Technology, Training and Trust:

The Management of Population Issues

Margaret Catley-Carlson*

This article is a lightly-edited version of the Author's notes for a talk to the Annual General Meeting of the Foundation for International Training (FIT), held in Ottawa on June 13, 1994. In her introduction, the Author called attention to "the long and distinguished FIT tradition related to improving international management, training – pulling the best from a number of sectors to promote development". She added: "I thought you would be most interested if I described the global population in terms of the management issues raised – because that is exactly the issue – how to manage this planetary challenge." We are grateful for her permission to publish it. Ed.

Population – Defining the Issue.

The overwhelming problem is that of sheer numbers. There are a lot of us around. The current population as of June 1994 is 5.7 billion, i.e more than half way between 5 and 6 billion. Depending on what we do in the next 10 years, it will continue to grow until some number between 8.5 billion and an almost unimaginable worst case scenario of 15 billion.

The determining decade is the one we are living in now.

- it took 1 million years to reach 1 billion people on earth; this growth now happens in a generation
- it took until 19th Century to reach 1 billion
- we reached 2 billion in the 1930s
- the third billion came in 1960; 15 years later the fourth; 12 years later the fifth.
- .If we met all unmet demand for contraception now, the global population could stabilize as **"low"** as 7.5 billion. Otherwise we will go to 10, or 12 billion or higher.

Population is a growth industry. It is highly unregulated. About one in every hundred heterosexual acts results in conception – 910,000 per day, or about 390,000 births per day which is about 124 million births per year. There is a difference between these numbers because a high percentage of conception spontaneously terminates, and because a good deal of fertility is unwanted and does not result in birth. (Just to show you that the problem areas are not all in the developing world: In the United States, every day 17,050 women become pregnant; 2800 of them (or 1 in 6.) are teenagers).

Human implications.

- About 50% of conceptions are unplanned
- Research suggests between 25% and 40% are not wanted.
- Pregnancies are terminated every day by induced abortion – about 2/3 under legal conditions, which doesn't always mean safe. On the other side of the coin, about 50,000 are performed under illegal, which too often means unsafe, conditions.
- Every 3 minutes a woman dies from unsafe abortion. In ethical terms, that is certainly bad news – for the women, for their families, for all of us.
- As many women die in India in a week from causes related to maternal mortality as in Europe in a year.

Environmental implications

- We can go on producing food at today's levels, and probably produce food for a much greater global population. The question becomes the cost.
- The perspective on this is often anthropocentric: we think that environmental degradation is bad because it directly or indirectly impacts adversely on human welfare. Radical ecologists consider mankind behaves as a cancer on the earth. Should the planet be used primarily for the benefit of man, or should the natural world around us have

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* *Margaret Catley Carson is the President of The Population Council, New York.*

independent rights that might compete with ours? How you answer that ethical question will determine your answer to a lot of subsequent questions I will be posing.

- There are environmental and ethical issues involved as we crowd out other species and irreversibly change our soils, woods and the habitat of rivers. Given that we have built cities on the best farmland, and are extending food production into marginal areas, we must acknowledge that new food demands and new intensified food production methods take soil nutrient and demand more energy. The cost to the future of our running down now the world's hydrocarbon reserves raises intergenerational transfer issues of very troubling dimensions.

- Each human being currently consumes water, soil, and fossil fuel and accounts for stress on the environment. Already some people place a great deal more stress on the environment than others. Specifically, **us**. The country of Bangladesh has a population of about 120 million and a 2.4% increase per year. That is about 25 times the increase in, for example, the United Kingdom. But each British resident consumes 35 barrels of oil year, each Bangladeshi consumes 3. You can see that the mathematics of carbon dioxide emission, global warning etc can get fairly complicated when we factor in how much of everything we use, in comparison with how many we are, or they are.

- If the whole world reached a population of 10 billion and consumed energy at the rate of the United States in 1988, all of our oil reserves would be burned up in 4 1/2 years.

The Development Dimension.

How do you manage population to promote more rapid economic development? Our media far too often portray LDCs in a very negative fashion – in fact, those associated with FIT know very well that per capita consumption has grown about 70% since 1965, life expectancy has gone up about 6 months every year, and infant mortality has fallen. Despite a doubled population, literacy has risen from 43% to 60% in the last 25 years.

But on the country level, population is growing fastest where people are poorest. Put another way, development is slowest when population grows fastest.

- The biggest problems can be found in countries where 40 to 50% of the population is under 15 years of age. In these societies, which all have a very low gross national products, development just doesn't happen. Think it through. How can a society at a low level of per capita wealth, technological development and efficiency hope to provide school, health services or jobs for half of its population, if its economic growth level is always less than its population growth level.

- Schools, factories, infrastructure have to be built as fast as the population growth just to keep living standards from falling.

Even if the overall growth levels are okay, it is quite likely that urbanization is taking place twice as fast as population growth, with all the quality of life and urban implications. Rates of urban growth in the developing world are often twice that of population growth – from 5 to 7%. They have spiralled out of control. This creates not only an urban, but a rural crisis – and environmental and developmental disasters.

Sticky Management Issues.

One of the factors that makes managing in this area very interesting is that there are a lot of **hot** and conflicting interests which play out. Let me give you a dozen of these.

- **Pronatalism**. Malaysia wants more Malays. In our country, Quebec – with one of the lowest birth rates and population growth rates in the western world – encourages larger families. The management dimensions of these policies differ considerably depending on the instruments used. Quebec's offer of increased family allowances to families who decide to have a third and fourth child has a quite different effect from Ceaucescu's decision to ban contraceptives and legal abortion to Rumanian women.

- **Target based coercion**. China has decided that the prosperity wanted by Chinese people could not be achieved with the size of the population that China would have if the level of population growth continued.

    - Now here is a real management issue: China moved to an official one-child policy,

women on welfare, women who abuse their children have enormous problems. Improved access to contraception could help them with the chaos in their lives. It is ethically not permissible use contraception as a judicial measure, or legal prophylactic – but folk still try.

- **Sex education in schools**. Governments have to decide whether they will or will not provide services or erect barriers to the provision services to young, sexually active persons, especially women. Child brides, school girls, young unmarried women are often excluded from services. Sex education in schools provokes as much controversy around the world as it does in B.C. And yet, mortality is greater for mothers under 18; sexual disease and AIDS transmission may be involved.

- **Pharmaceutical companies** are essential to success to get products manufactured, advertised and distributed. And yet they have been reluctant to pursue longer acting methods of contraception vs. the pill with its monthly sales. They have been discouraged by litigation and huge awards. In the 1970s at least 13 major pharmaceutical firms were actively involved in contraceptive research; today there are about 4. It is a considerable decrease in the investment in contraception.

- **Money** is a problem here too – just as it is for all of us. Most money for the work in population comes from people and governments in developing countries themselves – competition for funds is stiff.

  In terms of overseas help, population assistance in fact accounts for about 1% of all development assistance. In fact the aggregate percentage of aid has **declined** from about 1.3% in 1986 to 0.9% in 1991. Only Norway, Finland, Sweden and USA have consistently exceeded 2%. – still a pretty small number.

Managing Right: Technology – But Technology Plus.

Beginning in the sixties, primarily in Asia, most developing countries decided that their population growth would have to be slowed to improve their ability to provide enough schools, jobs and health care. And most of them have done so quite successfully. Contraceptive use in South East Asia is around 60%; in the subcontinent in India and Pakistan, the level of use is less than 30%

- As a result, family sizes have already decreased around the world.

- The total fertility rate – the average number of children per woman – has declined in developing countries from 6.1 in 1965-70 to 3.9 in 1985-1990; (in the whole world the decline is from 4.9 to 3.4)

- This process has in fact been faster in the LDC world than in the industrialized world, The time taken to go from 6.5 to 3.5 children per family is:

  - USA: 58 years
  - Indonesia: 28 years
  - Colombia: 15 years
  - China: 7 years

- It is an exciting moment – perhaps, in the new jargon, even a defining moment – for those of us working in the reproductive health area. The new American Administration has removed some very constraining shackles from the provision of services needed by many.

- There are good things happening around the world, too. Contraceptive usage continues to climb – from 10% to 52% in three short decades. 90% of Governments who spoke at the Rio Conference included population issues in their lists of things to do; many at the top of their list. 95% of the world's people live in countries with population programmes.

- New technology brings us the reality of great new advances in injectable and implantable contraceptives, and the promise of even better developments to come, with disease prevention added in.

- New communication tools bring the news of child-spacing and protection to more people around the world.

We are learning some fascinating things about what makes family planning programmes work. We are using research as a tool to help in this. And the lessons are exactly those that institutions such as FIT have grappled with in what they do, Note these points:

- The first issue is that technology is not enough. We have to pay attention to the **context** of

delivered services. Technology alone never has been – and probably never can be – the answer to any problem. The "product" that is delivered to clients includes the technologies but also includes the important "software" of information, counselling, advice, and all of the interpersonal cues that signify caring and respect. The purpose of technology should be to empower individuals as well as to cure or to protect them.

- Secondly, knowing about the clinical condition is not enough. We need to know and think clearly about the real **context** of peoples' lives. How did this person get to this particular condition? Is advice and information realistic for the ways in which this person lives?
  Are we meeting the needs of groups of the population with the services and technologies we have and are developing – or are we missing the mark because those for whom they are intended can't really make use of them?

- These questions are key in contraception and prevention of the spread of sexually transmitted diseases, but for any of you working in the social, health or educational area they will sound totally familiar to you.

- What has motivated much management interest in "Quality of Care" within the family planning field is the finding that clinic accessibility frequently does not show a significant or uniform association with contraceptive behavior. When women do not go to the nearest family planning facility to obtain services, the outlet they do select may depend on the type of services available and the treatment received there. Indeed, in Nigeria we discovered that 41% of the family planning clients did not go to the clinic nearest their home. The majority said it was because of "better" services at the more distant site.

- In fact, success is directly proportional to the quality of family planning services. Attention to quality is sometimes undercut by global demographic concerns. The "urgency" attached by many countries to reducing their population growth rate has led them to elaborate family planning delivery systems more rapidly than they have developed necessary and related primary health services or related reproductive health services. Family planning services are not only offered in clinical settings, but also through house-to-house visitors and contraceptives are sold at subsidized commercial and social marketing outlets. These services have often been deployed without adequate attention to quality. At some point, an insufficient quality means that there is no service at all. And the figures show it – no fertility decline.

- At the Population Council, we have devised a framework which emphasizes six dimensions of quality including
  - Choice of methods
  - Information given clients
  - Technical competence
  - Interpersonal relations
  - Follow-up/continuity mechanisms
  - Appropriate constellation of services

- we have developed research-proven, professional rapid-appraisal techniques to find out what quality of care is being offered in given cities or countries.

- Just as is the case with the people FIT works with around the world, one of the most gratifying parts of working in the population area is the obvious interest of providers and national governments in improving quality. Without arguments of demographic effectiveness or human rights arguments about clients' rights, many providers themselves say in one way or another: "We want to do things better. We were trained to help people; we want to help them." It is this strong will and desire to help others, to be of service, to do a fine professional job which we believe will be the engine of improvements in quality of services- and the engine of improved demographic pictures.

What We Have To Do – The Trust Factor

So is it all doom and gloom? Hardly. We should at the outset recognize is that we have been a remarkably inventive and innovative species. When Malthus was making his gloomy projections that countries would not be able to feed an expanding global population, he was writing over 150 years ago. We have not only fed ourselves, but have created amazing improvements in the lives and life-expectancy of most of us on the planet – for billions more than he ever envisaged.

There is a lot we have to do above and beyond family planning. Family planning will be useful in the reduction of **unwanted** fertility. To reduce fertility levels, families and women in particular need to have

greater trust that they will find a place in the world; that the world will value them for other than their fertility.

We want girls and women in school. We want it because it will enhance their lives in immeasurable ways, and because if all young girls were in school, it would dramatically bring down population growth rates in both the numbers of children wanted, and the age of first childbirth.

We want later babies – to have healthier babies and less infant mortality, to give girls a chance to be educated, to find values and because this could cause a decline in the maximum population the world will reach.

We want infant mortality to decline because it is wrong that babies and young children should die, that families should suffer and because there is no country on earth where fertility has declined before infant mortality has fallen.

We want better quality of care because people should be well treated, given choices. This promotes more contraceptive prevalence and therefore a better demographic outcome.

We want to meet unmet demand because it is wrong that women should have fertility which they do not want, which impedes them and their families from living better lives and because there would be as many as 1.9 billion fewer people in our future forecasts if we started to address these needs seriously.

And perhaps the most interesting lesson for all of us is that the bedrock answers depend on movement toward positive social change in societies and sound management techniques which work for both the service deliverers and those to whom service is given. To those of you who do the sort of marvellous work that FIT does, all of this is both universal and shared. Let us create a world where it is possible.

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