the commitment of governments. Stronger opposition comes from political groups, the nationalists and the extreme right and left.

Nevertheless, rapid population growth presents major problems and the familiar pattern has emerged. The economies do not offer enough employment opportunities to absorb the growing labour force and many people are unemployed or underemployed, mainly in the cities. The poor from the country migrate to the town, the shanties and slums grow. In town and country alike there are many who do not benefit from health, welfare and educational services, and despite growing investment, it is not possible to meet the basic needs of the populations at the present rate of growth.

2.32. Conclusion

These pages present a generalised and somewhat inadequate glimpse of the beginning of what promises to be a long story. I have concentrated on the international voluntary movement for many reasons, despite the fact that other organisations have been working in this field for some time and they have perhaps been better financed and extremely expert. The voluntary movement reflects the thought and actions of a great many men and women who were prepared to do something about the problems that surrounded them. As a result of their work, opinions have changed and programmes have developed from nothing. They have managed to reach into sensitive areas and have worked where family planning was unknown or bitterly opposed. They have made the movement grow until support, money, experts, trained staff, improved contraceptives and large-scale programmes became possible.

There is still much to be done. The IPPF has 79 member countries now and is working in others where even forming an association is difficult. There are many inadequacies, and the whole subject is surrounded by idealised, uninformed and optimistic thinking. Yet perhaps those who complain and condemn would do well to reflect on the story so far and the reception that many of the associations have received. In this light, it seems a near-miracle that there are now so many countries in which there is an association made up of people dedicated to the belief 'that knowledge of planned parenthood is a basic human right and that a balance between the world's population and its natural resources is a necessary condition of human happiness, prosperity and peace'.

3

Ten institutional obstacles to advances in family planning

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3.1. Introduction

The 1960s might be considered the first international birth-control decade. During this period oral contraception became a reality and birth control thereby a respectable topic of conversation. But more important still, politicians at last came to recognise population growth as a genuine threat to the future of mankind. On 10 December, 1966, 12 governments actually signed a Declaration on Population, and this was endorsed a year later by 18 others. The malignant possibilities in man's power of procreation had finally achieved formal recognition on a global scale.

During this period, too, the local political and religious barriers against the right of man to regulate the size of his family began to dissolve. By the end of the decade, 66% of the people in the developing world lived in countries whose governments had adopted population policies—and the Vatican's rearguard action against the forces

of demographic logic had largely failed. Apparently our task was to ensure 'enough bread on the tables of mankind', and not to 'diminish the number of guests at the banquet of life' (Pope Paul, 1965). But for the leaders of the countries where the larders were already bare, such exhortations only increased the size of the religious credibility gap.

It was also during the 1960s that the demand for the non-sex-related methods of contraception, which required medical skills for their prescription and application, did much to involve the reluctant medical profession in family planning. And despite both medical and religious opposition, restrictive abortion laws in a number of countries were challenged and many began to tumble.

Probably most important of all, it was during the 1960s that foreign assistance funds were specifically allocated for birth control—a move pioneered by the Swedish International Development Authority (SIDA). In 1962, less than five million dollars were available through international sources for family-planning programmes, but by the close of the decade, over one hundred million dollars of foreign assistance funds had been specifically allocated for this purpose in developing areas.

But what were the actual demographic achievements of the decade? Unfortunately, there is little firm evidence that the family-planning programmes had any significant impact on population growth rates. It is true that fertility rates have declined in many countries, but was this a result of these programmes? It is argued by 'demographic agnostics' (Bogue, 1970) that this result could be due principally to the influences of modernisation and socio-economic advance rather than the use of contraceptives by the relatively small number of couples actually served by the programmes.

Clearly, then, as we enter the 1970s many of the traditional hurdles to advances in family planning have been overcome. We are now faced with the central problems of mobilising adequate resources, evolving appropriate delivery systems, developing more acceptable methods of birth control, and persuading people to use them. Fortunately, however, the resources required are being made available both nationally and internationally on an ever increasing scale; prostaglandin development and simple, safe methods of out-patient abortion now make *post hoc* contraception (as distinct from *propter hoc* contraception by the pill and IUD and *ad hoc* contraception by the traditional methods) a reality. In the meantime the burgeoning

mass media will facilitate the delivery of birth-control promotional campaigns.

But despite such dramatic advances, there are a number of disturbing features within the family-planning movement which are emerging as serious checks to this momentum, features which in many cases are already impairing the evolution and development of effective programmes, namely,

(*a*) committee management, (*b*) amateurism, (*c*) the growing entanglement of the medical profession, (*d*) the symptom of over-anticipation, (*e*) the lack of definitions, (*f*) confused and inappropriate operating philosophies, (*g*) territoriality, (*h*) tunnel vision, (*i*) belief in organisational omnipotence, (*j*) emergence of a family planning establishment.

3.2. Committee management

A legacy of the pioneer and voluntary organisational background from which family-planning programmes (and some international agencies) have evolved, is the tradition of management by committee. There is hardly a family-planning association or national programme in the world today in which the executive directors are not tightly shackled to cumbersome management committees, the natural consequence of which is ponderous and vacillating administration.

The necessity for such committees is usually rationalised on the grounds that involvement undermines potential opposition and helps to legitimise the programme. It is true such a strategy does tend to placate opposition, but this is partly a function of the resultant inertia rather than democratic participation. The dividend of legitimisation is more than offset by the accumulated losses due to inefficiency and waste inherent in such a bureaucratic structure.

If family-planning programmes are to be effective, they need responsive and dynamic management. An organisation can only operate efficiently if it has the flexibility and freedom to manoeuvre, not only within the confines of planned strategy, but also to meet contingencies. Constant referral to large committees wastes time, absorbs precious energy and stunts creative leadership—all too often this ensures the evolution of a bureaucratic dinosaur, which must consume vast resources to maintain its metabolism, is slow in response and generates prodigious amounts of wind.

If population growth rates are to be reduced with the limited

resources available, it is imperative that we develop forceful and business-like organisations. This means we must recruit, train and pay for top management and most important of all—we must let them manage.

3.3. Amateurism

The history of family planning is studded with stories of single-minded pioneers who overcame bigotry and inspired their followers with a sense of burning vocation. No doubt it was the ready availability of these disciples combined with economic necessity which has meant the traditional dependence of family planning on voluntary and part-time labour. But as a consequence, many local associations and some international organisations have acquired a kind of 'sewing circle' mode and, not unnaturally, there has been a certain reluctance to open these up in order to accommodate the rapid changes in this field. Because of this unwillingness to evolve, institutional amateurism has become a serious check to innovative and efficient expansion of many programmes. Almost diagnostic of this amateur organisational situation is the Roneo or Mimeo Syndrome in which every committee, debate and crisis is concluded in an orgasm of duplicated 'memos'.

But as we begin the second international birth-control decade conditions have changed irrevocably. Family planning needs professional skills from a wide variety of disciplines and backgrounds. It is no longer satisfactory to capitalise on low-paid missionaries to undertake activities for which they have little appropriate training or experience. This is, of course, not to deny that the vocational amateur has a continuing and important role to play in the future of family planning; but it is both short sighted and ultimately unkind to build such good people into the key positions of an organisation merely as a just reward for an enduring contribution. Appropriate skills must be properly matched to jobs.

The population problem is too serious and complicated to be left principally to amateurs. If family-planning organisations are to be effective, they must recruit people for their expertise, abilities and performance, rather than for reasons of social theology. This means, of course, paying the rate for the job. It also means increased productivity, cost effectiveness and enhanced organisational growth potential.

3.4. The growing entanglement of the medical profession

The body of the medical profession only recognised contraception as a legitimate instrument of health when it was forced to do so. It was not until contraceptives required medical skills for their prescription and application that doctors began to consider birth control relevant to preventative or curative medicine. It is, therefore, ironic that this long-delayed commitment should now pose a possible restraint to the expansion of family-planning services.

This development and the long-standing 'clinic' tradition in family planning has meant that the medical profession has become increasingly involved in the delivery and administration of birth-control services. While it is desirable that contraception should be a prescriptive tool in clinical practice it would be unfortunate if the delivery of such services were to become unduly dependent on this profession. This would mean drawing upon scarce and expensive health personnel to care for the fertile and fit, thus imposing restrictions on the expansion of future programmes. Health services in most parts of the world are already unable to cope with the sick, let alone assume responsibility for the fertile and well.

Even more serious is the growing interest of the medical profession in the administration of family-planning programmes. The present rate of world population growth is one of the gravest problems ever faced by man. It is creating a social revolution, the combat of which demands innovation and even a moral and ethical flexibility. These are qualities which have not been demonstrated by the medical profession in the past. Indeed, medicine has a particularly reactionary history. The traditions, rigid hierarchies and out-dated priorities of venerated and established institutions are not conducive to a progressive outlook. Moreover, the profession has a dubious record for working harmoniously with other disciplines on equal terms. Therefore, in view of the multi-disciplinary nature of the problem and the need for flexibility, it would also be unfortunate if the medical profession were to assume (at the expense of increased involvement by other disciplines) any greater administrative responsibility for family planning than it has today.

We are already experiencing the consequences of medical intransigence, which has effectively limited the availability of birth-control services. On the insistence of medical advisers, only a doctor may perform an abortion or vasectomy, fit the loop or, in most countries, even prescribe the Pill. Yet the technical skills and know-

ledge required for any one of these minor procedures are minimal and can be adequately learned by repetition. The sanctity of 'professional standards', however much they may restrict the health and social benefits of birth control to a privileged few, are held to be inviolate. The idea that a nurse or a medical auxiliary should perform, fit or prescribe is considered profane, despite ample empirical and scientific evidence of their ability to achieve comparable medical results.

Furthermore this restriction of birth control to the catchment areas already served by health services is medically short sighted. Family planning is a powerful and inexpensive agent of health, especially maternal and child health. A birth prevented, after all, is a possible illness avoided and a death averted. Therefore, when such a significant vehicle of health can be made available without utilising sophisticated medical resources some professional compromises should be made in the wider interests of the community.

3.5. The symptom of over-anticipation

Common to most family-planning programming is the symptom of *over-anticipation*, a legacy of past battles and a reaction to the delicate nature of contraception as a topic. This is the 'we-can't-possibly-do-that-because-what-if . . . ' syndrome. Almost every new idea and every innovation is greeted by this deadening quibble. The constant anticipatory reflex of adverse publicity, public reaction or political antagonism was reasonable in the 1950s and possibly justified during the 1960s, but is surely unacceptable at the local level, if not internationally, in the 1970s. It can exhaust the best people and sap initiative from any organisation.

Historically this hyper-sensitivity to adverse reaction and publicity is not justified. It seems to have been forgotten that the Bradlaugh-Besant trial in Britain and that of Margaret Sanger in America did more to publicise and advance birth control during the early years than almost anything else. We must learn to anticipate and utilise, not avoid critical publicity. One of the basic tenets of revolutionary warfare is that counter reaction (or better still) over reaction, can be exploited. If nothing else, it makes news and provides free access to the mass media. The time has come to drop this defensive psychology and take on an offensive initiative.

3.6. Lack of definitions

In the past, confusion over the terms 'family planning' and 'fertility control' actually served a useful strategic purpose in a delicate situation. But in the 1970s this ambiguity is no longer advantageous. It not only leads to uncertainty as to *how* we should provide services but also, in some cases, *why*. This kind of confusion tends to impair the formulation of clearly defined goals and objectives—and lack of which invariably leads to institutional malaise and confusion.

A *family-planning* programme may be defined as: the provision of birth-control services in order that individuals may regulate their fertility for reasons of personal convenience or welfare. In the past such services have been offered for many different purposes, ranging from charity to politics. But today, the only acceptable goal must surely be a reduction in fertility in order to enhance human well-being and reduce population growth rates. Defined in these terms an entirely voluntary family-planning programme can be no more than a process of mass birth control education, persuasion and supply.

A *fertility-control* programme, on the other hand, might be defined as: the reduction of population growth rates to a level compatible with the socio-economic aspirations of a society. This implies much more than the provision and promotion of birth-control services. It also involves the use of legislative leverage as a means of changing social attitudes toward child-bearing in order to reduce family-size ideals. In addition to providing liberal abortion and contraceptive services, a fertility-control programme would also involve such active measures as reduction of socio-psychological support for large families and increased support for the childless, realignment of tax structures in favour of the single or childless, educational campaigns for all ages against large families, postponing the legal age of marriage (with concomitant reinforcing measures such as some form of conscription) as well as the development of social and legal sanction for new forms of sexual unions, the development of welfare for the aged and realignment of inheritance laws in favour of females in order to remove the need for filial support. A true fertility-control programme embraces the possibility of using even more compelling measures, such as mass medication. Clearly, fertility control has more serious implications for mankind than the cosy concepts of family planning.

3.7. Confused and inappropriate operating philosophies

Most family-planning programmes have evolved without clearly-defined operating philosophies, probably as a consequence of this ambiguity of definition. The staff involved tend to identify their role as vaguely medical and perceive the task in terms of medical concepts of delivery and starched white coats, 'clinics' and 'patients'.

In consequence there is an idea prevalent in family-planning circles that one has merely to open a few 'clinic' doors and the fertile will immediately attend. It is, moreover, a universal practice to deal with the fertile as if they were as captive and highly motivated as the sick. They are usually expected to visit distant clinics at inconvenient hours on vague promises of future intangible benefits, to wait in intimidating surrounds, to tolerate treatment by authoritarian and patronising staff and to undergo embarrassing interrogations and 'internals' with the stoic tolerance of ill patients. But since the majority of the fertile are certainly not sick, the medical concepts of health care delivery are largely irrelevant to family planning.

Obviously if family planning is to be voluntary and yet function as an effective instrument of government population policy, a large proportion of the fertile at risk must be persuaded to adopt and practice some form of sustained birth control. A purely voluntary programme can only achieve this objective through the use of mass persuasion. Here the medical concepts of health care delivery are inappropriate. After all, aggressive promotion is generally anathema to the medical profession.

Medicine is a discipline evolved under conditions in which demand has always exceeded supply. The motivation to attend a physician, however remote, is sustained by persistent and unpleasant symptoms. But with family planning this is not the case. There is no overwhelming or latent demand for contraceptive clinic services. Unlike disease, birth control is not self-motivating, but is dependent on 'foresight' and 'planning' which are by no means universal attributes. Indeed the powerful and pleasant symptoms of sexual desire normally usurp planning considerations during the appropriate moment.

Family planning is the process of creating and meeting a mass demand for contraceptives. This is not medicine, it is marketing. Unlike medicine, marketing concepts are based on the premise that all activities must be tailored to the wants of the consumer. The customer becomes the pivot around which all other organisational activities are evolved. One begins with the consumer and orientates

plans, policies and operations to the potential customers. In medicine, on the other hand, the patient is expected to conform to the requirements of the service or the doctor. Medical professionals know the patients will attend for they are captive by virtue of their disease.

Marketing is a highly developed set of skills which have been evolved empirically at enormous cost over many years. The acquired technology and concepts involved are more relevant to the design, implementation and management of family planning than are the skills of medicine. To be successful, it is imperative that we begin to think in terms of 'customers', not 'patients'. We must *market* birth control, which means that we must offer professionally-promoted packaged and readily-available services and products in the manner most acceptable to the customer. Family-planning clinics should be attractive and colourful places, free from the image of the *clinic*. Vasectomies, abortion and IUDs should be available at modern high-street family-planning 'boutiques' staffed not by doctors but by specialised registered contraceptive technicians. Contraceptives should be on the shelves of the supermarket and the village store. Family planning must be aggressively marketed, not passively delivered.

3.8. Territoriality

A major problem in any area of endeavour in which more than one organisation is involved, seems to be that of interagency strife and family planning is no exception. In fact, experience tempts one to postulate that there is a direct correlation between staff vocational commitment and interorganisational jealousy. This conflict is understandable, perhaps even desirable, in politics and commerce. But why such petty jealousies (as distinct from healthy competition) should be so bitter between agencies and people with the same overall humanitarian goal is not clear. Defusing the population bomb will be one of the most difficult tasks ever attempted by mankind and no single person or organisation can hope to dominate the field. In some cases, no doubt, the hostility is stimulated by competition for funds while in others it appears to be caused by a fear that someone will actually *solve* the problem and render 'competitors' redundant. Perhaps the answer lies deep in the complex personal aspirations of those involved in voluntary organisations. Whatever the cause, be it poor communications, stupidity or bad management, it is a serious

source of friction, heat and unnecessary duplication.

3.9. Tunnel vision

A major problem in family planning has been the tendency to become obsessed with one method, one approach, one sex and one answer. The Pill was hailed as the solution to unwanted pregnancy; then it was the IUD and post-partum programmes and more recently maternal and child health. However, the experiences of the last decade suggest the obvious. There is no single key to a problem as highly personal and intricate as excessive human fertility.

The fertile in any country are not homogenous. They are of different sexes and come from different regions, religions, tribes, backgrounds and sectors of the society. What is appropriate or acceptable to one group is unsuitable for another. If a family-planning programme is to be successful it must operate flexibly on a number of fronts in order to accommodate these differences. Obviously it must pursue a multi-contraceptive, multi-channel approach in response to the demands of consumers, rather than conform to the biases of experts.

Another manifestation of tunnel vision has been the tendency to ignore valuable untapped resources which do not conform to the ideals of voluntary organisations. For example, it is curious that the whole private sector as a suitable vehicle for the promotion and delivery of family planning has hitherto been generally ignored. Yet it is an area with proven performance, good administration and ubiquitous distribution and it is rich in appropriate skills.

3.10. Belief in organisational omnipotence

Many family-planning organisations have a tendency to dabble. Rather than enter the open market and buy appropriate services, there seems to be an innate belief that every aspect of a programme can best be undertaken by the staff of the organisation. This is particularly illustrated in the realm of motivation. Almost every organisation has its own 'education department' staffed largely by part-time 'creative' personnel.

With one or two exceptions few organisations have seriously attempted to sub-contract their promotional campaigns to the professional, experienced and highly-effective marketing industry.

This is an industry which has demonstrated clearly its ability to persuade rational human beings to buy almost anything. It seems reasonable to assume therefore, that marketing experts are the most qualified professionals available to create demand.

An organisation sub-contracting to an advertising agency would not only get more professional service, it would also make more efficient use of a limited promotional budget. All the fixed costs would be shared with the other clients of the agency and such costs would, in any case, be incorporated in the media commission. In this way every penny of the promotional appropriation would be spent on persuasion and would not evaporate in the overheads of an education department. This argument is usually countered in family planning circles by claiming that such people 'do not understand'. But we are talking about the 'hidden persuaders' who have managed to create markets for a wide range of highly-sensitive and personal products. These are the people for example, who have actually created a market amongst millions of educated, middle-class American women, for variously-*flavoured* vaginal douches. If anything, it can only be concluded that they understand too well.

Some of the reluctance amongst organisations in this field to harness commercial companies to undertake specific functions stems from fear that someone will 'make a profit'. This overlooks an important point. By failing to sub-contract, family-planning organisations tend to utilise scarce, and often donated, resources both inefficiently and ineffectively. In other words, the additional costs incurred in achieving a given target are likely to be greater than any 'profit' which might have been made by a commercial concern in the first place. It is surely preferable for someone to make a profit and produce a handsome social dividend than for a voluntary organisation to take a loss and only produce a small one.

There is, incidentally, much confusion over this term profit, a term often loosely used to describe the difference between the buying and selling price of a commodity. Many people, therefore, have the exaggerated idea that all commercial transactions make huge 'profits'. Most of this difference is not real profit but goes to pay for the expenses incurred in providing capital and facilities, as well as handling, storing and promoting the goods or services. Only a small fraction of revenue from most transactions end up as true profit, the incentive that (for better or worse) drives a system which produces the wealth and that enables us to support the voluntary organisations.

3.11. An emerging family-planning establishment

It is apparent that an establishment is beginning to emerge in family planning. Such is the pace of change that many of yesterday's pioneers have already become sheet anchors to today's innovators. The elder statesmen in family planning tend to be retrospectively orientated and plan, like generals, for bygone campaigns. Their reactions are still attuned to the defensive battles of only a decade ago. To the 'young' and to the new generation of family planners, this is already ancient history. They look forward with growing alarm to the over-populated and polluted world they will inherit. To them the 'slow and responsible' posture of their elders is not often seen as a desirable stance. While they recognise the need for tact and diplomacy they often feel, perhaps cynically, that these attributes are used primarily to achieve organisational tranquillity rather than desirable objectives.

This situation would not be so serious (and would perhaps provide quaint fodder for an aspiring sociological Ph.D.), if it were not for the fact that it is largely the establishment which controls the direction of research and development. Little research, outside contraceptive development, has apparently been undertaken into the needs of the 1980s, when even the developed countries will be faced with the stark socio-economic horrors of excessive fertility and the realities of harsh fertility-control programmes. In spite of the demographic arithmetic, even to talk in most family-planning circles about research into possible coercive measures produces an emotional reaction akin to what one might expect from say, indecent exposure. But unless we prepare for future realities, the consequences of such *naïveté* will be more painful than ever.

3.12. Conclusion

The growth of institutional resistance in family planning is a serious problem. It can only be overcome by a painful overhaul of many of the concepts and precepts inherent in our existing organisations and by the creation of new ones. In this way it should be possible to realign and set up family planning organisations which could bring some of the style of the private sector to this problem, so that the zest and pragmatism, aggression, risk-taking and the drive of commerce can be effectively harnessed to meet this supreme social objective.

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