DISCOURSE AND PRACTICE ON FAMILY PLANNING: THE CASE OF LATIN AMERICA

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INTRODUCTION

The present paper intends to undertake a conflictive subject insufficiently dealt with in literature: the "style" of family planning programs. Doubtlessly, these programs share some characteristics with other social policies, at the same time that they display certain singular features. The first part of this paper is devoted to presenting the problem of implementation within the political process. The emphasis in this stage is due to the fact that it is in it where the policy "styles" can be more neatly observed.

The second part is devoted to the presentation of the characteristics of the family planning discourse in Latin America, and the sources of legitimation for its practice. The third part will attempt to show the gaps between such discourse and the practice. Thereby we especially try to exemplify what, in our opinion, constitute coercitive practices in family planning. The empirical evidence given are only some of the available. Their force does not allow being categorical concerning conclusions, but the seriousness of the problem justifies even the hastening of hypothesis proposal. In any case, it is clear that this is only a preliminary attempt and that it only constitutes the prologue to a research of wider reach which must be carried out.

THE ROLE OF IMPLEMENTATION IN THE POLITICAL PROCESS

The influence that the application of the Systems Theory bore upon Political Science is probably accountable for the major importance conferred to the analysis of certain stages of the study of policies while others were neglected. The attention received by the stages of formulation, input production and analysis of results was out of proportion if compared to the importance given to the analysis of implementation processes. Such processes were, in many cases, treated as a "black box". As pointed out by Grindle,[1/] "the politics of policy implementation has recently emerged as a topic of interest for students of politics in both industrial and Third World countries. Implementation has captured their attention because it is evident that a wide variety of factors can and do frequently intervene between the statement policy goals and their actual achievement in the society".

This relatively recent emergence of policy implementation analysis in the field of political analysis determines, at the same time, that while certain aspects have been sufficiently elaborated upon, still others remain deferred.

We shall here devote some brief paragraphs to clarify what we are talking about. When referring to implementation we intend to characterize the group of activities -decisions, processes, relations, actions- which constitute a link between

policy goals and their results. If the objectives answer the question concerning "what to do", and the results show "how it worked out", then implementation is the answer to "how to do it". Only an ingenuous, simplistic or deliberately malicious understanding would consider this to be a trivial matter. From our standpoint, the problem of "how to do it" becomes the main course which allow a deep analysis and evaluation of public policies and, particularly, of social policies. To stop analysis at the level of objectives would be highly impoverishing. To bring up the example of a field closely related to family planning, that of public health, some years ago we witnessed the unanimous agreement of all governments of the region concerning the need to "extend the coverage" of medical attention, through the mechanism of primary health care.[2/] It would be naive to think that for such different governments as the ones coexisting within the Latin American region, a strategy which triggers complex social processes affecting the power structure at different levels, would mean the same and be implemented in the like manner. It is licit to think that, in many cases, the explicit objective is only an excuse to cover up a more important one: the way of implementation. As pointed out by a Latin American health worker, "the extension of coverage is not a policy, but the vehicle for such".[3/] From this perspective, it becomes easier to handle certain contradictions which an exclusively technical view of the problem would not permit to solve. In other words, we do not believe that the analysis of implementation be pertinent only when a differentiation shows up between the objectives and

results of public policies. Neither should it be confined to the characteristics of the administrative apparatus and of the bureaucrats which conform it.

In the bibliography on this subject it is often pointed out that the problem of implementation is associated, at the same time, to a group of important factors which it is indispensable to include in the analysis. The first one refers to the impact that the contents of a policy will bear upon its implementation. It is obvious that different policies would produce different amounts and types of political activity. They would also determine, to a great extent, the institutional place for implementation. Likewise, the "distance" between the present situation and the one proposed by the policy objective determines the magnitude of the desired change. This, in time, exerts an influence upon the ways selected for their achievement.

Another main aspect refers to the context within which policies take place, which must be understood in a double sense. In a restricted way, we refer to the local entour when dealing with policies of a geographical micro-location or with overall policies of local application. In a wider sense, it is intended to consider also the existing political regime as well as the structure and nature of political institutions. The relation between these two elements -government and institutions- is not constant.[4/] From it, combinations derive which will lead to different ways of implementation. Context-related aspects should

also include the simultaneous carrying out of other policies, which leads to the result of one depending from what happens with others; this directly affects their implementation. In this short summary about the implementation problem within the development process of a policy, it seems necessary to point out an aspect generally missed. It refers to the role assigned to the groups that receive social policies. This becomes especially evident when trying to determine what, in Cleaves[5/] terms are the "conditions for a successful implementation of policies or programs". He states that the conditions are basically two:

a) the power of political and administrative actors to carry out a policy design, and

b) the contents of policies, which he calls "the policy's problematique".

In order to maximize the success possibilities of a policy, variables must be manipulated by assigning additional political resources and/or by making less complex policies, respectively,

However, Cleaves does not overlook the highly subjective character of the concept "success" and accepts it depends on the observer's position. He further accepts that "when the policy itself, however, contains features that are contrary to the interests of the target population, successful implementation will not cause them to rejoice. Indeed, the failure of such a program may be a source of relief". Then he proposes that the evaluation of success is to be made omitting those considerations:

"(...) when the words "successful implementation" have been used (...) they refer to the outlook of those groups that favor the respective policy objectives".[6/]

This way of posing and evaluating problems predominates in Political Science. Both for the evaluators of social policies as for the ones who elaborate them, the success of policies -in terms of goals achievement- is, in many cases, more important than the well-being of the target population. If we match our point of view with the perspective of the target population, a correct understanding of the social policies will point out that the best that could happen is that these policies failed, and the worst would be that they succeeded. This, because the latter would imply the use of coercitive practices.

Family planning policies are a particular case of social policy. They may take the form of population policies or of health policies. They may be explicit or not; they may be in charge of the public sector, or of the private sector or of both.

But what is more important to underline is that in the same way that other social policies in the majority of Latin American countries, they are elaborated and carried out by social groups different from their supposed benefitiaries.[7/] Differently from others, it fundamentally constitutes a normative intervention of the public in what is the private. It even includes corporal manipulation aspects. In our opinion, these two elements cause

the problem of implementation of family planning programs to be decisively important, becoming the stage upon which to analyze the nature of these policies. Due to the same reasons, this analysis cannot omit the discourse level, nor can it be circumscribed only to it. Quoting Lévi-Strauss in his analysis of institutional forms, "conscious models -commonly named norms- are among the poorest since their function is not to expose the causes of beliefs and uses, but to perpetuate them".8/ The analysis of facts is indispensable but even more so is the analysis of the relationship between discourse and practice. This is the exercise we will try to carry out in the next pages with respect to family planning.

FAMILY PLANNING IN LATIN AMERICA: THE DISCOURSE

In the decade of the sixties the family planning programs began to be encouraged by the government sectors of Latin American countries. This took place parallelly to the development of a varied educational and services infrastructure which made them possible. This story, to a greater or minor extent, is known by everyone and the bibliography describing the different national experiences is large. For this reason we will not stop to repeat the account. However, what we would like to emphasize is that although these programs have particular and occasionally different modalities, all of them share a common basis constituted by the official discourse which intends to legitimate them. This discourse refers to several dimensions of social life, making it possible to recognize, at least, the appeals to national interest, to family life and to individual rights.

With respect to the first dimension, a first source of legitimation of the family planning programs is derived from the characterization of the demographic phenomenon. The point of departure is the idea that it is necessary to adapt the dynamics of population growth to the economic and social development goals; this in order to achieve that the groups integrating society fairly and equitatively profit from the benefits of development. A population growth which harmoniously relates to the capability of society to produce and distribute goods and services is feasible and desirable from the point of view of

national interest, since it constitutes the necessary mechanism to answer in a planned manner to the concrete demands of social justice.

Secondly, there is an argument related to the sanitary aspects of the phenomenon. Family planning is understood as a component of health programs directly benefiting women by allowing them to plan the number and spacing of children, thus diminishing high fertility and short intergenesic interval related risks. It is also benefitial for children since they are thus able to count on larger possibilities of receiving better attention from mothers who would then be healthier and would not have to divide their attention among a large number of children. From the standpoint of health services structure, the pressure exerted on them by a high fertility would decrease, enabling them to answer to a more regular and planned demand.

A third source of legitimation is based upon the contemporary revaluation of the role of women in society, and of her part on productive work in daily life. Family planning thus becomes an instrument which allows all women to directly take charge of their reproductive functions, without affecting their sexuality, and orienting it according to their needs, interests and personal life projects. This argument meets the consensus of even the most radical groups, which propose it as a revindication in women's fight for their own emancipation.[9/]

A fourth element common in the discourse of family planning, and a direct consequence of the points proposed hereby, holds that the offered family planning services are the answer to their actual demand by society. By coinciding with the national interest, first argument, they do not provide a counterpoint for postponing their satisfaction. It is also proposed that such demand may be latent and that it is only necessary to inform the potential clients so they may find that family planning is an indispensable tool for improving their health, well-being and social integration, and consequently their living conditions.

It is therefore frequent that the nature of these programs be defined by population laws or by specific regulations on family planning as indicative an not compelling. The obligation is exclusively reserved to program managers, who must provide all the general and individualized information about the objectives, the methods and the consequences, to enable people to responsibly exercise their right to determine the number and spacing of children. With respect to a context different from the Latin American one, Vicziany points out that in India the subject was proposed in the following terms: "Thoroughly convinced of the necessity for and desirability of family limitation, they assumed that everybody else felt the same way. A latent demand for family planning services was presumed to exist among the peasant masses also. Thus, from the very start of the family planning program, the promotion of modern birth-control was perceived to be a

delivery problem -a question of making contraceptives available to a needy and willing people".[10/]

An additional source of this legitimation is constituted by the indorsement which the Bucharest Conference meant at the international community level. After expressing its concern for the course followed by the demographic phenomenon, it proposed that governments took the concrete measures to enable its regulation.

Summarizing, we are then facing a program with a flawless legitimation which, at the discourse level, finds no contradictions which may prevent it from translating into concrete benefits for the society.[11/] On the one hand, there is an actual or latent demand and, on the other, there is the political will to satisfy it. This agreement between managers and benefitiaries of family planning programs would favor the view that problems in the implementation of family planning policies should be circumscribed exclusively to logistic matters: like making available to the population the means and methods necessary to exercise family planning.

Nevertheless, alongside the history of family planning in Latin America, a set of evidence has been accumulating with respect to certain facts which question such supposed harmony. The joint analysis of these facts allows to discover the existence of a differentiation among the concrete family planning practices,

policy implementation and the legitimating discourse. The common trait outstanding from the facts to be described is the presence of authoritarian and coercitive elements.

FAMILY PLANNING IN LATIN AMERICA: SOME EVIDENCE ABOUT PRACTICE

In sociological theory and psycho-social research there are numerous references to and definitions of the concepts of authoritarianism an coercion. It may be that some definitions were incomplete, whereas others are contradictory among themselves. Without intending to minimize the importance of a deep discussion on these concepts, we believe that it would dettach from the objective of this paper. Conversely, and in order to facilitate the understanding of what we will describe as examples of authoritarian and coercitive practices, we deemed convenient to adapt two of the definitions which have larger consensus.

Authoritarianism refers fundamentally, but not exclusively, to the relationship kept by the individuals with authorities. In an extreme sense, it appears as a power-centered system with unquestionable authority in which hierarchy is important and where the predominant relations rest upon dominance and submission. The phenomenon of authoritarianism appears at diverse levels or profiles of reality. Studies distinguish at leat three main levels: as an ideological system, as a trait of personality and as an acting and performing system, that is, as a conduct system. It is this last meaning which we are most interested in emphasizing. At the conduct system level, especially of administrative nature, authoritarianism is characterized by the predominance of methods by which decisions are made without consultation with subordinates.

Decisions are imposed, even through coercitive means, without attempting any explanation; obedience and respect are explicitly or implicitly demanded, emphasizing differences in status.12/

Coercion, on its side, constitutes a specific conduct type adopted in order to obtain a concrete action or result from an individual or group. It can be exerted by physical means -direct coercion- or by moral means -indirect coercion.

To exert coercion it is necessary to possess a minimum of authority with respect to the person or group to be dominated; in the case of indirect coercion -typical to the examples we will refer- this authority is based on credibility. As a matter of fact, coercion is possible from parent to child, from teacher to pupil, from priest to believer or from doctor to patient. This because all subordinates (child, pupil, believer or patient) acknowledge in their superiors an authority worth of credit. Furthermore, coercion is frequently accepted as good or logic by both parties involved.13/

From the definition of coercion given above, a set of conclusions are derived from which we are interested in rescuing at least two. In the first place, equating coercion and violence leads to an impoversishment of the concept which leaves out the possibility that the individual and free election may be limited by less spectacular but equally effective methods as the use of

force. In other words, programs may be coercitive despite not using physical force. Secondly, there is no need for a deliberately planned effort to make a program coercitive. This character may result, although we cannot affirm so for all cases, from the perverse effect of factors combination.

As mentioned above, in Latin America reference has been made, on several occasions, to the existence of family planning practices that would be comprised within the terms of the definitions we have given. These references sometimes assumed the character of denounces and were exposed by different communication media, such as the cinema and the written press. They included accusations which went from involuntary sterilization[14/] to the implantation of an IUD without the patient's knowledge,[15/] going through the use of Latin American countries and populations to carry out clinical trials of drugs with side effects that had not been discarded,[16/] or the large-scale use of hormonal contraceptives with tested side effects.[17/] Less are the examples of research where the presence can be detected of more subtle and maybe more generalized practices of what we have called indirect coercion.

The information from a survey taken in Mexico[18/] show that for the period between 1970 and 1981, 1 million 300 thousand female sterilizations had place, from which the majority, 75%, were carried out by the public sector's health services.

The Mexican laws and regulations which rule over the practice of sterilization clearly establish that this may only be executed having the written agreement of the patient, once she has received all information available about the irreversible nature of this method, its characteristics and effects. This legislation which might seem sufficient to warrant a correct implementation of the program is scarce when facing facts. In the above mentioned study, attention is attracted to the close relation between the date of the sterilization and that of the birth of the last child of the sterilized woman. This coincidence, shown in the diagonal concentration of table 1, features 68% of sterilized women during that period. This percentage is not even affected when analyzed according to the number of children that women had. Contrarily to what could be supposed, the ratio of simultaneous sterilizations becomes larger as the number of children decreases. (See table 2.)

We believe that it is licit to review the circumstances under which that high percentage of women "decided" for a final contraceptive method. It is obvious that the delivery conditions place women under exceptional circumstances. They are, at best medicalized conditions under which women feel abnormally exposed to suggestions, advice or pressure from those providing attention. If, besides it is a more painful delivery than usual, an additional subjective element is included which complicates circumstances. The adoption of a final method such as sterilization, which has consequences not only for the reproductive life, constitutes a serious decision under circumstances when their emotional stability

Table 1

PERCENTUAL DISTRIBUTION OF STERILIZED WOMEN ACCORDING TO THE BIRTH YEAR OF THE LAST CHILD BORN ALIVE AND TO THE YEAR OF STERILIZATION, 1970-1981

	70	71	72	73	74	75	76	77	78	79	80	81	TOTAL
70	100.0 (0.6) (2)												7,900 (0.6)
71	15.1 (0.2)	84.9 (1.2)											17,900 (1.4)
72	4.4 (0.04)	40.0 (0.4)	55.6 (0.6)										13,500 (1.1)
73	27.8 (0.5)	9.2 (0.2)	1.3 (0.02)	61.7 (1.1)									23,000 (1.8)
74	- (-)	3.7 (0.1)	11.9 (0.4)	13.4 (0.4)	71.0 (2.2)								40,400 (3.2)
75	0.7 (0.03)	6.4 (0.3)	5.4 (0.2)	5.4 (0.2)	4.7 (0.2)	77.4 (3.2)							53,500 (4.2)
76	1.6 (0.1)	4.8 (0.3)	4.1 (0.3)	18.5 (1.3)	3.0 (0.2)	10.0 (0.7)	58.0 (4.1)						89,700 (7.0)
77	2.4 (0.3)	0.7 (0.1)	3.3 (0.5)	3.2 (0.4)	2.6 (0.4)	11.2 (1.5)	12.0 (1.6)	64.5 (8.8)					173,500 (13.6)
78	5.3 (0.7)	3.9 (0.5)	0 (-)	4.1 (0.5)	6.9 (0.9)	2.5 (0.3)	2.3 (0.3)	12.9 (1.7)	62.2 (8.3)				170,700 (13.4)
79	0.2 (0.02)	2.3 (0.3)	1.2 (0.2)	2.6 (0.3)	5.8 (0.8)	1.7 (0.2)	0.6 (0.07)	1.9 (0.3)	6.1 (0.8)	77.6 (10.2)			168,500 (13.2)
80	0.9 (0.2)	0.7 (0.1)	5.6 (1.0)	5.2 (0.9)	1.8 (0.3)	2.0 (0.4)	2.3 (0.4)	8.5 (1.5)	4.8 (0.8)	3.5 (0.6)	64.7 (11.3)		223,200 (17.5)
81	- (-)	1.9 (0.4)	0.7 (0.2)	2.4 (0.6)	4.2 (1.0)	- (-)	5.5 (1.3)	0.9 (0.2)	2.6 (0.6)	3.4 (0.8)	7.2 (1.7)	71.2 (16.4)	294,800 (23.1)
TOTAL (70-81)	(2.7)	(4.0)	(3.3)	(5.9)	(6.0)	(6.4)	(7.8)	(12.4)	(10.6)	(11.6)	(13.0)	(16.4)	1,276,600 100.0

(1) There are 42,600 sterilized women for the period 1970-1981, who had their last child borne alive before 1970. These were eliminated from this table, but for the total of sterilized women during this period -3.1%, they cannot in any way affect the results shown here.

(2) Percentages in parentheses have been estimated for the general total.

Source: National Demographic Survey, 1982.

Table 2

PERCENTUAL DISTRIBUTION OF WOMEN WHO UNDERWENT STERILIZATION SIMULTANEOUSLY TO THE LAST BIRTH, ACCORDING TO THE NUMBER OF CHILDREN BORN ALIVE.

	NUMBER OF CHILDREN			
	0-2	3-4	5 & +	TOTAL
SIMULTANEOUS	72.8	69.0	66.8	68.1
NON-SIMULTANEOUS	27.2	31.0	33.2	31.9
TOTAL	100.0	100.0	100.0	100.0
BASIS	(109000)	(465700)	(702200)	(1,277,690)

Source: National Demographic Survey, 1982.

was altered and their perception of the context is reduced, opens an important way to think that it constitutes a coercitive condition.[19/] This doubt is reinforced when we observe that half of the sterilized women had never before used any other method (see table 3). It becomes at least attractive that women who never did anything to regulate their fertility, chose to start doing it with a method which, besides being irreversible, implicates all the traumatic charge related to any surgical operation, especially one with mutilating characteristics.

Another aspect with respect to sterilization refers to the quality and quantity of information made available to adopters at the moment of decision-making. The accumulated evidence, some of which comes from statistical information or from other less systematic field experiences, give way to pointing out the existence of a phenomenon of double ignorance. On the one hand, sterilization is turned attractive by keeping the patient uninformed about the existence and characteristics of other less drastic methods. On the other hand, ignorance about the singular and irreversible nature of sterilization prevent the decision from being as documented as regulations prescribe. In the report of results of the Rural Survey on Family Planning taken by the Mexican Institute for Social Security in 1981, it is stated that "from the adopters who use a surgical method giving as a reason the spacing of births, despite this being a final method, it could be assumed that this is due to lack of information of the adopters about the method they are utilizing".[20/] Another research carried out in Costa Rica[21/] by a

Table 3

PERCENTUAL DISTRIBUTION OF WOMEN WHO UNDERWENT STERILIZATION AS A FIRST METHOD, ACCORDING TO SOCIAL CLASS

FIRST METHOD	SOCIAL CLASS											
	1	2	3	4	5	6	7	8	9	10	11	TOTAL
FEMALE OPERATION	50.0	48.1	50.3	60.2	43.4	57.0	56.6	31.9	62.4	62.8	56.6	49.3
PILLS	25.8	27.1	21.3	27.2	40.3	21.9	25.3	44.3	11.7	35.0	36.1	32.7
INJECTIONS	6.6	3.8	8.3	2.1	3.6	5.1	8.5	3.8	0.7	-	0.9	3.9
IUD	-	7.5	5.3	3.9	10.7	9.3	5.1	12.7	25.2	2.2	6.4	8.8
OTHER NON-TRADITIONAL METHODS	-	7.9	2.2	5.3	1.0	5.7	-	6.7	-	-	-	2.6
TRADITIONAL METHODS	17.6	5.6	12.6	1.3	1.0	1.0	4.5	0.7	-	-	-	2.7
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
BASIS	23,500	151,400	96,900	77,400	512,200	99,900	92,800	111,000	44,400	85,500	67,300	1,362,300

Source: National Demographic Survey, 1982.

government agency states that "one out of every three sterilized women declared they had not been provided information adequately". The same study points out that "many (of the women) said they would have liked to receive more information concerning the operation and its consequences or risks".

As stated above, it is necessary to notice the coercitive character of these actions, not necessarily in the conscious will of service providers, but in the particular style acquired by the implementation of services. It is within the nature of actions carried out to provide services to a patient, in the way these are structured, an in the pressure exerted by the evaluation of programmatic achievements upon people in charge of their execution where the transformation takes place from a legitimating discourse into a coercitive practice.

A specialized review[22/] makes an account of the "Mobile program of surgery for family planning in the ambulatory patient". This study describes a female sterilization program carried out on Saturdays (Saturday Journeys) utilizing mobile units which are transported to the communities where women to be operated are residing. Each adopter woman is devoted an average of 30 minutes, during which the operation is completed, without need for later hospitalization. The paper indicates that in only three months of operation, 254 women were sterilized.

There are several elements in which the coercitive nature of this type of program can be located. In the first place, the celerity with which these operations are carried out does not warrant an adequate post-surgical care. Once more, the achievement of quantitative goals seems to be placed before the provision of a good-quality service. Secondly, the date for sterilization of each woman, according to the mentioned description, depends more on the itinerary of the people in charge of executing the program than on the individual will and need of the patient. In the third place, a set of additional information concerning the patient's characteristics throw a new light on these practices. From the total number of women sterilized through this program, 32% were under 27 years of age; 54% were illiterate; 21% had not completed the third year of primary education, and 98% lived in indigenous communities. The marginality of groups from where new adopters are recruited seems clear. In this sense, it is worth pointing out toward the basically unequal character of the relationship of actors that the program brings in touch. In this context, coercion becomes an inevitable dimension of the program. Adding to this that the main concern resides in the achievement of goals an not in the education of the patient, as is evident from the characteristics of the program, the result is obvious: instead of reducing the distances, these are exploited as a resource for achieving the program's success.

One of the elements of major importance within other contexts is the control that the population exerts through legal

mechanisms on violations of the medical practice. This control is in fact weaker in the Latin American countries. In the case of female sterilization, carrying it out in an identifiable institutional context (for example a hospital) offers the mechanisms for this indispensable control to be carried out, avoiding violations to a certain extent. The appearance of ambulatory programs reduces even more those possibilities and opens the doors for violations. This condition corresponds to the available information, according to which certain institutions of the public sector demand from their physicians quotas of women that must be under contraceptive control. This fact compels the program's personnel to work more toward the achievement of goals than with respect to the existing demand.

Both the Chiapas report as the information from the National Demographic Survey[23/] seem to evidentiate the concentration of these practices in certain groups of society. In this last case, information supports the hypothesis which proposes the existence of class-related differential modalities in the prevalence of sterilization. In general terms, it can be affirmed that among groups not devoted to agricultural activities sterilization has selectively intensified in the more stable sectors of proletariat, while in groups devoted to agricultural activities the same has taken place for the more numerous and less favored classes of the social structure. For all the years of the period 1970-81, the weight of the proletariat for the total of sterilizations is always larger than for the total of the population. The result is that

about 500 thousand women from this group are irreversibly sterile, and one fifth of them are under 30 years of age.

In this context, the words of Vicziany become meaningful, when he says that "the identity of the adopters raises a basic question about the way in which the process of demographic transition should be studied. Aggregate statistics about the government family planning programs in a society which patently lacks a popular birth-control movement, cannot be taken as any measure of demographic change. The relevant level of analysis is the community -the various castes, classes and social groups- and how these are recruited for fertility control".[24/]

Answering to this last question is, in our opinion, under the present conditions, one of the main tasks of researchers in family planning.

FINAL COMMENTS

In this paper we have tried to show the hiatus existing between the family planning discourse and some evidence of its practice in Latin America. The emphasis given to the arguments should not lead to the belief that our description is exhaustive. Quite on the contrary, we can vouch for it, and evidence supporting the fact are numerous, that many of the family planning programs, the majority maybe, do not correspond to the description we have made. Nevertheless, and in our opinion this legitimates our work, one single case where coercitive practices were detected would be more than enough reason to expose it and start elaborating a theory in search of its explanation. Unfortunately, our modest contribution reflects the existence of many more cases, in a magnitude that does not allow further postponing this search.

Our overall hypothesis is that coercitive and authoritarian practices in the implementation of social policies in Latin America depend on the type of objective set, on the criteria for evaluating their achievement, on the role played by target groups during the process and on the social "distance" existing between those in charge of policy elaboration and those receiving it.

A deeper analysis should determine if such a dynamic is an undesired effect -perverse effect in Boudon's terms-[25] of political process, or whether it has to do with the kind of relation prevailing in Latin America between political society and individuals.[26]

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3/ Testa, Mario, "Planificación estratégica en el sector salud" (Strategy planning in the health sector), CENDES, Venezuela, 1981.

4/ A good analysis of this account referred to the case of medical institutions can be found in: Madel, Luz, "As instituçoes médicas no Brasil", (Medical institutions in Brazil), Ediçoes Graal, Rio de Janeiro, 1979.

5/ Cleaves, Peter S., "Implementation amidst scarcity and apathy Political power and policy design, pp. 281, in Grindle, Meriliee S., op.cit.

6/ Idem, pp. 282.

7/ In this sense, it may be pointed out that an important consequence of this condition is that policies are formulated for population groups which include clearly different classes This is equivalent to not taking into consideration the specificities of the reproductive logic of each one of these groups. Thus, while for some the decrease of children is the immediate consequence of the search for better well-being, for other groups this may appear as the up-keeping of a high fertility. The obvious conclusion is that population policies must be formulated considering these specificities.

8/ Lévi-Strauss, C., "Antropológía estructural", (Structural anthopology), Eudeba, 1961, pp. 253.

9/ Mass, Bonnie, "Population target", Charters Publishing C.O., Canada, 1976.

10/ Vicziany, M., "Coercion in a soft state: the family planning program of India. Part 1: The myth of voluntarism", Pacific Affairs, Vol. 55, No. 3, 1982, pp. 375-376.

11/ It is worth noticing that there are some Latin American countries whose population policies are oriented toward an increase. This is the case of Argentina, Boliva and Chile.

12/ This version of the concept Authoritarianism was taken from the "Diccionario de Ciencias Sociales" (Dictionary of Social Sciences), Instituto de Estudios Políticos, UNESCO, Madrid, 1975.

13/ Concept taken from the "Encyclopedia of the Social Sciences", The MacMillan Company, New York, 1962.

14/ This fact is dealt with in the Bolivian film "Yawar mallku" (Condor's blood), by Jorge Sanjinés.

15/ "Testimony of a woman used as a guinea-pig at the Instituto Nacional de la Nutrición, El Día (journal), Mexico, July 23, 1984.

16/ "On again off again", Intercom, Family Planning Newsletter, Vol. 2, No. 11 (November, 1974).

17/ Doyal, Leslie, "The political economy of health", Pluto Press, London, 1979.

18/ Bronfman, López y Tuirán, "Práctica anticonceptiva y clases sociales en México: la experiencia reciente", (Contraceptive practice and social classes in Mexico: the recent experience), CEDDU, El Colegio de México, 1984.

19/ This information could have two additional interpretations to the ones we propose in the paper: a) it can be thought that not all women made the decision in the immediate post-partum; b) it could be indicating about the efficient functioning of a program which takes advantage of a hospital condition to save the patient another confination. Even if these two explanations were valid for a percentage of the sterilized women, the magnitude of the figure would still validate our explanation for an important group of sterilized women.

20/ IMSS (Mexican Institute for Social Security) "Encuesta Rural de Planificación Familiar, 1981. Resultados nacionales", (Rural Survey on Family Planning, 1981. National results), Mexico, 1983, pp. 56.

21/ Blanch, Pastor de Avila y Prada, "Estudio de mujeres esterilizadas" (Study on sterilized women), Caja Costarricense de Seguro Social, San José, 1975.

22/ Hernández y Hernández, "Programa móvil de cirujía de planificación familiar en el paciente ambulatorio" (Mobile program of surgery for family planning in the ambulatory patient), en Boletín Médico del Hospital Rural "S" de San Felipe Ecatepec, San Cristóbal, Vol. VI, Núm. 25, January, 1984.

23/ The National Demographic Survey (END) was taken by the National Population Council (Mexico) during 1982. The paper by Bronfman, López y Tuirán is based on it.

24/ Vicziany, M., op.cit., pp. 559-560.

25/ Boudon, Raymond, "Efectos perversos y orden social" (Perverse effects and social order), Premia Editora, Mexico, 1980.

26/ The concept political society refers to the group of apparatus, among which the State is fundamentally included, as well as the government agencies responsible for the political conduction to be exerted on a society (Gramsci, "Los intelectuales y la organización de la cultura" (Intellectuals and the organization of culture)), Juan Pablos Editor, Mexico, 1975, pp.17