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FAMILY PLANNING PROGRAM EFFECTIVENESS IN ASIA

EVALUATION FINDINGS FROM 1976 TO 1980

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Bangladesh - BP

Indonesia - in 1978-80 summaries

Nepal orig in Resource Ctr

Pakistan

Philippines - In 1978-80 IS

Thailand - in 1978-80, plus separate  
FY 1981

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Prepared by Jinny Sewell with the assistance of Barbara Pillsbury  
AID Asia Bureau, Office of Development Planning, Evaluation Division  
December 1980

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From 1976 to present, nine major in-depth evaluations have been conducted of AID-supported family planning programs in Asia (see listing). It is the purpose of this overview to summarize the impacts of this multimillion dollar investment and to try to identify factors that explain the varying effectiveness of the programs that AID has been supporting. The impetus and underpinnings of this review derive from premises set forth in the report, "Study of Family Planning Program Effectiveness," by Steven W. Sinding (AID Program Evaluation Discussion Paper No. 5, April 1979). What is presented here is a partial, mid-course draft, the main portion of which was compiled by Jinny Sewell during a brief rotation in ASIA/DP/E; the Bangladesh section, taken from the draft of a December 1980 evaluation report, is yet to be finalized and the Philippine section is to be modified pending the results of yet another evaluation of that program, which is scheduled for January-February, 1981. Your comments and suggestions are welcomed.

Barbara Pillsbury  
 Acting Chief for Evaluation for Asia  
 1.21.81

## BANGLADESH

Overview. During the last eight years, the U.S. government, through AID, has obligated well over \$40 million toward helping Bangladesh bring its rapid population growth under control. Following AID's lead, other foreign donors have contributed yet another \$50 million or more to the effort. At a policy level, government commitment to lowering fertility is strong and the president's leadership and support is exemplary, straight-forward, and stated repeatedly in public.

Nevertheless, while some short-range achievements have been scored, investments have as yet failed to have the desired impact in lowering the growth rate. This raises very serious questions with regard to future investment in Bangladesh. Despite indications of demand -- desire on the part of individual Bangladeshis to limit their family size -- the government's family planning program has been relatively ineffective when compared to programs in other Asian countries. Yet, unless rapid population growth can be brought under control all other development efforts to benefit Bangladesh's very poor majority will have been in vain.

Demographic Crisis. Bangladesh faces a demographic crisis of greater magnitude than nearly any other country today. With a population that has more than doubled since 1951, Bangladesh has already become the eighth most populous country in the world. Its 90 million people, however, are crowded into a land area which is only the size of Wisconsin. The average life expectancy at birth among this largely malnourished, illiterate, rural population is only 46 years. Infant mortality hovers stubbornly around 150 per thousand live births; one out of every five children born dies before age five; approximately 27,000 women die in childbirth each year and another 8,000 from septic abortion. Ninety percent of the population is rural, 50 percent of rural dwellers are landless, and landlessness is increasing. Demand for labor has risen by only 1.2 percent per annum in recent years while the population has been growing at 2.8 percent.

U.S. Assistance to Date. U.S. support to family planning in what is now Bangladesh began with assistance during the 1960s to private voluntary organizations in East Pakistan. Assistance to Bangladesh itself began in 1972 shortly after independence and before the new government was able to recover from the ravages of war, famine, and natural disasters to launch its own population program. U.S. support has been in the form of 1) relief and rehabilitation funds administered by AID (1972-73); 2) bilateral assistance through USAID from 1973 to present (funds totaling \$40.9 million); 3) population intermediary organizations centrally-funded by AID/Washington; and 4) U.S. funding to multilateral organizations, notably the World Bank and the United Nations Fund for Population Activities, the two other major population program donors in Bangladesh.

AID Project Objectives. The stated purpose of AID's bilateral project of FY 1973-75 was "to help the BDG [Bangladesh government] make available basic contraceptives to as many eligible couples as possible and to institutionalize family planning delivery services on a national basis." Its longer-range goal was expressed as "1) to slow population growth by reducing fertility rates to replacement level with low birth and death rates in 30 years, or as soon thereafter as possible, and 2) to reduce the annual population growth rate from an estimated 3 percent to 2.8 percent over the [BDG's] five-year plan period ending June 1978."

The stated purpose of the bilateral project of FY 1976-80 has been "to develop a functioning national institutional structure providing family planning services and population/family planning information and education on a continuing basis to the people of Bangladesh." This project had a less specific goal, namely, "to reduce the rate of natural population growth as a critical factor in social and economic development."

AID Accomplishments. AID has been the principal donor of contraceptive supplies and of U.S. and third-country training for Bangladeshis. Under the first bilateral project, AID established an ample in-country supply and "pipeline" of contraceptive supplies as well as a contraceptive distribution system

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-- without which the BDG would not have been able to begin nationwide delivery of family planning services. This project also provided long-term academic training to 27 Bangladeshis and short-term training to another 167. At the same time, through its centrally-funded intermediary organizations, AID succeeded in launching an experimental community-based distribution project, research on the acceptability and effectiveness of various contraceptives under Bangladeshi conditions, and, most importantly, a commercial contraceptive sales network that has made pills and condoms readily available in thousands of small shops throughout the country. During the second project period, AID has continued to be the major provider of contraceptive supplies while providing standard-setting support for the nationwide introduction and provision of voluntary sterilization services and the launching of additional private-sector community-based distribution projects. Also during this time, USAID/Dacca initiated an innovative project to give Bangladesh's family planning field supervisors practical training in Indonesia. USAID/Dacca and AID/Washington's Office of Population have played crucial complementary roles in providing the above support.

AID is praised by Bangladeshis and other donor representatives for USAID/Dacca's competent and cooperative population officers, provision of contraceptives and medical kits, supporting participant training opportunities, and the ability to rapidly make available high-quality short-term consultants. AID is faulted for providing only the Norinyl brand of oral contraceptives (which is criticized nationwide for causing side-effects) and for impeding Bangladesh's attempts to meet the considerable demand for menstrual regulation (MR) services (which often serve as a means of introducing more effective contraception).

Effectiveness. The range of evidence establishes that AID has been an effective supporter of the Bangladesh population program even while it has been only partially successful in meeting its project objectives. A "functioning national institutional structure providing family planning services and population/family planning information and education on a continuing basis" has been established, but it has yet to begin to function effectively. While most personnel in the government program are in place, the 41,000 fieldworkers are typically poorly trained and not highly motivated in their work. Organizational issues stemming from the latest attempt to integrate the family planning and health systems will have to be resolved and the quality of fieldworker training and supervision vastly improved before either AID's project goals or those of the BDG will be met. Private voluntary organizations supported by AID have proven much more effective although among smaller target populations.

#### Major Recommendations for Immediate Consideration.

1. The USAID/Dacca plan to revise its assistance portfolio to give population planning first priority should be endorsed and vigorously supported by AID/Washington.
2. To effectively implement an expanded scope of family planning services delivery and "beyond family planning" measures, organizational and staffing changes should be made within USAID/Dacca. For greatest likelihood of effectiveness it is suggested that an Office of Population Planning be established headed by an Assistant Mission Director. Alternatively the Population Health, and Women's Division should become a Population Division, with all other activities undertaken only if they directly support the mission priority on reducing population growth.
3. Conditions precedent or covenants for the project agreement for the proposed new project should include (a) specification of minimal criteria for the BDG sterilization surveillance agreement. It is also suggested conditions or covenants include: (b) implementation of an emergency resupply action to bring contraceptive stock levels to at least three months' supply at all service sites before the next monsoon; (c) a requirement that voluntary organizations supported by USAID adopt "prevalence programming" as a basic target-setting and performance measurement tool; and (d) an understanding with the Ministry of Health and Population Control about filling key vacant positions, especially in logistics and training, according to an acceptable timetable.

BASIC PROGRAM IDENTIFICATION DATA

1. Country: Bangladesh
2. Bilateral project titles: "Bangladesh Population/Family Planning"
3. Bilateral project numbers: 388-11-580-0001 and 388-0001
4. Program implementation
  - a. First project agreement: FY 73
  - b. Final obligation: Ongoing
  - c. Final input delivery: Ongoing
5. Program funding:
  - a. A.I.D. bilateral funding \$40,900,000 (grant, FY 73-80)
  - b. Other major donors:
    - IBRD
    - UNFPA
  - c. Host country counterpart funds:
6. Mode of implementation:
  - a. Project Agreements between USAID/Dacca and Bangladesh Ministry of Health and Family Planning (v);
  - b. Centrally-funded agreements between AID/Washington (Office of Population) and selected population intermediaries;
  - c. Agreement between USAID/Dacca and Population Services International.
7. Previous evaluations and reviews:
  - a. Project Appraisal Report (PAR), June 27, 1975;
  - b. Project Appraisal Report (PAR), February 18, 1977;
  - c. "First Annual Joint BDG-USG Population/Family Planning Program Review, 17-18 February, 1977."
  - d. Project Evaluation Summary covering period 2/77 to 2/78.
8. Responsible mission officials
  - a. Mission directors: Anthony Schwarzwalder 1972-74, Joseph Toner 1974-79, Frank Kimball 1979-present;
  - b. Responsible project officers: Michael Jordan 1972-77, Dallas Voran 1973-77, Charles Guerney 1977-present, John Dumm 1977-present (all direct hire).
9. Host country exchange rates
  - a. Name of currency: Taka
  - b. Exchange rate at time of project: 15 taka = \$1

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## II. CONCLUSIONS AND RECOMMENDATIONS

The major findings and conclusions of the present evaluation are summarized here, each followed immediately, where appropriate, by one or more recommendations that derive from the respective conclusion or "finding." In Part V below, sections with corresponding headings present details upon which these findings and conclusions are based.\*

### MAJOR CONCLUSIONS AND RECOMMENDATIONS

1. Impact of the Bangladesh Program.\* Ultimately, a successful population program is one that produces a demographic impact (actual reduction in the population growth rate) leading thereafter to a socioeconomic impact (smaller families that are healthier and wealthier). In Bangladesh, the population and family planning program has not yet begun to have this demographic impact. Contraceptive use has increased, however, from approximately 8.3 percent of married couples of reproductive age in 1975-76 to about 13 to 14 percent at present, a rise of about 1.5 percentage points a year. The crude birth rate is estimated to have declined during this time from 47/1000 to about 44/1000 making for an estimated 2.4 million births averted during 1976-1980. It is reasonable to believe that the population and family planning program is one of the leading causes of the decline. Prevalence levels above 30 percent have been achieved by intensive community-based distribution projects, which demonstrates that much more can be accomplished with the right mix of inputs -- supervision, training, community participation, and commodity support.

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\*Throughout this report "program," when used without further specification, means the total effort in Bangladesh to reduce fertility through both governmental and non-governmental promotion of family planning as well as "beyond family planning" developmental activities such as female income-generating projects or integrated rural development schemes. Where reference is to the government (i.e., national) program per se, this will be made explicit.

2. Political Commitment of the Bangladesh Government. The commitment of the government of Bangladesh to a policy of energetic fertility control is strong and unequivocal at the pinnacle of government with President Ziaur Rahman forthrightly taking the lead in setting the tone for policy and exhorting the bureaucracy and citizenry to reduce fertility. This commitment is also pervasive within the Planning Commission where the need for unambiguous "population control" and ambitious targets to reduce fertility form a central part of the 1980-85 Five-Year Plan. Nevertheless, the well-articulated policy of the President has yet to be effectively acted on by the various parts of the bureaucracy charged with implementation.

Recommendation: USAID, the Embassy, and AID/Washington should continue to provide reinforcing support for senior policymakers in the Office of the President, the Planning Commission, and the Ministry of Health and Population Control in their efforts to maintain a strong fertility control policy and should strive to develop means to reward this commitment and especially its translation into action. In particular, USAID should consider offering technical assistance to the BDG in conceptualizing and implementing innovative measures in "beyond family planning."

3. Effectiveness of the BDG Program. The government program is still of limited effectiveness in promoting and delivering family planning services. In large part this is due to the general handicaps under which any national BDG program suffers: the grappling for a "right" path in the highly politicized environment of this nation only eight years old, over-centralized and administratively weak bureaucracies, the lack of a "serve-the-people" orientation among government workers, a weak physical infrastructure, traditional political patronage relationships, and a widespread fatalism among the peasantry expressed as "the will of Allah." In addition, the program has suffered from disruptions and staff disgruntlement through repeated reorganization. First

it was a "vertical" program, then integrated with health, then "dis-integrated," and now again reorganizing to become "integrated" once more. Despite this, it seems generally regarded as one of the most effective of all of the government's programs. A functioning national infrastructure providing family planning services and family planning information is now in place. What remains is to energize it.

4. Effectiveness of AID Support. While AID has not fully succeeded in meeting all its project goals and purposes, it has been effective in its provision of support. AID was the first donor to have a staff person working full-time on Bangladesh population problems (1972), to develop a major project in support of the national program (1973), and to supply contraceptives on a large scale (1973). AID is praised for having had competent Dacca-based population officers able to work effectively with both the Bangladeshis and other donor representatives. AID/Washington's Office of Population has also played an important role through its intermediaries and its reliable provision of contraceptives and medical supply kits as well as high-quality short-term technical advisors. AID efforts will not succeed in producing a demographic impact, however, until the BDC service delivery program becomes more effective or unless AID is able to channel resources in ways least likely to be thwarted by the lethargy and bottlenecks of the government program.

5. AID Funded Intermediary and Private Organizations. Achievements in the private sector by AID-funded U.S. intermediary and private organizations have been impressive and of a scale probably unmatched in any other AID-assisted country. The presence and roles of the intermediaries are well-accepted by the government and the people they serve. Their enhancement of community participation is exemplary; their service, standard-setting, training, and ability

to undertake innovative activities constitute an essential mix of actions highly complementary to government programs. Both USAID/Dacca and AID/Washington's Office of Population deserve high marks for their skillful and facilitative management of this important cluster of resources.

Recommendations: AID should continue to fund and guide private-sector organizations into areas that bolster the government program or where high prevalence rates (e.g. 25-40 percent) are likely to be achieved. All AID-funded organizations with community-based distribution programs should be required to adopt the "prevalence programming" tool (see below) as a measure of performance and goal setting. Assuming it proves workable, this experience should demonstrate applicability of prevalence programming to the government program and hasten its wider adoption.

USAID and AID/Washington should again explore with the Syntex Corporation the development of special packaging for both the "Maya" and low-dose "Ovacon" oral contraceptives supplied by AID through the Social Marketing Project.

6. USAID-Proposed Project for FY 81-83. The evaluation team endorses the new Project Paper and its assistance strategy for the period, FY 1981-83. Successful implementation, however, will require greater commitment and effort by both USAID/Dacca and AID/W than comparable projects in more rapidly modernizing countries (e.g., Thailand and the Philippines).

Recommendations: The evaluation team suggests the following be specifically addressed in the subsequent project agreement, either as covenants or as formal understandings within implementation letters:

- a) Minimal criteria for surveillance of voluntary sterilization activities including service standards and provisions to assure compliance;

b) Completion of an emergency contraceptive resupply action before the next monsoon;

c) That those NGOs/PVOs funded by USAID which service discrete geographic areas be required to implement the prevalence programming tool.

The team further suggests that AID tranche funds by year contingent upon successful implementation of the sterilization portion of the agreement. As stated elsewhere, the team believes it essential that the population staff be expanded with the recruitment of a public health physician being first priority.

#### OTHER CONCLUSIONS AND RECOMMENDATIONS

7. Population Growth and Fertility Reduction Goals. Virtually all development goals adopted by the BDG under President Zia are intentionally set perhaps unrealistically high, the belief being that this is necessary to energize people to bring about the progress that is realistically achievable. <sup>Thus</sup> The government's ambitious population growth reduction goals, desirable as they may be, are almost certain to be unachievable. However, in part because they are perceived to be unrealistic, service delivery staff tend to ignore them. Already field staff do not appear to take very seriously targets that have been assigned them. To the extent that actual economic planning and investment decisions are based on these unrealistic assumptions and projections of population change, serious misallocations of resources could result and the entire development planning mechanism could be distorted, proven faulty over time, and lose credibility.

Recommendation. USAID, in consort with other principal donors (especially the World Bank, the UNFPA, and the Asian Development Bank) should consider once again engaging in a dialogue with the BDG at appropriate senior levels of the Planning Commission, the Ministry of Health and Population Control, and the Office of the President to urge an overhaul and revision of growth rate goals, targets for program achievement, and future population size projections.

## INDONESIA

An AID funded evaluation of population activities in Indonesia, AID's Role in Indonesian Family Planning: A Case Study with General Lessons for Foreign Assistance by James R. Heiby, M.D., Gayle D. Ness, Ph.D., and Barbara L. K. Pillsbury, Ph.D. was submitted December 1979. The evaluation identified sources of strengths and sources of concern.

Findings perceived as sources of strengths will be incorporated into the three broad areas of political commitment and population policy, administrative capabilities, and socioeconomic and cultural factors recognized as determinants of family planning program effectiveness. Sources of concern will follow.

### FINDINGS

#### 1. Political Commitment and Population Policy

The Indonesian family planning program has been successful in large part because it has strong political support from a president and government unambiguously committed to fertility reduction as an integral part of overall national economic development. AID assistance has helped the program's personnel to sustain and even increase top-level political support by providing political leaders with low-cost program successes.

The Indonesian government's commitment to fertility reduction as an integral part of economic development reflects a set of dynamic conditions

that are the product primarily of internal sociopolitical developments interacting with worldwide forces. The specific form and content of the political commitment are purely Indonesian. There is little the United States did or could have done to bring about this initial set of conditions. Nevertheless, the character of AID assistance helped the Indonesian family planning personnel to sustain and even increase the political support of their national leaders.

The commitment to national economic development led quickly and directly to a commitment to public action for controlling population growth, and thus to support for family planning. As in the development commitment, words and actions have been consistent. President Suharto was one of the signers of the World Leaders Declaration on Population in 1968. He has emphasized the need for fertility limitation in each of the five-year guideline statements. In 1976 he opened the presidential office space to a BKKBN family planning display. The display is said to have been important in giving governors and other national elites a clear statement of the president's commitment to population control and, equally important, in showing the how they could carry out the president's wishes. Suharto has also been willing to respond to suggestions from central BKKBN personnel that he apply pressure upon specific governors in provinces where program progress is judged inadequate.

In all plans and government statements the link between economic development and family planning is explicit. For Indonesian development planners

every problem identified and every program planned is directly affected by rapid population growth. Problems are exacerbated and program costs mount rapidly given past and projected rates of population growth.

Translating words into actions, the government created the autonomous National Family Planning Coordination Board (BKKBN) reporting directly to the president with a program funded by domestic and foreign sources.

## 2. Administrative Capabilities

The National Family Planning Coordinating Board (BKKBN) is a semi-autonomous government board that reports directly to the president. Since its establishment by presidential decree in 1970, the BKKBN has been responsible for all government population activities. As its name implies, it functions primarily by directing resources to other agencies, such as the ministries of health, interior, and education. It is largely these agencies that actually implement the program.

Grant support permitted the government to develop a major family planning program at little cost to its other programs. Grant support has also provided greater flexibility. Loan negotiation is always a more time-consuming process involving the national planning agency, and agreements typically carry rigid specifications for use of funds. Indonesian family planning officers have often expressed frustration over the delays, complexity, and inflexibility they have experienced with other donors' loan arrangements. The availability of grant monies as well as the use of local costs programming, to move money rapidly -- in weeks

rather than months -- to provincial staff are two elements in the support AID has given to the Indonesian program.

Major AID and BKKBN decision-makers responsible for the program have been intently goal- and outcome-oriented and consistently emphasize that this firm commitment to goals demands flexibility in approaches. Activities are evaluated on the basis of the specific goal of fertility reduction, which is estimated directly or through careful use of surrogate measures.

By 1974 the national program had expanded to 2400 clinics on the islands of Java and Bali where two-thirds of Indonesia's population is concentrated. The computerized family planning data system that had been established two years earlier indicated a slowing of program growth. This apparently confirmed the fairly widespread impression that a clinic-based family planning program alone would not be able to achieve adequate population coverage, even with the assistance of nearly 7,000 full-time family planning field workers to carry on out-reach activities.

The BKKBN consequently instituted a number of experimental service delivery projects, the most successful of which was termed "village family planning." This has involved establishing contraceptive resupply posts operated by trained volunteers and administratively supported by the local clinic. Village family planning initiated a major new expansion of the program with the total number of contraceptive outlets increasing from 4,000 in 1975 to 75,000 at the time of this evaluation. This also changed the role of the family planning field worker who assumed much of

the responsibility for supervising the village volunteers. Since village family planning is a generic model rather than a detailed blueprint, the BKKBN was able to adapt it to a variety of different local circumstances.

Facilities established for the distribution of oral contraceptives appear adequately stocked and provincial personnel at all levels say they have never experienced shortages of oral contraceptives. Mission staff maintain that the large supply of oral contraceptives that AID/Washington's Office of Population recommended and made available in the early 1970s was an essential element in the rapid expansion of village family planning.

An important part of the supply success has been the BKKBN logistical system. This is an example of an important program element created with AID technical and financial assistance but now an independent Indonesian program activity. Because of this system contraceptive shortages have been infrequent in Java and Bali. More importantly the system appears capable of keeping up with the rapid increase in demand and extension of services now occurring in many parts of Indonesia's Outer Islands.

The logistical system includes effective linkages between the program's data system, warehousing, inventory systems and procurement procedures. The logistical system is divided into two components, however, one for consumables and one for equipment delivery.

AID spending for training Indonesians in population skills has been a major contribution to program success. Both in-country and U.S. training

have been used to reward BKKBN staff for good performance while building the technical capacity the program needs for self-sufficiency. U.S. training, particularly advanced degree programs, has been especially effective. Virtually all trainees have returned to Indonesia and now hold key positions in the BKKBN and other governmental agencies and academic institutions that support the population program.

A BKKBN deputy chairman terms his program's predominant philosophy as management by objective, an orientation consistently apparent in a variety of program contexts. The timeliness and completeness of the data system, for example, is the result not only of a practical design but also of a program-wide, ongoing goal of maintaining an effective system. These data are regarded as essential for outcome-oriented management; budgets, supervision, public recognition, and training all appear to be linked primarily to performance, as expressed in contraceptive use, rather than to friendship, political influence, or any other arbitrary formula.

A family planning program works primarily by creating a distribution network, with contact points at which contraceptives can be supplied to users. Contraceptive use produces a demographic impact by reducing fertility. The Indonesian family planning program has been highly successful on all counts -- establishing contact points, recruiting contraceptive users, and reducing fertility.

### 3. Socioeconomic and Cultural Factors

By comparative standards Indonesia has not, or not yet fully, reached levels of socioeconomic development at which fertility is thought to

decline rather automatically. The country is poor, with a per capita gross national product of only about \$200. Life is precarious; infant mortality rates vary from 100 to 150. The population is about 80 percent rural with about two-thirds of the labor force engaged in agriculture. It is also conservative in its adherence to Islam, Hinduism, and local tradition. This is not the general set of conditions believed to precipitate fertility decline.

But Indonesia has not stood still in the past generation. The independence that was proclaimed in 1945 brought the changes that most developing nations have experienced. Indonesia's new government initiated efforts to provide schools and health services to the population. Literacy rates now stand at 75 percent and primary school attendance at about 50 to 60 percent of the school-aged population. Health services have gradually expanded, bringing the overall death rate down to about 14 per 1,000. Government development efforts have been erratic since independence, but more concerted and sustained in the past decade, bringing per capita growth rates to above 5 percent per annum, however unevenly the growth may have been distributed. Although the country is not, and may never be, self-sufficient in foodstuffs, rice production has risen and yields are now near three tons per hectare, the highest in Southeast Asia.

The Indonesian slogan, "unity in diversity," is not a hyperbole. The nation's one thousand inhabited islands are commonly said to contain more than 300 different ethnic groups, each ordered by one of at least 19 systems of local customary law (adat), each with its own pride and identity, and most with their own languages or dialects. Overwhelmingly

Muslim, Indonesia also has other active and cohesive religious groups and Islam itself is differently interpreted throughout the archipelago. The majority of ethnic groups are patrilineal but there are also major groups following strong matrilineal codes.

An underlying Malayo-Polynesian culture that is shared with the rest of Southeast Asia, the years of Dutch colonialism, and the three decades of independent government attempts to foster a national unity have produced some conditions more or less common throughout the nation. Four seem of special relevance here: traditional values surrounding reproduction, Islam, the traditional position of women, and community solidarity.

As in all agrarian societies, Indonesia's people have numerous indigenous means of fertility regulation, but place much greater emphasis on reproduction than on limitation. A conventional Batak blessing is "May you bear 17 sons and 16 daughters." Women gain status by producing children. A childless union is considered the fault of the woman, and justifies the husband taking another wife. Young married women are pressured by family and friends to produce a well-rounded family, which traditionally meant at least four children.

When the national family planning program began in Indonesia, there was a certain amount of free-floating fear that family planning might be against Islam. This in fact is not true, and eminent Muslim authorities from Cairo to Jakarta have made explicit pronouncements asserting that

the Quran itself supports family planning as a means of assuring that all God's children will be cared for. Islamic leaders are among the members of provincial and lower level family planning coordinating teams and in many rural communities the local religious leader serves as the village family planning post leader (petugas pos K.B.).

The position of women in Indonesia as well as throughout Southeast Asia is one of active involvement in village economic and public life. Although there is some agreement that women are more oriented toward children and men toward public roles, sex-role differentiation is not rigid and women are by no means secluded as they are in other Islamic nations. Traditionally women have played important economic roles, especially in marketing and controlling household finances, and there is extensive female ownership of property. Engagement in many public activities ties women into social networks through which information, such as on family planning, travels rapidly. The government has also organized women's clubs at the village level, which have been used effectively in the family planning program.

Finally, there exists throughout Indonesia a strong cultural tradition of "mutual assistance for self help," or gotong royong. Local communities frequently act collectively, both for routine cooperative tasks and for emergencies. Thus the village is an accepted arena for mobilizing human resources -- for motivating people and organizing them for action. This tradition of local mobilization has been used with great astuteness

by the national family planning program in making family planning the modern thing to do.

### SOURCES OF CONCERN

While the evaluation did not make specific recommendations, five sources of concern were identified:

- . Organizational Memory
- . Urban Program Failure
- . Geographic Expansion to the Outer Islands
- . Expansion of Scope: Nutrition and Health
- . USAID - BKKBN Relations

#### 1. Organizational Memory

The mission's office faced (at the time of the evaluation) the imminent prospect of an 80 percent reduction in its memory. Staff turnover implies a reduction from over seven years to less than two years in direct personal experience with the Indonesian program. Despite extensive routine documentation over the years, retrieving information about the past decade of AID population assistance to Indonesia is difficult. A system of brief annual reports might provide an organizational memory that could transcend the personal memories of staff and thus be less subject to the fluctuations that occur with turnover.

Annual reports by each office, which would provide summaries of major activities, problems, plans, and yearly expenditure levels, could provide

the mission with substantial organizational memory. If the reports are simple and brief they need not be costly. They would induce officers to take stock of plans and progress in a systematic, periodic fashion and provide new appointees with a ready access to some of the more important events in the history of their office.

## 2. Urban Program Failure

Family planning program services have not been effectively extended to the country's urban areas, particularly Jakarta. Extending effective services, especially to the urban poor, poses a serious problem for BKKBN and for AID support. The considerable family planning success in Java and Bali has occurred largely in rural areas. It has not yet been possible to adapt the successful village family planning strategy to the cities and especially not to servicing the urban poor. Unless effective means are found to reach the urban populations there will be a growing service gap that will be costly in both human welfare and social tension. Much of the service gap appears concentrated in Jakarta, whose five million people constitute about 20 percent of Indonesia's entire urban population. Effective attention to the Jakarta problem could provide both a pilot for other urban programs and a substantial solution to the overall problem.

## 3. Geographic Expansion to the Outer Islands

Family planning success has been largely confined to Java and Bali where program activities have been concentrated until only recently. The 50 million people in Indonesia's Outer Islands have a low level of contraceptive

use (less than 10 percent of fertile age women) and are widely scattered and ill-served by basic health and communication infrastructures. Extending family planning services to the outer Islands constitutes a major, immediate challenge for the national program and for AID assistance.

The problems ahead are formidable. With less than 10 percent contraceptive prevalence and with population growth at about 2.4 percent per year there is much to be done in basic service provision. Outer Island prevalence rates are about the same as on Java when the program began there. Nevertheless, with the other islands' low population densities, widely scattered settlements and poorly developed health and transportation infrastructure, the monetary costs and organizational demands will be immense.

#### 4. Expansion of Scope: Nutrition and Health

Family planning success in Java and Bali has led to an expanded scope for the program, adding nutrition and health activities to the family planning service delivery system. The rationale for this expansion is sound but the expansion itself will pose serious problems. Management, technical capacity, logistics, and the data system will require sensitive adjustment to meet the needs of the new activities without simultaneously weakening the family planning services.

Family planning workers must be trained in nutrition and health; new logistical problems will arise in the movement of foodstuffs, medicines,

and additional equipment; the data system must be extended to include additional forms of information; and management will be faced with new problems of integrating a larger number of activities under one structure. The BKKBN is aware of these problems and is moving to address them through field experiemnts. However, current plans for rapid extension to broader coverage will constitute a major challenge for both BKKBN and AID.

#### 5. USAID-BKKBN Relations

Relations between BKKBN and the USAID mission have been very fruitful to date. BKKBN's major reorganization, the current increase of other foreign donor funding, and the very success of the program, however, may pose problems for continuing collaboration.

The successful AID support of Indonesian family planning has been based upon highly collaborative relationships between USAID and BKKBN personnel. Several new and pending conditions may challenge the future of this relationship. The BKKBN has (at the time of the evaluation) undergone a major reorganization and expansion of top-level professional staff and its chairman has recently been appointed Minister of Health. The full import of these changes was not yet clear, but it will undoubtedly present USAID staff with both new opportunities and new problems.

Both the IBRD and the UNFPA have greatly increased their financial commitments to the Indonesian program. This promises expanded resources

to the program, yet it also greatly increases BKKBN administrative work. Even now BKKBN staff express frustration over the complex, intricate, and different accounting demands of these two major donors and the former is already experiencing difficulty in disbursing its obligations to Indonesia. It is unclear how this will affect BKKBN's need for USAID financial and technical assistance.

The Indonesian Family Planning Program is widely recognized as one of the most successful family planning programs in the world.

There is no single secret to the Indonesian success. What can be observed is the convergence of a number of possibly fortuitous and certainly advantageous conditions. Many of these conditions are distinctly Indonesian and certainly their convergence at this time is unique. Some of the conditions are diffuse throughout Indonesian society, while others are more specific to the family planning program. The precise relative importance of these conditions is difficult to determine.

Population growth and socioeconomic development have produced powerful forces for fertility limitation in Indonesia. The diffuse political culture and specific political commitments to economic development, family planning and administrative reform have produced an important Indonesian readiness and ability for collective action in fertility limitation. These conditions created a favorable climate for donor support to Indonesian population activities to which USAID responded effectively.

NEPAL

AID-funded population activities in Nepal were evaluated during the period January 26-March 26, 1980 and are reported in Evaluation of Two AID-Financed Health and Family Projects in Nepal by Robert Y. Grant and F. Curtiss Swezy,

The report conveniently lays out a series of paired findings and recommendations related to:

- . USAID/Nepal financed Health and Population Family Planning Projects
- . The Demographic Setting
- . National Population and Health Policy
- . The Nepal Context
- . Service Delivery
- . Financing of Programs
- . Program Supply and Logistics
- . Technical Assistance
- . Program Staff Development and Training
- . Non-Government Service Delivery
- . Population Growth

The report's executive summary is presented here as it relates to the three determinants of family planning program effectiveness (that is, political commitment, administrative capability, and socioeconomic and cultural factors). Findings and recommendations follow.

EXECUTIVE SUMMARY

1. Political Commitment and Population Policy

The fact that new health and family planning service delivery systems are in place in Nepal is noteworthy, given conditions in the country. Nepal is one of the least developed countries in the world. It began the development process less than 30 years ago. For 100 years, it was ruled by a government that proscribed mass education, did not build roads, did not develop a health delivery system. There was virtually no administrative structure. The country has few resources, its transport services and communications facilities are rudimentary, and the terrain difficult. Still, Nepal is striving to become a viable nation. The international community is assisting in the effort, but Nepal's absorptive capacity is sorely taxed. To add to the many difficulties, Nepal's ecological and demographic problems are becoming critical.

The population of Nepal is not only large in absolute terms; the rate of growth (2.6 percent annually) has soared to the highest point in Nepal's history. Population density per cultivatable hectare exceeds that of Pakistan, Bangladesh, and India. Economic growth (3 percent annually) barely exceeds population growth. Many sectors of the society have seen their standard of living decline; health services cannot keep pace, and social unrest is increasing. If population growth is not checked, HMG's development effort will have been in vain.

Until recently, Nepal has been able to cope with its expanding population through migration to the Terai (the lowland area bordering northern India). But most of the arable land in the Terai is now under cultivation and the area is densely populated. Migration to the Terai is no longer an attractive option.

The King and senior officials have stated publicly that HMG is committed to controlling population growth. Few in Nepal's traditional society have, however, accepted the concept of family planning or are willing to limit the size of their families. Firm national population goals and targets were established when the Fifth Five-Year Plan (1975-1980) was implemented, and a National Commission on population was created in July 1978. (The Commission is not yet functioning.)

Population concerns have been expressed in the statement of principles for the Sixth Five-Year Plan (1980-1985), but these principles have yet to be translated into a comprehensive program to stem rising population growth.

A specific policy on population growth in Nepal did not appear as a development goal until the Fourth Plan (1970-1975). The First Plan concern with population involved only employment. The Second Plan also covered employment and stressed resettlement in the Terai to deal with population growth. (This was recommended in the First Plan.) The Third Plan contained a chapter on population and manpower but did not address the problems stemming from population-related objectives: the effective use of manpower resources and control of population growth. The need for changes in economic and social conditions and for a family planning program were recognized.

Goals and priorities for health and population for the Fifth Plan period were specific. At this time, the Government of Nepal adopted a policy to deliver at least minimum health services to a maximum number of people. Among the specific health priorities were the following:

- Develop integrated basic health services to provide these to villagers as soon as possible.
- Operate countrywide the Family Planning/Maternal and Child Health Program to control population growth and to balance economic development.
- Strengthen and expand the programs to eradicate and control communicable diseases (malaria, smallpox, tuberculosis, and leprosy).
- Strengthen, develop, and expand curative services.

As for population concerns, the Fifth Plan (1975-1980) went well beyond what had been included in previous plans. It recognized the adverse effects of population growth and migration and the need for effective policies for the use of manpower and to raise the standard of living. The objectives were to:

- Reduce the birth rate by direct and indirect methods. (The plan called for a reduction in the crude birth rate from 40/1,000 to 38/1,000; a reduction in infant mortality from 200/1,000 to 150/1,000; and an increase in the number of family planning users--from 90,000 (Nepal Fertility Survey) to 700,000.)
- Control in migration (minimize the role of foreigners).
- Regulate resettlement between the Hills and Terai and from rural to urban areas.
- Increase the population density of the Terai, especially the Western Terai, to achieve a rational distribution of the population.
- Promote regional development by establishing urban centers with modern facilities in selected areas.

A wide range of population problems was recognized. The plan covered the growth of school-age and working populations; population pressures on social services, housing, health, food, and agriculture; problems of economic growth exacerbated by population growth; high dependency ratios; and high population densities. Socioeconomic measures to reduce population growth, improve the provision of family planning services, and resettlement to relieve high-density areas were recommended. Specific programs to respond to the problems that had been identified were not included in

the plan. The Fifth Plan did call for the creation of a Population Policy Coordination Board (POPCOB). That agency was established under the National Planning Commission (NPC) in 1975 with financial assistance from USAID/N. It was charged with coordinating the population-related activities of the various ministries and with proposing ways to control population and achieve spatial distribution. By the end of 1977, it was apparent that POPCOB would not be able to meet its objectives.

*How much cost?*

In July 1978, HMG created the National Commission on Population (NCP). The NCP was to devise national population policies and programs and oversee their implementation. (A permanent executive director has not been appointed and the Commission has yet to begin its work, although frequent assurances have been given by top levels of Government that movement was about to begin.)

The first "modern medicine" hospital was established in Nepal at the turn of the century. By 1952, when Nepal overthrew the Ranas and began to move into the modern world, 33 hospitals, most of which were in the Kathmandu Valley, had been built, and 33 Nepali physicians (all trained outside Nepal) were delivering services. The Ministry of Health was created in 1956 under the First Five-Year Development Plan (1956-1961). The National Malaria Eradication Program began during the First Plan period; smallpox and leprosy control programs were initiated during the Second Plan period (1962-1965). In the Third Plan period (1966-1970), the first national health survey was made. The first steps toward tuberculosis control were taken and the Family Planning/Maternal and Child Health Program was initiated. By the end of the Third Plan period

(1970), 37 hospitals and nine health posts (peripheral service centers) had been built, and 248 physicians were delivering services.

HMG recognized the desirability of providing more community-oriented health services and incorporated into the proposals for the Fourth Plan (1970-1975) the concept of integrated basic health services. Pilot integration projects were launched in 1971 and 1972 in two districts, Kaski, in the mid-mountain area, and Bara, in the Terai. By the beginning of the Fifth Plan (1975), the Government decided to create a national Integrated Health Service (later called the Integrated Community Health Service) using elements of the pilot projects in the system design. (This decision was not based on an analysis of the pilot projects, "proving" that integration was the best solution to delivering health services throughout Nepal.)

By the beginning of the Fifth Plan period, 62 hospitals had been built, 301 health posts were operating, and 311 physicians were available to the health system. The FP/MCH Project had expanded to 62 districts and was operating largely through static "clinics." (The term "clinic" refers to a service delivery point, and may or may not mean a clinic in the western sense of the word--a medical facility.) By 1975, the stage had been set for the implementation of HMG's Fifth Plan health and family planning programs (which covered many elements of maternal and child health, malaria eradication, leprosy, and tuberculosis control).

Health policy development from 1962 to 1975 was clearly related to the operationally-oriented health service expansion. Health posts were established, paramedical personnel trained, and specific single-service "vertical" programs implemented. These programs addressed high-priority health problems (family planning, smallpox, malaria, tuberculosis, and leprosy). The Fifth Plan included a policy statement on the Government's commitment to provide minimum health services to the maximum possible number of people, especially the rural majority.

The services seem to be lacking in quality, quantity, and assured availability, but they are being delivered. Medical supplies for health posts are a problem, sufficient for only three months of the year. Problems in management, supervision (especially at the field level), reporting, financial and accounting operations, supply and logistics, and training facility availability and staffing continue to plague the project.

Service delivery is hampered by construction and equipment problems. Most communities in the Middle Hills cannot be reached by car or truck. This makes the transport of building materials and equipment a major problem, regardless of resource availability.

The project's absorptive capacity is overtaxed. Few trained personnel are available. High schools and universities are not graduating sufficient numbers of students who can be given specialized training and be brought into the health system. The problem extends from low-level managers to physicians.

### 3. Socioeconomic and Cultural Factors

Nepal is among the poorest of the developing countries. The annual per capita income is approximately \$120. At least one-third of the population lives below the officially accepted minimum level of subsistence (\$60 per capita). Nepal's landlocked economy is strongly influenced by that of neighboring India, where inflation is accelerating. The expanding money supply (approximately 15 percent annually) and the increasing availability of domestic credit are expected to contribute to inflation in Nepal. Because of population growth, poor harvests, and inflation, no real economic growth took place in Nepal in 1979.

Given the 2.6% annual growth rate, Nepal's population is likely to increase from 14 million to 22 million by the year 2000. The cumulative fertility rate among Nepalese women,

6.1, translates into a completed family size of 4.0 children. Nepal has one of the highest infant mortality rates in Asia, 152 per thousand. Malaria, smallpox, and cholera are under control, even though the health delivery system is weak. But diarrhea, dysentery, respiratory diseases, and measles continue to be the principal causes of high morbidity and mortality. Nutritional levels are low, although 95% of the country subsists on agriculture; over one-third of the population exists below the minimum subsistence level. This low nutritional level accentuates every health problem.

Not surprisingly, children are important in this agriculturally-based country where land ownership is a mark of wealth.

The population is predominantly Hindu, and thus strongly pro-natalist. Children are not only important economically; they are also a measure of a woman's status.

The origin of many illnesses in Nepal can be traced to physical causes as well as to metaphysical and supernatural forces. Generally, villagers accept modern health care, though on their own terms. Modern medicine often is viewed as a prophylaxis, a charm to ward off the spirit world. Some villagers combine visits to a health post with visits to one of a variety of traditional healers, known collectively as dhami jhankri.

The introduction and acceptance of modern health care in Nepal society are hampered because there are too few qualified personnel in the system, medical supplies are inadequate (logistical problems often create shortages), and services at the health post are delivered on the basis of wealth and caste (the poorest and lowest caste receiving the least service last). This society is accustomed to paying the traditional healer for health service. It may view Government health services negatively simply because they are free.

### Findings and Recommendations

#### USAID/N Financed Health and Population/Family Planning Projects

- A. Finding: The goals of the two USAID/N financed projects for the most part have been met.
  
- B. Recommendation: USAID/N should continue to provide support to HMG's health and family planning/population activities. USAID/N should continue to coordinate its support with the contributions of other donors.

### The Demographic Setting

A. Finding: There is a demographic crisis in Nepal. The growth rate, 2.6 percent annually, is at the highest point in Nepal's history and is still climbing. Marginal land is being farmed and yields are dropping. Economic growth, approximately 3 percent annually, is barely holding its own. By any standard, the health situation is poor: life expectancy short, infant mortality high, and malnutrition widespread.

B. Recommendation: USAID/N should make sure that population concerns are addressed in all USAID/N-supported development projects. It should encourage HMG and other donors to address the population growth problem, as well as the health of the nation, in development projects.

### National Population and Health Policy

A. Finding: In the last 10 to 15 years, Nepal has developed a national policy to control population growth. The country also is determined to provide minimal basic health services to all through an integrated delivery system.

B. Recommendation: USAID/N should assist Nepal in its efforts to implement the stated policies. It should continue to encourage the Government to establish the Population Commission (POPCOM) as a fully operational agency. USAID/N also should continue to support HMG's efforts in health and family planning by channeling support through the

technical/administrative structures (i.e., FP/MCH and ICHP projects) established by the Government.

### The Nepal Context

A. Finding: Given the socio-political and cultural environment, development work is difficult and takes longer than in Nepal than in most other developing countries.

B. Recommendation: USAID should plan to provide more funds and technical assistance to support Nepal's health, family planning, and population programs than it usually provides to most developing countries. USAID/N should plan to contribute increased family planning and health program support to Nepal during the Sixth Plan and for another 10 to 15 years.

### Service Delivery

A. Finding: The health and family planning service delivery systems provide inadequate coverage and the quality of the services could be improved. However, the systems are expanding and reaching a steadily increasing proportion of the population. The number of family planning acceptors continues to rise.

The demographic impact of the family planning program is minimal. The health status of the population has not improved significantly, according to the data now available. These situations may reflect

inadequate reporting, inadequate supplies and inadequate management and staff skills and training.

B. Recommendation: USAID/N should continue to encourage HMG to increase health and family planning service availability, to improve the quality of the service delivered, to strengthen family planning motivation, to include more women in the service delivery system, and to increase its effort to retain family planning acceptors. Additional emphasis should be placed on strengthening the voluntary surgical contraception (VSC) service component of the family planning program, especially at static sites. Improved client follow-up should be stressed. Supervision, especially supervision of health-related activities, should be emphasized. Increased USAID/N support is strongly recommended.

#### Financing of Programs

A. Finding: HMG is contributing substantial financial support to health and family planning programs. Government support, especially for health service development, has been increasing. Donor support (both contributions in foreign exchange and in Rupees) has covered roughly 50 percent of total program costs. However, fewer funds than are required have been provided. Funds release difficulties have compounded the problem of insufficient support. The national expansion of health and family planning services to meet the country's requirements will place an almost intolerable financial burden on Nepal.

B. Recommendation: USAID/N should try to ensure that increased local currency support will be available for health and family planning service programs; it should encourage other donors to do the same. Efforts to improve financial administration and accounting should continue. Nepal should continue to review priorities when preparing five-year plans to ensure that sufficient financial resources are available.

#### Program Supply and Logistics

A. Finding: The supply of contraceptives, except injectables, for the family planning program is more than adequate, but there is a continuing and chronic shortage of medicines for the health delivery and MCH systems. Commodity management, though poor, is improving. Transport availability has been inadequate in both programs. Commodity storage, training, and administration facilities do not meet program needs.

B. Recommendation: USAID/N, other donors and HMG, should seek ways to make more medicines available to the programs. USAID/N also should continue to provide assistance to HMG in improving commodity and logistics management.

#### Technical Assistance

A. Finding: USAID/N has provided strong technical assistance to HMG health and family planning agencies. Other donors also have provided such assistance. The USAID-financed University of California and Management Science for Health teams have been instrumental in the development of

family planning and health service organizations in Nepal. However, the service networks are weak technically and poorly managed, hampering efficient and effective service delivery. USAID/N health and family planning staff are effective. However, the staff appears to be too small to adequately supervise the contract teams or to monitor program surveillance.

B. Recommendation: USAID/N should contract for more technical assistance to help correct service delivery problems. A single institution with a strong institutional development bias (as opposed to a purely problem-solving function) should be selected to provide assistance. USAID/N should monitor contracts more closely and try to increase the number of staff in the health and family planning office.

#### Program Staff Development and Training

A. Finding: USAID/N and other donors have supported and encouraged Government efforts to train and develop service and management staff. Through contractors and directly, USAID/N has provided large-scale overseas technical training for program personnel. The USAID/N participant program has been instrumental in developing staff capability for the health and family planning service delivery programs. The returnee retention rate is high, and staff training is strongly emphasized. Nonetheless, both the number of staff trained and the skills acquired are inadequate and do not meet the programs' requirements.

B. Recommendations: USAID/N should continue to support participant training for health and family planning staff development. It should encourage and support HMG staff training efforts, and encourage other donors to assist the efforts.

Non-Government Service Delivery

A. Finding: Innovative, non-government service delivery modes, such as the AID/W-financed Commercial Retail Sales Project (a contraceptive distribution program), have made a unique contribution to the Nepal family planning program. The Nepal Family Planning Association (FPAN), (with support from the London-based International Planned Parenthood Federation -IPPF) pioneered the development of family planning programs and continues to play an important role. The FPAN is cooperating with the AID/W-financed Association for Voluntary Sterilization (AVS) on service expansion. Other foreign volunteer groups are making useful, innovative contributions to the health field. For example, one group is studying fee-for-service health care.

B. Recommendation: USAID/N should encourage HMG to allow non-government groups to enter the health and family planning service delivery fields. HMG should promote innovative service delivery and seek "beyond family planning" inputs. USAID/N should seek the resources needed to continue the CRS Project another two years. (Commercial viability should be de-emphasized.)

Population Growth

A. Finding: Although the Nepal Government has adopted a national policy to control population growth, it does not, the evaluation team believes, fully recognize the serious consequences of rapid increases in population. Neither HMG officials nor the Nepalese population at large seems to fully understand or be aware of the detrimental effects of rapid, unchecked population growth. (Some HMG officials do understand.)

B. Recommendation: USAID/N and other donors should encourage HMG to establish the Population Commission as a fully operational entity and to support its work.

Nepal has reached a critical point in its development in which population growth is sorely taxing its resources. An unusual set of circumstances related to terrain, economic, and cultural constraints have proven difficult in the implementation of the family planning program. HMG appears responsive to tackling its high growth rate through family planning efforts. A series of problems ranging from adequate personnel, equipment, service delivery infrastructure, transportation, and others confront the family planning program in Nepal. It will not be an easy task to seek appropriate solutions within the Nepal context, but it is a task in which AID should continue to provide assistance.

## PAKISTAN

The most recent AID-funded review of the population program in Pakistan was conducted in 1976 by Family Health Care, Inc. Their final report, A Review of Pakistan's Expanded Population Planning Program, was submitted in December, 1976.

Historically, the population program in Pakistan has somewhat of a dismal evolution based on project outcomes and program impact. A series of chronic problems seem to have plagued the program since the 1960s. Family Health Care concluded that the population planning program in Pakistan is not working. Findings presented appear to support this conclusion.

### FINDINGS

#### 1. Political Commitment and Population Policy

There has been little evidence to suggest the presence of a comprehensive government strategy to guide the magnitude of public investments necessary for implementing a coherent, fully accountable national population planning program in which the commitment of resources is consistent with the magnitude of the target to be achieved.

Policy guidance from high level government officials (then Prime Minister Bhutto) and on the ministry level have not been clear cut nor rapidly forthcoming. Federal capabilities to undertake a coherent social effort in a policy area which cuts across traditional institutional lines have

been weak, compounded by the inability to systemically address the complex and changing relationships between policy and implementation. Consequently, national goals set were overly ambitious, largely unattainable with the resources available, and inconsistent with the social norms of the target population.

Population goals have often been unrealistic in the Pakistan population program as evidenced by a sharp rise in unit costs while acceptance rates remained much the same over the years. Some basic assumptions regarding the necessity for a population program on a national scope, the demand for family planning, and appropriate mechanisms for family planning delivery may have been misjudged as mirrored by poor program outcomes.

Population program impact was equated with the number of couples reached through the Continuous Motivation Scheme (CMS), couple acceptance/user rates, as well as reduced trends in fertility. Assessments of population project achievements indicated that only a small percentage of couples were reached by the CMS, acceptor rates remained low, and fertility continued to be high. Evaluation findings related to program impact suggested that only 8% of the target group females were practicing family planning.

The population planning program has come to represent a very large share of the total Ministry of Health budget. Population planning and malaria

eradication took the lion's share of the budget for most of the period for 1965-70, leaving little else for the development of new health projects. This phenomenon has resulted in only an estimated 15% of Pakistan population being marginally covered by public health and primary health care; consequently infant mortality remains very high. The evaluation noted that while the population planning program's financial costs did not appear to be excessively high, the per unit costs is relatively high as judged by program outcomes. More important, perhaps, has been the tilt the program has given to the overall health infrastructure. Ironically, the program may well have slowed the creation of an adequate health infrastructure--one of the programs most urgently needed for population planning to succeed in Pakistan.

## 2. Administrative Capability

Planning and management capabilities at the federal, provincial, and district levels have been consistently weak in Pakistan. Problematic issues emerged in the areas of:

- . Service Delivery
- . Logistics/Supplies
- . Training
- . I E & C
- . Research
- . Demographic Measurement

a. Service Delivery

Ministry of Health (MOH) facilities tend to have scanty or non-existent family planning services. Yet, MOH Family Welfare Clinics (FWCs) serve as the primary field facility for the provision of family planning services. In some instances, FWCs also conflicted with services provided by other MOH facilities such as MCH centers, that are often located near FWCs. The Continuous Motivation Scheme (CMS), designed to insure that Field Motivation Teams (FMTs) visit 75% of all eligible couples three to four times each year for the purpose of contraceptive motivation and acceptance of family planning practices, served as a field referral system for FWCs. However, many FMT staff were young, unmarried individuals from urban areas that appeared as inappropriate role models to the target groups in the villages, and thus unable to reach the unrealistic goals of the CMS set by the GOP. The entire CMS required monumental financial supports that represented 55% of the total family planning budget (composed of GOP and donor funds), yet failed to significantly impact on contraceptive prevalence.

Sterilization, though at low levels, is increasing as a method of contraception; abortion is not yet acceptable, yet increased demands are being made upon the system for this service.

b. Logistics/Supplies

A transportation system to support a massive field program as well as a coordinated logistical system for the orderly flow of consumable contraceptives does not exist in Pakistan. Most MOH FWCs had moderate supplies

of contraceptives available with a need for additional supplies if inundation levels purposed as one project achievement were to be attained.

Contraceptive Sales Agents had varying amounts of contraceptive supplies on hand, with more severe shortages evident in rural areas. Due to cultural constraints, there was hesitancy to openly display contraceptives, with many shops having no display or identifying features indicating that contraceptives were available. Additionally, some reluctance was evidenced by pharmacies to sell contraceptives due to low profit margins. All of these combined factors tended to undermine the entire program since availability and accessibility of supplies is crucial for success.

c. Training

Chronic problems with inappropriate training and lack of materials for Family Welfare Center personnel as well as adequate field supervision persisted. Training of MOH personnel in family planning delivery seems to have contributed little to the provision of additional or upgraded family planning services through MOH facilities.

d. I E & C

There appeared to be adequate funding for the development and implementation of a communication strategy, yet there was a lack of management and technical expertise at the federal level to appropriately utilize available funding from donors. Communication strategies in Pakistan have tended to be poorly planned with little effort made to identify target groups

and tailor appropriate messages and delivery vehicles for a variety of audiences. There has been more emphasis on the use of mass media to the exclusion of other communication techniques such as interpersonal communication, community organization, and group dynamics. This focus indicated a misunderstanding of the special and limited utility of each approach that must be skillfully integrated into a communication program.

e. Research

There is a huge knowledge gap as concerns possible modes of intervention for family planning/fertility control in Pakistan. Much of what has been attempted in the past has demonstrated what does not work. The findings suggest that more effort should be directed toward research of innovative program and project approaches in rural Pakistan.

f. Demographic Measurement

It was difficult for the evaluation team to accurately measure program impact through acceptor rates and fertility trends. A lack of reliable data in Pakistan obscures Pakistan's true level of fertility as well as contraceptive prevalence. The registration system is recording only a small percentage of total vital events, with better recording occurring in urban rather than rural areas.

The World Fertility Survey for Pakistan released in 1976 provides the most comprehensive data presently available. An attempt was made to conduct a contraceptive prevalence survey in 1976 which was unsuccessful

due to political upheavals in the country at that time. Program statistics can be utilized to indicate number of contraceptive devices distributed and clients seen in health facilities for contraception, but again these may also be an inaccurate picture of the program impact.

### 3. Socioeconomic and Cultural Factors

The seven socioeconomic variables most powerfully associated with fertility decline of adult literacy, primary and secondary school enrollment, life expectancy, infant mortality, percentage of males in the nonagricultural labor force, GNP per capita, and percentage of population in cities of 100,000 and above all act adversely in the Pakistan situation. Literacy (20%) and school enrollment rates are low, life expectancy is only 48 years, infant mortality is high at 100-120/1000, 57.3% of the population are in the agriculture force, the GNP is \$130 and 70% of the population is rural. Although not addressed specifically in the evaluation, these are obvious retarding factors to fertility regulation. Family planning has had difficulty in gaining cultural acceptability in this Islamic state in which a significant portion of the female population remains in purdah. Lack of trained female health professionals to serve these women continues to retard cultural acceptability as well as create problems with regard to accessibility of services.

### RECOMMENDATIONS

Serious questions remain about the net value of the almost \$84 million public investment during 1965-75 and of the net effect of the estimated \$24.3 million investment for FY 76-77.

Family Health Care has made a series of recommendations seen as long-term goals rather than short-term changes to occur within months. As envisioned, these recommendations are considered to be interdependent variables in which acceptance or rejection of any will interplay and consequently influence the others. The following five recommendations were made in the evaluation.

1. The Role of the Prime Minister

Primary to the success of the population program in Pakistan is the strong support of the top government official who alone has the capacity to relate a multitude of issues to a set of reasonably coherent national policies. This authority can assist in the formulation of policies to insure inter-ministerial support and cooperation for reduced fertility and to create accountability throughout the government administrative structure for program compliance.

2. The Government of Pakistan's Population Planning Organization

Policy implementation for population planning should be organized around a Population Planning Coordination Council (PPCC) as an integral unit of the Federal Ministry of Planning, Finance, and Economic Affairs. Population planning policy would be established by an Advisory Council of federal and provincial authorities representing the interests of civil administration, health, education, agriculture, social welfare, information, and so on, plus representatives of the private and quasi-governmental sectors (e.g., health, social security agencies, industry, unions and concerned, respected citizens). The PPCC unit should be administered by an energetic

individual of significant esteem in society and of the highest managerial talent. The creation of such a planning body should provide stronger direction and impetus to the population movement from the setting of more realistic planning goals to coordinated and viable field implementation efforts.

3. The Population Planning Division in the Interim

Prior to the initiation of the PPCC, the currently existing structure of the Population Planning Division should take a number of actions to enhance its present capabilities.

- a. Management training programs and other types of staff development for various levels of workers.
- b. Coordination of the public and private sector.
- c. Examination of the feasibility of integration of existing health care facilities.
- d. Increase of staff at FWCs by at least worker.
- e. Provision for increased supervisory responsibility roles for program managers of FWC personnel.

- f. Strengthening of communication strategies through new leadership and further planning in all communication techniques,
- g. Increase in pilot project testing length prior to national implementation,
- h. Strengthening of the voluntary sterilization program for both males and females,
- i. Research regarding contraceptive preferences, and
- j. Creation of a wider dialogue and awareness in varying sectors of society to elicit a broader base of support for the family planning program in Pakistan.

As noted by Family Health Care, many of these recommendations for program strengthening have been made before but, due to the staggering growth rate in Pakistan, warrant immediate action by the GOP now.

#### 4. The Agency for International Development

Under the assumption that the government improves the population planning structure and operations, and that AID seeks a lower-profile assistance role in the program, Family Health Care recommended that the Agency consider the following future projects;

- a. Population Research and Development designed to enlist support from major employers village organizations, public and private research organizations, and others to develop and implement innovative programs to encourage small families.
- b. Population Management Services Project to increase the accessibility of family planning services through improved program management and logistics.
- c. Field projects that can be supported by excess PL 480 currencies (Mondale rupees) such as local procurement of equipment for sterilization procedures and compensation and local procurement of bicycles and motor vehicles to support field workers.

5. The Pakistani Donor Community: Future Foreign Assistance

To facilitate and maximize donor assistance a system of coordination should be established among the donor agencies. When each donor acts independently with the GGP there tends to be misinformation, competitiveness, and redundancy resulting in unnecessary burdens on the government. Alternatively, AID should take a decreasing leadership role while encouraging broader donor assistance to Pakistan's population planning program. By confining assistance to more specific activities, AID and the government can better engage in the collaborative design and review of critical segments of the program. AID's rights of overall program review would be minimized. Rights of specific project activity through mutual collaboration should be enhanced.

The need for immediate progress in reducing the rate of population growth is urgent and unquestioned; the probable consequences of Pakistan's population continuing to grow at the present rate are a persistent dilution of all economic advances and a constant pressure on the nation's food-producing capacity. Postponement and delay in achieving a reversal of fertility increases will bring closer the possibility that the expansion of the population will overwhelm its ability to support itself.

PHILIPPINES

Two recent evaluations have been carried out on AID-supported population activities in the Philippines. A Review of the Philippines Population Program conducted by Family Health Care, Inc. (FHC) submitted April 30, 1977 and Report on the Evaluation of the Population Planning II Program of the Philippine Population Planning Program (Operational Year One) jointly conducted by the Commission on Population, the National Economic and Development Authority and AID/W-USAID submitted in October 1978. The former report provides a more general view of the Philippines Population Program while the latter focuses more specifically on the functioning of one project component, Outreach. For purposes of this overview findings and recommendations of the two evaluations will be jointly synthesized.

FINDINGS

1. Political Commitment and Population Policy

The political situation in the Philippines is over-shadowed by martial law in which President Ferdinand E. Marcos provides sole leadership for the country. President Marcos supports a population program for the Philippines through low-key sanctioning of population activities in an attempt to lessen tension and opposition from the Catholic Church. The Catholic Church in the Philippines represents a strong political force within the country and will most likely continue to wield influence in the political arena. Thus, according to FHC, it appears reasonable to expect that President Marcos's current mode of support for population programs will remain much the same for the immediate future.

In the Philippines, the Population Commission (POPCOM) is charged with the coordination of a national population policy which is implemented by both central and local governmental units and private agencies. Initially, POPCOM conducted its programs primarily in urban areas (cities and small towns) through a clinic-based system. Between 1970 and 1973, acceptor rates continued to increase, then plateaued from 1974 until the time of these evaluations. The first attempt to move from passive recruitment to active recruitment of acceptors came with the hiring of part-time motivators under the Department of Health. Since this attempt met with only limited success in terms of increased acceptor rates, a new population program was initiated, entitled Project Outreach.

Government budgetary support of the population program began on a small scale within the program budgets of the line agencies in FY 69, but within five years had increased into annual budget obligations of almost \$9 million. Through FY 76 the Philippines government had contributed about 40% of the total financial cost of the population program, and it was funding 50% of program costs at the time of the project evaluation. Changing budgetary allocations and project design to include extensive outreach mirrors the evolution that the population program and its implementing agency, POPCOM, have undergone since 1970. The initiation of Project Outreach seemed to signal one of the more dramatic shifts in the program. Briefly, the outreach project is an effort to provide contraceptive techniques and sterilization services to a predominately rural population through the use of approximately 3,100 full-time motivators. Physicians are trained in sterilization procedures, and hospitals and

clinics are equipped to support the clinical aspects of the program. The major outcomes of this program are projected upon the basis that:

- a. Local government units will implement a centrally funded program, with the requirement that the former cost-share, on an increasing basis throughout the life of the program, with the latter.
- b. Outreach will contribute substantially toward the national reduction of the current growth rate in the Philippines by an average of one-tenth of one percent annually for the life of the program.
- c. The primary target population of the program is in rural areas, and full-time staff can be effective in motivating this group toward acceptance of family planning concepts.

With the initiation of this project came a considerable dissent within the government as to the organizational processes and structures requisite for the achievement of outreach purposes. Therefore, a population policy which previously received widespread strong governmental support and commitment moved toward uncertainty within the Philippine setting.

The POPCOM Board claimed that the acceptance of the Outreach Project came without the Board fully understanding its intent and scope for implementation. Thus, there is an impression gained that the POPCOM

Board views the Outreach Project more as an AID imposed population program rather than truly a POPCOM-sponsored program supported through AID funding. This was reflected in the lack of coordination between POPCOM and other governmental agencies at the central level on down to the local level where implementation occurred. Thus, there was an absence of program acceptance and accountability on many levels.

2. Administrative Capabilities

a. Service Delivery

Services in early 1972 were directed toward urban and semi-urban people. The Outreach Project and its development of Barangay Supply Posts have provided corrective action for this deficiency. Utilization of paraprofessionals to dispense contraceptives has greatly increased the availability and accessibility to the general populus, especially in more rural areas. Sterilization continued to gain greater acceptance. Clinical services in urban and semi-urban areas were not well dispersed, and in some cases these services were duplicative of other efforts.

b. Logistics and Supplies

At the time of these evaluations in-country supplies of contraceptives were more than adequate at all levels; a considerable amount were stocked in Manila. Although the program made various methods of contraceptives available, multiple brands (of orals in particular) that appeared to be in demand at the Barangay Supply Post were not supplied.

POPCOM's ability to ensure timely delivery of supplies appeared limited to the distribution of contraceptives; its slow distribution of medical kits to physicians trained in surgical contraception and to hospital-based clinics constrained progress in the sterilization process. The Outreach logistics plan warranted review of the Full Time Outreach Workers (FTOWS) role in the distribution chain. Initially, there were problems noted in delays in payment of salaries and travel for FTOWs, but this appeared to have been improving as of 1978. The lack of sufficient, reliable transport in the field is a potential constraint on implementation of the Outreach Project.

c. Training

Training emerged as a significant need for:

- . outreach workers
- . clinical services personnel
- . local officials

Outreach training tended to be too theoretical and too brief in family planning specifics of contraceptive techniques, human sexuality, and family planning management. Clinical training was needed to increase or upgrade skills of practitioners in both sterilization and IUD insertion. And lastly, local officials expressed a desire for training beyond the one-day orientation seminars that POPCOM had conducted. Provincial officials specifically identified the need for more knowledge about family planning/population planning and its role in economic growth and development.

d. IE & C

While IE&C capabilities vary from region to region, non-availability of the regional level funds seriously hampered IE&C activities in planning, developing, producing, and distributing materials to support program needs. Survey data indicated that enormous gains have been made in educating and informing, particularly the urban and semi-urban middle and upper classes; yet they substantiate that a considerable deficiency in family planning knowledge and attitudes existed among certain population segments in those living in remote rural areas with less education and lower literacy. As the entire program entered a rural orientation, the need emerged for a new rural focus to the IE&C written materials and mass media campaign.

e. Research

At the regional level, there was increased awareness about the need for operations research types of activities to support program implementation. Small scale research activities were being undertaken by the Regional Population Offices and/or research institutions contracted for this purpose. This was indicative that regional capabilities, including the presence of regional and provincial research institutions, were getting stronger.

f. Demographic Measurement

A Management Information System provided national data for the population program. However, the quality of this system was questionable according to both evaluations. Additionally, training at all levels and secure control of the system needed to be implemented to provide a more functional and reliable system.

### 3. Socioeconomic and Cultural Factors

The Philippine socioeconomic determinants appear generally positive as reflected through high literacy (87%) and school enrollment rates. The GNP is \$410. As in most Asian countries, the majority (70%) of the population reside in rural areas. Life expectancy is 60 years. Infant mortality rates of 74/1000 seem high.

However, cultural factors have an adverse effect on the positive impact of these determinants. Catholicism, in particular, serves as a powerful deterrent to family planning progress.

### RECOMMENDATIONS

The following recommendations are a composite of the two evaluations of AID population activities in the Philippines.

1. POPCOM/Policy. As the implementing arm of the government for population policy, POPCOM needs to examine alternative methods to improve population policy formulation by the POPCOM Board, and to consider broadening the Board membership to include the Department of Local Government and Community Development and the Department of Labor.
2. POPCOM Linkages. POPCOM should reexamine its organizational links to the President and other governmental agencies, providing clarity of roles for planning and implementation efforts, especially for local political officials.

3. Political/Financial Support. The inability or lack of will of local officials to pick up program costs must be recognized and a realistic financial plan must be established to provide for GOP assumption of costs. POPCOM's Board should communicate to the highest political level the need for sustained political and financial support for the program, and the need to develop a realistic financial plan.
4. Staff Vacancies. POPCOM should take necessary measures to fill the many existing staff vacancies ASAP with competent personnel. Given the low salaries in POPCOM, a survey should be carried out to determine appropriate salary levels and make adjustments as needed.
5. Planning. There should be better bottom up planning in order to create a more realistic planning and target-setting process. This requires clarification of lines of authority and areas of responsibility between POPCOM/Central and the Regional Population Offices. It also requires the strengthening of the planning capabilities at both levels.
6. Consultants. Experienced management consultants should be contracted by POPCOM on a short-term basis if necessary, to address pressing management needs (including a policies and procedures manual, logistics, and sterilization training/certification coordination).
7. Operations Research. POPCOM/Central should provide the direction for Operations Research, strengthen Central and regional capabilities to meet the growing demand for operations research activities, and coordinate with the regional staffs in order to assure the program relevance of the research.

8. Outreach Project. Since it was too early to clearly determine program impact of outreach, it was recommended that outreach continue and that the design and implementation of the project should not substantively changed.
9. Training. Full Time Outreach Workers (FTOWs) were found to be inadequately trained. Areas where FTOWs required additional skills were in family planning (especially contraceptive techniques, human sexuality, and family planning program management). Additionally, Barangay Supply Point Officers should receive formal training to equip them with the necessary skills for family planning motivation and promotion.
10. IE&C. Funding for both personnel and materials should be increased to promote capabilities at both Central and Regional population office levels. More current and appropriate materials should be produced for rural audiences, especially on side effects of oral contraceptives.
11. Paramedicals. Clarify, through written directives from the Department of Health, the use of trained paramedicals and lay-persons in the distribution of oral contraceptives.
12. Logistics System. Program logistics must be strengthened. For this it is necessary that outreach workers receive their salaries and travel allowances on time and have more adequate transportation. This may necessitate purchase of additional vehicles and provision of additional brands of contraceptives (that may be recommended as a result of preference research).

13. Data Collection. Improve data collection mechanisms through:
  - Training necessary people to improve the timeliness and accuracy of the Management Information System.
  - Encouraging NCSO to prepare computer user files from its 1970 and 1975 censuses and to also include questions on contraceptive prevalence in NCSO quarterly household surveys.
  
14. Voluntary Sterilization. Expedite payment of current VS reimbursements. Review subsidies to determine possible increased reimbursement levels. Modify VS consent form to allow the MOH National Family Planning Office to certify procedures performed in MOH-NFPO hospitals and clinics.
  
15. Cultural Factors. Recognize the possible dissent emerging from the Catholic Church, and consider the establishment of continuous dialogues with church leaders to avoid misinterpretation of new program initiatives.
  
16. Meetings. Resume the convening of regular meetings between POPCOM and USAID to discuss program progress and the resolution of specific problems.
  
17. Funding. Review funding requirements for OY 3 by POPCOM and USAID to avoid short term funding short-falls.
  
18. BSPO. Conduct incentives study to determine if Barangay Supply Point Officers should receive incentives, and if so, at what level.

The Philippines has not achieved the more dramatic results of the population programs undertaken in Indonesia or Thailand, creating an even more urgent need for continuing support. Since it was too early at the time of the recent evaluation to determine any significant impact of the Outreach Project, the evaluators felt that further implementation was necessary before a full and fair assessment of the project could be undertaken. In general strengthening at all project level from POPCOM policy to the provincial level for implementation purposes was seen as critical to program success.

THAILAND

Three evaluations have been conducted of the Thailand National Family Planning Program, with the most recent report, Third Evaluation of the Thailand National Family Planning Program submitted in February 1980 by joint Thai-American evaluation team. Three other reports, "CPBPs in Thailand: A Community Based Approach to Family Planning" (July, 1978), "The Community-Based Family Planning Services Family Planning Health and Hygiene (FPHH) Project" (February 1979) and "Report to Trip to Thailand, Assessment of Family Planning Health and Hygiene Project" (February 1980) that assessed the Mechai program were also reviewed. For the purpose of this review more emphasis was given to the government sponsored National Family Planning Program which is AID funded.

FINDINGS

1. Political Commitment and Population Policy

Thailand has a constitutional monarchy with the Prime Minister as the head of state. The King, however, provides guidance and advice. A highly centralized system of territorial administration prevails and is organized into Changwads (provinces), Amphoes (districts), Tambol (sub-districts), and Mubans (villages).

Attempts at democratic government have been short-lived, whereas authoritarian ruling bodies have remained in power for most of the life span of Thai political history. The Thai political system is characterized by a noninstitutionalized pattern of change that has traditionally been

brought about by the ruling class. In all political change, however, the bureaucracy has remained as the backbone in the implementation of all government policy; it has thus become predominantly powerful in the Thai society.

Throughout the first half of this century, the Royal Thai Government (RTG) continually upheld a policy encouraging large families and a high rate of population growth. However, like many other countries, Thailand faced the problem of an accelerating population growth rate and decline in mortality, primarily as a result of improved health standards and services. It was not until 1958, when a World Bank Economic Mission first pointed out the implications of rapid population growth in Thailand's development efforts, that the RTG started to review its existing population policy. A number of studies were undertaken during the period 1959-1967, with no immediate population policy taken by the RTG. Despite the lukewarm support of the RTG for family planning, the Ministry of Public Health (MOPH) commenced a pilot project in 1964 and started providing family planning services in 1968. At this time, Thailand's King, who is greatly revered, provided strong support for the family planning program, lending great credence and continuity to the program. It is somewhat unique that while Thailand has undergone a series of governmental changes over the years, the King remains as a constant figure which the people look to for guidance. This support lent itself to the formulation of the National Population Policy by the RTG in 1970. As a result, the National Population Policy Committee (NPPC) was established for planning and coordinating policies on family planning. To strengthen the role of

family planning services, the MOPH was made responsible for implementing this newly approved policy, and the Family Health Project was retitled the National Family Planning Program (NFPP). In 1974, the National Family Planning Coordinating Committee (NFPPC) was set up to replace NPPC and it has been functioning since that time. The NFPPC's functions encompass the supervision and coordination of family planning programs and population activities of various agencies.

The Population Policy of 1970, a complete reversal of an earlier policy for large families, took many years to evolve, but now seems to have achieved and maintained full governmental support of all successive governments since 1970.

## 2. Administrative Capabilities

### A. Service Delivery

In 1965 family planning services were added to selected facilities of the Ministry of Public Health (MOPH). From 1968 to 1970, family planning was a low key activity, operating without public information support, without full time family planning workers, and without incentives. Since the declaration of the 1970 National Population Program the MOPH took a key role in implementing family planning policy in the country. Traditionally, the MOPH is one of the weakest and least influential ministries in government. However, the Thai MOPH appears to be an exception in that it is one of the most influential ministries, receives

significant recognition and, more importantly, substantial budgetary allocations. Leadership within the MOPH for family planning has been consistent, dedicated, energetic and dynamic. Financial resources and leadership have facilitated the evolution of one of the most effective population programs in Asia. The program has achieved involvement of health personnel at all levels in family planning.

Family planning services were successfully integrated with MCH from the program onset. Para professionals have been effectively utilized in family planning tasks such as dispensing of contraceptives to insertion of IUDs by nurses. Widespread availability of contraceptives has been instrumental in program success. Pilot projects have been undertaken to test and then, if appropriate, integrate innovative family planning delivery systems. Vehicles and equipment, often a critical missing link in family planning programs, have been available at the provincial and local level for program implementation.

Aside from the government's implementation of family planning efforts through the MOPH, a significant private sector exists in Thailand for the promotion of family planning. Most notable is the Community Based Family Planning Services started by Mechai. This project has served as a complement to the government's program by successfully targeting more rural areas than commonly served by MOPH facilities. This program has had exceptional leadership through Mechai as well as the management and functional supports necessary at the field level to implement the program.

B. Logistics and Supplies

Program supports critical to the family planning program such as supplies and transportation for field personnel has been given priority by the RTG. Supply amount and distribution has been substantial and well coordinated. An extensive network of transportation and communications exists. These inputs have generated support for program implementation, particularly from the field, where adequate supplies of contraceptives and mechanisms for distribution encourage the staff to give full support and effort for the program.

C. Training

Training in the family planning program is an on-going process for workers from high level officials downward to field implementation staff. The training division of the Family Health Division is responsible for carrying out all training endeavors. As noted in the 1977 evaluation this department was understaffed and not capable of carrying out all the training requested. Since 1977, the training staff has increased from 22 to 40 persons. In general, the training department continues to do an excellent job. Its greatest weakness is the supervision of regional trainers, once the training of trainers courses are completed. There is a move to decentralize training so that more training is carried out in the field at various levels. This seems appropriate. There are some inherent weaknesses in this approach, however, since there is little control on the implementation of training, especially at lower levels.

D. IE&C

The IE&C unit has concentrated its efforts in disseminating family planning knowledge through a variety of vehicles of written literature, audio-visuals and personal communication from field workers. Thus far, the efforts have concentrated almost exclusively on information giving. Problems have been encountered with the use of inappropriate materials that tended not to fully enhance the information or was not used at all by field workers. Some materials were either too technical, too frightening for the lay individual, or too embarrassing.

E. Research

Research of innovative programming goes on in both the public and private sector. The MOPH has supported various pilot projects through the years and will continue to do so. The CBFPS has tried various innovative approaches on a pilot basis throughout its program history.

F. Demographic Measurement

The infrastructure for demographic measurement seems reliable and well established in Thailand. However, measurement of program impact tended to be largely statistical rather than a more critical analysis of population as it related to over-all development efforts and subsequent socioeconomic improvements.

### 3. Socioeconomic and Cultural Factors

The socioeconomic picture in Thailand is fairly supportive of family planning efforts. Adult literacy is 79%, primary school enrollment rates are high at 58%, while tending to be much lower at the secondary level of 22%. The GNP is \$420. As with many other Asian countries the majority of the population, 87%, remains concentrated in rural areas. The one most discouraging figure is infant mortality of 68/1000 which is still relatively high.

More than 90% of the population are Buddhist. The Buddhist temple has normally been the center of all important village activities and the influence of Buddhism upon the Thai way of life and mode of thought is predominant and profound. Buddhism is not opposed to birth control. An old Buddhist proverb even says, "Too much births cause suffering. There is therefore no conflict between religious and cultural beliefs and family planning concepts and practices.

### RECOMMENDATIONS

A series of recommendations were made as a result of the 1977 evaluation. Most were acted upon by 1978, with only the following three still to be implemented at the time of the 1978 report:

Recommendation: "Policies and Regulations which are still in conflict with the national population policy should be reviewed and revised by the NFPP with the appropriate RTG agency."

Agencies with a more indirect relationship to the NFPP may be inhibiting the wide distribution of contraceptives through their policies and regulations. Serious discussion needs to occur among agencies involved in the importing, manufacture, and distribution of contraceptives to correct conflicting policies and regulations.

Recommendation: "There should be more frequent meetings of the NFPP committee as well as the NFPP coordinating subcommittee."

In view of the rapid changes taking place in the program as well as in the country's demographic situation as a whole, meetings should be held at least four times per year.

Subcommittees (Research and Private Sector Coordination) are now appointed and expected to meet on a monthly basis.

Recommendation: "A comprehensive operational planning process should be adopted by the NFPP."

The NFPP does not function in isolation. An overall operational plan, phased appropriately with the plans of the other related agencies is necessary to achieve better coordination among specific projects as well as between the NFPP and other administrative entities.

Further recommendations for program improvement were made in the 1978 evaluation in the area of General Recommendations, Information Education and Communication, Training, Voluntary Surgical Contraception and Evaluation and Research.

A. General

1. The NFPP should continue to focus its efforts on all regions of the country, including Bangkok.
2. The NFPP should give priority to those geographic areas and segments of the population where family planning acceptance is low and/or availability of information and services are not fully developed.
3. Targets should be set in terms of a combination of new and continuing acceptors in the next five-year plan. (With emphasis on percent of eligible couples practicing contraceptives.)
4. Greater emphasis should be given to management and supervision at the village and health center levels.
5. The international donor community should give full recognition to the necessity of maintaining a level of direct support for the NFPP to assist the RTG in achieving the goals of the Fifth National Economic and Social Development Plan (1982-1986).

**B. Information Education and Communication**

1. IE and C activities of the NFPP should be extended from the present emphasis on providing information to an approach which combines information-giving with a focus on interpersonal communication and assistance in decision making.
2. Health education provided in context of primary health care services should include family planning related IE&C.

**C. Training**

1. There should be more emphasis on training of at least one supervisor at the provincial level in proper procedures for reporting service statistics. This person should ensure that persons in charge of service statistics at all service units are properly trained in reporting and recording procedures.
2. The training department of the Family Health Division should undertake operations research on the effectiveness of its various programs, especially those for lower level paramedical personnel, i.e., TBA's, Tambol Doctors, etc.
3. The Family Health Division, Training Division, and the Rural Health Division of MOPH should coordinate their training courses, materials, and other efforts in order to maximize effectiveness.

4. Formal training in the theory, practice and planning of health education should be assured for all personnel responsible for health education in the expanded rural health and family planning delivery network.

D. Voluntary Surgical Contraception

1. The RTG and international donor agencies should continue to support each component of the present packages of combined public and private sector activities in the field of voluntary sterilization. Moreover, given anticipated higher annual VSC acceptance in the 1980s, the levels of total support should be increased.
2. The subsidy to health facilities for Voluntary Surgical Sterilization should be continued, as well as a subsidy differential between urban and rural sterilizations. The subsidy for both male and female sterilization should be the same. Hence, the additional subsidy for vasectomies beyond the target should be dropped.

E. Evaluation and Research

1. Frequent assessment of fertility and contraceptive prevalence should continue to be made and greater attention be given to dissemination of the findings.

2. Evaluation of the impact of the NFPP should be extended from a largely demographic focus to an analysis of its micro- and macro-level effects on the quality of life in Thailand.
3. The impact of the NFPP on the health status of the people should be investigated. Specifically, the effort on maternal and infant mortality and morbidity attributable to alterations in fertility resulting from family planning practice should be ascertained.
4. The evaluation team supported the MOPH policy of carrying out pilot projects in order to determine the use of various categories of non-physician personnel in the delivery of certain family planning services. The team recommended that pilot projects be continued and that careful selection of trainees in reasonable numbers and adequate precautions regarding supervision and medical consultation be given high priority.

In addition to these recommendations made for the National Population Program a series of similar recommendations were also made for the Community Based Family Planning Service, a non-governmental program which is the other most significant program in family planning in Thailand. These recommendations originate from the report, "The Community-Based Family Planning Services Family Planning Health & Hygiene (FPHH) Project" by Bruce D. Carlson and Malcolm Potts (February 1979).

Recommendations:

1. The RTG and USAID should continue support to CBFPS for operations research on the cost-effectiveness of variations in family planning delivery systems.
2. The RTG and CBFPS should identify and discuss alternative ways in which the CBFPS can best complement the government's existing and planned family planning services, particularly the Village Health Volunteer (VHV) program.
3. Projects involving simple health care and family planning should deal with each type of service on a separate analytical basis unless documentation is provided which demonstrates that any component of health care when linked with family planning services will increase the acceptance of contraception and voluntary sterilization.
4. The CBFPS, in consultation with the Project Review Committee, should continue to modify the FPHH contraceptive delivery and operations research strategy through pilot testing to determine the most appropriate supervisory and logistical systems for CBFPS to adopt in order to complement the RTG program in simple health care and family planning.

5. The FPHH and former IPPF project review steering committees should be combined. The new Committee should meet at least twice per year to review progress reports and set guidelines and be charged with the responsibility of establishing liaison with a representative of the Ministry's Population Project.
6. The supply of additional family planning methods appropriate for extending the pregnancy interval, including attention to the selection of appropriate steroids for women who are lactating, should be made available.
7. CBFPS village distributors should be more effectively used as referral agents for voluntary sterilization.
8. The CBFPS should explore ways, under the guidance of the RTG, in which the private sector can complement the government's voluntary sterilization services, particularly with respect to male sterilization.
9. The RTG should use the experience of CBFPS to complement government family planning activities throughout the country by developing a network, particularly among village shopkeepers, to widen the mix of contraceptive services to that portion of the population who can, or prefer, to pay.

Thailand's family planning program has achieved its targeted goal to reduce its growth rate from 3.0 in 1970 to a projected 2.1 by 1981. While the success in reaching the targeted reduction in the growth rate is to be commended, it is necessary to keep in mind that a growth rate of 2.0 percent is still rapid and would lead to a doubling of the population within 35 years if not reduced further.