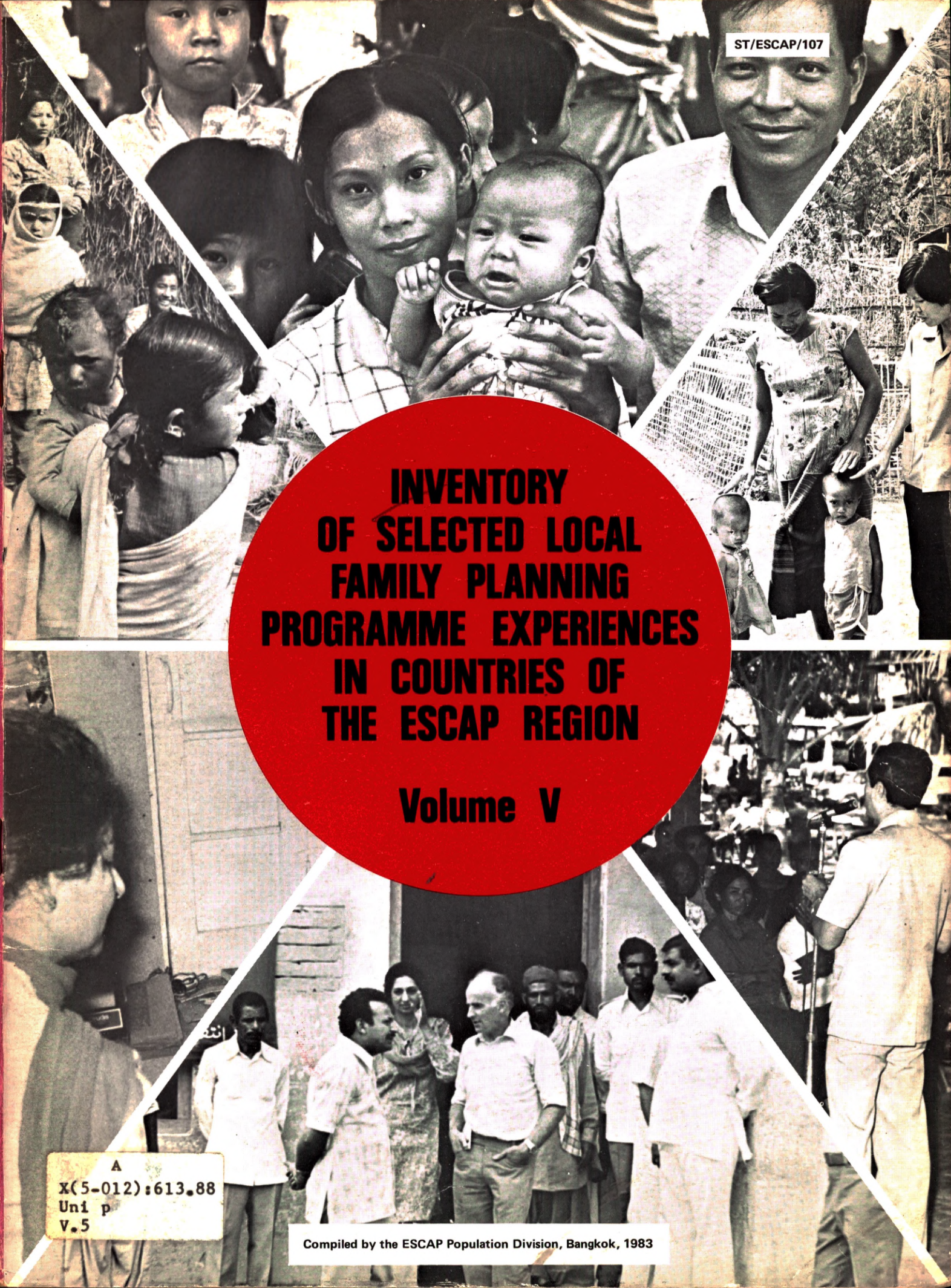

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INVENTORY OF SELECTED LOCAL FAMILY PLANNING PROGRAMME EXPERIENCES IN COUNTRIES OF THE ESCAP REGION

Volume V

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UNITED NATIONS

ESCAP

Economic and Social Commission for Asia and the Pacific

The Economic and Social Commission for Asia and the Pacific (ESCAP) is the regional arm of the United Nations, with headquarters in Thailand. It is administratively responsible to the Secretary-General of the United Nations. At the same time it is responsible to the member countries of the ESCAP region and is subject to their parliamentary control and guidance in policy matters, under the over-all control of the Economic and Social Council.

This unique organization brings together, within Asia and the Pacific, representatives from countries throughout the world. Eastern and Western, large and small, developed and developing States sit as equals at the annual sessions of ESCAP, often called the "Parliament of Asia and the Pacific".

ESCAP POPULATION PROGRAMME

The population activities of ESCAP are based on two principles: (a) there is need for greater awareness and understanding of the size, complexity and significance of the population problems that Governments will face in the decades ahead, and (b) population problems must be dealt with as an integral part of the over-all process of economic and social development.

Throughout the Asian and Pacific region served by the FSCAP secretariat, Governments recognize the need for action programmes, and the secretariat seeks to improve the effectiveness of these programmes.

The Asian and Pacific population programme, which was endorsed by ESCAP in 1968, is implemented by the Population Division of the ESCAP secretariat. Population activities are centred in three Sections – General Demography, Fertility and Family Planning, and Clearing-house and Information, including the Reference Centre.

The Division as a whole co-ordinates its activities with other programmes of ESCAP, the United Nations system, ESCAP member Governments and various non-governmental organizations.

CONTENTS

I. PROGRAMME IMPLEMENTATION

It is, of course, one thing for a nation that wants to restrain population growth to set demographic goals and quite another to achieve them. In the ESCAP region the means adopted to reach the demographic ends usually includes a family planning programme whose overall success will be crucial for hitting the targets. The programme's success, in turn, will be determined by its ability to reach the people in the villages and cities – as well as by the over-all persuasiveness of the family planning message and the availability and quality of service.

A number of common denominators have emerged that characterize successful programmes. Perhaps the most obvious is the number and availability of service points. Making villagers trek many hours to receive contraceptives may be convenient for the family planning official, but bad for the programme – especially if the clinic is out of supplies when the acceptors arrive.

There are indications that the mix of contraceptives could influence acceptance. As noted in an article in this section, the belief that contraception is meant for couples who have completed their families is difficult to change when only a few methods are available, since these become associated with older, high parity women. In the case described ("Offering a variety of methods results in younger acceptors"), addition of other methods allowed contraception to spread among younger women for spacing purposes.

The attitude of workers is important. Undertrained and uninformed workers can harm the programme by failing to properly inform acceptors of contraceptive side effects or giving them improper instructions about the use of such methods as rhythm.

Workers who lack motivation will no doubt fail to motivate acceptors. Workers who are pressured to meet targets, on the other hand, may in turn pressure potential acceptors into using a targetted method – at the expense of the long term popularity of family planning.

Because programmes often operate with scarce resources, management to achieve maximum results is especially crucial. In "Improving the management of population programmes" contained in this section, Rushikesh M. Maru notes that in many programmes "neither clear-cut motives, such as profits, nor the instruments for managerial control, such as performance budgeting, are well developed." He sees the need for the administrators and doctors who direct the programmes to perceive themselves as managers "who generate opportunities within constraints as one of the major components of the managerial role."

One strategy for increasing the effectiveness of programmes is the integration of family planning and other development activities, such as parasite control, maternal and child health, and community or income generating projects. Not only can combining programmes help maximize resources, the coupling of family planning with other activities can increase the acceptance of the programme. However, integration can also bring its own problems, such as assuring that family planning is not being neglected in favor of other programme components.

A recent study notes that some economist calculate that nations with a surplus of unskilled labor experience a substantial savings with each prevented birth. Incentives and disincentives for family planning can be viewed as a means for spreading the savings. The study also notes that incentives re-enforce positive behaviour which "is for the ultimate good of the individual.... Acceptance of an incentive as a reward to change one's fertility behaviour is not monetary opportunism but an action which confers benefits in the long run." (Incentives and Disincentives to Promote Family Planning; Family Planning Foundation, 1982).

Incentives take many forms. They can be offered to individuals (usually for terminal methods) or offered to groups or communities (usually for lowering total fertility). In Sri Lanka couples whose marriages were registered after January 1978 will be eligible for a 10 per cent increase in pensions if they have only two or fewer children. In Indonesia, trust funds were provided to the community at the beginning of the programme rather than wait for a specific performance to be rewarded. In Korea, the emphasis is on social support for the two child family and discouraging son preference.

But whatever the family planning strategy, the programme's ultimate success depends on the follow through, which means effective implementation and a good deal of dedication from family planning workers and administrators.

A. MANAGEMENT OF FAMILY PLANNING PROGRAMMES

1. China: Sichuan province strengthens leadership over family planning work

New conditions and new problems have appeared in family planning work in Sichuan province. The principal problems are the following: some of the population believe that one must have sons in order to become rich; following the development of production, some individuals who have obtained more income and want to have more children pay no attention to the economic sanctions; and the original regulations regarding award and punishment and birth control measures have lost their restrictive power.

In May and June of 1981, the provincial government and provincial family planning leader-

Family welfare and mothercraft go hand in hand at this embroidery class held outside a temple. Organized by mahila samithis (village women's clubs) the programme includes many elements together with family planning motivation.

Income generating projects such as fish cultivation, organized by the Family Planning Association of Bangladesh, may be considered as a practical first step in reaching out to future parents as family planners.

Prizes for sterilized women are distributed by a local opinion leader in a community based project.

Keeping up to date with programme developments is an important aspect of the involvement of both professional and voluntary staff engaged in programme efforts that require high level commitment and in-puts.

ship team personally led the cadres of the provincial agricultural, educational and family planning offices in conducting an investigation of more than 10 counties and municipalities and some district communes. By conducting symposiums from the bottom level up, the provincial family planning department set forth its preliminary proposals for discussion by relevant leadership and the masses.

"A tentative Opinion on Strengthening and Making Perfect the Family Planning Work under the Agricultural Production Responsibility System" has been formulated. Its contents include: awards and punishments linked under contract and with specific tasks contracted to individual labourers, with the single child being allocated one-half or one additional plot of land under contract, a three-way-link cadre job responsibility system to be universally established in counties, districts, communes, and brigades, meaning that targets for grain, cash and population are to be included in one contract; and strengthening leadership and assuring that all policies concerning planned birth are carried out.

Source: *Sichuan province strengthens leadership over family planning work;* Renim Ribao, Sept. 29, 1981.

2. India: Improving the management of population programmes

The Indian Institute of Management, Ahmedabad, conducted a five-year experimental project in six districts of Uttar Pradesh to gather insights into the management needs of population programmes.

Although the fundamental managerial tasks of planning, programming, and controlling of population programmes are similar to those of enterprise management, the organization, performance, and evaluation of these tasks can differ significantly because of the special characteristics of public bureaucracies. This is particularly striking in those countries which have experienced colonial domination. The hierarchically organized, procedure-bound civil service tradition in India and other South Asian countries presents special problems in changing bureaucratic style and gaining acceptance for modern management ideas. Thus, substantial differences exist between enterprise management and management of population programmes, as reflected in the following characteristics:

– Population programmes are funded and administered by the Government, and governmental procedures are applicable although programme tasks might require more creative and innovative approaches than are commonly found in governmental systems.

– Opportunities to improve performance depend on conditions largely local in origin and character. Therefore, decentralization of programmes is necessary. It is not enough just to provide freedom and flexibility to plan programme methodology; organizational process must also be stimulated to implement such plans.

– Because of the way population programmes deal with entry and advancement, administrators have either medical or general administrative backgrounds instead of special management training.

– Neither clear-cut motives, such as profits, nor the instruments for managerial control, such as performance budgeting, are well developed. The need for improving management in an enterprise is necessary for its viability because market forces will drive a poorly managed enterprise out of business. Such forces, however, do not operate in population programme management.

These distinguishing features of public systems need to be grasped fully before attempting to introduce management ideas in population programme organizations.

Management information systems

The initial studies of the performance of the family planning and health programmes in the six project districts indicated two related characteristics. First, there was considerable unmet need for all types of health and family planning services. At the same time, however, the existing service capacity of the primary health centres (PHCs) was not being fully used. These cover a population of 80-100,000 and are generally staffed by two medical officers and 28 paraprofessionals. Second, performance varied widely from PHC to PHC in spite of similar inputs.

These findings indicated the need to strengthen supervision and control of PHC operations. *Control* here means identifying poor PHCs and taking corrective action. State administrators also saw the need for a monitoring system, which was designed and implemented in all the six project districts. The main features of the system included:

– Coverage of all health and family planning activities of the PHC and measurement of efficiency and effectiveness through a few key indicators.

– Comparison of performance of all PHCs in a district and their categorization as good, average, or poor. This helped the district health officer to identify poor PHCs and take corrective action.

– Streamlining the recording system at the PHC level and introducing a one-page summary report with information on programme activities, inputs and performance for all programmes.

– Providing feedback reports sent from the state headquarters to the district and PHC managers. These reports provide feedback not only on how well the PHCs were doing but also on why their performance might be poor.

The new system had two immediate effects. First, the evaluation generated interest among administrators and PHC doctors because of its grading system. Second, the administrators at the higher

level were able to uncover "problem PHCs" not previously identified.

Because of these positive features, the monitoring system has been legitimized in the departmental bureaucracy and all PHCs now send in reports regularly and feedback is provided within 45 days. However, the main purpose of the system is to initiate a cycle of problem identification and corrective action which will ultimately lead to improvement in overall performance. A few district officers have used the system to improve performance; however, in most cases diagnosis and corrective actions have not been undertaken. Moreover, even among those officers who have taken action in the case of identified poor PHC performance, little attempt has been made to learn from PHCs showing consistently good performance.

It was also found that an original objective to streamline records and reporting has not been achieved. The old system of keeping separate reports for each activity continues to the present. Also, as new schemes are implemented by the state government they bring with them their own separate reporting system.

Improved work technology

One experimental study was aimed at understanding the extent to which family planning workers are equipped with the technology and skills for interpersonal communication and influence.

Unfortunately, the project had to be terminated due to disturbances arising out of coercive family planning policies that existed for a short time in India. The experiment revealed, however, that workers lacked communication skills as well as credibility among villagers. Many of them were not equipped with adequate knowledge about family planning methods. Some were not even convinced about the need for family planning. Thus, training could be very helpful to improve knowledge and instill positive attitudes.

However, obsession with targets seemed to make workers impatient with the slow rapport-building communication activities needed for gaining voluntary acceptance of family planning. This resulted in poor transaction with clients, leading to further weakening of the credibility of the workers. This vicious circle can be broken only if improvement of worker communication skills is supported by changes in personnel policies as well as policies regarding targets.

A follow-on experiment initiated activity planning in four selected villages which had a large number of couples with favourable attitudes toward family planning. Special tasks in the form of multipurpose health care service camps were planned. These camps were very effective in generating enthusiasm in the population and building a rapport between the village field workers, leaders, and clients. They were also successful in mobilizing villagers for immunization and family planning services.

Management development training

It was found that health administrators were suspicious of any training effort which did not draw on material from the health sector. Thus, a major effort to develop cases on various dimensions of programme management was launched, and after two and a half years of research the first management development programme for medical district officers began. The case studies identified the following training needs:

– Planning is nearly nonexistent at the PHC and district levels. Activities are carried out on an ad-hoc basis based on instructions received from higher levels.

– The officers at the PHC and district levels generally do not use a problem solving attitude. Each officer, in listing problems, either blamed his subordinates or superiors.

– Supervision has consisted of fault-finding and record keeping. Supervision style among managers needs further improvement.

– Most officers see their role as that of carrying out orders from above. They do not perceive their role as that of a manager, trying to achieve programme objectives within the given resources and constraints.

It was found that the training intervention convinced many administrators of the relevance of management concepts in health, although high level quantitative techniques were not useful because of the limited scope of their application. Therefore, the programme concentrated more on changing the perception of the doctor's role from that of a physician to that of a manager who generates opportunities within constraints as one of the major components of the managerial role.

Despite positive achievements, actual use of the knowledge in practice is not very high. Using these skills depends on a number of factors and on the organizational climate. Unless the organizational climate supports innovation, new management ideas cannot be realized. Newer training methods have to be developed to ensure closer linkages among training, systems development, and organizational development efforts. Training needs to go beyond case method and emphasize more experience sharing.

Source: *Approaches to Management Development in National Population Programmes,* Rushikesh M. Maru; In: Management Development in Population Programmes, S.C. Jain ed.; University of North Carolina, Department of Health Administration, 1981.

3. India: Good service brings success

In India, family planning programme evaluation has largely been concerned with measuring the demographic effects rather than with the as-

sessment of short term accomplishments and ongoing programme operations. However, feedback on the strengths and weaknesses of the delivery system is essential for the success of the programme.

Recently a micro-level study was completed that evaluated the family planning programme in two Development Blocks of one district in Punjab. The Development Blocks each contained a Primary Health Care Centre and were selected on the basis of their performance in relation to Punjab's average. The first Development Block, Chankaur Sahib, had shown better than average performance while the second, Boothgarh, displayed poor performance.

First, the accuracy of the records were checked. A comparison between the number of couples according to the official lists and expected number of eligible couples according to population size showed gross under-enumeration in both PHC's. Records of the family planning acceptors (sterilization and IUD) were in much better shape, because this matter involves the payment of incentive money. But the records of condom users were not maintained by either PHC.

On the basis of the population estimates of the study villages, acceptance rates for sterilization and IUD were 3.38 and 3.39 per 1000 population in Chamkaur Sahib and 1.29 and 0.09 in Boothgarh.

There could be many reasons for Boothgarth's low acceptance, including socio-economic factors or the slackness of the delivery system.

The easy availability of services is often positively associated with the acceptance of family planning. To test this hypothesis, study villages were divided into two categories on the basis of their distance from the nearest family planning centre, with villages in the first category located within five kilometres of a centre. Since Chamkaur Sahib had 80 per cent of its population in the closer category, compared with 70 per cent for Boothgar, this factor could account for a small part of the difference. However, the above average Development Block outperformed the other, even in comparable categories. In Chankaur Sahib, acceptance rates for sterilization and IUD in Category I villages were 3.75 and 4.32 per 1000 population respectively, while in Category II these rates were 1.71 and 2.09 respectively. In Boothgarh, the sterilization acceptance rate was 1.36 per 1,000 in Category I villages and 1.12 per 1,000 in Category II.

A "basic facilities index" was constructed to study the impact of development on the acceptance rate. The index showed Chamkaur Sahib villages were more developed but the difference was small.

The villages in the study were further divided into two categories on the basis of the presence (A) or absence (B) of a village level family planning workers. In Chamkaur Sahib, over 90 per cent of the population had access to a local worker, while less than half had access in Boothgarth. In Chamkaur, the difference in acceptance rates among the two types of villages was high. In villages with workers, the IUD acceptance rate was 4.09 per 1,000 in Category A villages and 1.59 in Category B. Boothgarh, the comparable rates were 1.39 and 1.14 respectively. The slight difference between the rate in the two types of villages in Boothgarh reflects the poor quality of service provided there.

An old saying in the business world is that a satisfied customer is the best salesman. It is equally true in propagating family planning. Higher incidence of post-procedure complications can easily ruin the credibility of the family planning programme. But from the findings it appears that this aspect of the programme is greatly neglected. Out of 145 acceptors who could be followed up, nearly half reportedly suffered from post procedure complications.

This study clearly demonstrates that the low acceptability of family planning is not a result of any lack of socio-economic development but rather it is due to the failure of programme managers in providing adequate service. Wherever adequate services are available, planning has been accepted to a greater degree.

Source: *Evaluation of the Family Planning Programme*, V.S. D'Souza and R.S. Goyal; The Population Research Centre, Punjab University, India.

4. Thailand: Redefining the role of the health professional

Thailand, one of the most recent and dramatic cases of family planning success, is receiving the increasing attention of many other developing countries. With a population of over 45 million, Thailand has reduced its annual population growth rate from 3.0 per cent in 1972 to 2.5 per cent in 1976. It further reduced its growth rate to 2.0 per cent in 1981.

The accomplishments of the Thai family planning programme deserves careful attention for several reasons. First, with nearly 85 per cent of the population living in rural areas, Thailand's programme has been especially successful outside urban areas – an unusual phenomenon for most family planning programmes. Second, the politics of the medical profession have been instrumental in assuring the success of the programme. Doctors helped develop the family planning programme in the absence of a government policy. Third, doctors revolutionized various aspects of the health care system be devolving traditional family planning roles, such as examination and prescription, to nurses and auxiliary health personnel. Fourth, Thailand has an integrated organizational framework for coordination and delivering family planning services, with the Ministry of Public Health (MOPH) providing family planning services along with other health services.

Prior to 1970 family planning services were mainly confined to Bangkok and a few provincial hospitals because only doctors were permitted to

prescribe pills, insert IUDs, and perform sterilizations. Since more than half of all doctors lived in Bangkok, and there was only about one doctor for every 100,000 population in the rural areas, few family planning services were available to the vast majority of the population.

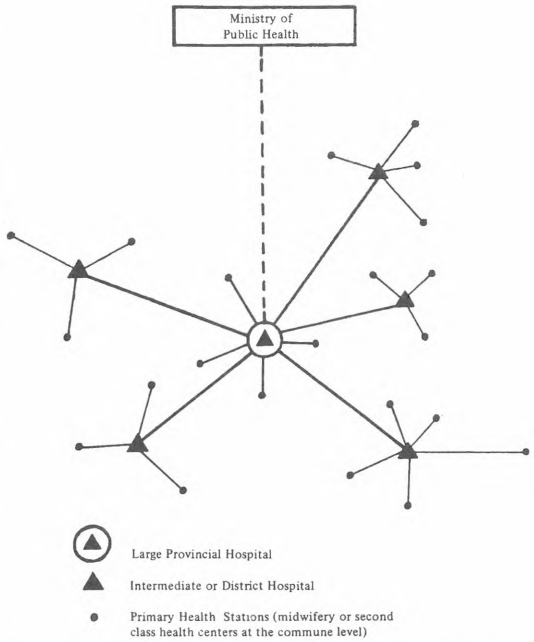
Recognizing the shortage of doctors, MOPH officials ruled that trained auxiliary midwives would be permitted to prescribe and distribute the pill. This decision was later followed by permitting nurses, after receiving special training, to administer injectables and to insert IUDs.

The decisions had a dramatic impact on the delivery of services, especially in the case of oral contraceptives. By devolving responsibility to midwives, the number of service points leaped from 350 centered in urban areas to 3,500, primarily in rural areas. The immediate effect was the increase in new pill acceptors from 8,000 per month to over 30,000 per month.

Auxiliary midwives quickly became an effective cadre of family planning communicators and providers at the village level. Acceptors, particularly those choosing IUDs, prefered working with midwives rather than male doctors. While also responsible for patient care and child delivery, midwives overwhelmingly viewed their family planning role as most important. By 1976 the role of midwives became the key to understanding the success of the National Family Planning Programme.

Additionally, MOPH physicians reduced their family planning work loads which allowed time for other types of patient care. Furthermore, the action resulted in moving the service centre into the rural areas where 85 per cent of the population was located and where demand for the services was greatest. The major physician-centered contraceptive method remaining was sterilization. Tubal ligations and vasectomies had to be performed by doctors in urban-based hospitals and in a few first class health centres.

Figure I Spatial Hierarchy of the Public Health System in Thailand



Source: Frederick A. Day and Boonlert Leoprapai, *Patterns of Health Utilization in Upcountry Thailand* (Bangkok: Institute of Population and Social Research, Mahidol University, 1977), p. 27.

Source: *Initiating a Population Revolution in Thailand: Politics, Bureaucracy, and Social Change; Asian Profile;* vol. 10, No. 2, April 1982.

B. CONTRACEPTIVES

1. Bangladesh: Offering variety of methods results in younger IUD acceptors

Within a two year period the introduction of a Family Planning Health Services Programme in rural Bangladesh significantly altered the profile of IUD acceptors and the overall pattern of contraceptive use. Analysis of the data suggests that a broad spectrum of methods delivered by trained workers produced the results.

Pre-programme data reveals the acceptors were older, higher parity women using IUDs to terminate childbearing, while post programme acceptors were younger, lower parity women using IUDs to space the next pregnancy.

In September of 1975, the government Thana Health Complex in Matlab established a family planning clinic staffed by two female family planning visitors trained to provide contraceptive oral pills, condoms and IUD insertions. Clinic records were maintained for all IUD acceptors detailing the obstetric history, family planning use and reproductive and breast-feeding status at the time of acceptance.

Two years later the International Centre for Diarrhoeal Disease Research introduced a family planning health services programme in the villages of Matlab Thana. In addition to the clinic in Matlab, four subcentre clinics were established. All the clinics made available a wide choice of contraceptive methods.

Significant differences were found between pre-programme and post-programme acceptors. The post-programme IUD users were not only younger (a difference of eight years in the median age) but were also of lower parity, with a median number of 3.3 pregnancies as against seven pregnancies experienced by pre-programme users. Post-programme acceptors were more intent on

delaying their next pregnancy while pre-programme acceptors wished to stop childbearing.

Analysis of the data reveals another important difference: at the time of initiating IUD use, 52 per cent of the post-programme acceptors had either no or only one surviving son, compared to 75 per cent of the pre-programme acceptors who had from two to seven sons. Although these results are a function of their lower parity, the fact post-programme acceptors withstood social pressure to produce more sons and chose instead to postpone the next childbirth is an important change.

Possible explanations for the differences can be found in the changes caused by the introduction of the programme. Services became more accessible and a wide choice of contraceptive methods became available through trained village women who informed the clients about the various forms of contraception and assisted them in selecting a method that suited their needs.

As a result of this activity, the women became aware of the benefits of spacing. Thus the programme attracted not only women who had completed their desired family size but also women who were eager to control their fertility.

The misconception that family planning is meant for couples who had borne the desired number of children is difficult to rectify when only one or two methods are available. In this situation, contraceptive use becomes associated with older, higher parity women who want to terminate childbearing. Younger women, especially in the rural areas, then tend to stay away from those methods. This could have been the fate of the IUD in the pre-programme period.

With the introduction of a wide array of contraceptive methods, not only did the overall percentage of contraceptive users increase in the area, but also a specific use pattern evolved. Older, high parity women opted more for sterilization. Injection (depo provera) mostly attracted women who either did not desire to accept or wanted to wait before accepting a permanent method of contraception. The pills, condom, and vaginal foam tablets attracted mainly women who were younger, lower parity and who were less motivated to delay the pregnancy than the IUD users.

Interpretation of the results cannot be conclusive beyond doubt, since a number of programme elements changed. However, the mean age and parity of the various method users among the post-programme acceptors are consistent with the idea that a broader spectrum of methods, delivered through trained workers, was of major importance in producing the difference.

Source: *Changing Profile of IUD Users in Family Planning Clinics in Rural Bangladesh;* Shushum Bhatia, A.S.G. Faruque and J. Chakraborty; Journal of Biosocial Science; vol. 13, No. 2, April 1981.

2. China: Cottonseed male pill nearly 100 per cent effective

PEKING– A male contraception derived from cottonseed has proven nearly 100 per cent effective in 12,000 clinical cases, according to a Shanghai newspaper.

The Wen Hui Bao said the contraceptive is now being used in 13 provinces and major municipalities throughout China. The WHO has expressed interest in using it.

Reports of the contraceptive, a pill containing gossypol, a chemical derived from cottonseed, have been published before, but the Shanghai newspaper report was the first detailed one in recent years. It said in 12,000 clinical cases since 1974, the male pill has been 99.98 per cent effective.

An outbreak of illness and impaired fertility among farmers exposed to raw cottonseed oil led to the discovery of gossypol by Chinese scientists in 1971.

Led by the Chinese Academy of Sciences and the Shanghai Pharmaceutical Research Institute, experiments were done successfully with rats, dogs and monkeys.

In April 1974, the clinical applications began.

Source: Bangkok Post; February 15, 1983

3. Malaysia: Study on long-term use of IUDs

Results of a study at a government supported health clinic in Malaysia indicate that longterm copper-bearing IUD users do not suffer significantly from the increase in menstrual blood loss (MBL) caused by the IUD. In the study sixty women completing two years of Cu-IUD use were investigated for this risk and no significant differences were found compared to a control group of women requesting interval Cu-IUD insertion.

Whether long-term use of the IUD causes iron deficiency is an important practical question where IUDs are used on a large scale in national planning programmes, especially in developing countries. It is often feared its use may cause a significant increase in the overall prevalence of anemia which is already high in the community because of a combination of factors, including high parity, a marginal diet and hookworm infestations.

MBL is increased by about 50 per cent following insertion of copper-bearing IUDs which could be associated with a potential risk of iron-deficiency anemia. Although this increase remains high throughout the first two years, if not longer, short-term studies show that the increment in MBL following insertion decreases significantly with time. The results of the present study tend to support this view.

However, the overall prevalence of iron-deficiency anemia in the test population was high (15.4 per cent of 104 cases) and justifies some form of routine screening. In this way, women whose iron stores are depleted may be identified for investigation and treatment, thereby enhancing maternal health. Blood Hb estimation is insufficiently sensitive for this purpose because a fall is only observed late, when iron stores are exhausted. Instead, measurement of serum ferritin levels is recommended as this is the most accurate practical method of assessing body iron stores currently available. Cost effectiveness may be improved by screening only those from the lower socio-economic classes as they constitute a high-risk group.

Source: "Iron-deficiency Anemia and Long-term Use of Copper-bearing IUDs," by T.H. Goh and M. Hariharun, in *Contraceptive Delivery Systems*, vol. 3, No. 1, January 1982

4. Malaysia: Pill continuation rates improve.

In order to obtain a more current estimate of use-effectiveness of contraception in Malaysia's family planning programe, an acceptor survey was undertaken in 1977. Unlike the previous survey in 1969, when the programme was in its earliest stages, the 1977 survey was confined to acceptors of the pill, who currently comprise about 85 per cent of all the programme acceptors.

The study universe comprised of those who accepted the pill in the public programme from January 1977 through April 1977, approximately 149,000 cases in all. As the field work was conducted during October 1977 through January 1978, the period of observation since initial acceptance ranged from a minimum of five months to a maximum of 37 months, the average period of observation being about 21 months. A sample of 4,976 acceptors was drawn.

The basic conclusion from the 1977 acceptor Follow-up Survey is that the continuation of contraception by acceptors is quite good. The 18 month continuation rates in 1977 were 55.9 per cent compared with 52.4 per cent in 1969, inspite of generally younger age and lower parity of the 1977 group.

The continuation rates vary most widely by ethnic background. The Malay acceptors have substantially higher continuation rates than either the Chinese or the Indians, the latter group having somewhat lower rates than the Chinese. Age-controlled comparison does *not* change the pattern. This may be due to the fact that Chinese (and to a lesser extent Indians) are using more induced abortion to overcome this failure in contraception.

The Malaysian acceptors are basically quite satisfied with the pill. This is indicated most strongly by their willingness to recommend the pill to others: 56 per cent say "definitely yes" and 29 per cent, "probably yes" when asked if they would recommend it. Furthermore, 41 per cent of all acceptors actually have recommended the pill to someone with only two per cent ever recommending against taking it.

About half of the women report the experience of side effects, with women under 35 reporting more and rural women reporting less. Slightly over one-half of those reporting side effects claim them to be somewhat serve (31 per cent) to very severe (24 per cent).

On the other hand, about two thirds report they feel somewhat better or much better when they are on the pill, with those 35 and over and rural women doing so more than the others. Libido generally is unaffected excepted for the young rural women who tend somewhat more often to report an increase.

Rural acceptors are more likely to regard the clinics to be either not too far or not far at all. This is in sharp contrast to the situation in 1969 when it was the rural acceptors who more often thought the clinics far. It is likely the extension of the programme into the rural areas since 1969 would account for this.

The service quality is assessed by the 1977 acceptors somewhat less favourably than the 1969 acceptors. However, the overwhelming impression is that the various aspects of the services provided by the clinics are regarded very favourably by the majority of acceptors even today. The rural women as compared to the urban women give a slightly more favourable assessment of the convenience of clinic hours, the amount of interest shown by clinic staff, and the quality of staff advice.

There is room for improvement in several aspects of the programme. The accidental pregnancy rate of the acceptors while on the pill is relatively high, a consequence of forgetting to take the pill regularly. Complaints of side effects comprise a large part of the reason for discontinuation. Efforts must be made to reduce this cause through greater education, adjustment of dosages and improvement of follow-up service.

In addition, local institutions and agencies should be involved in local level policy decision with the necessary delegation of administrative and financial authority to utilize resources to meet the needs of the local communities.

Source: *Family Planning Acceptance, Continuation and Discontinuation Rates, and their Management: the Malaysian Experience*, Dr. Tan Boon Ann; Paper presented at the Regional Meeting on Social and Cultural Factors Affecting the Acceptance, Continuation and Discontinuation of Family Planning Practice, ESCAP, 2-8 November 1982.

5. Pakistan: Gap between knowledge and use

A study on family formation patterns in Pakistan by WHO revealed a wide gap between knowledge of contraception and its actual use, and that the percentage of users was higher in the urban areas than in the rural.

On the positive side, an overwhelming majority of women interviewed approved of birth control irrespective of their age, parity or residence. In the semi-urban area, 90 per cent of the women expressed approval of birth control while in the urban area, the figure was 91 per cent. In both areas, birth control was approved of more often as a method of spacing pregnancies than for limiting their number. It was found that the preferred ideal family size was about four children.

Reasons given for the approval of birth control were the preservation of the mother's health, better care of the child, improved child health, and

Table: Knowledge and use of fertility control methods among eligible women, by residence, social status, use, and method.

Social status and method	Knowledge and use of fertility control methods among eligible women (%)							
	Semi-urban				Urban			
	Never heard of	Heard of and used	Heard of and using	Heard of but never used	Never heard of	Heard of and used	Heard of and using	Heard of but never used
Middle								
Condom	0.4	5.4	11.7	74.2	8.5	14.4	23.1	53.3
Withdrawal	43.9	0.4	0.8	44.2	62.0	2.2	6.4	29.1
Rhythm	54.5	0.7	0.9	43.6	50.3	3.0	4.3	42.1
Diaphragm	44.1	0.7	0.3	53.8	52.6	2.0	0.5	44.1
Douche, etc.	27.3	1.8	1.6	69.1	39.4	3.1	2.0	55.1
Coil or IUD	4.8	5.0	1.8	87.8	10.2	5.7	1.3	82.2
Orals	3.0	7.9	4.3	84.6	3.9	13.0	5.3	77.4
Tubectomy	7.1	0.0	1.7	92.0	7.4	–	3.5	88.9
Vasectomy	11.0	0.0	0.5	88.3	12.6	–	1.1	86.0
Abortion	2.9	0.8	0.0	95.0	7.3	3.7	–	87.5
Others	5.3	0.2	0.3	0.8	7.1	0.1	0.2	0.6
Low								
Condom	9.5	4.6	7.1	78.6	21.2	10.1	10.1	56.4
Withdrawal	45.5	0.3	0.4	53.3	72.1	1.1	4.5	20.7
Rhythm	61.1	0.5	0.8	37.3	66.5	1.1	3.9	27.4
Diaphragm	48.5	0.6	0.1	50.1	60.9	–	1.1	36.3
Douche, etc.	30.9	1.8	0.8	66.6	46.4	0.6	1.1	49.7
Coil or IUD	5.3	5.5	2.8	85.9	10.1	5.0	1.1	82.1
Orals	3.1	8.8	7.0	81.1	6.7	8.4	3.9	79.3
Tubectomy	7.4	0.0	1.7	90.0	13.4	0.0	2.2	83.2
Vasectomy	13.4	–	0.4	86.1	20.1	–	–	78.2
Abortion	3.2	0.5	0.0	95.1	15.1	0.6	–	81.0
Others	5.9	0.9	0.7	1.6	10.1	–	–	0.6
Both categories								
Condom	9.0	5.0	9.4	76.4	9.4	14.1	22.2	53.9
Withdrawal	44.7	0.4	0.6	53.7	62.8	2.1	6.3	28.5
Rhythm	57.8	0.6	0.9	40.4	51.5	2.8	4.2	41.0
Diaphragm	46.7	0.6	0.2	51.9	53.2	1.8	0.6	43.6
Douche etc.	29.1	1.8	1.2	67.8	39.9	3.0	1.9	54.8
Coil or IUD	5.1	5.3	2.3	86.9	10.2	5.7	1.3	82.2
Orals	3.1	8.3	5.7	82.5	4.1	12.7	5.2	77.6
Tubectomy	7.2	0.0	1.7	91.0	7.8	–	3.4	88.5
Vasectomy	12.2	0.0	0.5	87.2	13.1	–	1.0	85.5
Abortion	3.1	0.6	0.0	95.1	7.8	3.5	–	87.1
Others	5.6	0.6	0.5	1.2	7.3	0.1	0.2	0.6

Note: Percentages do not add up to 100 as "no response" cases were not included.

economic considerations.

A substantial proportion had some knowledge or a general awareness of contraceptive methods, perhaps because the study areas were well covered by the family planning programme. Although knowledge was widespread, not all methods were equally well known. The overwhelming majority of women interviewed had heard of the condom, the IUD, oral contraceptives and abortion. The women were also well informed about tubectomy and vasectomy but only about half of them were familiar with the withdrawal, rhythm, and diaphragm methods.

Although the number of women who approved of birth control was large, only one third to one half of them had ever practised or were practising contraception.

Source: *Family Formation Patterns and Health;* World Health Organization, 1981.

6. Philippines: Rhythm still popular

The rhythm method has been found to be popular among Filipino couples. A recent nationwide survey of outreach areas with Barrio Supply Points (BSP) has shown that nearly one-half (48 per cent) of married couples of reproductive age were contracepting at the time of interview. Of this number, roughly 28 per cent were using either rhythm, abstinence, withdrawal or condom either alone or in combination.

The popularity of rhythm as a method is further supported by findings from the 1976 National Acceptor Survey. This study showed that the most common back-up methods reported were rhythm and condom (20 per cent each) and pills and withdrawal (17 per cent each) and then IUD.

Despite the little attention given the rhythm method, it is widely used and is considered relatively effective. It is found that rhythm continuation rates can be compared to the pill: the 12-month continuation rate for the rhythm rivals the pill's 45 per cent. Furthermore, when rhythm was used in combination with other less effective methods, like condom or withdrawal, the continuation rate increased to 64 per cent.

Despite the above phenomenon, the National Population Programme has given little emphasis to rhythm and no systematic effort has been made to promote its effective use.

The calendar rhythm method is currently provided in the service delivery programme of the National Population Programme, and efforts are being exerted to improve the understandability of the method among both workers and clients. One practical consideration in the choice of calendar as an appropriate technique to be taught field workers and clinic staff is its relative simplicity compared to other rhythm methods. However, the fact that it is only suitable for a women with a regular menstrual cycle (a variance of not more than plus or minus two days from the average) is an important limitation. The Billings-ovulation method, on the other hand, is theoretically applicable to all types of women regardless of the regularity or irregularity of their cycle.

Both are relatively simple compared with other rhythm methods. For example, the Basal Temperature Method (BTM), while claimed to be the most reliable and substantially effective of the rhythm methods, has been found to be difficult to use correctly. A relatively low continuation rate of BTM has been attributed to a number of reasons including: a bias against taking the temperature daily; difficulty with basal temperature charts; unavailability of thermometers; incidence of communicable disease affects body temperature; and the resupply of thermometers.

Source: *Proposal for a Comparative Study of the Calendar and Billings Rhythm Methods in Selected Philippine Parish Organizations;* 1981; unpublished.

7. Thailand: Contraceptive use encouraged among abortion clients

Induced abortion, whether legal or illegal, is the most overt expression of a women's desire to limit her fertility. A recent programme in Thailand capitalized on this and provided family planning services to all post-abortal women admitted to the provincial hospitals where the study was conducted. The project was to promote contraceptive acceptance and prevent abortions.

The characteristics of abortion patients were compared to a control group of delivery patients to determine whether those seeking an abortion presented a unique profile. The study found that "cases of incomplete abortion appear to be more resistant to adopting approved methods of family planning than do a comparable group of delivery cases. Thus, it is not unlikely that many of these abortion cases would seek to abort once again should an unwanted pregnancy occur."

A disappointing 28 per cent of the post abortion patients accepted a form of birth control at discharge compared to 36 per cent of the delivery patients.

The hormonal pregnancy protection of a first trimester abortion is considerably less than that provided by a live birth process. Hence the women needs protection quickly to avoid the risk of pregnancy.

Source: *Abortion in Thailand: A Review of the Literature;* the Population Council, 1981.

Reported Incidence of Repeat Abortion in Selected Studies in Thailand

	Population group	Percentage of women acknowledging prior abortion experience
1.	27 Septic abortion patients seeking care at Ramathibodi Hospital, 1969-1970	33 percent admitted one or more previous abortions
2.	210 patients seeking medical care at Ramathibodi Hospital for complications of abortions done elsewhere, 1972-1974	70 percent attempted to abort more than once
3.	624 patients seeking medical care at Siriraj Hospital for complications of abortions done elsewhere, 1976	7 percent admitted previous induced abortions
4.	226 patients seeking medical care at Ramathibodi Hospital for complications of abortion done elsewhere, 1977-1978	29 percent
5.	802 patients seeking pregnancy terminations at Ramathibodi Hospital, 1977-1978	8 percent
6.	5,275 obstetrical patients at Ramathibodi Hospital, 1977-1978	4 percent

C. STERILIZATION

1. India: Reliance on sterilization

Since its inception, the Indian Family Welfare Programme has relied on sterilization in its campaign to limit family size. In the early years, this emphasis may have maximized programme effects. However, at the present stage of development, continuation of such an emphasis will be an important constraint to achieving the rapid increases in prevalence of contraception desired.

As an irreversible method, sterilization is useful only for couples who are ready to cease childbearing altogether. In India, with its high infant and child mortality levels, most couples are not willing to use an irreversible method after having only two or three children, even if that is their desired family size, for fear that one or more children may die. Thus sterilization is not an acceptable method, even for many who may be ready to limit the size of their families.

Though Nirodh (condoms) and the IUD have been available as programme methods for years, neither has been made widely available nor used by very large proportions. At present, only one per cent of the eligible couples are using the IUD and no more than four per cent are using Nirodh. In contrast, about 21 per cent are sterilized.

The Lippes loop has never attained a high level of popularity. However, their appears to be great interest in the Copper-T at present, and the demand for this device is said to far exceed existing availability. If true, it presents an important opportunity for the programme to achieve major increases in the use of contraceptive methods for spacing.

Expansion in the use of oral pills appears to present a greater problem, since there is a pervasive resistance among medical professionals. Some medical personnel hold that rural women have difficulty remembering to take a pill every day, but no one can point to hard evidence supporting this assertion, which appeared to be more a stereotypic prejudice than a well-established, empirical fact. Another constraint is the requirement that pill acceptors be examined by a doctor.

Source: *India's Population Policies and Programmes,* the Population Council, August, 1982.

2. Pakistan: Few regrets about sterilization

One of the first controlled studies of the psychological and physical effects of female sterilization in a developing country has been carried out by the Family Planning Association of Pakistan (FPAP) with the International Project of the Association for Voluntary Sterilization (IPAVS).

The results of the study show that few women regretted the operation and that physical side-effects were rare, although some women suffered some psychological set-backs.

The study, which was carried out at the FPAP's model clinic in Lahore, measured the effects of minilaparatomy, a simple method of female sterilization by tubal ligation, on 215 women, as compared with a control group of 200 women who

were using contraceptives. Follow-up interviews were conducted after one year.

Asked before the operation why they had decided to be sterilized, half said they were influenced by relatives or friends who had already been sterilized, 28 per cent were influenced by family planning workers, and eight per cent by their husbands. Interestingly, in this Muslim country, 62 per cent thought that religion favoured the operation.

Both groups showed an improvement in sexual relations from pre- to post- interviews, although the last time the sterilized women had intercourse was significantly more recent than the control group.

There was little difference between the groups, either, in their ratings of happiness, ability to work or health. However, the sterilized group was more likely to have negative feelings such as "bored, guilty, confused, anxious, weeping easily." Despite any psychological effects, only 2.2 per cent were "not glad" that they had been sterilized while another 3.4 per cent were uncertain.

As expected, the biggest difference between the two groups one year after was fear of pregnancy: 80 per cent of the sterilized group no longer felt it, whereas 67 per cent of the control group feared becoming pregnant all the time. In the control group, as many as 13 per cent of the women who said they did not want any more children became pregnant during the following year although most were using contraceptives.

Source: "Sterilization: few regrets in Pakistan," Maggie Jones; *People*, vol. 10, No. 1, 1983.

3. Philippines: The most effective male method remains unpopular

As a contraceptive method, vasectomy is said to be unbeatable. In a simple operation, taking no more than five minutes – with minimum discomfort and no side effects – the volunteer is assured of a planned family. Despite this glowing virtue, men in the Philippines still shun vasectomy like the plague. Instead, they opt for the rhythm method or the condom or simply leave the responsibility of contraception to the wife.

The vasectomy section of the Advanced Family Planning Technology (AFPT) clinic at the Children's Medical Centre in Quezon City is a case in point. The clinic services Metro Manila and nearby provinces. Still, in its six years of operation, it can count only 1,531 males – or an average of one every two days – as having reached its operating table.

Vasectomy's meager contribution to the national family planning effort can best be illustrated by contrasting it with the performance of its female counterpart, tubal ligation. Of some 66,400 persons who opted for surgical contraception, 90 per cent were women.

Local family planning authorities have traced the men's resistance to vasectomy to cultural values and misconceptions about the method itself. Recalling his experience in the field, Dr. Oscar A. Estrada, head of the itinerant team of the Ministry of Health's National Family Planning Office, explained why ligation was more accepted in the rural areas. "Tubal ligation is equated with caesarian section/pregnancy and thus, natural," he said, "while vasectomy is equated with castration/reduced fertility and therefore, unnatural."

These cultural values and misconceptions have undoubtedly limited the full potential of one of the most effective forms of contraception ever devised. In fact, vasectomy in the Philippines has been so simplified that it takes only three to five minutes to perform.

Mrs. Alicia Arca, a nurse at the AFPT clinic, thinks the key to attracting men to the vasectomy centres is "more promotions." Mrs. Arca discloses that in the clinic team's weekly promotion sorties in Manila's depressed areas, "we talk about vasectomy – and sterilization for that matter – very, very subtly." Apparently, the approach has not been quite effective.

The experience at AFPT clinic proves this point. Dr. Reyes, in his assessment of the first two years of the programme, said that "the class of present acceptors is on the side of the more educated segment...with a relatively high income level."

Thus, the direction for the country's vasectomy programme is all too evident. A decidedly more aggressive education campaign is necessary to break down the cultural values that stand between the men and the vasectomy clinics.

Source: *Vasectomy: Said to be the most effective male contraceptive method, yet it is the least popular*, R. Chris Teston; Population Forum, vol. 7, No. 1, 1981.

D. ABORTION

1. Bangladesh: Abortion laws cause complications

Although induced abortion is illegal in Bangladesh, except when done to save a woman's life, the practice is nevertheless believed to be common, and frequently known to result in complications and deaths. A number of hospital based studies in Dhaka, Chittagong, and some local rural areas, as well as anecdotal evidence, suggested that termination of unwanted pregnancy, often induced by village "dais" and other untrained practitioners using indigeneous methods, might contribute sub-

stantially to maternal mortality. In 1979, a more detailed study was initiated to analyze abortion related health problems over the whole of the country. It was hoped that the study would assist national policy-makers in determining the need for including menstrual regulation in the services provided by the National Family Planning Programme.

Of the estimated 21,600 pregnancy deaths that occur yearly in Bangladesh, 1,933 were identified in this survey. Of these, 498 (25 per cent) were due to induced abortion. Health workers reported 1590 cases of complications from abortion, of which 31 per cent ended in deaths. Village dais and traditional practitioners were the largest groups of operators (42 per cent and 18 per cent respectively). Menstrual regulation or dilatation and curettage (the medically approved procedures) were used in only 9 per cent of cases. Nearly half of the complicated abortions were induced by inserting a foreign object, such as a stick or root (sometimes treated with a herb), into the uterus and leaving it until either abortion or complication occurred. The proportion of complicated abortions resulting in death was lowest for medically approved procedures (5 per cent) and highest for vigorous physical activity (100 per cent) and abdominal pressure (67 per cent), although the last two together accounted for only 2.5 per cent of abortion procedures. An extrapolation from these results gives a figure of 780,000 abortions in Bangladesh yearly and 7800 deaths from complications.

Source: *Induced Abortions in Rural Bangladesh*, M. Obaidullah, A.R. Khan, A.R. Measham, M.J. Rosenberg, S. Jabeen, R.W. Rochart and A.Y. Chowdhury, Rural Demography, vol. 8, No. 1, 1981.

2. Japan: The pill is disallowed but abortion still popular

Two facts struck us immediately during our tour of Japan: the oral contraceptive is not approved by the Government, and induced abortions are currently running at more than 600,000 per annum, six times as many as in the United Kingdom with only twice the population. Japan was the first country to pass a law legalising abortion. This was in 1948 when the government was worried by a huge post-war baby boom, with two and a half million births per year. It had the almost immediate effect of reducing the birth rate from 34/1000 to 14/1000. In spite of an intensive family planning campaign that was launched simultaneously, it seems that one in five women have had one abortion, one in 10 have had two, and one in 22 have had three or more. Approximately one in four pregnancies end in abortion.

Since 1950 an excellent survey has been carried out every two years by the Mainichi Newspapers and this has shown that 36 per cent of wives have had an abortion at some time and two-thirds of these express feelings of guilt or regret. At recent survey shows that 70 per cent of couples are now using contraception, an increase from 19 per cent in 1950. Of these, 80 per cent use a condom and 23 per cent the rhythm method. Surprisingly, in spite of non-approval, three per cent are using the pill and this is also increasing, although Japanese couples tend to think it is dangerous.

Although the Ota ring was invented in Japan in the 1920s, it fell into disrepute and was only approved, with other IUDs, under certain limited conditions, in 1974. They have little experience in Japan with medicated IUDs although some research is going on.

We were curious about the reason for not approving the pill and eventually found an article that suggested that some gynecologists are doing so well financially out of induced abortions that they are not interested in pressuring the Government to approve the pill. Neither have they much interest in low dose (30 microgram) pills or progestogen only pills.

Source: *"A crowded country where the pill is disallowed," Gill Cardy; The British Journal of Family Planning, vol. 8, No. 1, April 1982.*

3. New Zealand: "Fallible contraceptives lead to abortions", doctor's letter explains

This doctor shares Mr. Azariah's concern regarding the high number of abortions in New Zealand and agrees that this is one of the more disgraceful aspects of the society. The excess at this time must represent either a marked deterioration in the physical and psychological health of New Zealand Women or a legal scandal. However, in contrast to Azariah, this doctor does not consider doctors to be primarily responsible for the situation through failure to provide contraceptive education. Neither are doctors responsible for New Zealand's control of reproduction.

It is impossible to believe that there is any one in New Zealand today who is unaware of family planning. The newspapers' prolonged vendetta against the oral contraceptive has assured that everyone is knowledgeable about the pills existence. What is absent among a portion of the society is the will to take responsibility for reproduction.

There is also a group that has used contraception, but the method failed. Most couples need about 15 years of contraception after completing their family. Peel has shown that if a 95 per cent effective method is used, 30 per cent of these couples will have one unplanned pregnancy during this time. Others will have more than one unplanned pregnancy

and 20 per cent will not exceed their ideal family size.

Unfortunately, patients expect 100 per cent reliability from a wide variety of fallible methods, and the failure of contraceptive technology results in a request for an abortion.

It is doubtful that doctors are responsible for implanting this idea of contraceptive infallibility. Society must be encouraged to remember two of its former beliefs: that contraceptives are fallible and that children, even if unplanned, are more important than the disruption they bring to "socio-economic placidity." It is not more education that is needed but more responsibility and purpose.

Source: *Letter to the New Zealand Medical Journal,* V.J. Hartfield, January 1982.

E. INCENTIVES AND DISINCENTIVES

1. Bangladesh: Debatable benefits of cash incentives for sterilization

In March 1974 a young girl, who appeared hardly old enough to have reached menarche, approached a sterilization centre in Sherpur, Bangladesh. She was accompanied by the local family planning officer, the dai (village midwife) and her mother-in-law, who asserted she had three pregnancies and two living children – the minimum number required in Bangladesh for a sterilization to be performed.

Reluctantly the paramedics proceeded with the operation. While closing the incision, the operating paramedic finally elicited an admission from the girl (who first ascertained that her mother-in-law had left the room) that she had, in fact, no children and had never been pregnant. She said her family had been convinced by the village dai and local family planning worker to accept sterilization on the false claim for great recompense from the Government, including a ration of wheat for life.

Two popular Bengali daily papers have recently carried articles citing the number of young girls and boys (16-18) in Dacca city presenting themselves for sterilization. Some are even unmarried, but in a country where the average annual income is $70, they are drawn by the attrative promise of 100 taka ($5).

Under the United States Foreign Assistance Act of 1961, no aid monies can be used to support contraception programmes that are coercive, and no funds may be used to pay incentives to induce patients to accept surgical contraception. There are ways, however, of giving compensation, even using aid funds. Compensation for reasonable patient costs involved in obtaining voluntary surgical contraception is permissible.

Though the terminology has become "compensation," not cash, it still spells "money" and leads to malpractice as either uninformed people are coerced into becoming "acceptors" or the actual number of sterilizations performed are falsified in order that the "bounty" may be divided up.

Thus the whole purpose is lost. Family planning should be for the benefit of the person and community, but in order for this to be so, it must be voluntary. This is why the sterilization system has failed to take hold of its own, and ever increasing incentives must be offered. If it had been done as part of a whole family planning service with proper motivation and good follow-up, it would have been an acceptable form.

Source: "Cash incentives degrade both parties", Dr. Zafrulla Chowdhury; *People,* vol. 9, No. 4, 1982.

2. China: The experience of Tianjin

The Tianjin Industrial City Programme is typical of the programmes using social and economic incentives and disincentives for family planning throughout China. Combined with an effective delivery system, the incentives help explain in the remarkably high rate of acceptance.

Under the programme, single-child certificates are issued by the Municipal Revolutionary Council. This certificate records the name of the child, mother and father and the place of employment. The advantages conferred by this certificate are:

– giving the couple priority for the assignment of living accommodations;

– assuring the child admission to a kindergarten;

– granting the mother the right to go directly to see the doctor rather than waiting in line;

– conferring a bonus to purchase food and clothing for the child;

– conferring a certain amount of prestige, since the bearer and her husband are perceived as persons with social responsibility.

In addition there are economic sanctions for couples who have a second child after being rewarded for having one child. The sanctions include deductions of ten per cent of the monthly wages until the child is 14 years old; denying the child participation in the family's cooperative medical programme and making the mother ineligible for paid maternity leave.

In addition, workers who violate even the two child norm will be denied promotion for two years.

The Tianjin programme does not depend for its success on incentives and disincentives alone.

The delivery system for contraceptives is highly effective, with many men and women receiving their contraceptive supplies at work. Where they are not employed, they are registered and supplied contraceptives by a voluntary community agent, generally an elderly retired woman. By a combination of these methods, Tianjin achieved the impressive record of affording contraceptive protection to nearly 86 per cent of the eligible couples in 1979, when the total population of the city stood at an estimated 7.4 million.

The most popular contraceptive method is IUD (30 per cent), followed by oral pills (25 per cent) sterilization (18 per cent) and condoms (14 per cent).

Admittedly, China's programme, as is to be expected, has a strong ideological background. There is publicity and family planning guidance programmes in the production brigades. In each production brigade, there is a special board of family planning headed by the party Secretary.

Supportive measures in the plan for population control include the free supply of contraceptives and services, equal pay for men and women, and provision of nurseries and kindergartens.

Source: *Incentives and disincentives to promote family planning;* Family Planning Foundation; November 1982.

F. SOCIO-CULTURAL FACTORS AFFECTING FAMILY PLANNING

1. Republic of Korea: Socio-cultural factors likely to hinder further improvement

During the last two decades, The Republic of Korea has achieved a remarkable increase in contraceptive prevalence and decrease in total fertility rates. Between 1960 and 1982, the total fertility rate of the eligible women in the 15-44 year old age group declined from 6.0 to 2.7. At the same time, contraceptive practice rate increased from 9 per cent to 58 per cent of the eligible population by 1982. Meanwhile, the Government hopes to attain replacement level fertility (TFR: 2.1) by the year 1988.

However, the presence of several restraining socio-cultural factors will make any additional improvement more difficult.

There is a strong persistence of son preference in the Republic of Korea. The ideal number of children decreased from 3.9 in 1965 to 2.5 in 1982, but survey results also show that the ideal number of sons has only decreased from 2.4 to 1.5 in the same period. Considering the 1982 ideals, a Korean couple would probably have about three children on average. Thus, the national family planning programme must modify this long-standing cultural value to continue lowering the ideal family size.

Son preference in the Republic of Korea exerts a substantial influence on family planning practice. Women with sons have a more favourable attitude toward family planning. Currently, about 71 per cent of couples with two sons and 83 per cent with two sons and one daughter are practicing contraception, while only 41 per cent with two daughters are doing so.

The discontinuation rates for IUD at twelve months increased from 44 per cent in 1973 to 51 per cent in 1980, with a similar trend observed among the oral pill users. It is assumed that the rates would have increased further in recent years since high acceptance of female sterilization has resulted from Government programme emphasis on this since 1977.

However, the high discontinuation rates seemed to come from such discrepancies in the programme management as the target, follow-up, and post treatment systems. Particularly, the inflexible family planning target system for workers, who are hard-pressed to recruit new acceptors, with little effort to provide after care services, coupled with the Government's emphasis on sterilization, seem to be partly to blame.

Late start of contraceptive use is a factor to be dealt with. The time at which most contraceptive users start practicing family planning is in the later part of their reproductive period. The 1978 survey showed that only 5 per cent of Korea married couples started practicing contraceptive methods before the first birth, compared to 20 per cent in Japan. While 83 per cent started practicing before the third birth in Japan, the corresponding rate in the Republic of Korea was only 27 per cent.

The 1978 survey indicated that the proportion of contraceptive users for fertility termination increased from 79.7 per cent in 1976 to 91.9 per cent in 1978. This trend has been accelerated by the government policy emphasizing the distribution of sterilization services rather than other traditional methods such as IUD. The late start of contraceptive use results in larger family size and a higher fertility rate. Thus, there is a strong need for the national programme to recruit more women in the younger age groups to practice contraception for birth spacing to attain the demographic goal.

Source: *Social and Cultural factors affecting the Acceptance, Continuation and Discontinuation of Family Planning in Korea,* Nam Hoon Cho, ESCAP, 2-8 November 1982.

2. Sri Lanka: Social welfare programme leads to smaller families

On a recent day, Kairu Kathija waits to give birth to her first child in the maternity clinic in Maradana, the Moslem corner of Colombo, a ghetto made less forlorn by a growth of banana trees and hibiscus. She was born in this clinic 16 years ago. Her mother was born here, too.

Mrs. Kathija can read. She receives subsidized rice and free milk powder. There is a fresh water pipe a short walk from her shack. She has been coming to the clinic free of charge since the fifth month of her pregnancy, and her child can come until he is five. There is every likelihood her child will survive. Other third world countries can only look on in awe.

No statistic better reflects the woeful condition of the third world than the infant mortality rate. By measuring how babies fare, it generally measures the abundance or meagerness of life.

In few countries is life as meagre as it is in Sri Lanka. Half the families have an income of less than $15 per month. Yet Sri Lanka's infant mortality rate is one-third that of Africa's and less than half that of the rest of Asia. However, bringing down the infant-death rate is such a vast, costly project that few countries can afford to copy Sri Lanka. Sri Lanka itself is having trouble holding onto success.

Sri Lanka's infant-death rate began falling in 1931, when for the first time Government was made answerable, says Hoda Badran, of UNICEF. "The voters were ready to show their teeth."

Sri Lanka built schools, clinics and public housing; trained midwives and doctors, and began a food-subsidy programme that now reaches 7.5 million people, half the population. Three-quarters of Sri Lanka's women can read and write now, and three-quarters of Sri Lanka's mothers give birth in hospitals or clinics.

But chances that the other developing countries can fight infant mortality so successfully seem slim. Just why can be summed up in two words: money and politics.

Sri Lanka's efforts were aided by a large, one-time infusion of money. During World War II, Sri Lanka's export earnings from its rubber crop piled up in the Bank of England. When the blocked funds finally were released, Sri Lanka had a huge windfall.

As for politics, the "strongman" governments in most of the third world are not sensitive to ballot-box pressures.

Keeping the infant-death rate low in a poor country is hard. Sri Lanka's success is "the cumulative result of 50 years of welfare," says Marina Fernando, Director of the Save the Children volunteer programme in Colombo.

A busier economy has offset cuts in welfare. But relief workers worry that while babies are surviving, their lives are more meagre than ever.

To sum up, the welfare system has sent out wide ripples of other benefits. Sri Lanka's Population is growing more slowly, for one. With free education, women are staying in school longer, marrying later, and so having fewer children.

Because fewer babies are dying than did years ago – and parents are surer they will have children to care for them in old age and tend their spirits after death – people aren't having so many children. Sri Lankan women have fewer than four children each on average. In India, with an infant-death rate of 123 per thousand births, women average five children. It is six children in Bangladesh, and seven in Pakistan.

With the birth rate falling here, a smaller slice of the population is under 15 – and dependent on the rest of the population. A smaller slice is living in Sri Lanka's cities, too, since services in Sri Lanka are sprinkled among the farms and villages. Colombo's population has actually declined over a decade.

Source: "Sri Lanka Shows Success in Paring Baby Death Rate," *The Asian Wall Street Journal*, May 25, 1983.

3. Thailand: Electrification lowers fertility

Results of a study analyzing fertility rates in two comparable villages, one having access to electricity in the immediately preceding four year period, show that rural electrification is a significant factor in lowering fertility.

In the study, a total sample of 609 households with married women 15 to 44 years old were randomly selected from two subdistricts in the north of Thailand. Both subdistricts were comparable in terms of basic physical infrastructure and distance from highways, district centres and provincial towns.

Analysis of data showed no significant difference in social and economic condition in the two areas and that electricity, in the subdistrict where it was available, was used primarily for consumption rather than production purposes. However, a greater percentage of the families in the electrified area practiced family planning, and showed a lower average fertility. In fact, a difference exists even between women in the two areas who do not practice family planning.

Source: *Fertility and Development Interactions in Thailand*, Suchart Prasith-rathsint, editor; National Institute of Development Administration, 1982.

G. COMMUNITY-BASED APPROACH

1. India: Private firms produce effective programmes

Case studies in India of six firms with effective family welfare programmes showed that while each organization had evolved its own strategy they contained a number of common features. In general both medical and social workers were involved in all the programmes and co-ordinated their activities with many other agencies in the organization. Most of the people initiating the programme continued to be involved over a long period of time and experienced the support of top management. The programmes were mostly financed by the organization themselves, with unions or other employee groups largely uninvolved. Although all methods were offered, the emphasis remained on terminal methods.

Comparing these programmes with the national programme, the companies' family planning efforts were interlinked with other welfare activities such as health, housing, school and did not operate in relative isolation as is often the case with the national programme. Also, the firms' programmes showed a continuity of personnel over a long period while government workers are often transferred. Finally, unlike the government, the emphasis of these programmes was on performance and not on targets.

Despite common features, all six firms had distinctive elements in their approaches. At Alembic Chemicals Ltd., the Labour Welfare Department had evolved a systematic procedure for conducting family planning activities in their plant. Popular individuals were asked to act as motivators and were trained to motivate workers. The concept of chain motivation was sucessfully employed, with a greater stress on motivation through awareness and education rather than on monetary incentives. The concept of total welfare was emphasised.

The management of Godrej and Boyce felt that family planning was an integral part of a worker's life and a very important factor in contributing to his happiness and welfare. Therefore, they decided to integrate it with the basic amenities like housing, education and health facilities offered by the company. A worker, according to their policy, was eligible for a flat in the company's housing scheme only if he had a restricted family (three children) and undergone sterilization. The fourth child was excluded from the educational scheme of the company. The Family Planning policy of the company was more radical and counselling was offered after two children. Couples were advised to undergo operation after three children.

At Hindustan Spinning and Weaving Mills, the family planning and health activities were an integral part of the organization's scheme for improving relations with the workers and their families. Motivation was a shared responsibility in

the organization and all levels of management, including the Director-in-Charge, were involved directly in motivating the workers.

The emphasis at Gujarat Refinery was on personal motivation with a greater emphasis given to personal counselling. There was house-to-house motivation in which voluntary social workers motivated the non-acceptors.

At Tata Chemicals, Mitapur, personal counselling in the clinic along with other medical services and door-to-door motivation was conducted by the doctor and social workers. While the management and the union extended co-operation when asked for, they were not directly involved in motivational work. Exhibitions and audio-visual aids were used but the major emphasis was on interpersonal communication and group meetings. The Sanitary Inspector and Welfare Officer of the Mithapur town council also helped in the motivational work.

From an examination of the incentives and disincentives offered by the firms, it was noticed that while compensation of some sort was offered by all programmes to acceptors of terminal methods, the quantum varied considerably. It could be concluded that for a successful programme incentives were neither necessary nor sufficient. However, they were a useful programme component to be used judiciously depending upon the environment.

It may therefore be concluded that all the unit based programmes studied seem to have reached a plateau in performance. To increase the performance further, different strategies may be needed.

The new strategy may focus on hard core, more resistant couples and would also have to be directed towards spacing methods. There is evidence to suggest that these programmes have already reached couples with three or more children. But now, the increase in performance will come

only from couples who have two or less children, and they are more likely to accept spacing methods. Consequently, the contraceptive mix has to be devised appropriately.

Source: *Family Planning in the Organized Sector,* Nirmala Murthy; Sterling Publishers Private Ltd., New Delhi, India, 1983.

2. India: Clubs link family planning and community improvement

In Hiregungal village in the Karnataka State, the beautiful colouring on the image of the deity in the temple had faded and needed repainting. This reverent task was allotted by the village elders to the members of the local Mahila Mandal (Women's Club). They not only undertook the labour but collected more funds to do a better job.

The Mandal, which had developed as part of a Family Planning Association of India Project, had won the regard of the villagers through its enthusiastic promotion of various local activities, including maternal and child health and family planning.

In another village, an unusual competition was arranged by the local Mahila Mandal. Women competed to see who was quickest at grinding a certain quantity of wheat on the heavy stone grinder used by the villagers. They were all very quick and they all had a tubectomy a month before, proving the procedure did not cause physical weakness.

The FPAI covers more than 2500 villagers in different parts of the country and has had encouraging results from its efforts. The reasons for success lie first in the choice of workers. They are all carefully selected and trained. Since they usually belong to the area, they are culturally attuned and can develop a sense of empathy with the people. At the same time, they bring a new outlook and refreshing enthusiasm that the villagers find stimulating without being traumatic. The principle is that activities initiated should induce small changes at a time in village thinking and action, but with as wide a participation as possible. Gradually, the small changes build into new ways.

In this atmosphere, the message of family planning, far from being resisted, tends to uncover unmet needs which can then be satisfied. The recent phenomenon where thousands of women are flocking to family planning centres and camps for laparascopic tubectomy, is ample proof of such a latent, unmet need.

In urban areas the FPAI has experimented with another type of community action by forming localised Pariwar Pragati Mandals (Family Betterment Clubs). Such Mandals have started in suburbs of cities like Bombay, Banglore, New Delhi, Jabalpur, Lucknow and Dindigul. The membership consists of women who have already accepted a method, and others, especially potential acceptors.

The Mandal's programme concentrates on two main areas. The first involves self-development by gaining additional knowledge on child care, nutrition, household budgeting, and the use of banks for small savings. The groups also organize recreational activities such as classes for yoga, games and beauty hints. The second area helps the women acquire training in income generating skills. In some Mandals, Balwadis (pre-primary classes) have also been started.

The end results of such clubs is to transform the members into informal change agents who motivate their friends and neighbours to adopt family planning methods.

Source: *Links,* Mrs. Avabai B. Wadia, President, Family Planning Association of India, March 1983.

3. Indonesia: Family planning takes hold in the countryside

Surprisingly, some city dwellers in Indonesia are not as keen on family planning as those in the countryside. Fewer than 25 per cent of the couples in Jakarta use family planning compared to 40 per cent in the country as a whole.

Results from a survey in the city point to some of the reasons and highlight a familiar conflict between the needs of the community and those of the individual.

Over 80 per cent of those questioned agreed that "there are already too many Indonesians." But over 70 per cent felt that "if I had only one or two children I'd be afraid of losing one." And the great majority felt that "children give their parents security in their old age."

But away from Jakarta attitudes can be different. In rural Bali it is frequently said that "two is the ideal number," and "you only need three if the first two are girls."

There are a number of reasons for this different view. Infant mortality, for example, is lower in Bali than in Jakarta, so families feel more confident that their first two children will survive.

But as far as family planning in Bali is concerned, the most crucial area has been community organization. Each Balinese village has a distinctive kind of community association called a "Banjar." In the interests of the village, the Banjar will take on anything – from organizing labour for a new irrigation system to raising a loan for an elaborate cremation ceremony. When Banjars take on family planning, they can be very well organized. Often, each banjar has a map showing the contraceptive method used in every household.

Source: *Indonesia Planning for "Heroes"; Popline,* vol. 4, No. 5, June 1982.

II. USE OF POPULATION COMMUNICATION AND INFORMATION

If the success of family planning programmes depended solely on making contraceptive services available to the entire population, it would be a much simplier affair. Unfortunately, family planning concepts often challenge long existing modes of behaviour and traditional values regarding family size, sex, and marriage life. In this situation, the success of the programme depends on a change in people's attitudes – a long, complex, and in some respects delicate, process. As a result a well structured Information, Education, and Communications component may well be crucial to success.

Family planning programmes are often launched in a period of profound change for a society. Indeed, it is a change that makes the programme necessary: the rapid fall in death rate that causes an exploding population. At the same time, improved health and material welfare results in rising expectations and demands for steady improvement. The result is an often volatile mixture of rapid modernization in the midst of traditional cultural beliefs.

Fortunately for family planning programmes, people in times of change also become increasingly open to new ideas, especially to ideas that demonstrate proven utility in their lives. How these ideas are presented, however, will help determine how well they are accepted. Basically, it is a process of education, informing the target population of how new patterns of behaviour can improve their lives.

Over the past decade, Information, Education and Communication (IEC) efforts in ESCAP have expanded enormously, and now family planning messages are presented through personal contacts, the distribution of printed material, the use of mass media and folk media and even through fairs and festivals. Cumulative experience indicates IEC programmes are most effective when they form a well co-ordinated campaign where the various components interact and compliment each other to effectively raise the level of awareness of the population.

Of course, implementing such a programme is not without its challenges, especially when such factors as limited budgets, diverse geography, and religious and ethnic differences are considered.

In a paper presented at the third APPC* *(Maximizing the Effectiveness of Existing Information Systems in Selected Countries of the ESCAP region)* Gloria Feliciano identified a number of problems that must be overcome to improve IEC programmes in the ESCAP region. These include:

- *Inappropriate materials:* The materials fail to concentrate on specific problems such as conteracting rumours on side-effects. Materials are lacking that deal with "how-to-do-it" type of information on specific methods; that relate family planning to overall socio-economic needs; and that are geared to husbands, who often have the greater share in deciding family size. Additionally, much of the material is addressed to general audiences which tends to sustain low levels of knowledge. Greater use should be made of radio, which is more accessible to most people.
- *Inappropriate approaches:* Often, IEC strategies fail to take full account of the multi-ethnic nature of ESCAP nations. In this connection, the lack of information on tested IEC methods, approaches, and strategies, poses a challenge. More material should be produced in the different dialects or more closely tailored to the needs of specific populations. In some areas, family planning remains a sensitive topic that requires care to prevent it from becoming a religious or political issue.
- *Lack of IEC evaluation:* There is an overall lack of pretesting of IEC material before mass production. More research and evaluation is needed to both explore specific IEC problems, especially those relating to motivation, and to assess the cost effectiveness of various media used in field campaigns.
- *Lack of training:* Training needs identified in many countries include those relating to IEC theories and principles and their practical application; IEC strategies and approaches, especially in motivational work; and development and production of relatively inexpensive audio-visual materials such as filmstrips, soundslides, audio-video spots and others. Training needs include the in-service type to resharpen IEC skills and longer term training to prepare students for a career in population IEC.

After improving the weak points, attention should be paid to developing well targeted audiences, which might require research on information needs by region, socio-economic class and other variables. This will allow the creation of more tightly co-ordinated programmes that more fully inform the population and motivate them more effectively towards accepting family planning.

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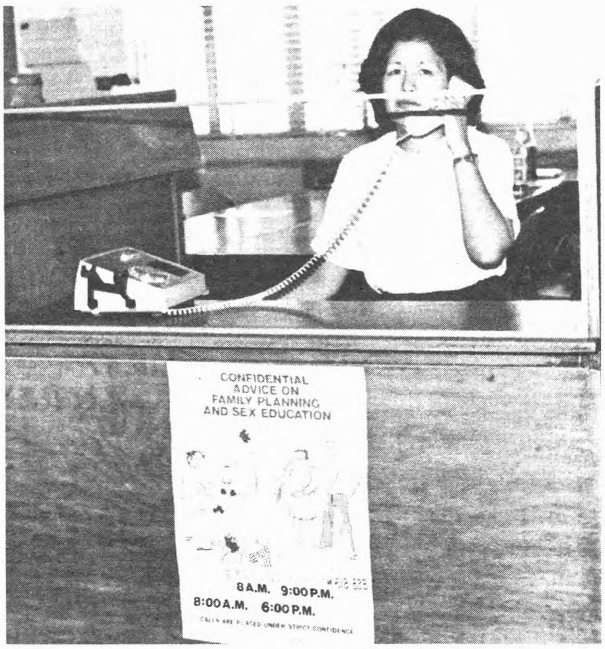
* *Third Asian and Pacific Population Conference*

An exhibition of products prepared by a mother's club, displayed together with family planning posters, is of joint interest to husbands and wives.



Counselling by telephone (above) and live T.V. shows (below) are two popular motivational approaches adopted in the Philippines.

T.V. programmes are increasing in popularity in Thailand where mass media motivation is well established.

Family planning association members from visiting countries view a puppet show produced in Bangladesh which has special appeal for illiterates.

1. Efforts made to strengthen IEC throughout the region

Throughout the ESCAP region the IEC programmes are increasing in effectiveness and proving a valuable to the overall family planning effort.

On the basis of *Indonesia's* past experiences, comprehensive plans were drawn up to transfer the task of informing, educating, motivating and recruiting family planning acceptors from the Government to the people themselves. The purpose here is two-fold: to make communities self-sufficient and capable of running their own population programmes, and to create a favourable psychological climate conducive to the social acceptance of the programmes. It is believed that the involvement of the private institutions, religious organizations and government agencies at all levels will make this transfer easier and faster.

The choice, planning and production of IEC materials in *Malaysia* is made rather complex in view of the multi-racial and multi-lingual character of its populace. Further, of the five Southeast Asian countries, it is the one where family planning remains a highly sensitive issue from the vantage point of politics and religion. In line with this situation, it is planned to pre-test all IEC materials as well as evaluate them after use. It is also planned to train select IEC staff in communication strategies needed in the development of IEC materials, planning of field campaigns and formulation of educational policies which will make family planning more socially acceptable in Malaysian society.

Philippine IEC has recognized its deficiencies and is gradually building itself up on its assets – the valued co-operation of its close to 50 partner agencies and the capabilities of its regional (subnational) offices. The present focus of IEC efforts is to strengthen its regional IEC materials development efforts through sustained IEC training, use of rigorous methods in research and evaluation, testing of IEC strategies and approaches such as the use of paramedics, non-clinic-based motivators, trained community-based volunteer field workers, including the traditional birth attendants, primary health care personnel, the full-time outreach workers and others; and pilot studies of integrated approaches, e.g., integrated programme of medical schools, the Bohol maternal and child care and family planning project, the Bicol integrated health, nutrition and population project, the integrated community approach to heal, population and nutrition in Davao City and several others.

In *Singapore,* the need is to make the Singapore Family Planning and Population Board (SFPPB) self-sufficient insofar as technical staff and IEC materials development resources and facilities are concerned. This will meet the problem of the failure of commercial firms commissioned by SFPPB in delivering the IEC materials they produce on the datelines agreed upon. Other areas of emphasis in the programme are the use of the delayed marriage theme targeted on the motivation of industrial managers so that factory workers will be allowed to listen to family planning and population IEC talks during office hours.

Thailand's plan is to further expand its family planning and population programme in scale and scope. This, it intends to do by initially undertaking communication research to analyze, in depth, specific problems in IEC and to come up with designs and tests for more effective family planning messages. Some specific steps have been taken to expand current IEC efforts, such as increasing the number of information units, development of a mass media programme and conduct of mass media campaigns, and the introduction of a mass mailing system. A carefully prepared population education programme has also been made part of the school system.

In *India, Republic of Korea,* and *China,* as in the five Southeast Asian countries just discussed, emphasis is being placed on person-to-person communication and the mass media with greater reliance being placed on the former. Countries with fairly well-developed mass media resources, such as *Singapore* and *the Republic of Korea,* give about equal emphasis to both forms.

To bring down birth rates, the following sectoral groups are addressed by the IEC efforts of the above countries, namely: a) pre-schoolers, b) out-of-school youths, c) students, d) married couples of reproductive age (MCRAs), e) premarriage couples, f) community/programme influential; and g) clients with special problem, e.g., hard core resisters, unwed mothers, semi- or nonliterates. The last group is being addressed in the Philippines.

In the formulation of IEC strategies, the following factors have been taken into consideration: a) strong pro-natalist tradition, b) the low status of women; c) the tradition of early marriage, d) sex preference and e) religion.

China refers to family planning as planned parenthood because the concept is much broader and involves the whole family. The carrying out of the programme depends on the masses. Hospital doctors and other staff members co-operate with the barefoot doctors or "first-line health workers in the field who work with the peasants." Main IEC efforts focus on information or propaganda work on very late marriages, fewer children (only one) and spacing.

In *Hong Kong, Japan* and *India* almost all the media, interactively and supportively, including newspapers, magazines, radio, television, film, filmstrips, slides, printed materials, billboards, exhibits, traditional or folk media have been used frequently in their programmes. Personal rather than national appeals have been used to motivate and persuade.

Training programmes in *Sri Lanka, Iran, India, Japan* and *the Republic of Korea* show a great need for strengthening the IEC component particularly in terms of improving the skills of family planning workers in interpersonal communication, encourag-

ing two-way communication between trainers and trainees, developing training manuals and other IEC materials and practical application of communication principles.

In *Pakistan,* extension communication technologies such as personal observation of demonstrations in their village through which they learn how to use the contraceptive methods, are used in addition to the print and other mass media.

For *Afghanistan,* a necessary approach or strategy is one which reorient people and form new attitudes and values for social change appropriate to the growing complexities of modern living. This is the rationale for population education in this country.

Source: *Maximizing the Effectiveness of Information Systems in Selected Countries of the ESCAP Region;* Gloria D. Feliciano, Third Asian and Pacific Population Conference, Colombo, 1982.

2. India: Family Planning Foundation communicates the need for family planning through film and print

A primary task of any population programme is to provide information, education and communication services. It is only through awareness and understanding of the problem that political commitment and popular acceptance – the two planks necessary for the programme to move – can be generated. The work in the communications field of the Family Planning Foundation (FPF) of India has covered several different aspects – from sensitising rural leaders in population and development concerns to developing material providing simple and accurate information on sex, contraception and family planning for neo-literates.

The FPF communications programme includes an audio visual component. One sociological study sponsored by FPF has provided insights garnered from a six month exposure to young married rural couples in the form of a report and a film with a strong family planning message in a popular idiom. Another FPF film – Paravati – which focuses on the women's status issue and its inextricable link with family planning, won the Best Promotional Documentary film award in the 1978 national film festival. It has been released by the government for wide dissemination throughout the country.

An important aspect of FPF's contribution in the communication field was a project launched in the wake of the post emergency derailment of the family planning programme. This has played a key role in regenerating a climate of concern and a mood for action in family planning. Two major highlights of the direct communication effort undertaken by the project were widely publicised

interviews in which a key political figure was brought on record in a public statement of support for family planning at a time when it remained a prickly issue.

The considerable efforts to depoliticise family planning culminated in a statement sponsored and published by the Foundation that was endorsed by leaders of 11 major political parties, leading to movement for a national consensus on the subject.

Further work with Parliamentarians and legislators on the one hand and large organisations like UNICEF, the milk co-operatives, and handicrafts structures on the other, has helped family planning take root in larger systems. In addition the Foundation has developed strategies to involve those engaged in child development, such as women's extension workers, in family planning in a more positive way.

Source: *Family Planning Foundation Report;* New Delhi, 1982.

3. India: Popular magazines form a good source of knowledge

A recent trend developed in the Indian press to include a number of articles on anatomy and physiology of human reproduction, family planning and population trends. An analysis of seven popular magazines showed that two of the three English periodicals published at least one article on these topics in more than 80 per cent of their issues whereas only one out of the four Hindi and Marathi magazines carried at least one topic in more than 66 per cent of its issues. Of the others, one Hindi weekly covered at least one study topic in 15.4 per cent of its issues, and the two monthly bilingual magazines in 33.3 and 41.7 per cent of the issues.

When judged by the number of words, lengthier articles of over 750 words were more frequent in the English press. The articles were largely written by specialist and the majority were presented in the form of long articles, thus giving exhaustive and detailed information on the topics covered. The other modes of presentation included stories and questions and answers mainly dealing with human sexuality or marriage adjustment problems of the readers.

A questionnaire was administered to 252 students, between 17 and 22 years of age, from selected colleges in Bombay, to explore their views on the role of popular Indian magazines in disseminating information on human reproduction, family planning and related social issues.

Out of 231 students, 93 per cent stated that they read one or more of the popular magazines analysed. More than 80 per cent of the students read the two English magazines and a little over 35 per cent read only the Hindi magazines. About a fourth of the sampled students claimed to have come across articles on the study topics on many occasions while the rest said they found such topics covered "sometimes".

When asked their opinion about such articles, about 47.4 per cent of the students felt that the articles were very informative and educative or that they helped remove gaps in their knowledge, though only about 20 per cent opined that students should be encouraged to read such articles.

As regards presentation, a little over 62 per cent of the students sometimes found the language too technical to understand and an almost equal proportion of students stated that the views expressed in the articles were the personal views of the specialists in their respective fields.

It was surprising to note that parents and teachers served as sources of further information to a small extent, friends in almost half the instances and books in over a third.

Recommendations for improvement

Magazines and newspapers are often considered authoratative and often reach large audiences and have secondary and even tertiary readerships. Also the repeated and ready availability of printed matter makes it a very effective communication medium. The disadvantage could be that no firm editorial control exists, especially for the selection of the right material. To avoid this, a panel of three to four members taken from different disciplines could be set up for the selection of articles. Other possible improvements include the following:

– It is widely accepted that media campaigns are most effective if they are co-ordinated with various services in the related field. For this, the addresses and references of well-known authorities and organizations in the field could be provided along with the article.

– Information on physical and emotional changes that are likely to take place during puberty, a topic which a large number of the young respondents wished to know, was not at all covered by these magazines.

– Topics pertaining to population problems, and the impact of population were not well covered. This lack of articles aimed at generating the small family norm among youth is depressing. It is felt that a page specially meant for youth should be devoted to such topics as over-population and happy family life.

– More factual knowledge about human sexuality, population and family living was a felt need expressed by the majority of the youth interviewed.

– It would be effective if these magazines could inculcate in the young a sense of responsibility with regard to sexually transmitted disease, sex counselling and information on family welfare. All of this should be given in a continuous, serialised form, keeping in view the cultural milieu of our country. In this context, two English magazines were found to be fairly good.

In addition, young readers themselves could be invited to write and share their experiences with their peer groups.

Source: "Education in Population, Human Sexuality and Family Living," Dr. Indira Kapoor and Dr. Saroj S. Jha; *The Journal of Family Welfare;* vol. 28, No. 4, June 1982.

Student's views on topics which need to be covered in the Indian press.

Topics to be covered			No. of students*	per cent
A. Overpopulation			33	20.5
B. Dangers of overpopulation in the world			60	37.5
C. I.	(a)	Anatomy and physiology of human reproduction	84	52.8
	(b)	Changes at puberty	74	46.5
	(c)	Fertility and infertility	57	35.8
	(d)	Contraception	45	28.3
II.	(a)	Psychological and emotional development and changes of youth	84	52.8
	(b)	Marriage and fitness for marriage	77	48.4
	(c)	Child care	62	39.0
III.	(a)	Social development	52	32.7
	(b)	Inter-personal relationships	66	41.5
	(c)	Views system	44	27.7
IV.	(a)	Aesthetics	28	17.6
	(b)	Grooming	51	32.1
	(c)	Family living, etc.	58	36.5

* *Multiple responses*

4. Philippine survey reveals high unmet demand for IEC material

Results of the Community Outreach Survey, conducted in 1978 and 1980 to evaluate the Philippine Commission on Population's Outreach Project indicates a large unmet demand for IEC material exists throughout the country.

The great majority of full-time Outreach Workers reported that they used flip charts during home visits that dealt with family planning methods, human reproduction or the advantage of having small families. However, they complained of a lack of printed material, mainly leaflets and comic books. Of the Outreach Workers interviewed, only 28 per cent said that they had given out any leaflets, and only 10 per cent comic books, during the previous week, averaging about 10 leaflets and one

and one-half comic books per worker.

These disturbingly low totals can be traced to inadequate supply. When asked to cite the number they would like to distribute weekly, the median amounts specified were 32 leaflets and 30 comic books – no doubt high estimates owing to the current level of unmet demand.

Response from wives indicated that the radio was the principal method through which they heard the family planning message. In general, exposure to the mass media and the family planning message through the media tended to be strongly correlated with socio-economic status, although less so for radio when compared to television and the print media.

Printed IEC material were seen by relatively small proportions of wives, ranging from 9 per cent to 27 per cent depending on the type of material. Comic books were more likely to have been seen during the previous year than leaflets. The proportion who had seen comic books were three times those who had received them, indicating comics were more likely to be shared with others. Of those who had not seen such materials during the year before the survey, the vast majority indicated that they would like to receive them.

Of the wives who had seen material, about two-thirds claimed it was not printed in the dialect they would have preferred.

Source: *Family Planning Outreach in the Philippines,* John E. Laing; Population Institute, University of the Philippines, November 1981.

5. Indonesia: Puppets promote family planning

In the living tradition of Java, *Wayang* has always played an important part. This unique form of puppet theatre, in which the shadows of leather puppets are the featured performers, was originally part of a religious rite. Literary proofs of the existence of the *wayang* in the eleventh century are found in many Javanese classics.

All *wayang* plays are performed by the *dalang,* who handles the puppets, recites the story and dialogue, chants and sings, and also directs the orchestra as to when to begin and to stop.

The Javanese *dalang* is generally highly respected for maintaining the old tradition. He is not an ordinary entertainer but a teacher and spiritual leader as well, although his formal education may be very limited. Some of the best *dalangs* come from the villages and learn their trade as an apprentice.

The structure of a *wayang* performance is still tightly preserved. The all-night play is divided into three parts. The first part has the exposition of the theme – for example, the disappearance of a princess and the plot complication of the arrival of a messenger from a powerful giant suitor.

In the second part, the hero of the story – the young *satriya* (warrior) – appears at the hermitage of a sage to ask for advice as the development of the theme becomes more and more complex. In the third part comes the solution with the defeat of evil after a decisive battle.

The power of traditional media lies in their community-oriented character. *Wayang,* due to its high cultural value, is considered very difficult to adapt to the needs of population programmes, which has led to the creation of new *wayang* forms, such as *wayang suluh* (information). The *wayang suluh,* which was designed for modern communication programmes, have less cultural value and are more loaded with innovative ideas. While they are less successful, the quality and stature of the *dalang* remains important. Most *dalangs,* however, prefer to insert small quantities of development – oriented material in their *wayang* presentations.

Source: "Shadow puppets and family planning: the Indonesian Experience," by Dr. Wasisto Surjodiningrat; in Folk Media and Mass Media in Population Communication, UNESCO, 1982.

6. Philippines: Telephone service rings new bells

The Institute of Maternal and Child Health, an implementing agency of the Commission on Population (Popcom), offers counselling service on health and family planning matters over the telephone in its "Instant Sagot" (instant reply) programme. The service is offered in eight major cities, throughout the Philippines, including Metro Manila.

Although face to face counselling is normally preferred, it's been found that most callers want to maintain their anonymity, especially when discussing more sensitive problems. However, with repeat calls, a bond of trust often develops between the counsellor and the callers that leads to person-to-person counselling.

Women callers outnumber the men, and most are aged between 15 and 30 – although the clients include a wide range of people, from business executives to unemployed youths.

The programme has received strong support from civic groups in its service areas, which have helped sponsor the project and have conducted intensive advertising campaigns.

The programme's success is demonstrated by the number of repeat calls, the referrals, and by the many anonymous clients who call back to express thanks for the service.

Source: Information supplied by Perla B. Sanchez, Population Correspondent, ESCAP Population Division, March 1983.

III. ASSESSMENT OF PROGRAMME PERFORMANCE

It is often noted that economic development and increased income results in lower birth rates. Certainly the experience of the industrialized countries offers proof for that proposition, indicating that such factors as the level and rate of economic development, education, the mortality rate, female participation in the labour force and intergenerational flows of wealth effect fertility.

However, the knowledge that development helps to control fertility is cold comfort for the nation whose spiraling population threatens the cure. In this case programmes aimed at controlling fertility must be designed to operate in a situation where the "socio-economic variables" are invariably of less help. A family plannning programme in this environment is not just offering a means to control reproduction to a society that is receptive to the concept, but acting as an agent of change for the entire culture – a role that requires much sensitivity in the way it is performed. Additionally, the resources available to devote to the programme are necessarily limited, and funds devoted to family planning may well come at the expense of other worthwhile programmes. That is why efficient and effective programme performance is important.

Assessing the impact of a family planning programme in the absence of any clear cut criteria for success, such as profits provide private corporations, is a difficult task. The lowering of total fertility is one commonly used criteria, and while it remains the bottom line of any evaluation it is, by itself, inadequate for several reasons. First, a large number of factors influence the fertility rate, including changes in cultural values and the over-all rate of development. Separating the effect of the family planning programme on fertility from these other forces is a vexing problem. A decline in the total fertility rate (TFR) may be comforting to population planners, but it is not a sure sign of an efficient programme.

At the same time, the lack of a decline in the fertility rate is not a sure sign of programme failure. The population could be receptive to family planning and confident of the available contraceptives. But they might also desire closely spaced children to shorten the number of years spent in child bearing and thus free the wife for other occupations. In this case there may be a lag in the programme's impact on a women's total lifetime fertility and on the immediate fertility rate.

To adequately evaluate the programme, it is necessary to look at the nuts and bolts of programme performance to determine such factors as:

- how well the programme meets the needs of the people it is meant to serve,
- it's impact on the people's attitudes, livelihood, and the society at large,
- how efficiently the programme deploys available resources to produce best results,
- how effectively the various programme elements, such as IEC and the provision of services, interact, and
- how dynamically the programme responds and adapts to new challenges and opportunities.

In addition, an adequate assessment requires an analysis of operations to determine the best methods for re-enforcing success and eliminating failures. It requires an examination of such considerations as the availability of family planning services, the contraceptive mix that produces the best results in a given environment, the knowledge and expertise of family planning personnel as well as their attitude towards the public, and the over-all management of the programme.

An ongoing evaluation of these factor, combined with actions aimed at improving performance, will likely produce continually improving results.

The Asia Call for Action of the Third Asian and Pacific Population Conference held in Colombo, states: "Greater efforts should be made in times of economic stringency to maximize use of available resources which will require greater attention to performance and management of population programmes." Learning from past successes and failures is essential for acting on that commitment.

1. The evaluation of population integration activities: A regional overview

The theory of integration in family planning is still based on untested and incompletely developed assumptions. On the demand side, it is argued that the provision of family planning along with other services will increase the demand for family planning, especially if those other services are highly valued and show immediate improvements in the quality of life. On the supply side it is argued that integrated services will be more efficient and cost effective than single purpose service. These are quite crude and unspecified arguements. They fail to consider the character of integration itself, how it is affected by various programme and environmental conditions, or how it is related to programme perfôrmance.

The core of the concept implies the development of interdependent and interactive linkages

Well attended FP/MCH clinics are fast becoming a familiar feature of welfare programmes which aim at a community based approach to family planning.

Instruction in family health and family life education, including family planning lays the foundation for the motivation of multi-purpose workers.

Young teacher trainees receive in-service instruction as part of a seminar programme organized by the Youth Division of the Family Planning Association of Sri Lanka.

The involvement of voluntary groups in population programmes has proved to be a very effective approach in Bangladesh where programme sensitivity is high.

Mothers clubs in far-to-reach rural areas are actively involved in outreach projects which aim at instruction, followed by peer group motivation.

between different specialised activities. Thus, the integration of family planning (FP) with maternal and child health (MCH) implies linking the specialized family planning activities with the specialized MCH activity in such a way that the two are dependent on and interact with one another.

One of the most important distinctions to be made in considering integration is that between structure and process. For example, one set of observations on the Bohol MCH/FP project in the Philippines noted that family planning work was the direct responsibility of the project and that MCH workers were directed to motivate people for family planning. This was a clear case of integration in the structure. Actual observation, however, indicated that the workers were not motivating women for family planning. There was integration in the structure without integration in the process.

Beyond this initial and important distinction, integration can vary in the number of activities that are linked, in their difference or similarity, or in its scope. Integration can also vary in its quality: it can be smooth and co-operative or it can be marked by competition and conflict.

Issues in integration evaluation

Two types of evaluation can be conceived. At the national level, we can ask to what extent population and family planning are integrated into over-all development policy. This type of question is addressed by means of policy research and organizational reviews.

A second type of evaluation focuses on specific service delivery systems and addresses the basic assumptions underlying the arguements for integration. For this type of evaluation, the more standard multivariate research strategy can be used effectively.

Since integration is basically an organizational issue, the unit of analysis for evaluating integration must be some distinct organizational unit, which presents certain methodological problems. Two important problems are the small numbers and their aggregation. To observe variance in integration in a way meaningful for its evaluation, it is necessary to use organizational units that have some administrative integrity, such as primary health care clinic in districts or countries. The numbers of observation points, therefore, are not likely to be large. For example, Malaysia has just over 60 districts at which it is reasonable to observe variance in integration.

The use of survey data to indicate clinic or organizational conditions raises problems of validity that are common to survey research, but are made more difficult in this case by the relatively small numbers of respondents that will typically be available. Observational techniques provide a useful alternative to survey data for adddressing this problem, but this raises additional problems of representativeness, and it often increases the costs of the research as well.

Finally, there are problems of deciding what variables to measure. These are also problems common to large scale survey research, but they are once again made difficult by the small number of observations used. This problem places heavier burdens on theoretical formulation than are normally found in large scale survey research.

Source: *A review of ESCAP's population integration evaluation activities,* Asia-Pacific Population Programme News vol. 11, No. 3, 1982.

2. China and Bangladesh: The world's most populous nation has lessons for one of the most crowded.

China got serious about population control in the 1970's and quickly brought its population growth rate down from 2.5 per cent in 1970 to 1.17 per cent by the decade's close. In 1980 the population growth rate in Bangladesh was 2.65 per cent with a target of 1.7 per cent by 1985 and NRR= 1 by 1990.

The Chinese Family Planning Programme is highly centralized but is characterized by a strong commitment on every level. The urban areas and cities have been divided into various neighbourhoods (zones) and lanes. The Municipalities and the lane committees have been assigned the responsibilities for family planning and maternal and child health activities. These tasks are carried out strictly in obedience to the directives from the higher authorities. All the inhabitants are registered. All pregnancies and childbirths are recorded. No pregnancy or childbirth can escape notice. Good maternal and child health care has lowered the infant mortality rate to 14.4 per thousand in 1979.

Rural areas are also tightly organized, broken down into countries, communes, production brigades and production teams.

Using directives from above, the production teams, production brigade and commune leaders, through discussion with the members, determine the desired number of children. The leaders spell out who may and may not give birth. If any couple declines to adopt any family planning method, the neighbours and number of leaders pursuade the couple and prevail upon them. The influence and motivation from the community are used this way in both the rural and the urban areas. There is, in addition, a system of incentives and disincentives to promote the one child family.

The National Population Council of Bangladesh was established in 1976 to formulate policy but implementation, especially in the urban areas, is left largely to approximately 80 non-governmental agencies that are only loosely linked and not well co-ordinated. The delivery of health services and fa-

mily planning services through the Thana health complex is increasing but is still inadequate. These complexes serve a population of about 200,000. The complexes have five doctors and a Family Planning Officer. The Family Welfare Centres at the Union level serve a population of 20,000 and contraceptive services are available.

The urban areas are looked after by the paid workers of the non-governmental organizations. The leading groups, community leaders and the elite are yet to be seriously involved in birth planning and working in conformity with the state policy. Although there are full time workers at the grass root level, non-performance of duty by them is still not condemned by the community. Incentives and disincentives at various levels have not yet been worked out.

With some strengthening and modification to fit the situation, the Bangladesh Family Planning Programme can produce dramatic results like that of China. Out of compulsive necessity, there has to be drastic birth planning in Bangladesh. Strong political and organizational commitments are essential for this, starting from the highest level down to the remotest corner. The leaderships of the towns and the villages should be vested with responsibility and answerability.

The programme has already shown signs of progress. In this field we can unhesitatingly use the experiences of the world's largest and most successful country, the Peoples Republic of China.

Source: *A Report on Bangladesh Family Planning Programme as Compared with that of China,* M.H. Ali; Bangladesh Fertility Research Programme, Fifth Contributors Conference, Dhaka, Bangladesh, 1981.

3. Hong Kong: Programme reaches plateau

People are no keener now about using contraceptives than they were five years ago, according to a 1982 Family Planning Association of Hong Kong survey.

However, the survey did show success for the association's "two is enough" birth control campaign, said Peggy Lam, the Association's Director. Not only is the average family getting smaller, but statistics show that almost 45 per cent of indigenous families are practising contraception before having children. If a family has two children, there is an 88.8 per cent chance they will be practising birth control, the survey shows.

But the survey points out "the current state of knowledge is more or less the same as it was five years ago. It shows, perhaps that with the present level of information, motivational and educational provisions this is the saturation point." The report adds "unless the intensity, method and skill in information, motivational and educational work improve, we probably cannot advance much further."

The comprehensive survey, conducted by the Association once every five years, questioned men and women clients aged 15 to 49. The study's results are a guideline for future policy decisions.

The survey discovered a "mysterious regression in attitude" towards contraceptives. The report cites the problem of men not responding adequately to family planning and discusses widespread naivete about the side-effects of the pill as two of the obstacles against birth control. The report also shows that traditional Chinese preference for male offspring has not changed. But the average family size has shrunk from 2.6 children per household to 2.4 children in 1982.

Source: Hong Kong Standard, February 3, 1983.

4. India: Integrated projects deliver

In 1981 the World Bank conducted a survey of health, nutrition, and family planning projects in India and concluded that integration of services in these three areas is the most cost-effective approach, whether projects are multipurpose or single purpose.

The survey analyzed 14 projects divided into three broad categories – research, pilot and service projects. The survey concluded that:

– Community participation, where stressed, leads to better handling of community health and welfare problems, better acceptance of health care services, and generally more equitable distribution of the benefits of services.

– In most projects paraprofessional staff delivered preventive and simple curative services and did promotional work in the villages. In some projects, even illiterate workers performed well with training.

– The more successful projects seem to have developed an effective supervisory and training system. Generally the smaller the project, the better the supervision and more impressive the results.

– For coverage, it is difficult to adhere to a selection criteria fixed at the outset. Nutrition and health criteria, even age criteria, cannot be strictly followed. Such flexibility often leads to a situation of much less coverage of the target group than desired. Projects with surveillance systems had more success in reaching target groups.

– The cost for nutrition programmes were often high when compared to the programme offered by the Government. In general, nutrition projects cost more per capita than health and family planning projects. In some, especially those with strong community participation, part of the cost could be recovered.

– In only a few projects were some attempts made to measure the impact of services, and where this was done, attributing changes in outcomes to

services was difficult. Most projects used output variables (such as service coverage) to monitor progress.

Although the experiments and special projects offer insights about different strategies of intervention, the coverage has been small in relation to the population eventually to be served. Moreover, the costs of replication appear to be high. One big problem is the inflexibility of large programmes. What is needed in the experiments and special projects is a better system of monitoring and evaluation – so that more can be learned about what they have achieved and about what the interventions have meant.

Source: *Health, Nutrition and Family Planning: A Survey of Experiments and Special Projects in India;* Rashid Faruqee and Ethna Johnson; Population and Human Resources Division Discussion Paper No. 81-14; World Bank, Washington, D.C., 1981.

5. Philippines: Survey indicates need for better training

Results of Community Outreach Surveys conducted in the Philippines in 1978 and 1980 indicate that local outreach personnel should receive more effective training, especially with regard to the relative merits of various contraceptive techniques.

The Philippine Commission on Population launched the Outreach Project in 1977 to take the family planning programme to the barangays (villages) in a departure from past, urban based strategies. The project deploys salaried full-time Outreach Workers whose efforts are complemented by barangay supply points manned by volunteers.

Questions asked of the Outreach Workers, volunteers, and wives in the communities provide insights into the effectiveness of their training in contraceptive methods.

Respondents were asked to compare three methods with regard to their effectiveness. With regard to pills and the IUD, most outreach workers and volunteers said, incorrectly, that pills are much more effective. They also were more likely to say that condoms are much more effective. than rhythm, whereas research has indicated no difference or relatively small differences that tend to favour rhythm. Among the three groups, only the Outreach Workers appeared to be aware that the IUD was much more effective than the condoms and a disturbing high proportion (42 per cent) of the responding volunteers said they thought condoms were more effective than the IUD, perhaps because of the emphasis placed on condoms in establishing the supply points.

The respondents were also asked about the best time to initiate contraceptive practice following a live birth. Immediate acceptance results in a long period of overlap with postpartum amenorrhea (about seven to eight months) during which the contraceptive method is unnecessary; many immediate acceptors can be expected to discontinue use before they resume ovulation. Those who delay acceptance until after the resumption of menstruation run the risk of getting pregnant, since ovulation may occur before the first menstruation. The best time to start contraception practice thus appears to be a few months after acceptance but before the time menstruation is likely to return.

There was a tendency for the Outreach Workers to select the "correct" response more often than the volunteers, and for the latter to select it more than the wives. But even among the Outreach Workers, only 21 per cent selected it. However, Outreach Workers were more likely to say "right away", which is the safer of the other choices, and wives were more likely to say "wait for menstruation." Thus it appears that training may have had some effect, but there is still much room for improvement.

Since calendar rhythm is a popular method, it is important that the timing of the fertile period be known, especially by service providers. When questioned, only about half of the Outreach Workers were able to specify correctly the first and the last days of the unsafe period for women with a regular 28-day cycle, even allowing a one day margin for error in the first or last day. Still fewer volunteers knew even that the unsafe period was about midway between menstrual periods, though they were more knowledgeable than the wives.

Outreach Workers have several years of college education and receive a standard three week training course in six topics areas: group dynamics and human relations, motivational techniques, community organization, the monitoring systems, contraceptive methods, and administration of the checklist for potential pill users. About half of all volunteers had received a formal three day training course and the remainder had been informally trained by an Outreach Worker.

Source: *Family Planning Outreach in the Philippines,* John E. Laing; Population Institute, University of the Philippines; November 1981.

6. Republic of Korea: Examining the cost-effectiveness of community-based family planning

The Republic of Korea established its national family planning programme in 1962 within the administrative structure of the Ministry of Health and Social Affairs. At present, the programme is

implemented through a network of nearly 200 city and county health centers that employ some 3,000 family planning field workers who recruit acceptors and supply them with pills for condoms. Clinical methods of contraception are usually available at the health centres. There are, in addition, roughly 1,500 private doctors under government contract to provide clinical services for a nominal fee to clients referred by the field workers. The programme is primarily supported by appropriations from the general budget of the Korean Government, although foreign donors have provided assistance in materials, training, public information, and evaluation.

The Korean programmme is generally acknowledged to be one of the strongest in the developing world. Nevertheless, it has a number of problems: the number of women (1,500) a field worker serves on the average, and the size and difficulty of the region a field worker must cover; financial burdens for the acceptors; a rigid target system (by contraceptive method) that may discourage clients from accepting by offering only methods for which the target had not yet been achieved; a maze of formalities and bureaucratic red tape that impedes access to supplies; and long distances between users and service points.

During the fifteen years from 1960 to 1975, fertility rates in the Republic of Korea fell markedly. The crude birth rate went from about 43 to 25 per thousand and the total fertility rate (TFR) from around six to about 3.6 births per woman. However, the decline varied greatly by region.

In 1973 the Cheju province TFR was at 4.5, in rural Cheju it remained at 4.9. In the regularly made ratings of provincial efforts in family planning, Cheju consistently ranked among the provinces lowest in achievement. Therefore a project was initiated in Cheju in 1976 designed to maximize the availability of contraceptive services and to remove many of the above problems through the use of community-based family planning delivery systems.

The programme recruited 365 canvassers, each of whom served an average of 180 married women between the ages of 15-49. Their primary functions included making house-to-house visits to recruit family planning acceptors; distributing oral contraceptives and condoms free of charge at initial canvassing; referring acceptors of IUDs and sterilization to the appropriate facilities; and maintaining resupply depots for condoms and oral contraceptives. The programme also eliminated the cost to the acceptors of tubal ligation.

After 40 months of project operation, the contraceptive prevalence rate in rural Cheju increased from 18.3 per cent to 38 per cent. In the control area, Hapchun county, where the national programme was in effect, the contraceptive prevalence rate increased from 26.6 per cent to 44.7 per cent. Thus the per cent reduction in non-use of contraception was about the same in both groups. However, the fertility decline during this period was more pronounced in rural Cheju than in rural Korea.

The Cheju project demonstrated that the removal of a substantial service charge has a major impact on contraceptive acceptance. When the cost of tubal ligation was reduced from $20 to no cost in 1976, the acceptance rate increased from 10 to 170 cases per month and sustained that level for the remainder of the project.

Source: *Cost-effectiveness of a Community-based Family Planning Programme in Cheju, Korea,* Kwan-Hwa Marnie Chen and George Worth; Paper presented at International Health Conference, Washington, D.C., June 1982.

7. Samoa: Family planning takes root.

A number of obstacles stand in the way of family planning as a way of life in a Samoan community. To begin with, the terminology used in family planning teaching is often regarded by parents and Christian educated youth as taboo and inconsistent with cultural beliefs. The lack of clinical services in remote areas is another factor, complicated by the fact that Chiefs in these areas prefer large families to provide labour in family land cultivation.

Nontheless, the practice of family planning in Western Samoa is gradually increasing. In 1977, about 13 per cent of women in the child bearing age group practiced family planning. In 1981, the total number of users reached 5,197, about 17 per cent of the female child bearing age population of 31,000. There was a further increase to 18.5 per cent users in 1982.

The development of family planning started during the Government's second five year plan period (1971-1974), resulting from an awareness of changing demographic trends and the health care needs of the population.

A Family Welfare Section was established in the Public Health Division of the Health Department in 1971, with a medical officer in charge. This centre became the main clinical facility for the delivery of antenatal and postnatal and family planning services to the metropolitan area of Apia.

Although family planning practices are spreading, their impact only relates to a small proportion of the population. In order to bring family planning awareness to rural populations, family planning propaganda should be designed and disseminated to meet the particular requirements of the rural population.

A reduction in fertility in Western Samoa is already noticeable. However, the recent decline in fertility is not of such a magnitude to ensure sound economic planning. The formulation of a Government Population Policy is therefore envisioned as an integral part of the welfare and development planning for the country.

Source: *Family Planning Situation in Western Samoa,* Tipasa Me Mauai; ESCAP Population Correspondent.

IV. DISTINCTIVE APPROACHES TO PROGRAMME FORMULATION AND IMPLEMENTATION

Government support for family planning programmes is often essential for long term success. A government, once committed to the programme as part of its long term development strategy, can supply reliable sources of funding, regular and stable programme administration, and an overall development and social-welfare policy in which the programme can operate. However, as national family planning programmes acquire hierarchical administration systems, and increase government funding necessitates increased – and often centralized – government control, the danger emerges that the programme may lose the flexibility and willingness to experiment that often characterizes less formal arrangements.

Perhaps the best technique for fighting this tendency is for programme administrators to keep their eyes, ears, and – most importantly – minds open to new ideas and appraoches. This means a willingness to learn from other national programmes, from the experience of colleagues and of other agencies, both public and private, engaged in family planning.

In addition, there is a whole world of expertise developed outside of family planning that provides a wealth of potential new approaches. In Bangladesh marketing techniques were applied to promote the pill (described in "New strategy should boost pill acceptance" in this section). After examining the target population's needs and attitudes, it was decided that a more "scientific" sounding name, a slightly higher product price, and more strictly controlled distribution, would build a mass following for the method. In this case, techniques developed by private, profit making firms to stimulate demand for their products were applied to generate broader contraceptive acceptance.

In other cases, private agencies can adapt approaches that may be difficult for government programmes to sponsor. Mechai Veravaidya of the Population and Community Development Association of Thailand has become a legend through such publicity generating activities as handing out contraceptives at diplomatic receptions and blowing condoms up as if they were balloons – measures that may be difficult for a high government official to copy.

In addition, privately funded programmes often have the freedom of action that allows them to experiment with new approaches that, should they prove successful, can later be adapted by publicly supported programmes. One such case was the Comprehensive Labour Welfare Scheme, which featured family planning as part of a total health programme, launched by the United Planters Association of India. The programme introduced the concept of the "Link Worker" who, after training, acts as a health motivator among his neighbors and as a link between the health professionals and the estate workers. The programme produced dramatic results, not only in family planning, but in the overall health of the workers.

The ESCAP region has incredible cultural, social, political, and economic diversity, a fact that creates an equally diverse set of programme experiences. Approaches that are suitable for a homogeneous nation that features strong central control, such as the Republic of Korea, may not be suitable for a more socially and politically diverse nation. Although all techniques cannot be successfully transplanted between countries, how one nation handles its unique problems may throw light on the best strategy for other nations to follow. A willingness to learn from others and to adapt family planning programmes to best meet local needs, are essential for maximizing programme performance.

1. Bangladesh: New marketing strategy should boost pill acceptance

Maya is a name often given to daughters in Bangladesh, and when they gave it to a new brand of oral contraceptive, they thought they had a winner. *Maya* was designed as an over-the-counter product available through a wide variety of vendors, including pan-wallahs (betal-nut sellers). The price was kept low to give it mass market appeal and a mass media programme was so successful at creating product recognition that *Maya* became the generic name for the pill.

Yet Maya sales grew slowly, floundered at 50,000 couples years of protection annually and then declined.

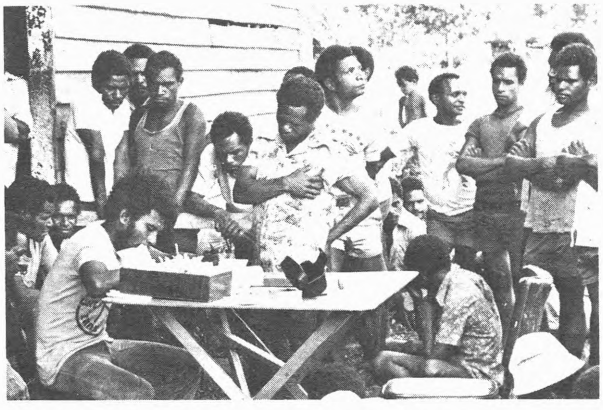
S. Anwar Ali, Director of the Bangladesh Social Marketing Programme pinpointed several causes for the disappointing performance. The name *Maya,* for instance, is perhaps too local and not "scientific enough to inspire confidence." In addition, packaging and price gave little prestige to the product.

Nevertheless, the number of potential users of oral contraceptives is high – less than five per cent of the 16 million fertile aged women in the country currently use oral contraceptives. Consequently, the Contraceptive Social Marketing Project decided that a new product with a new mar-

Integrating family planning with MCH activities has worked well in semi-urban areas where facilities through this integrated approach are made more readily available to young mothers.

Where literacy rates are high, motivation through the print medium is still an effective means of reaching parents who are jointly responsible for decision making.

Nutrition and health go hand in hand with family planning programmes which aim at reducing mortality levels as a first step towards acceptance of the small family norm.



Population programmes need a good base of demographic data for the formulation of realistic goals and targets. The recent census operation in Papua New Guinea provided a good opportunity for the collection of such data and statistics.

Winners of a Children of Planned Families Competition in Hong Kong. This is one of the many innovative projects launched by the Family Planning Association, which is aimed at the total involvement of the family.

keting strategy might stimulate pill acceptance.

The CSM programme chose Norminest, a low does (0.35 ethinyl estradiol) pill made available through USAID. The brand name *Ovacon* was selected as a result of consumer test. It was slightly, perhaps enticingly, difficult for Bangladesh speakers to pronounce. The packaging, developed and tested prior to introduction, was significantly different from other products and included gold-leaf to suggest a high quality product.

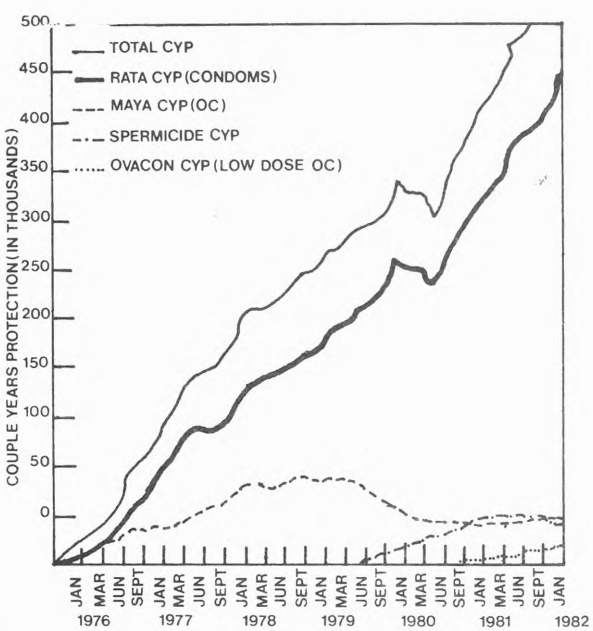
At the same time, the price for *Ovacon* was set at taka 4.00 per cycle (about US$0.21) which is substantially higher than Maya at taka 1.00, but much lower than commercially available oral contraceptives.

The most significant difference between *Maya* and *Ovacon* was the distribution method, which for *Ovacon* centered around qualified medical professionals in urban areas. Outreach to other medical personnel, the aryuvedics and homeopaths who have a higher potential for demographic impact, would occur later.

There were two objectives for this distribution strategy. The first was to establish a personal contact with users. It was felt that informed physicians and pharmacists could screen customers and explain common side effects and thus help promote higher oral contraceptive acceptance. The second was to overcome the common practice of medical personnel to blame ill-defined complaints from under nourished clients in poor health on their use of the pill.

Ovacon sales have grown as projected, slowly but steadily and currently are about 20-25,000 cycles per month. It is hoped that over the long term, as more prescriptions are written for *Ovacon* – in a country where prescriptions for anything are rare – the approach will yield more acceptors with higher continuation rates than would otherwise be possible.

"New Marketing Strategy should boost Pill acceptance"



Bangladesh CYP by Product since 1975

Source: *Experience with Low-dose in Bangladesh; Social Marketing Update,* vol. 2, No. 1, March 1982.

2. Bangladesh: Pullers for family planning

With a dedicated and lively batch of 10 social workers at the grassroots, the Comilla branch of the Family Planning Association of Bangladesh has struck what demographers can call a miracle: an innovative approach has motivated 12,000 rickshaw pullers towards family planning.

Dr. Syed Ahmed, a veteran of 30 years in the field of population control, leads the project and believes family planning must aim for more than demographic effect if it is to succeed. "Family planning must put more emphasis on the human elements and must ground itself on the concept of aiming for man's happiness," he said. And so he designed a project that tackled, with immediate and dramatic effect, the debilitating worm infestations and other primary diseases and the curse of illiteracy among the children. In the process, the programme enlisted the support of parents not only for the programmes health and welfare goals, but for the planning and spacing of offspring as well.

The project works closely the rickshaw pullers union, which was 3,500 members and is led by some dedicated social workers who hope to enroll the entire 12,000 pullers. Ten of the unions leaders work as teachers at five literacy centres run by the project, which has helped inject enthusiasm among the target group while supplying teachers who have empathy with the taught.

It has been found that most of the rickshaw pullers could not be reached by the project, since the nature of their work physically exhausts them. But the response from the wifes has been overwhelming. In the two years until December 31, 1982, the 10 units of the project recorded a total of 2015 sterilizations out of 3031 fertile couples. Additionally, there are 750 acceptors of other family planning methods.

"The central lesson," commented Dr. Ahmed, "is that birth planning is most successful when people participate in the spread of this new idea. Almost all experts misunderstood people's thinking and people's desires. It is necessary to find out how to fire people's hearts."

Source: The Bangladesh Observer, March 1, 1983.

3. Hong Kong: Help for the mentally handicapped

In May 1979 the Family Planning Association of Hong Kong (FPAHK) established a clinic for the mentally handicapped to offer help with fertility related problems.

Considering their vulnerability to sexual exploitation, the need to help the mentally handicapped protect themselves and to provide remedial services for them were often neglected. In the past few years, the Association had been approached by parents and social workers bringing along mentally handicapped females for assistance. The majority of their problems were related to their fertility and many were actually having unwanted pregnancies resulting from sexual exploitation or rape. It was obvious that such problems should not be overlooked.

After studying the situation, the Association introduced a special programme consisting of training for professionals who will teach the mild to moderate grade mentally handicapped youths sex education; a montly sex education course for parents of mentally handicapped children; and a special clinic for the mentally handicapped.

The clinic has a team with a gynecologist, psychiatrist, clinical psychologist, counsellor and nurse. The services range from training the mild grade mentally handicapped in menstrual hygiene skills and performing preliminary assessment of appropriate birth control methods to interacting with parents, guardians, and social workers via sex education classes and individual counselling.

When the clients are brought to the clinic, they are interviewed by the counsellor who assesses their problems before referring them to the psychiatrist and gynecologist for further consultation. If the client requests contraceptive advice, the gynecologist will consider the client's condition and conduct an examination to decide on the most appropriate contraceptive methods. Cases requesting termination of pregnancy, complaints of being raped or requests for sterilization will be referred to the psychiatrist for assessment of the client's degree of mental retardation in order to find out the best way to help them.

The programme rarely refers mentally handicapped women for hysterectomy, although many parents insist on their daughters having the operation without realizing its consequences. Sterilization is not advocated as a contraceptive method, especially for the younger women, because there are many other suitable contraceptive methods which they can use effectively.

Mentally handicapped people have the same physical needs and desires as anyone else but they do not know how to handle them. Since the decision about having children depends on the circumstances, the programme does not discourage the mentally handicapped from having a family if they can cope with the responsibility. The service is offered to help the women manage their own fertility problems.

However, clinical service by itself is not enough. It is essential to educate not only the parents but also the general public to heighten awareness of their own attitudes towards the sexuality of the mentally handicapped.

Source: *The Family Planning Association of Hong Kong's service for the mentally handicapped,* Peggy Lam; unpublished, 1981.

4. Hong Kong: Competition shows small is beautiful

The Family Planning Association of Hong Kong organized the "Children of Planned Families" competition to demonstrate that a planned family is a happy family. The contest was held in October 1982. The contestants were aged between six and ten years and came from families of not more than two children, to help stress the "two is enough" concept.

During the competition, each contestant was judged according to their health, appearance, response, intelligence and performance of their choice, such as dancing, drawing, or singing.

The winners were awarded scholarships and valuable prizes, while the parents received electrical applicances.

The judges included prominent movie and television personalities, doctors, teachers, and family planning personnel.

Source: Family Planning Association of Hong Kong; October 1982.

5. India: Linking workers with health and family planning programmes

The United Planters Association of Southern India undertakes voluntary development programmes to benefit the working community while furthering the nation's development objectives. One such programme was the Comprehensive Labour Welfare Scheme launched in 1971.

As early as 1967, there was concern over the high birth rates prevalent in the plantation, inspite of the financial incentives given to those who accepted contraception.

However, surveys revealed that plantation workers, due to the greater security of their jobs, placed health as their first priority. Non-acceptance of contraception was due to the perceived fears of the methods and their ill effects on the health of the workers which might affect their earning

capacity. In plantations, both the husband and wife are generally employed.

It was therefore decided that for effective acceptance of a small family, there was need to move away from the isolated approach to the concept of total health care of the family. The multipronged approach consisted of the following components: Family planning, care and training of the young, nutritional support, social education, population dynamics, environmental and personal hygiene, craft training, planning of leisure, and preventive medicine.

Experience showed that the quality of life of the plantation workers could be improved only if there were effective communication channels to raise the level of health consciousness and greater community participation in the programme.

For this reason, a new concept of "link worker" was introduced into the Comprehensive Labour Welfare Scheme. A link worker is a member of the working team who after a short period of training, acts as an opinion leader on the estate and takes responsibility for the health of a group of families living nearby. As the term implies, the link worker acts as a link between the people and the medical department and does not assume the role of a health worker.

The "link worker" scheme has now been in operation in the plantations in the south for 3.5 years, and the response has been overwhelming. Positive results have been achieved in contraception and morbidity, utilization of antenatal, postnatal and child care services, information on births, deaths, and marriages, personal hygiene, and better utilization of latrines.

The percentage of eligible couples on contraception increased from 9.5 per cent in 1970 to 41 per cent in 1980. Of the 40,000 children aged 0-6 years, 30,000 are monitored on the "Road to Health" cards, and 20,000 receive nutritional supplements. By 1980 there had been striking improvement in the nutritional and protection by immunization of the children. Of children 1-11 years, 90 per cent were receiving vitamin A concentrates at six monthly intervals, compared with 2 per cent in 1971.

In 1973, antenatal care covered only 27 per cent of the mothers, in 1980 the coverage was 98 per cent; institutional deliveries rose from 42 per cent to 74 per cent in the same period.

In conclusion it can be stated that the health and welfare programme should be integrated into the normal working of the estate for best results. The workers, as consumers, must be motivated and educated on the actions to take to remain healthy. This demand in the community for health care services means that providers must take an interest in bettering the quality and efficiency of the services and improving the professional standards of the health staff.

Source: *Comprehensive Welfare Scheme on South Indian Plantations,* V. Rahamathullah; *Tropical Doctor,* vol. 12, No. 2, 1982.

6. Special problems of island nations

Why should an area of the Pacific that covers 10 per cent of the earth's surface with a total population of only 5 million people worry about population and development problems?

Why do tiny Pitcairn Islands, the smallest trust territory in the Pacific, with a population of only 57, or Cook Island, where the birth rate can't keep pace with the number of people who leave, care that the population in the entire Asian and Pacific region may reach 4 billion by the year 2000?

Yet the small island countries of the Pacific and Indian Oceans sent a delegation to the Third Asian and Pacific Population Conference in Colombo, Sri Lanka, to learn all they could about the problems of population and development.

As Christina Kadoi, Project Director in population education from the Republic of Palau said, "It is a rather important conference where the information on the effects of population on societal development are shared and solutions to these problems are provided. Population must be an integral part of development."

But without planning, the total population of the sub-region may easily double by the early 21st century. The population of Papua New Guinea, the one macro-nation in the area, is expected to increase from 3 million to 5.2 million by the year 2000.

Unless development keeps pace with population increases the problems of youth dependency on the labour force and the doubling of the aged population will reach critical levels.

The small island nations want to secure adequate and relevant data for demographic policy analysis and integrate these data into population and development planning and policies. They want to plan for rapid population growth in restricted environments or, in some cases, seek emigration as an answer. They want to deal with rapid urbanization, assessing whether fertility reduction is the answer or whether urbanization can be achieved when areas of origin are "outlying islands" which are always difficult to service.

Finally, members of the small island country delegations want recognition of the fact that their

concerns involve implementing projects in countries which, in terms of geographical spread in relation to land areas and population size, are the world's most extensive.

Source: *Special problems of Island Nations, Popline,* vol. 4, No. 10, 1982.

7. Sri Lanka: Bringing Ayurvedic practitioners into the family planning programme

Doctors trained in Western medicine are scarce in developing nations, and when available, generally are concentrated in the cities rather than in the rural areas where most of the people live.

In Sri Lanka Family Planning International Assistance is supporting a project designed to make family planning services available through the country's Ayurvedic Practitioners (APs), physicians practicing indigenous medicine with a long history in Sri Lanka. Project operations cover seven of the country's 24 districts and, if successful, may be expanded.

Involving the APs makes sense. There are some 1,600 nationwide, and most of them live and work in the villages. AP practices are traditionally handed down from father to son, after years of apprenticeship training. Increasing number of APs have graduated from one of the two recognized AP colleges or are practicing with certificates awarded by private schools.

Community Development Services, a private organization, is managing the project. CDS provided family planning training for more than 1,500 APs, as estimated 30 per cent of the APs in the project area. In the early days of the project, contraceptives were made available to the APs free of charge, and the APs, in turn, distributed them without charge to family planning acceptors. This year the APs have to purchase the contraceptives, at discount rates, and are expected to sell them at suggested retail prices. APs and project associated voluntary health workers are expected to sell some 400,000 cycles of oral contraceptives, 4.5 million condoms, and 17,500 cans of foam this year.

The nominal charge for contraceptives is expected to help the project achieve some measure of self-sufficiency. CDS officials think the sales approach will affect the programme positively because they feel that people do not place much value on something given away free.

APs can order their contraceptive supplies direct from CDS headquarters or from CDS field coordinators, who are responsible for maintaining contact with APs at the district level and insuring adequate stocks of contraceptives. APs are expected to refer people interested in voluntary sterilization to regularly scheduled sterilization clinics.

Source: *Family PLanning aid in Sri Lanka,* Hans C. Groot; Planned Parenthood review, vol. 2, No. 2, 1982.

V. POPULATION POLICY

Malthus may still rule the world, but in some countries Suhtlam is King.

Suhtlam, Malthus spelled backwards, was coined by Ben Wattenberg of the American Enterprise Institute to remind us that population, when changing at a constant rate, not only expands geometrically, but contracts geometrically as well.

A husband and wife with four children whose progeny all live to produce four children, will have 1,024 descendants by the fifth generation. But in the case of 1,024 husbands and wives, where each couple and their descendants have one child, the fifth generation will produce only 32 potential parents.

Either way, up or down, the tune played on this population accordion reverberates throughout the entire society. The prospects for education (will there be too few schools or too many teachers?) for infrastructure development (will a city become a drinking water desert and a sewage swamp?) and for industry (should an investor put his money into a labour intensive child care products factory or into the automated production of canes?) are all effected.

Japan, one of the great family planning success stories, has a total fertility rate (TFR) of 1.8 children per woman, below the developed nation replacement level. *The Economist* (May 14,1983) points out that the economic advantage Japan receives from having a young working population compared with other industrial nations will recede over the next generation. If retirement benefits remain unchanged, their cost will rise from 10 per cent of national income in 1980 to 32 per cent by 2025. Meanwhile, the number of contributors in pension schemes will decline, from seven workers for each pensioner today to 2.5 workers per pensioner in 2015. Already politicians are struggling with the issues inherent in these numbers.

For much of the region, however, these are the types of problems population planners dream of having. They are still grappling with such mundane issues as where the food for the extra mouths and work for the additional hands will come from. In Bangladesh, the average annual growth of the population increased from 2.4 per cent in the decade of the sixties to 3 per cent in the seventies. Some corresponding figures are 2.6 and 3.1 per cent in Pakistan and 2 and 2.3 per cent in Indonesia. Even though efforts at family planning are beginning to bear fruit, the population express is still on the tracks in many countries.

It should be remembered, however, that population increases may also carry good news. As Godfrey Gunatilleke told the third Asia-Pacific Population Conference (APPC) (in *National Strategies for Meeting Basic Socio-economic Needs in the Context of Over-all Population and Development Policies)* these accelerating trends resulted when "the decline in the death rate significantly outpaced the drop in the birth rate." Lower infant and maternal mortality and longer life expectancy speaks of an over-all improvement in the life of the population.

But the object, of course, is to have the best of both worlds – a healthier and more prosperious society and a manageable growth in population.

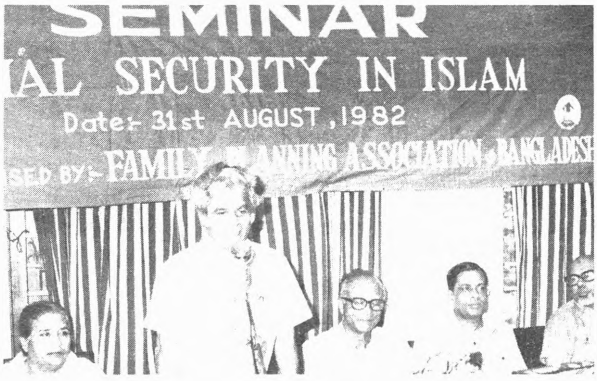
Certainly family planning programmes have an important part to play in achieving this end and, as Gavin W. Jones noted at the third APPC *(Review of the Integration of Population and Development Policies and Programmes in Asia),* "the relative costs and fertility impacts of family planning programmes and other development programmes appear to be such that family planning would be an automatic first choice among policies designed to lower birth rates." Integrated with other effective programmes, such as maternal and child health care and income generating projects, family planning can help produce health and prosperity as well as population control.

But family planning, by itself, will likely produce disappointing results when working in a society that is not prepared for the concept. In trying to explain why the rate of "demographic transistion" to a lower birth rate is more difficult in some societies than in others economist P.T. Bauer used Professor John C. Caldwell's analysis of intergenerational flows of wealth in primitive, traditional, and transitional societies. Writing in "The Population Explosion: Myths and Realities" (Economic Impact, 1982, No. 4), he argues, "...in primitive and traditional societies the intergenerational flow of wealth is overwhelmingly from children to the parents, and more generally from the younger to the older generation. The contribution of the children who work in the fields or in the households exceeds the cost of maintaining them." In the transitional society, which is significantly more modernized, many people adopt a more Western attitude, which includes a reversal in the flow of wealth which, in turn, prompts a limitation in family size. Arguing that fertility decisions are based on rational decisions on the part of parents, he pleads for a more *laissez faire* approach to population control. "Where these policies involve no more than dissemination of information about birth control techniques, or even the subsidized distribution of contraceptives, they may do little harm, and may at some cost improve the range of alternatives open to people. However, the policy may set up tensions and provoke feelings of insecurity and vulnerability if its announcement and implementation are accompanied by official propaganda insistently deprecating prevailing attitudes and behaviour."

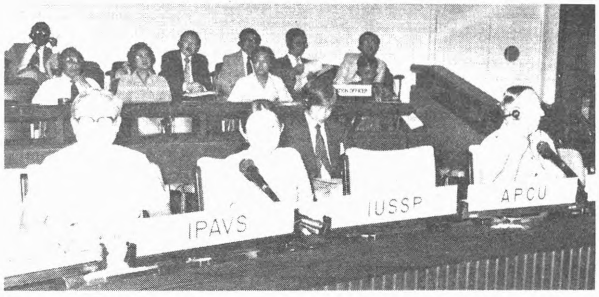
Edwin M. Martin of the Population Crisis Committee picked up Dr. Bauer's gauntlet and, writing in the same issue of Economic Impact ("Rapid Population Growth Hampers Development") notes that improving

Flashback to the first International Meeting of Parliamentarians. The movement now extends to all developing countries in which parliamentarians have been mobilized to lend their support at the highest level to population programmes.

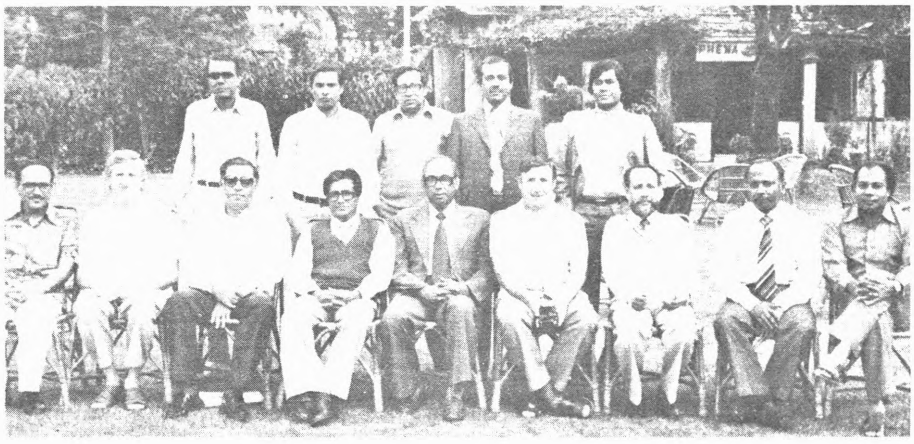
Overcoming socio-cultural barriers receives support at policy level in Bangladesh where the Minister for Education and Religious Affairs is seen inaugurating a seminar on Social Security in Islam.



At the International Institute for Population Studies (IIPS), Bombay, India, professionals from countries throughout the ESCAP region up-grade their expertize in modern technologies and methodological approaches applied in solving population problems.



At an ESCAP Committee on Population Meeting, the integrated approach to population and development is made visible by the presence of representatives of international agencies and staff of many ESCAP divisions.



Participants at a training workshop on new approaches to population programme planning, budgeting and reporting, which was organized at Kathmandu, Nepal.

peoples living standards requires added investment in such things as infrastructure, education and manpower development whose payoff comes years later – but only if there is added capital available to invest in jobs.

"Because the volume of both types of investments required are necessarily measured by the number of persons to be taken care of, it would seem logical to believe that it will be easier to accumulate the volume of savings required if the rate of population growth is slower rather than faster."

So what is the answer for the struggling, nontransitional society – to tax children? Not exactly, but experience is showing the adoption of the right development mix can have a favourable influence on fertility related decisions. Godfrey Gunatilleke notes that those nations that have combined family planning with programmes that help meet basic socio-economic needs seem to do best at lowering both the birth rates and the death rates. Gavin W. Jones, in an article contained in this section, shows how population policy formulation may be brought into the over-all development policy formulation process.

In this view, population policy becomes closely interlinked with a wide range of policy decisions. The goal is not just one of slowing down population growth, but to treat people as an asset – as, quite simply, the most valuable and adaptable resource a nation has.

1. Defining the proper role of family planning and population planning

Some of the key issues in the integration of population and development policies and programmes would seem to relate to the appropriate location of a population policy and development planning unit within the structure of the central planning authority; the relative weight to be given to establishment of a population policy and development planning unit within the central planning authority compared to fostering the planning capacity of the sectoral ministries in this field; the degree of decentralization of population planning appropriate in cases where the central planning authority has regional units; the relative position of the national family planning co-ordinating board and the central planning agency in cases where (as in Indonesia and Malaysia, for example) the mandate given to the National Family Planning Board (NFPB) is in fact broader than the planning and oversight of the national family planning programmes; and the role of high-level Population Policy Co-ordinating Committees such as those established in Korea and Thailand.

In some countries, although over-all development planning (which should automatically include population planning) is the responsibility of the central planning authority, an independent agency set up to implement the national family planning programme has been given a mandate broad enough to include more general aspects of population policy formulation and implementation. For example, in Indonesia the Presidential decree outlining the functions of the National Family Planning Co-ordinating Board (BKKBN) noted an over-all responsibility in the field of population policy that was considerably broader than the planning and implementation of the family planning programme.

Such a situation raises the possibility that the division of planning responsibility will not be clear, and a more precise delineation of responsibilities seems desirable. In the Philippines, this has been emerging, with POPCOM responsible for the formulation and co-ordination of the fertility aspects of population policy, mainly family planning; and NEDA for the formulation and co-ordination of the broader aspects of population policy and their integration into socio-economic plans and policies.

In countries, e.g. Thailand where the family planning programme is placed directly under the Ministry of Health and is integrated with health activities, such problems do not arise, since the Ministry of Health is clearly not in a position to take a policy position on migration policy and other broader aspects of population policy.

This is not to argue for any particular organizational arrangement for the family planning programme, but only to note that where a separate agency is established, its over-all role in population policy formulation and implementation needs to be clearly defined.

The role of a high-level Population Policy Co-ordinating Committee in countries (such as the Republic of Korea and Thailand) where such a committee has been established is normally seen as giving a high level imprimatur (or alternatively, the red light) to policies proposed by the planning office or other agencies before they go for Cabinet approval; and that of ensuring appropriate co-ordination between various government departments and agencies and private agencies in the implementation of agreed policy. To fulfill these roles adequately, such a committee needs high-level representation (sometimes Department Head or even Ministerial representation) from a considerable number of departments or agencies in order to give it the required authority. The dilemma is that a committee with this kind of representation is almost never able to meet because of the very tight schedules of most of its members. Three alternatives present themselves:

(a) to lower the level of representation (with the danger of lowering the authority of the committee);

(b) to convene the committee only on those rare occasions when a major policy decision is in the offering;

(c) to appoint a sub-committee (perhaps a technical sub-committee) which can meet more frequently and discuss population policy issues in

more detail. This alternative can, of course, be combined quite satisfactorily with alternative (b).

One dilemma facing population planning units in development planning agencies is that such agencies rarely give really serious attention to long-run (perspective) planning. The implications of demographic trends and processes assume major importance over the perspective plan period; yet they will *never* become apparent if planning is viewed as an endless succession of short periods. To the extent that politically costly decisions may be needed now to yield benefits (or avoid catastrope) in the relatively distant future, the population planner is in a rather individous position. To base planning only on those benefits that would be realized within a 5-year plan period will lead to serious biases: longer-term benefits, suitably discounted, must be considered in national planning.

Source: *Review of the Integration of Population and Development Policies and Programmes in Asia,* Gavin W. Jones; Third Asian and Pacific Population Conference, Colombo, 1982.

2. Bangladesh: Assessing the impact of female sterilization

If no sterilization programme existed in Bangladesh, 771 of the 159,000 women sterilized in 1980 would be expected to die over the following two years, according to a recent study using Decision Analysis techniques. The study was undertaken to compare the benefits of the sterilization programme in Bangladesh – unplanned pregnancies and maternal deaths averted – with the deaths and illness caused by the programme.

Recent research into fertlity control in Bangladesh made possible a decision analytic model, which follows the 159,000 women sterilizd in fiscal year 1980 for two years to predict the health outcome after sterilization and if sterilization had not been available. The model indicates that sterilization results in 79.2 per cent fewer deaths and 99.5 per cent fewer pregnancies. The most important determinant affecting this balance is the sterilization mortality rate: if the true rate were five or more times greater than that reflected in the country's first national prospective study of sterilization, the programme would cause more deaths than it prevented, although it would still greatly reduce the number of unwanted pregnancies. This favourable balance is independent of the pregnancy rate in women using effective means of contraception, the proportion of pregnant women having abortions, and the rate of abortion and maternal mortality.

Decision analysis, developed to aid decision making under conditions of uncertainty, uses a decision tree that structures the logical and temporal sequence of events. At each branch point in the tree, a probability is assigned to each possible outcome. At a branch point, a circle indicates that chance will dictate which path is taken, and a square indicates that a decision determines that path. Terminal branches of the tree represent measurable outcomes – in this instance, whether a woman becomes pregnant and whether she survives or dies. The cumulative probability of each outcome is the product of the probabilities at each branch along the path that terminates with that outcome. Outcomes of each tree are summarized and compared with those of other trees to indicate a preferred course of action.

Source: Decision analysis for assessing the impact of female sterilization in Bangladesh, Michael J. Rosenberg and Roger W. Rochat; *Studies in Family Planning;* vol. 13, No. 2, February 1982.

3. China establishes a State Family Planning Commission

Vice Premier Ji Pengfei, in his address to the seventeenth meeting of the Fifth National People's Congress Standing Committee during March 1981, reported that China's goal of controlling its population within 1.2 billion by the year 2,000 is a gigantic task. He explained the need to establish a commission to guide the work, and a decision to establish the Commission was adopted at the meeting. According to Ji, the past 30 years has seen an increase of more than 430 million in China's population, which has contributed to China's problems in providing the population with adequate food, clothing, housing, communication facilities, mecial services, education and jobs, despite the tremendous progress in the national economy.

It has been shown that planned population control has a direct bearing on the speed of the country's socialist modernization programme, on the improvement of the people's livelihood, and on the future of the Chinese nation.

China's natural population growth rate was lowered from 2.09 per cent in 1973 to 1.17 per cent in 1979. The 1980 growth rate is estimated to have further dropped to around 1 per cent. According to Ji, still greater efforts must be made to control population growth in the coming years.

He called for organizing all relevant forces. Ji defined the task of the new Commission as supervising China's family planning work, implementing the state policies and laws governing family planning, and formulating long-term and annual plans for population development.

Source; State family commission established, *Chinese Medical Journal,* May 1981.

4. Papua New Guinea: Moving towards a decentralized programme

In 1982 the government of Papua New Guinea decided to abolish the family planning programme at the national level and transfer this function to provincial governments, which simultaneously reducing the level of funds available from the centre for training, education, and co-ordination. This decision was part of the policy for decentralizing health functions to provincial governments.

A population policy was approved for funding in 1978 as a result of pressure and initiatives from concerned individual ministers and bureaucrats. The population programme was established within the Office of Environment and Conservation (OEC), perhaps not the logical base for a population programme. It was a pragmatic choice, however, since the OEC contained many supporters for family planning.

The programme was to progress in three stages: research and education; population policy formulation; and policy implementation, monitoring and evaluation. The last four years have featured activities in the first area.

In 1978, a draft population policy was jointly submitted to the Cabinet by the OEC and the Mi-

Figure 1 Two-year health outcomes if 159,000 women in Bangladesh did not undergo sterilization

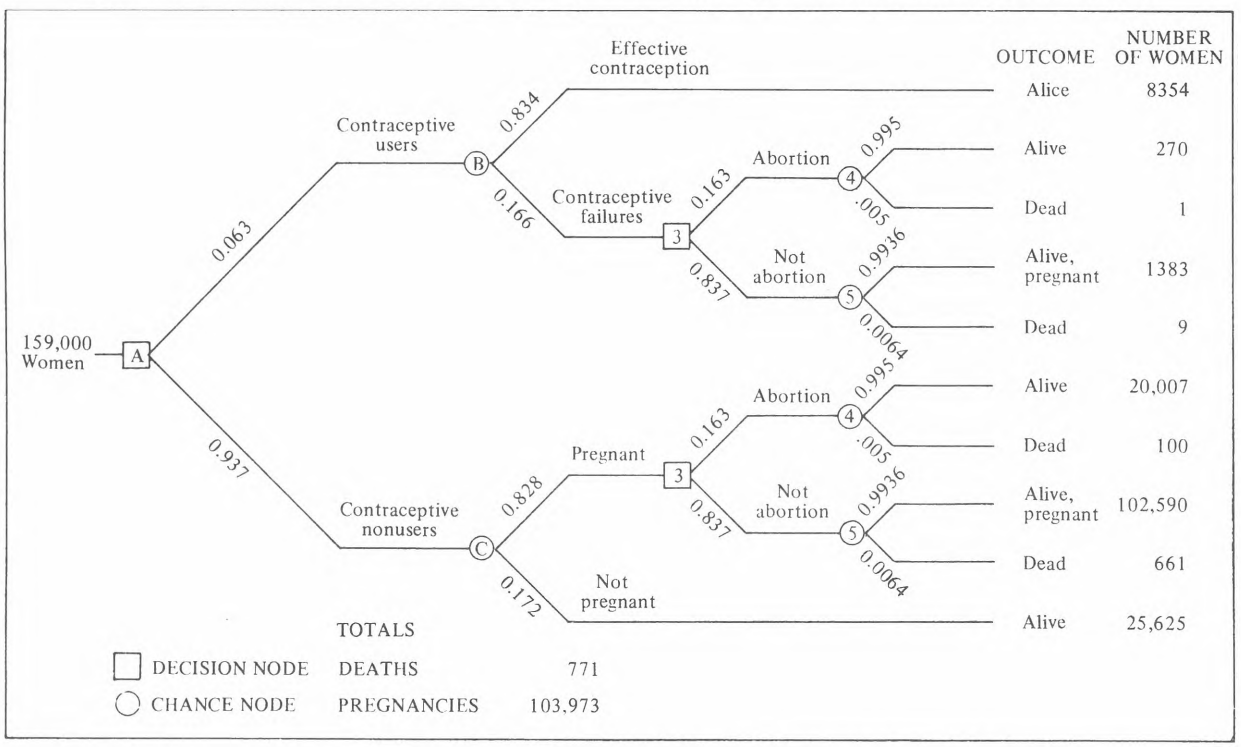
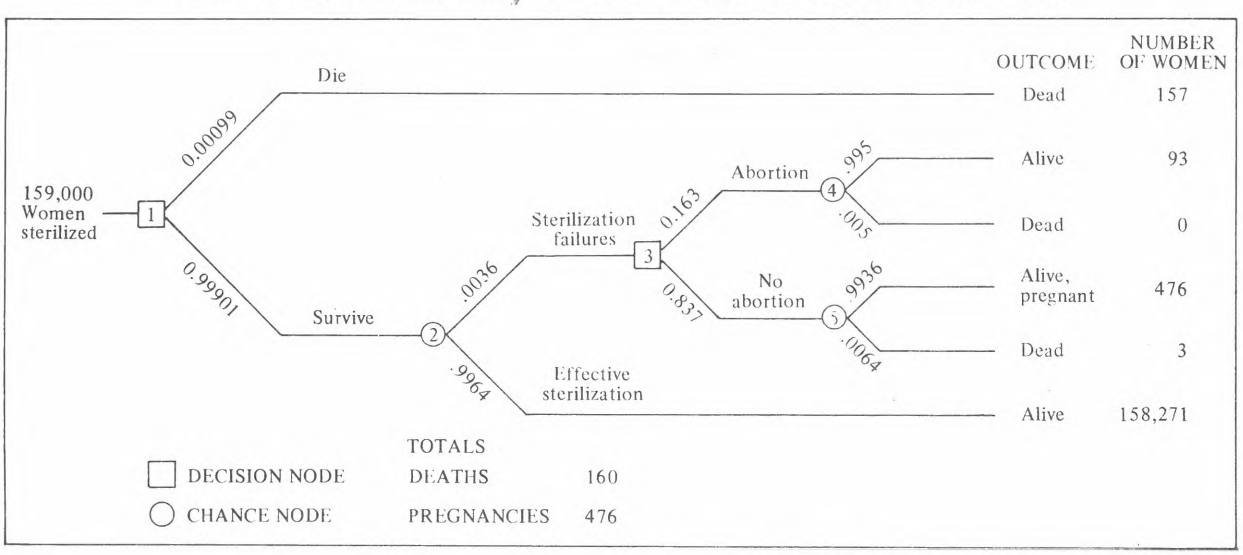


Figure 2 Two-year health outcomes if 159,000 women in Bangladesh were sterilized



nister of Health but failed to receive approval.

Subsequently, the Director of the National Planning Office pointed out several reasons for the rejection. To begin with, the impetus for a population policy seemed to be externally generated, and local decision-makers were not convinced of a danger of over-population. Also, socio-cultural attitudes were against a population control policy, since large families were traditionally seen as a form of security. Then there was the organizational and policy jurisdictional disagreements between the department of Health, which was responsible for family planning, and the OEC, which conducted the population programme.

Against such a background, political decision makers have not responded favourably to attempts to formulate a national population policy.

The programme

The long-term effects of the decentralization of family planning are not yet clear. Some provinces seem prepared to go much farther than the national Government did in establishing population control policies. Others have strong lobbies against contraception which are sure to check the growth of the family planning programme.

The most important factor regulating fertility in Papua New Guinea is the virtually universal prolonged breastfeeding. There is unique legislation to protect breast feeding by requiring prescriptions to purchase baby bottles and teats.

Papua New Guinea is culturally diverse and traditionally not uniformly supportive of the large family ideal. Traditional forms of family limitation have for sometime been widespread. It is perhaps an advantage that family planning has been introduced in many areas before the disappearance of traditional methods and the values associated with them.

The main pressures toward large families are those associated with having children as a source of support in old age.

Although almost all family planning services are supported by the Government, many of these services are actually delivered by non-government organizations. Church run health centres and subcentres provide a major share of the rural family health services. They are not only subsidised by the government but integrated with government services in policy, supply lines, reporting systems and so forth.

Pills (Eugynon, Microlut) and injections (Depo-Provera) are the most widely available contraceptives. Depo-Provera is restricted to women with four or more children because of concerns about fertility. Pills are the only method provided at aid posts by the lowest level of health worker. The usefulness of this outlet is limited by the fact that aid post orderlies are almost all male and are often poorly trained and supplied. Few aid posts have pills.

Maternal and Child Health services will become a responsibility of the provincial governments in 1983. This will mean that it will be left to these units to strengthen or expand the scope of the FP/MCH programmes. The national Government will retain certain functions such as training and education of FP/MCH personnel, co-ordination and the provision of funding to maintain the existing level of services. The FP/MCH units at the national level will also be responsible for liasing with international aid donors and technical assistance.

Source: *Papua New Guinea: At the cross-roads,* Marjorie Hinawaeola; APPN, vol. 11, No. 4, 1982.

5. Thailand: The development of a population policy

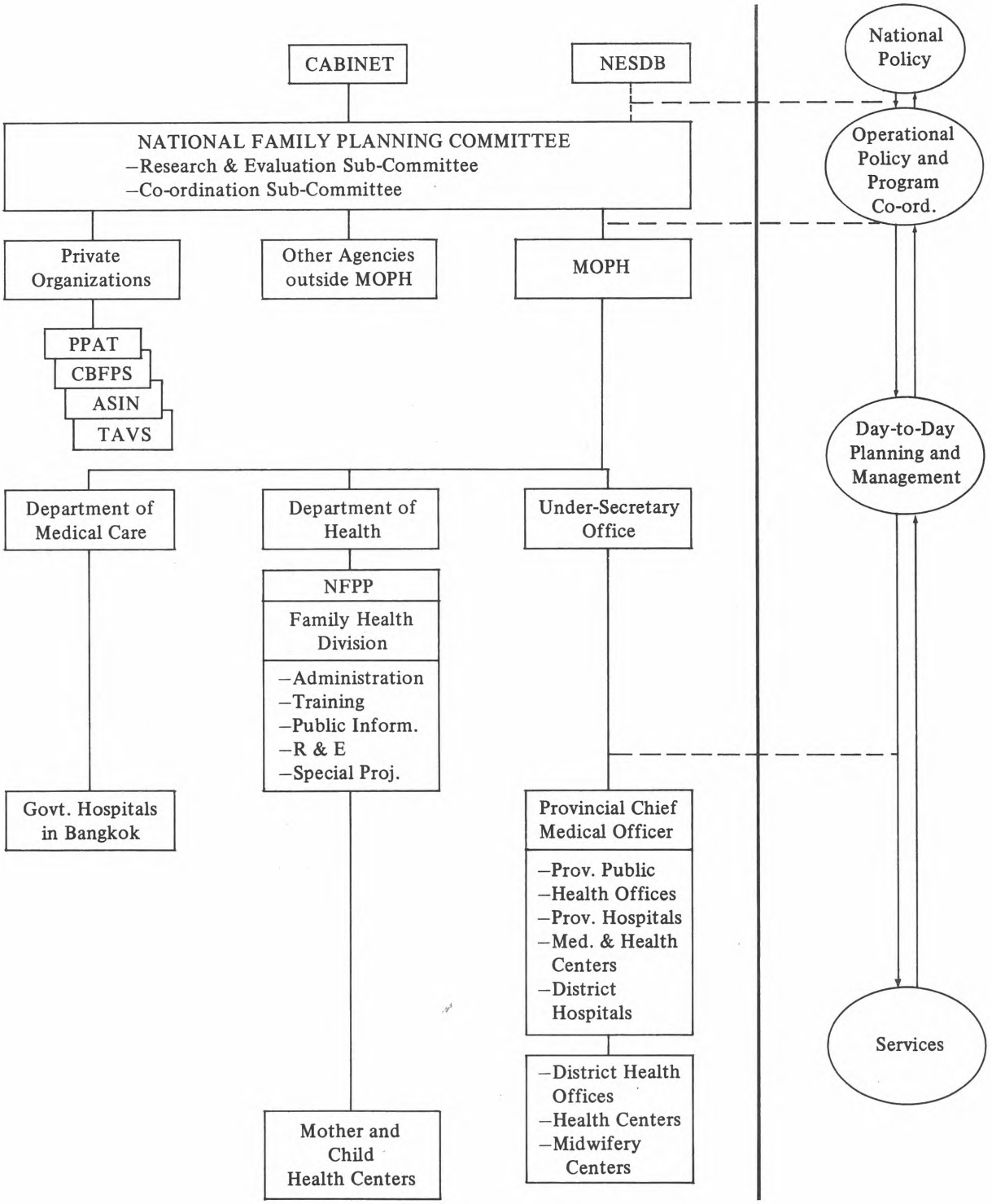
Until the late 1960s the proponents of a national family planning policy in Thailand were opposed by pronatalist military leaders who viewed Thailand as a small and insecure nation which required a large population, preferably 100 million or more – in order to be strong. As a result the Government embraced pronatalist policies such as encouraging early marriages under the slogan "Get married young and make the nation prosper" and authorizing bonuses for large families.

The first major challenge to these policies came in a 1958 World Bank report which warned of problems relating to the shortage of housing, schools, and public services as a result of high population growth rates. The solution would be "largely in the limitation of family size through the dissemination of information about birth control techniques."

While the Government continued to support pronatalist policies, several leading doctors and bureaucrats took the initiative in promoting family planning activities. Three important national population seminars were held between 1963 and 1968. As a result of the 1963 seminar, a National Committee on Family Health was established. Shortly thereafter the Committee initiated a baseline population research project in the rural district of Potharam. This project provided an important information base from which to argue for a national population policy. Studies showed that only 5 per cent of married women betweeen the ages of 15 and 45 practiced contraception and the overwhelming majority of women were eager to limit family size but they lacked sufficient information and services. A highly successful pilot project also concluded that the education and economic status of women was less important for acceptance of contraception than availability of family planning information and services.

Additional policy developments occurred during the 1960s to further legitimize the concept of family planning. In October 1967 the Prime Minister signed the World Leaders Declaration on Population sponsored by the United Nations. In

Figure 1. The Organization of Family Planning in Thailand



1968 the Cabinet permitted "family health services", which had been successfully introduced into the Potharam project, to be extended to married women with children in other areas of the country. That same year the King of Thailand publicly expressed concern over the high rate of population increase and endorsed the extension of family planning services.

Several concerte pre-policy activities during the 1960s contributed to developing a basic network of population planning institutions. Major activities took place under the euphemism "family health research project". During 1965-66 family planning clinics were introduced that soon attracted thousands of women from 66 of the nation's 71 provinces. Postpartum programmes were started in from 66 of

the nation's 71 provinces. Postpartum programmes were started in Bangkok as a part of the Population Council's international postpartum programme. Four hospitals participated, and Thailand quickly became a leader in the number of IUD insertions performed during the immediate postpartum period.

In 1968 the Ministry of Public Health became directly involved in providing family planning services. Assuming that a national population policy would be declared shortly, Ministry officials established a family planning section, initiated a three year Family Health Research Project, and began training public health personnel in the field of family planning. As a result, the Ministry trained 330 doctors, 700 nurses, 3,090 auxiliary midwives, and 1,985 male sanitarians in family planning methods.

When the National Family Planning Programme was announced in 1970, professional leadership, organizational structure, and family planning expertise were already in place, highly motivated, and experienced. In effect, family planning had become institutionalized before commencing an official government programme.

Ministry of Public Health units, other government agencies, and private family planning organizations are integrated through an inter-agency committee structure, the National Family Planning Committee. This committee is supposed to be the nation's key policy and coordination group, but because of its high level membership it meets too infrequently to perform this task. To help fill the gap, a National Family Planning Coordination Centre was set up in 1975. Its members represent the implementing level of public and private family planning organizations.

One of the central reasons for the inertia of the National Family Planning Committee is perhaps the most important factor in the successful development, coordination, and implementation of the National Family Planning Programme (NFPP).

However, there has been a remarkably degree of co-operation among the organizations involved in NFPP resulting in a high lead of programme implementation.

Source: *Initiating a population revolution in Thailand: politics, bureaucracy and social change*, by Ronald L. Krannich and Caryle Rae Krannich; *Asian Profile*, vol. 10. No. 2, April 1982.

6. Key population targets of selected ESCAP countries

A review of the current population policies of the ESCAP countries aimed at influencing population growth, structure and distribution shows a growing convergence towards a broad spectrum approach, which seeks an integration of activities in the area of maternal and child health, nutrition, education and family planning to lower the rate of population growth. Some countries had aimed at such an integration even in the early 1960s or earlier when official family planning programmes were first promoted in the most populous countries such as India.

The table below provides selected examples of this broad spectrum or integrated approach.

Summary of the key targets of selected ESCAP countries with respect to population variables

Country	*Year of adoption*	*Major target(s)*
Bangladesh	1978	The policy envisages a net reproduction rate of unity by 1990 and an average growth rate of 1.5 per cent over the period 1978-2000. The total fertility rate is to be reduced from 6.2 during 1977-1978 to 5.6 by 1980 to ensure better health for women and children. Population control and the family planning programme are to be made an integral part of social mobilization and national development efforts with maternal and child health and nutrition integrated into family planning services, liberalization of the abortion law and raising of the minimum age at marriage for females to 18-20 years and for males to 26-28 years.
China	1980	(a) To stabilize the total population at 1,200 million by the year 2000. (b) As a means to achieve (a), to encourage one child families, with two children as the maximum, and to eliminate the third and higher parity births. (c) Incentives to the only children and their families. (d) The Government guarantees the five basic needs of "food, clothing, shelter, medical care and decent burial" to widowed, the child-

Country	*Year of adoption*	*Major target(s)*
		less and the old people as well as orphans; but old age social security measures need to be devised.
Fiji	1981	The eighth development plan (1981-1985) has set the target of reducing the birth rate (from about 28 in 1981) to 25 by 1985 with a view to improving national and community health and family care. Efforts to improve primary health care services will cover nutrition, environmental sanitation/ waste disposal, family planning, control of communicable diseases and chronic disabilities immunization, appropriate health care, essential drugs and health education. The number of acceptors of family planning is to be increased by 40 per cent. The seventh plan (1976-1980) sought to limit growth rate to 2 per cent along with a reduction in emigration (to stem the outflow of skilled personnel).
India	1980	(a) A long-range goal of a net reproduction rate of unity for the country as an average by 1996 and for all its states by 2001 from the present level of 1.67. (b) To lower the vital rates as follows between 1978 and 2001: Birth rate: from 33 to 21. Death rate: from 15 to 9. Infant mortality: from 129 to 60 or less. (c) To increase the contraceptive practice rate from 22 to 60 per cent. (d) To stabilize the population at 1,200 million by the year 2050. The family planning programme would be integrated with the health care programme (with the objective of health for all by the year 2000, and the minimum needs programme.
Indonesia	1974	The long-term policy to reduce the birth rate to "at least half of the present level" (of between 40 and 49 per 1000) "within a period of 25 years" mainly through the implementation of the family planning programme, but also through "integrated efforts" to reduce the birth rate and the development programme.
Kiribati	1979	The 1979-1982 Development Plan seeks, as one of its major objectives, to maintain a balance between population and natural resources due to the special geographical circumstances of the islands which impose limits on the population that can be accommodated.
Malaysia		The goal is to reduce the birth rate in peninsular Malaysia from 29.0 in 1980 to 26.0 in 1985. With the death rate expected to remain stable at 6, the growth rate would to decline rom 2.6 per cent during 1971-1980 to 2.0 per cent. A small decline in fertility is expected also in Sabah and Sarawak. The programme seeks to improve family planning services, strengthen family health care and nutrition.
Pakistan	1978	To reduce the growth rate from 2.98 per cent in 1977-1978 to 2.53 per cent in 1982-1983, with a faster decline in the birth rate than that in the death rate. The birth rate would drop from 43.6 in 1977-1978 to 35.5 in 1982-1983 and the TFR from 6.75 to 5.00; the contraceptive practice rate would rise from 6.0 to 15.4 per cent. The population planning programme would be merged with the health system, with emphasis on information, education and communication activities, expansion of female education and literacy (particularly among females) and a lowering of infant and child mortality.

Country	*Year of adoption*	*Major target(s)*
Philippines	1978	The goal is to lower the growth rate from 2.6 per cent in 1976 to 2.4 per cent in 1980 and 2.1 per cent in 1987. The crude birth rate should decline from 37 in 1976 to 34 in 1980 and 30 in 1987, faster than the death rate. Family planning is integrated with programmes in health, education, social welfare, and community development and the clinic-oriented approach has been replaced by a community-based approach.
Republic of Korea	1981	The fifth five-year plan aims at a birth rate of 22.1 in 1986, compared to 23.4 in 1980 (and 43.0 in 1960). The post-Korean War baby boom cohorts will enter reproductive ages during 1982-1986. Sterilization services will be expanded. The Korea Institute for Population and Health will retain health centre workers and family planning field workers as multi-service workers. Medical specialists will be mobilized for family planning by exempting their service fees from income taxes. Birth control devices and the supply distribution system will be improved. Institutional rearrangement in favour of the status of women, adoption of children and old age security will be considered to transform the traditional value system. Emigration will be encouraged to increase the outflow by 5 per cent per year from 43,000 in 1982 to reduce the net growth of population by 6.3 per cent in 1982 and 7.2 per cent in 1986.
Thailand	1981	The aim is to accelerate the reduction of the growth rate from 2.1 per cent in 1981 to 1.5 per cent by 1985 through increasing the role of the private sector, clear delegation of family planning activities between private and public sectors, mobilization of international co-operation and with emphasis on the impact of population distribution pattern on the environment and the distribution of available services.
Viet Nam		The objective is to reduce the growth rate from an estimated 2.23 per cent to 1.7 per cent by 1985.

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