coordinating Board was constituted in 1970 to plan and coordinate the work of the several ministries, institutions and agencies active in family planning. The program, which provides education on population and family planning, maternal and child health care and family planning services, has been remarkably successful in recruiting new acceptors and raising contraceptive prevalence rates (CPR). By December 1983 overall contraceptive prevalence had reached the relatively high level of 47 percent. However this overall success masks distinct variation in achievements across provinces is the result of different sets of underlying problems. Contraceptive prevalence rates averaged 53 percent in Java-Bali, but only 16 percent in the 11 provinces in the Outer Islands region where services are not yet widely available.

This variation in the CPR points to distinct challenges for program development in different provinces, especially as achievement of GOI's demographic objectives will require a substantial increase in overall contraceptive prevalence. In the Outer Islands, where access to program services is limited, substantial program effort is necessary to overcome basic supply constraints to meet unmet demand for contraceptives and create family planning awareness. On the other hand, in Java-Bali where this initial phase has already been successfully accomplished, the program faces

´second generation´ challenges. These include: (i) the need to forestall rising discontinuation rates as women experience side-effects from long-term contraceptive use and find that economic and other rewards promised to them for limiting family size do not materialize; and (ii) the need to motivate groups which have thus far remained impervious to the family planning message. This will require improvements in service quality and new demand-creating initiatives including stronger motivational efforts, provision of education, health and nutrition services, economic incentives, better follow-up to treat side-effects and diversification of method mix (away from heavy reliance on the pill).

Bank Role: The Bank´s role in helping to achieve program progress has been important, as the three Bank-financed population projects in Indonesia were a significant part of the expanding national family planning program. For the future, the Bank is proposing to continue its strong support for population activities in Indonesia. Sector work is being undertaken to arrive at a more complete evalutation of the country´s family planning program. This evaluation forms part of the preparatory activities for a fourth population project on population sector loan proposed for FY85. The Bank is also planning to support development of needed health manpower and provincial health care services which will support family planning efforts.

NIGERIA

Population size (1982):	91 million
Annual population growth rate (1982):	3.3%
Contraceptive prevalence (1982):	6.0%
Projected population (2000):	161 million
Bank operations in PHN:	PHN Sector Review FY84-86
Bank lending in PHN:	Sokoto Health FY85 ($34 million/IBRD) Health II FY87 ($50 million/IBRD) Population I FY86 ($25 million/IBRD)

A reliable assessment of demographic trends in Nigeria is precluded by the lack of accepted census data since 1963. Efforts during the past decade to enumerate the population were hindered by political and cultural sensitivities associated with Nigeria's ethnic composition, memories of the civil war and the role of population size in determining the allocation of political power and tax revenues among states. The National Population Commission has recently raised its estimate of the population growth rate from 2.5 to 3.3 percent.

Policy Objectives: The Fourth Development Plan states that the fertility rate should be reduced to ease the adverse economic consequences of high fertility. It also states that the Government will support development of family planning information and service delivery through the health sector. However the Government has not yet developed a population policy with explicit demographic objectives or operational targets for contraceptive use.

Programs: The National Population Commission has been restricted to population enumeration, demographic research and vital statistics. Operational responsibility for family planning services as part of maternal and child health care lies with the Federal and State Ministries of Health, although the Government has not yet organized a national family planning program.

Bank Role: The Federal Government was not receptive to discussing population and family planning issues because of their political and cultural sensitivity. However, a marked change in attitude occurred recently with increased awareness among senior officials of the impact of rapid population growth on economic development and the need for public intervention. The possibility of Bank support for the first phase of assistance to the population sector is now being considered. A population project has been proposed for FY86 to provide assistance for strengthening data collection and planning capacity of existing Federal population agencies, and for supporting delivery of family planning services through both the public and the private sector. A first health project in Sokoto State awaits final approval by the Government before presentation to the Board. The project will strengthen the delivery of maternal and child health care, including family planning services. Further support of direct family planning activities is envisaged as an integral component of future State-level health projects. Proposed sector work will focus on population policy development in preparation for the proposed population project.

SENEGAL

Population size (1982):	6 million
Annual population growth rate (1982):	2.9%
Contraceptive prevalence (1978):	4.0%
Projected population (2000):	10 million
Bank operations in PHN:	Population Sector Memo FY84-85 Health Sector Memo FY86
Bank lending in PHN:	Health I FY83 ($15 million/IDA) Population I FY88 ($15 million/IDA)

Policy Objectives: The Government of Senegal (GOS) recognises the adverse health consequences of high fertility and supports the provision of family planning services within the framework of maternal and child health services. However, despite the formation of the National Population Commission, (responsible for population policy and planning) the GOS has not formulated explicit demographic goals or operational targets for contraceptive use.

Programs: No organised national family planning program exists in the conventional sense, although the GOS is laying the basis for its development through national conferences and increased media emphasis on population issues. Nevertheless the elements of a national program are visible in the Ministry of Public Health, responsible for supplying family planning services through the health delivery system, and the Ministry of Human Promotion which is responsible for supporting information services. In the medium term the major operational issues are to strengthen the institutional capability to increase the supply of family planning services and to promote the demand for their use in an economic and social context which encourages high levels of desired family size.

Bank Role: An IDA credit of US$ 15 million was approved in 1982 in support of a Rural Health Project that will develop rural health centres in underserved areas. Family planning services, hitherto limited to the capital city, will be integrated with the health services provided through these centres. The project will substantially strengthen the national health delivery system which will provide a vehicle for providing extensive family planning services. Preparation of a population sector memorandum in FY85 will provide the basis for sector dialogue focused on future population policy and program development. It is expected that this dialogue will result in preparation of the first population project, scheduled for FY88.

THAILAND

Population size (1982):	49 million
Annual population growth rate (1982):	2.2%
Contraceptive prevalence (1982):	59%
Projected population (2000):	68 million
Bank operation in PHN:	Population Policy Study FY84-85 Health Sector Financing Study FY86
Bank Lending in PHN:	Population I FY78 ($33.1 million/IDA) Population II FY87 ($50 million/IBRD) Health I FY89 ($50 million/IBRD)

Thailand made substantial progress in reducing its fertility rate during the 1970s. The total fertility rate fell by more than one third between 1965 and 1978 - one of the most rapid fertility declines on record. However recent evidence indicates that this rapid progress has begun to slow down.

Policy objectives. The Royal Thai Government (RTG) has been committed to an explicit policy of fertility reduction since 1970. Its current objective is to reduce the population growth rate to 1.5 percent by the end of the Fifth Five Year Plan, 1986.

Programs. The fertility reduction effort has been narrowly focused on integrated delivery of family planning with health services through the Ministry of Public Health. This has successfully overcome the supply constraint that characterized the program during the 1970s and has raised the contraceptive prevalence rate to a relatively high level, nearly 60 percent. However further increases in prevalence will be necessary to attain the RTG's demographic objective. This will require new initiatives to: (i) improve the quality of contraceptive services to reduce persistently high contraceptive discontinuation rates, (ii) target services and motivational activities more effectively to resistant or underserved groups (e.g., muslims in the South, slum dwellers, and adolescents), possibly through the involvement of additional agencies -- such as the Ministries of Interior, Education, Community Development, Agriculture, and selected non-governmental organizations, (iii) create additional demand for contraceptive use through beyond family planning measures such as population education and economic incentives.

Bank Role. The Bank's first population project -- aimed at expanding access to the Ministry of Public Health's family planning and health services in underserved areas -- will close at the end of 1984. A population policy review paper will be prepared during FY85/86 to assess future policy options to promote further fertility reductions. A second population project (programmed for FY87) would be designed on the basis of this sector work and would be likely to include (i) broader multisectoral involvement, (ii) incentive schemes and (iii) institutional support for a multi-agency coordinating and monitoring unit, probably located in the national planning agency (National Economic and Social Development Board). The Bank's ability to develop a strong population policy dialogue and lending program is constrained, however, by the RTG's strong reticence to borrow on IBRD lending terms for 'soft' sector projects.

18 July 1984

LIST OF DELEGATIONS PARTICIPATING IN ICP-1984

COUNTRY	DELEGATION	PLACE ON SPEAKERS LIST
AFGHANISTAN	D. Sadeqi Dpymin Central Statistics Office	
	F. Maroofi Vice Chairman State Planning Committee	
	Dr. H. Mal President MCH Department	
	Dr. A. Sekandary Planning Department Council of Ministers	
AUSTRIA	Elfnede Karl ** Minister for Family Affairs	8/9 p.m.
BAHRAIN	Habib Hassan Acting Director of Directorate of Physical Planning	7/8 a.m.
BANGLADESH	Shamsul Haq ** Minister of Health and Population Control	7/8 a.m.
	Abu Hena Director General Population Control Directorate	
	Azizul Karim Deputy Chief Planning Cell Ministry of Health and Population Control	
	Najmul Huq Director IEM	
	Abdus Salam Private Secretary to Minister	

	Alamgir Kabir President BFPA
	Moulana Nuruzzaman Khan Professor Alauddin Dhaka University
	Dr. Azizur Rahman President BAVS
BHUTAN	Dasho T. Tobgyel Foreign Secretary
	Dasho T. Younten Director of Health Services
BOTSWANA	M.G. Mooka Principal Statistician
	A. Matlhaku Senior Planning Officer Ministry of Finance and Development Planning
	W. Manyeneng Chief Health Education Officer Ministry of Health
BURMA	U Paw Thein Deputy Minister Ministry of Home and Religious Affairs
	Col. Maung Maung Zin Director General Immigration and Manpower Department
	U Than Shwe Deputy Assistant Director Demographer
	U Saw Thoe Mah Statistical Officer Census Division
	U Maung Maung Lay Statistical Officer Census Division

CHINA	Want Wei ** Minister in Charge of Family Planning Commission	7/8 p.m.
COMOROS ISLANDS	Mohamed Moumini	
	Ahmed Zaidou	
	Mohamed Loutfi	
CYPRUS	Euripides Demetriades Director of Statistical Department	
CZECHOSLOVAKIA	Vladimir Marik Deputy Minister of Labour and Social Affairs	
	Dr. Ing. Vaclav CAP, CSc. Deputy Chairman of the Federal Statistical Office	
	Jindrich Tucek Ambassador to Mexico	
	Vaclav Oklestek Third Secretary Permanent Mission to the UN	
	Jiri Siktanc Head of Department Federal Ministry of Labour and Social Affairs	
DEMOCRATIC KAMPUCHEA	M. Thiounn **	8/8 a.m.
DEMOCRATIC REPUBLIC OF YEMEN	Dr. Farag Bin Ghanem Minister of Planning	7/8 p.m.
	Hassan Hubaish Assistant Deputy Minister of Planning	
	Salim Ben Human Director-General Central Statistical Organizations	
	Mohamed Ban Raiyah Department of Population and Social Statistics	

DJIBOUTI	Will Not Participate	
EGYPT	Professor Aziz El-Bendary President Supreme Council for Family Planning and Population	
	Aziz Seif El-Nasr Ambassador of Egypt to Mexico Embassy of Egypt, Mexico	
	Maher Mahran Head of Gynecology Division School of Medicine Ain Shams University	
	Abbas El-Ammary Counsellor Embassy of Egypt, Mexico	
ETHIOPIA	Merssie Ijigu Head of Macro Planning, with a rank of Minister	
	Miteke Beyene Head of the Central Statistics Office	
	Abdulahi Hassen Head of Population and Social Statistics in the Central Central Statistics Office	
	Meshesha Getahun Senior Expert in the National Revolutionary Campaign and Central Planning Supreme Council	
	Habetemariam T/Giorgis Head of Population and Housing Statistics in the Central Statistics Office	
FEDERAL REPUBLIC OF GERMANY	Waffen Schmidt ** Secretary of State Ministry of the Interior	6/8 p.m.
FIJI	Apenisa Kuruisaqila Minister of Health	
	Timoci Bavadra Director of Health Services	

FINLAND	E. Kuuskoski-Vikatmaa ** Minister of Social Affairs and Health ALTERNATE REPRESENTATIVE Seppo Kauppila Assistnat Director Ministry for Foreign Affairs Erkki Laatto Director Ministry of the Interior Markku Lehto Director of Planning Ministry of Social Affairs and Health Elina Visuri Counsellor Ministry of Foreign Affairs Tapani Valkonen Professor University of Helsinki Jouko Hulkko Executive Director Population Federation Marja-Liisa Kiljunen Second Secretary Ministry of Foreign Affairs	6/8 p.m.
FRANCE	Georgina Dufoix ** also Leon Tabah	6/8 p.m.
GABON	N'Nang Ekomie Barthelemy Health Minister Counsellor	
GAMBIA	Momodou Manneh Minister of Economic Planning and Industrial Development Mrs. Mboge Ministry of Health Thomas Gambia Family Planning Association	
GREECE	Minister JJJ Floros	
GUINEA	M. Bartolomeu Simoes Pereira	

HOLY SEE *	H.E. Archbishop Jan Schotte	
	Monseigneur Antonio Mattiazzo	
	Monseigneur James T. McHugh	
	Rev. Diarmuid Martin	
	Mr. Guzman Carriquiry Lawyer	
	Dr. Andrew Kiura	
	Mrs. Marie Mignon Mascarenhas	
HUNGARY	Ierecme Nyitrai ** State Secretary, President of the Central Statistical Office of Hungary	8/8 p.m.
INDONESIA	Emil Salim ** Minister for Population and Environment ALTERNATE Haryono Suyono Chairman, BKKBN	8/8 a.m.
	Dr. Kartomo	
	Dr. Ascobat Gani OG KLH	
	Dr. Hosni Suradji Foreign Affairs	
	Mrs. Luhulima State Ministry Roles of Women	
	A.R. Surono, M.D. Department of Health	
	Kartono Mohamad, M.D. FISKA (Forum for Population Activities of NGO)	
	Sutjipto MSC' IPPA	
	Prof. Sudradji, M.D. PKMI (Association for Secure Contraception)	

ISREAL	Ben Zion Rubin Deputy Minister of Labour and Social Affairs	
	Moshe Arad Israeli Ambassador in Mexico	
	Moshe Sicron Government Statistician	
	Chaim Kubersky Director General Minister of Interior	
	Roberto Bachi Professor Emeritus of Demography and Statistics	
	Shimon Yair Director of the Demography Center	
JAMAICA	Dr. Kenneth Baugh Minister of Helath	
	Mavis Gilmour ** Minister of Education	7/8 p.m.
	Dr. Headley Brown Director General Planning Institute	
	Dr. Barbara Boland Director Population and Manpower Division PIOJ	
	Dr. David Thwaites Chairman NFPB	
	Mrs. June Rattray Executive Director NFPB	
	Mrs. Edna Tulloch Director Planning and Evaluation Unit MOH	

	Mrs. Merle Higman Head of the Division of Population and Census in Statistical Institute of Jamaica	
	Prof. Dr. Hugh Wynter Director Department of Obstetrics and Gynaecology UWI	
JAPAN	Kozo Watanabe ** Minister of Health and Welfare	7/8 a.m.
JORDAN	H.E. Tayseer Abduljaber Minister of Labour Chairman/National Population Commission	9/8 p.m.
	Borhashrydeh Director General Department of Statistics Secretary General/National Population Commission	
	Tertio NGO Specialist Population to be identified ASAP	
KENYA	** Mwai Kibaki Vice President	
	One member of Parliament	
	Chairman National Council on Population and Development	
	Two permanent secretaries Directors of National Family Welfare Centre and national Council on Population	
	Government Chief Demographer	
	Director Population Institute	
	Executive Director Family Planning Association of Kenya	

	Director FLE National Christian Council of Kenya
	Programme Director of Meals for Millions/Freedom from Hunger Campaign
	Demographer National Environmental Secretariat
LEBANON	Fouad Aoun Ambassador of Lebanon in Mexico
	Saad Zakhia Secretary of the Lebanon Embassy/Mexico
	Francois Farah Prof. Lebanese University

LESOTHO	PHP Lehoenya Minister of Health	
	T. Makeka Ambassador	
	G.P. Khojane Counsellor UN Mission	
	M.F. Morojele Demographer Bureau of Statistics	
	A.P. Maruping Director Health Services	
	P.N. Fanana Sen. Planning Officer Central Planning	
	A.M. Mokokoanek Commissioner Womens Bureau	
LIBREVILLE	N'Nang Ekomie	
LUXEMBOURG *	M. Georges Als Director Central Service of Statistical and Economic Studies	
MALAWI	Minister of Health	
	Deputy Secretary Health	
	Asst. Chief Medical Officer (MCH)	
	Commissioner Census and Statistics	
MALAYSIA	Head of Delegation **	7/8 p.m.
MALDIVES	Mohamed Musthafa Hussain Perment Representative in the United Nations in New York	
MALI	Ahmed Mohamed AG Hamany	

MOROCCO	2 from the Ministry of Planning 1 from the Ministry of Social Affairs 1 MOH, Presided by a Minister	
MOZAMBIQUE	Pascoal Mocumbi Minister of Health	
	Manuel Lourenco Rodrigues National Director of Statistics	
NEPAL	Minister of Helath	
	Nepal Ambassador	
	Member of National Parliament	
	Chief FP/MCH Project	
	Secretary of National Commission on Population	
	Chairman Nepal Elders Association	
NETHERLANDS	Mrs. Schoo ** Minister of Development Co-operation	7/8 a.m.
NIGERIA	Director National Population Bureau	
	Representative of Ministry National Planning	
	Representative of Nigeria Institute of Social and Economic Research	
	Executive Director PPFN	
PAKISTAN*	Mahbub Ul Hag ** Minister of Planning, Development, Population, Welfare	8/8 p.m.
	Attiya Inayatullah Adviser to the President of Pakistan for Population Welfare	
Norway	** Ms. Reidun Brusletten, Min. of Dev. Assistance	

Amir Usman
Ambassador of Pakistan
Mexico

S.K. Mahmood
Member(Projects)/Additional
Secretary Planning
Commission

Begun Zeba Zubair
Chairman,
Executive Board Secretariat
Pakistan Voluntary Health
and Nutrition Association

A. Razzaque Rukanuddin
Director General (NIPS)

PERU	Carolos Nuñoz Torcello ** President of the National Population Council	8/8 p.m.
	Andres Cardo Vice-Minister lEducation	
	Carlos Bazan Vice-Minister Health	
	Graciela Valdez Head National Statistical Institute	
	Luis Pacheco Advisor National Planning Institute	
	Luis Sobrevilla Executive Secretary National Population Council	
PHILIPPINES	Sylvia P. Montes Minister, Ministry of Social Services and Development Chairman, Board of Commissioners Commission on Population	

	Vicente Valdepeñas Minister of Economic Planning Director-General, National Economic and Development Authority Member, Board of Commissioners Commission on Population	
	Mercedes B. Concepcion President, International Union for the Scientific Study of Population Member, Board of Commissioners Commission on Population	
	Eugenia G. Jamias Executive Director Commission on Population	
	Francisco Faller FPOP President	
	Senon Posadas FPOP Executive Director	
PORTUGAL	Maldonado Gonelha ** Minister of Health	7/8 p.m.
SAINT LUCIA	Minister of Health, Housing and Labour	
	Clendon Mason Permanent Secretary Ministry of Helath, Housing and Labour	
	Marilyn Floissac Family Planning Association	
SAINT VINCENT AND THE GRENADINES	Joel G. Toney Permanent Representative to the United Nations	
	H.A. Jesudason Senior Medical Officer	
	Faustina Eustace Executive Secretary St. Vincent Planned Parenthood Association	
	Rene Baptiste	

SAO TOME AND PRINCIPLE	Agapito Mendes Dias Planning Minister and President of the National Population Commission	
	Carolos Gustavo dos Anjos Director, Statistical Office Vice President of the Population Commission	
	Dulce Fernandes Gomes National Coordinator for Family Planning Programme M.C.H. Director	
SIERRA LEONE	S.H. Kanu ** Minister of Economic Development and Planning Chairman, National Population Commission	8/8 p.m.

Clifford Roberts
National Council for Social Services

Amy Kallon
Parliamentary Special Assistant
Ministry of Tourism and Cultural Affairs

Emanuel O. Grant
Parliamentary Special Assistant
Ministry of Education

Madam Sally Gendemeh
Member of Parliament

D. A. B. Minah
Development Secretary
Ministry of Development and Economic Planning
Member, National Population Commission

Gerald J.W. John
AG Senior Development and Planning Officer
Ministry of Development and Economic Planning

Arnold Aubee
Government Pathologist
Ministry of Health
Honorary President
Planned Parenthood Association
Member, National Population Commission

Sylvia Blyden
Administrative Officer
Ministry of Finance
Member, National Population Commission

Septimus George
Principal Medical Officer
Western Area
Ministry of Health
Member, Medical and Dental Association
Member, National Population Commission

	Harold R. Davies AG Senior State Counsel Ministry of Justice Member, National Population Commission	
SOMALI	Ahmed Mohamed Adan Permanent Representative to UN/New York	
SRI LANKA	Ranjit Atapattu ** Hon. Minister of Health	8/8 a.m.
	Wickrema Weerasooria Secretary, Plan Implementation	
	D.P. Wijegoonasekera Director, Population	
	Vinitha Jayasinghe Director, Women's Bureau	
SUDAN	Minister of Finance ** and Economic Planning	8/8 p.m.
	Deputy H.E. the President of the Sudan National Population Committee Secretary-General of the Sudanese Women's Union	
	Director-General of Statistics Department Member of the Sudan National Population Committee	
	Representative of the Ministry of Health Member of the Sudan Natonal Population Committee	
	Representative of Non-Governmental Organization Chairman of Sudan Family Planning Member of the Sudan National Population Committee	
	Representative of Ministry of Education and Guidance Member of Sudan National Population Committee	

Representative of the
Ministry of Foreign Affairs

Representative of Sudan
Mission (UN-NY)

Adviser of Delegation and
Member of Sudan National
Population Committee

SWEDEN*

Gerdnel Sigurdsen ** 7/8 a.m.
Minister at the Ministry
of Health and Social
Affairs

Karl-Anders Wollter
Ambassador
Mexico City

Jan Bergqvist Soc. Dem., Head of Prep. Comm., Head of UNA, member Foreign Relations Comm.
Member of Parliament

Ingrid Sundberg Conservative
Member of Parliament

Karin Soder Center, Former Foreign minister
Member of Parliament

Anita Persson Soc. Dem., Social affairs Comm.
Member of Parliament

Ingemar Eliasson Liberal, Former labor market Minister
Member of Parliament

Egon Diczfalusy
Professor
Karolinska Institute

Carl Wahren
Head of Division
Swedish Interntional
Development Agency

Rolf Andreen
Director
Ministry of Foreign Affairs

Marianne Millgardh
Press Secretary
Ministry for Health and
Social Affairs

	Anita Melin First Secretary Ministry of Foreign Affairs
	Fredrik Schiller First Secretary Permanent Mission of Sweden to the UN
	Erik Hammarskjold Second Secretary Mexico City
	Lucie Elmdahl Head of Section Swedish International Development Agency
TANZANIA	Prof. Kighoma Malima Minister of Planning and Econ. Development
	Christina Nsekela Executive Secretary Umati National Association for Responsible Parenthood
	Wilfred Mlay University of DSM
	Mr. U. Tenende Population Officer Ministry of Planning and Economic Development
TOGO*	S.E.M. Koffi Katanga Walla Minister of Planning
	M. Nouridine Bouraima Demographic Director of Statistics
TRINIDAD AND TOBAGO *	Mr. D. Hunte Senior Statistician Central Statistical Office Ministry of Finance and Planning
TURKEY	M. Sydin Minister Mohsa
	Dr. Tokgos General Director of GD FP/MCH

	A. Toros Hacettepe University Turkish Ambassador to Mexico	
UNITED ARAB EMIRATES	Said El-Gaith Acting Minister of Planning and Minister of State for Council of Ministers' Affairs Chairman	8/8 p.m.
	Abdul Sallam Muhammad Director of the Department of Planning Acting Director of the Central Department for Statistics	
	Khalifa Shaheen Al-Merre Second Secretary Permanent Misson of the United Arab Emirates to the United Nations	
	Ali Abdul Salam Director of Planning Acting Director of Central Statistics Department	
VIETNAM	Hoang Dinh Cau Senior Vice Minister of Health	
	Huynh Cong Tam Deputy Director Department of International Organisations Foreign Ministry	
	Dang Thu Ministry of Labour	
	Nguyen Thi Xiem Deputy Director Institute for Mothers and Newborn	
YEMEN ARAB REPUBLIC	Mohammed Ahmed Elkustabon Director of General Department for Studies and Research in the Presidency Office	

	Yahya Al Qaisal Director General of Statistics in the Central Planning Organization
	Ali Abdullah Abdo General Manager for Planning in the Central Planning Organization
	Abbas Ali Zabara Director of PHC Ministry of Health
	Ahmen Ali Alhammamy Director-General Health and Medical Services Ministry of Health
ZAMBIA	Kankasa, MCC
	Tambatamba Ministry of Health
	J.P. Banda Director of CSO
	Raymond Chipoma Planning Officer NCDP
	Musambo Health Planner
ZIMBABWE	Gibson Mandishona Director CSO
	Stanley Mahlahla Deputy Secretary Ministry Finance Economic Planning
	Naison Muroyiwa Member of Parliament

* Official response received

** Fro OSSECs speakers list

UNITED STATES

James L. Buckley
(Head of Delegation)
Director of Radio Free Europe and
former Senator (Rep.-N.Y.)

Alan Keyes
U.S. Representative to U.N. Social
and Economic Council

William H. Draper III
President
Export-Import Bank

Danny J. Boggs
Deputy Secretary of Energy

Ben Wattenberg
Author

Jacqueline Shafer
Council for Environment Quality and
former Buckley Aide

Gregory J. Newell
Undersecretary of State

James L. Malone
Assistant Secretary of State

M. Peter McPherson
Administrator
U.S. Agency for International Development

July 20, 1984

Mr. Rafael M. Salas
Secretary-General
International Conference on Population
United Nations
New York, N.Y. 10017

Dear Mr. Salas:

I refer to your letter of June 8 (ICP(1984)) advising that the International Conference on Population will be held in Mexico City from August 6 to 13, 1984.

I am pleased to inform you that The World Bank delegation to the Conference will comprise the following:

Mr. A.W. Clausen, President, Chairman of the Delegation - August 6 - 9;
Mr. John D. North, Director, Population, Health and Nutrition Department, Chairman of the Delegation - August 10 - 14, and Representative;
Mr. Stephen Denning, Division Chief, Representative;
Ms. Barbara Herz, Senior Economist, Representative;
Ms. Ishrat Husain, Division Chief, Representative;
Dr. Kandiah Kanagaratnam, Special Adviser, Representative;
Mr. Emmerich Schebeck, Division Chief, Representative;
Ms. Nancy Birdsall, Staff Director, World Development Report, Adviser;
Mr. Ciro Gamarra, Information and Public Affairs Department, Adviser;
Dr. K.V. Ranganathan, Economic Development Institute, Adviser.

Sincerely yours,

Alexander Shakow
Acting Director
International Relations Department

cc: Members of Bank Delegation

MMcDonald

POSTAL ADDRESS—ADRESSE POSTALE UNITED NATIONS, N.Y. 10017
CABLE ADDRESS—ADRESSE TELEGRAPHIQUE UNATIONS NEWYORK

REFERENCE:

ICP (1984)

9 July 1984

Sir,

I have the honour to refer to my letter of 8 June 1984 in which your Organization was advised of the action taken by the Economic and Social Council at its first regular session of 1984 on the report of the Preparatory Committee for the International Conference on Population, 1984.

The purpose of this letter is to inform your Organization of the arrangements being made by the Government of Mexico for the inaugural ceremony for the Conference which is to be held on 6 August 1984 immediately before the convening of the first meeting of the Conference.

The ceremony, which is being arranged by the Government of Mexico, will be held at the Palacio de Bellas Artes, Paseo de la Reforma. Admission to the ceremony will be by identification cards issued to delegations on registration before 6 August or by special invitation of the Government of Mexico to be issued by the Government.

Registration of delegations, it is recalled, will begin at the Conference Area of the Ministry of Foreign Affairs, Tlatelolco Centre, Mexico City, at 9 a.m. on Thursday, 2 August 1984. The registration desk will be open from 9 a.m. to 6 p.m., including the weekend of 4-5 August.

All participants are required to be seated in the Palacio by 9:30 a.m. The ceremony will commence at 10 a.m. sharp. His Excellency Mr. Miguel de la Madrid Hurtado, Constitutional President of the United Mexican States will deliver the inaugural address.

UNITED NATIONS NATIONS UNIES

At the conclusion of the ceremony, the Mexican authorities will provide transportation to the Conference area at the Tlatelolco Centre and the first meeting of the Conference will be convened there by the Secretary-General at 11:45 a.m. At that meeting the Conference will, on the basis of the recommendations of the pre-Conference consultations, elect the President of the Conference and take action on other organizational and procedural matters. It is expected that these actions will enable the Conference to continue its work as foreseen by the Preparatory Committee, that is that the general debate will begin in plenary at 3 p.m. of the same afternoon and that the Main Committee will start its work, also at 3 p.m. on that day.

With regard to the availability of seats, in addition to seats for representatives of governments, seats for representatives and observers of the national liberation movements, specialized agencies and intergovernmental organizations will be available as will be a limited number of seats for observers from non-governmental organizations.

Accept, Sir, the assurances of my highest consideration.

Rafael M. Salas
Secretary-General
International Conference on Population, 1984

ITINERARY

TUESDAY, AUG. 7