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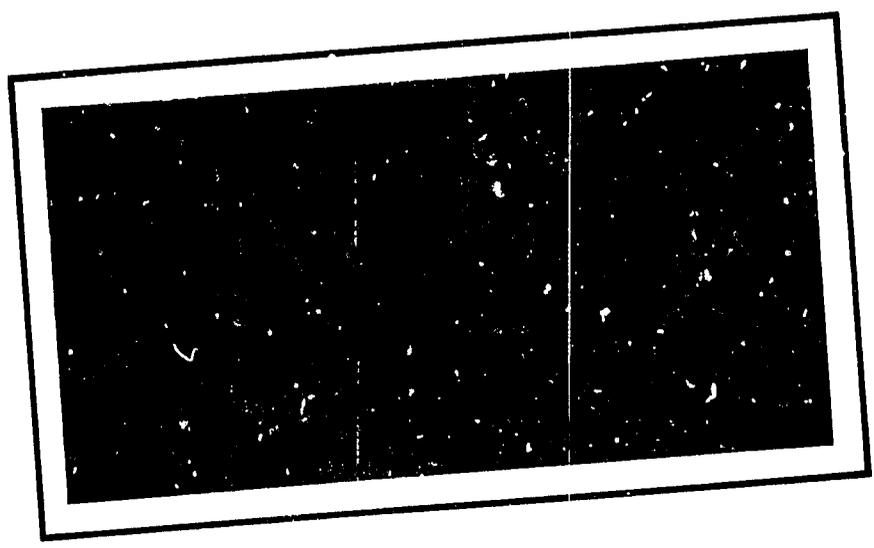
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EXCHANGE OF EXPERIENCE THROUGH A  
WORKSHOP ON ENCOURAGEMENT, IDENTIFICATION  
AND EXTENSION OF INNOVATIONS IN FAMILY  
PLANNING PROGRAMS

A Report Prepared By:  
Pi-Chao Chen, Ph.D.

During The Period:  
SEPTEMBER 11-23, 1978

Under The Auspices Of The:  
AMERICAN PUBLIC HEALTH ASSOCIATION

Supported By The  
U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT  
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## Background

At the request of Dr. L. S. Sodhy, Secretary General of I.G.C.C., Kuala Lumpur, Malaysia, I prepared an Aide Memoire some time ago, outlining the rationale and objectives of a workshop to exchange innovative experiences for the family planning administrators in the Southeast Asian region. On the basis of this Memoire, the I.G.C.C. and the I.P.P.F. decided to co-sponsor a workshop at Jakarta, Indonesia, September 13th through 15th, inviting selected family planning administrators and researchers in the region to participate. The sponsors also extended an invitation to me to deliver a keynote speech and present a paper on the Chinese innovative measures in family planning. Under the auspices of the APHA, I undertook a trip in September to participate in the workshop.

## Scope of Assignment

In the letter of authorization dated August 29, and signed by Ms. Suzanne Olds, it was stated that my assignment consisted of two related parts: (1) act as a resource person to deliver the keynote address; present a paper on "Innovative Measures Carried Out by the Chinese Family Planning Programme" (that is, the Chinese experience); assist the Rapporteur-General to draft the Summary of Discussion and Recommendation; and (2) assist on behalf of I.G.C.C. to draft the final Report after the workshop.

## Assignment Carried Out

I left the States on September 9th, and arrived at Jakarta in the afternoon of September 11th. On September 12th, I participated in the Steering Committee meeting convened to finalize the agenda for the workshop. On September 13th, the workshop began, and lasted until September 15th. It was held at Hotel Hyatt Aryadut, Jakarta. For the details of the workshop, please refer to the workshop agenda, a copy of which is enclosed. During the duration of the workshop, I carried out my responsibilities as stipulated in my letter of authorization. I assisted in finalizing the agenda; I delivered the keynote speech and presented a paper on the Chinese innovative experiences; and I also assisted the Rapporteur-General drafting the Summary of Discussion and final report. (For details please refer to my itinerary.)

## Expansion of Assignment

During the group discussions, held in the afternoon of September 14th, the participants dwelled at length on the community-based distribution scheme, and more or less reached a consensus that cbd was the in-thing, in whose

direction more and more organized family planning programs would have to move in the years to come. Among the participants there existed a great deal of intellectual confusion as to what cbd actually was or meant. Different participants used the same term to refer to different projects whose common denominator was delivery of family planning service outside of clinical channel. Many participants felt that it would be most desirable if some kind of conceptual clarification of cbd could be achieved and that someone would undertake steps to achieve it. Such an undertaking was believed to be a necessary first step to achieve a firmer intellectual grasp of cbd and would facilitate designing and managing cbd projects in the future.

In the light of this intellectual confusion about and intense interest in cbd, Dr. Sodhy asked me whether it would be possible for me to visit a few better known cbd programs in the ASEAN region and write a report as a follow-up to the workshop. Since I noticed in my letter of authorization that my assignment was made for "a period of 15 days beginning on or about September 9, 1978," and since I happened to have a week or so to spare, I agreed to his suggestion. Consequently, Dr. Sodhy, Dr. Haryono Suyono of Indonesian BKKBN, Professor Viton (from Bangkok), and I discussed and decided that I should make a trip to take a close look of the Village Contraceptive Distribution Center (VCDC) Scheme in West Java, the community-based distribution through the bandjur system in Bali, and the community-based distribution scheme implemented by the CBFPS in Thailand.

While in Jakarta, an official from the USAID Mission in Indonesia called me to confirm my arrival. (I cannot remember his last name, but vaguely remember his first name to be Philip. He said there was no need for me to report to his office. All he was concerned with was that I arrived in time and did not encounter any problems that required his Mission's assistance.)

On September 16th I set out for my journey that took me to Bandung in West Java, Bali, and Bangkok and other places in Thailand. For a brief summary of the places I visited and the persons I met and interviewed, please refer to my itinerary. On the basis of the field trip, I drew up a report entitled, "Toward a Typology of Community-based Family Planning," a copy of which is enclosed. I have forward a copy of the same report to Dr. Sodhy. It has been my understanding that this report will eventually be distributed to the workshop participants and those on the I.G.C.C. mailing list as a follow-up to the Jakarta workshop.

## Itinerary

- September 11, 1978: Arrived at Jakarta at 4:30 P.M.
- September 12, 1978: Attended the Steering Committee Meeting in the morning.
- September 13, 1978: Workshop began; presented the keynote speech; participated in the workshop.
- September 14, 1978: Workshop continued; presented "The Chinese Experience: Innovative Measures in the Chinese Program;" participated in the workshop; helped draft the final report.
- September 15, 1978: Workshop continued and concluded in late afternoon.
- September 16, 1978: Left for Bandung for a field visit to the West Java family planning program; briefed by Dr. Soemarno, Chairman of BKKBN of West Java Province; visited the family planning program at Desa Ciboda with Dr. Soemarno and Prof. Lopez.
- September 17, 1978: Further briefing and discussion with Dr. Soemarno, in the morning; left for Bali via Jakarta at noon.
- September 18, 1978: Visited Karagonsen, on the eastern tip of Bali accompanied by Mr. Gorde and Mrs. Wirati; briefing by Mr. Gorde and the chairman of BKKBN, Karagonsen regency.
- September 19, 1978: Briefed by Dr. Astawa, Chairman, the BKKBN of Bali Province; visited Kuta Health Center; briefed by the bidan in charge of the center; visited bandjur Seminyak, and briefed by its kelian on how he performed family planning program among the members of the bandjur.
- September 20, 1978: Left Bali for Bankok at 3:20; arrived at Bankok 11:00 P.M.
- September 21, 1978: Worked out itinerary with a staff at the CBFPS; visited Dr. Siam-tee Quah, Division of Population and Social Affairs, U.N. ESCAP; used the ESCAP Library file on CBD projects.

September 22, 1978:

Brief by Mechai of the CBFPS in the morning, with Asa and others visited Near Plub Wan (Village) in Choeburi Province in the afternoon; briefed by the village volunteer-distributor (an old traditional birth attendant).

September 23, 1978:

Further discussion and clarification with Mr. Asa Kanchanahoti in the morning; left Bangkok for London at 11:30 P.M.

## AIDE MEMOIRE

### JOINT IPPF/IGCC PROJECT ON EXCHANGE OF EXPERIENCE THROUGH A WORKSHOP ON ENCOURAGEMENT, IDENTIFICATION AND EXTENSION OF INNOVATIONS IN FAMILY PLANNING PROGRAMS

In all the IGCC countries (Indonesia, Malaysia, Nepal, Philippines, Singapore and Thailand) an official population programme is now part of each country's national socioeconomic development plan.

In the early 1950's, none of the IGCC countries' government policies exhibited so much as an anti-natalist stand. In fact, all family planning activities within these countries were initiated by private efforts whereby family planning associations were established.

In mid-1960's, when economic planning became central to national development, most of the governments of the IGCC member countries began to include population policy in their national development plans.

During the first decade, the family planning programme administrators in the IGCC region have learned much through trial and error. They have acquired an immense amount of valuable, practical experience on how to develop and manage programmes and improve their performance. Most would agree that existing programmes could be better managed and performance improved, primarily through extension of successful innovations. Much more can be done and programme efficiency can be improved, provided that there are fresh ideas and workable methods to translate them into concrete programmes.

The programme administrators, at various levels of government and private voluntary agencies in the IGCC region, possess an immense amount of intimate knowledge about their programmes. They often have insight into the strong as well as the weak points of those programmes. Probably more than any other personnel, including external advisers, they intuitively know what is wrong with the programme, what can be done to remedy it, what more can be done and how it should be done.

In spite of this, the personal experience and tacit knowledge possessed by programme administrators at various levels in the IGCC region have not been systematically tapped and used to improve programme management and performance. There are a number of reasons for this. For one, administrators or field workers, hard pressed by daily administrative tasks, seldom have the leisure or energy to write down their thoughts.

For another, they are seldom asked to do so. To the extent that they are consulted, more likely than not it is in the form of a long, structured questionnaire. While there are merits to the "objective" questionnaire, it tends to force the respondent to assume the frame of reference worked out by the designer of the form. To the extent that there are open-ended questions, the respondent is usually expected to answer in a few sentences; the findings from this source generally are subordinate to those derived from quantitative analysis or are presented as secondary findings calling for further investigations. In other words, personal experience and tacit knowledge are either subordinated to the "scientific" findings of the researchers or drowned in a sea of statistics and quantitative analysis.

Whatever the reason, this state of affairs is regrettable. The personal experience and tacit knowledge of programme administrators are a treasure house that, if properly systematized and utilized, could be of immense value in improving programme management and performance. Proven successful innovations developed by substantial units should be given greater attention and, if feasible, extended to a wider geographical area.

#### Objectives of the Conference

In view of the foregoing observations, the IGCC proposes to organize a workshop of administrators, government and private voluntary, in the IGCC region. This workshop will enable the administrators to exchange personal experience and tacit knowledge, and to learn from one another in the interest of improving programme management and performance. The proposed conference is not unorthodox at all. It is one of the fundamental tenets of "policy science," as opposed to "normal" (including behavioral) sciences, that efforts to distill the tacit knowledge of policy practitioners and to involve them as partners in theory building may yield potentially useful knowledge. Application of the useful knowledge thus derived should immensely improve programme management and performance.

The conference participants will be asked to address some or all of the following questions:

- (1) What are the specific programme inputs or measures in their own programmes, from the grass roots to the national levels, that need to be abandoned, changed, modified, replaced or improved? Why and how?
- (2) What are the additional inputs or measures that can and should be introduced into their own programme in view of political feasibility and socio-cultural environment? What probable results may be anticipated? What are potential limitations and difficulties?

- (3) What are the successful innovations developed by some of their subnational units that deserve more careful scrutiny with a view to extending them to a wider or national scale? Should they be extended more widely, what modifications or local adaptations are needed? What are the potential difficulties and limitations of widespread extension of innovations that originally worked well in one or several subnational units? How should such limitations or difficulties be overcome?
- (4) What successful innovations developed by their own programmes are worth more careful scrutiny and possible adaptation (not adoption) by other countries? What are the potential pitfalls of transferring and adapting such successful innovations? What are the initial difficulties they themselves encountered in evolving these successful measures? What advice do they have to others so that the latter may avoid the mistakes or minimize difficulties?

It is proposed that at least one participant from each participating country be asked to write a paper addressing some, but preferably all, of the general questions listed above. This should give each of the participating countries the opportunity to evaluate their own programmes, and to offer their strong points for consideration and adaptation by others. The paper must be prepared well ahead of the conference and be circulated among the participants in advance so that all participants will have ample time to read and reflect upon the issues and ideas raised.

#### Proposed Criteria for Choosing Conference Participants

It is proposed that one or, in some cases, two participants from each of the IGCC countries be invited to the conference. In making the final decision on the list of participants to be invited, the following criteria will be followed:

- (1) Middle or high echelon programme administrators or workers, with preference given to person(s) with community-level, especially grass roots, experience;
- (2) persons known for their administrative competence, managerial resourcefulness, creativity, and receptivity to new ideas;
- (3) persons who are in a position to put whatever useful knowledge they learn to effective use, with preference given to those who can induce the highest policy makers to let them try some new ideas or experiment with a pilot project or projects.

## Proposed Conference Procedure

Since the conference is designed to facilitate exchange of experience among the participating countries, it is proposed that maximal time be reserved for both formal and informal interchange of ideas and experience. Each of the paper writers will be given an opportunity to make a presentation. The purpose of this is not so much to let him repeat what he has already written in a systematic and much more detailed way, but rather, to give him an opportunity to recapitulate his most important thoughts and to clarify or elaborate on thoughts that occurred to him following the submission of the paper. Since social, economic, cultural and political conditions vary from one country to another, some of the excellent ideas or measures presented may not work in other countries. The participants will have plenty of opportunities to discuss the feasibility and possibility of transferring and adapting some of the measures in their own countries.

## Possible Follow-up

To encourage mutual learning through sharing of experiences and knowledge it would be extremely desirable to convene a follow-up conference six months or one year later if funds could be found for this purpose. At the follow-up conference, one participant from each country would talk about what they had done about the good ideas they picked up at the first conference, what local adaptation they had made, what difficulties they had encountered, how they managed to overcome them, and what advice they have to offer others.

JOINT IPPF/IGCC PROJECT ON EXCHANGE OF EXPERIENCE  
THROUGH A WORKSHOP ON ENCOURAGEMENT, IDENTIFICATION AND  
EXTENSION OF INNOVATIONS IN FAMILY PLANNING PROGRAMS

TENTATIVE AGENDA

11 SEPTEMBER 1978

Arrival to Jakarta of IGCC Secretariat Staff and all Resource Persons.

\*12 SEPTEMBER 1978

|                 |   |
|-----------------|---|
| 0900 - 1200 hrs | Steering Committee Meeting of Secretariat Staff and Resource Persons on the final arrangements for the 3-day proceedings. |
| 1200 - 1400     | LUNCH BREAK   |
| 1400            | Continue as above if necessary. Otherwise free.   |

13 SEPTEMBER 1978

|                 |  |
|-----------------|--|
| 0900 - 1000 hrs | (i) <u>Opening Address</u><br>By either the Indonesian Minister of Health or Assistant Minister of Health. |
|                 | (ii) <u>Introduction</u><br>By Dr. L. S. Sodhy   |
|                 | (iii) <u>Keynote Address</u><br>By Prof. Pi-Chao Chen  |
|                 | (iv) <u>Announcement of Chairman and Rapporteur-General</u>  |
| 1000 - 1300     | COFFEE/TEA BREAK   |

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\*Also arrival to Jakarta of all Participants.

1030 - 1200 hrs

Country Presentation

Indonesia  
Malaysia  
Nepal  
Philippines  
Singapore  
Thailand

1200 - 1400

LUNCH BREAK

1400 - 1730

Presentation and Discussions on Specific Topics  
by Resource Persons and Participants (Plenary)

- (i) Application of Commercial Resources as an Innovative Measure.  
To be presented by Mr. Manuel Ylanan.  
Discussions followed by Participants.
- (ii) Community-Based Program as an innovative measure.  
To be presented by Mr. Mechai Viravaidya. Discussion followed by Participants.

2000 hrs

DINNER

14 SEPTEMBER 1978

0900 - 1030 hrs

"Integration approach" towards Population/Family Planning Programs as an innovative measure.  
To be presented by Prof. Gayl D. Ness  
Discussions followed by Participants.

1030 - 1045

COFFEE/TEA BREAK

1045 - 1200

- (iv) The "China Experience in Population/Family Planning." A case study.  
To be presented by Prof. Pi-Chao Chen, U.S.A.  
Discussions followed by Participants.

1200 - 1400

LUNCH BREAK

1400 - 1730

Group Discussions

The group discussions will focus not only on the four (4) specific topics mentioned above; in addition, the group will:

- (i) Review the strength and weakness of their own Population/Family Planning Program.
- (ii) Exposure of any other innovative measures considered applicable to their own Population/Family Planning Programs.

2000 hrs

DINNER

15 SEPTEMBER 1978

|                 |  |
|-----------------|--|
| 1000 - 1030 hrs | <u>Presentation of Draft Plenary and Group Reports by the Rapporteur-General</u> |
| 1030 - 1045     | COFFEE/TEA BREAK   |
| 1045 - 1200     | As above (continue)  |
| 1200 - 1400     | LUNCH BREAK  |
| 1400            | FREE   |

16 SEPTEMBER 1978

Departure from Jakarta.

TOWARD A TYPOLOGY OF COMMUNITY-BASED DISTRIBUTION  
FAMILY PLANNING PROGRAMS

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# Toward a Typology of Community-Based Distribution

## Family Planning Programs

### Introduction

According to Rogers, the family planning programs in the developing nations have passed from a clinic era (up to 1965) to field era (between 1965 and 1970) to contemporary era (since 1970). An inadequate supply of contraceptive service was the main perceived constraint to greater program effectiveness; and inadequate contact of potential clients with family planning services the main constraint during the field era. During the contemporary era, the main constraint has been an inadequate demand for family planning service. An inadequate demand has been manifested in several forms: a small number of new acceptors; low current user rate; the KAP gap. While the specific situation varies, all the KAP gaps have the familiar pattern: the current user rate either reaches a plateau or fails to rise as rapidly or steadily as in the past, while the survey indicates that a substantial proportion of married fertile women indicate a desire to practice family planning or do not want any additional children. For example, in South Korea in early 1970 the current user rate was 35 percent. A sample survey, however, revealed that 30 percent of the married fertile women did not want any additional children but did not practice contraception. This KAP gap existed in a country generally recognized as having one of the most effective family planning programs in the Third World!

The existence of "inadequate demand" or "unmet demand" or "KAP gap" calls for solution if the fertility is to be reduced. The solution proposed by the experts varies, and the contents generally reflect the proponent's disciplinary background and ideological inclination. Some urge a policy designed to maximize the rate of socio-economic development in the belief that "the best contraceptive is development." Others believe a more equitable participation in the benefits of development, especially in the field of education, health and so on, is the solution. Still, others believe that better communication strategy and program redesign will do the job. A communication expert, Rogers, for instance, proposes that the main task of the contemporary era is to motivate the resistant audience (namely the married fertile women who constitute the majority of target population) to accept the small family norm, to adopt family planning by utilizing better communication strategy (e.g., deployment of an army of "change agent aides" to conduct

interpersonal communication), and by resorting to various "beyond-family-planning" approaches.

Still, there are others who believe that the problem of "unmet demand," or "KAP gap," can be better solved by improving the availability of contraceptive services. According to this school of thought, the persistence of "KAP gap" may be accounted for in terms of the barriers experienced by the non-acceptors, the majority of whom reside in remote isolated villages. Barriers cited are the time, effort, and cost required to reach family planning services; the inconvenience of limited opening hours, long queues, lengthy intake forms, unfriendly and non-courteous services and exclusion of certain types of services based on age/parity requirement, etc. If the barriers discourage or prevent the eligible women from stepping forward to receive service, the obvious solution is to remove them. And the concrete solution is to take the services to the clients (or potential clients) instead of waiting for them to come forward to the clinics for services.

In retrospect, out of the debate and search for solution that began in early 1970, and especially after the Buchrest, the school of thought that emphasizes improving the accessibility and quality of contraceptive services has won the day. It has captured the imagination and absorbed the energy of many innovative and energetic program managers throughout many parts of the Third World. One reason for its popularity is that, while the program manager may be receptive to the idea of accelerating socio-economic development and/or more equitable distribution of the benefits of development, he can do very little or nothing about them.

Beginning roughly in early 1970, one project after another, inspired by this school of thought, has made its appearance on the population planning scene. Some are called "community-based distribution;" others are called "depot holder system." Yet, other projects are referred to as "household distribution;" some as "household (or community saturation) model." Others are termed "social marketing" or "commercial distribution." Regardless of what they are called, all programs aim to maximize the accessibility of modern contraceptives in the belief that enhanced accessibility will increase the number of acceptors, raise the current user rate, and ultimately reduce fertility. All such programs have the following denominators: All utilize channels and/or social organizations other than the regular health system to make supplies and services widely and easily available to the clients and potential clients; all distributed contraceptives to men and women without required attendance at clinics; all distributed contraceptives free or at subsidized price.

For the purpose of our discussion, we shall call all such schemes or programs "Community-based distribution" or CBD.

Because the adoption and extension of CBD is within the financial and organizational capacity of the family planning

programs, and because many of them improve the sale/distribution of contraceptives and often the current user rate, we can expect its wider adoption or, or rather adaptation in the years ahead. There exist however, widespread intellectual confusion about the model due mainly to the conceptual ambiguity surrounding the model. CBD has meant different things to different people; different people have used the same term to refer to different projects which have no common denominators other than those referred to above. In view of its potential and the intellectual confusion, it may seem desirable to achieve a firmer intellectual grasp of the model. We propose to do this in this report.

### Definition of CBD

For the purpose of our discussion, we define CBD as "any scheme of family planning delivery system that distributes contraceptives free or sells them at a subsidized price through field workers or local grass roots depot holders without required client attendance at clinics." Needless to say, the model has many variations in terms of what contraceptives are offered, what types of persons are recruited to serve as distributors, what kind of training they receive, how they are assisted and supervised by the field workers, what responsibility other than distribution they are expected to perform, and how the clients are resupplied, etc.

With our definition the CBD model may subsume different programs ranging all the way from India's Nirodh program to China's three-tier integrated health care/birth planning delivery system.

### The Rationale and Advantages of CBD

Many experts have put forth the need for CBD approach by way of pointing to the existing barriers to wider acceptance of family planning. One of the best such attempts was done by Duff Gillespie. According to Gillespie, there exists four types of barriers:

Economic: (The cost of contraceptives can be a barrier to family planning practice, especially in the poor countries. Contraceptives should therefore be provided free.) This means that the person does not have to pay for contraceptives or fertility regulation procedures. They are free. Thus, persons outside the cash economy are not excluded from participation. Equally important, those in the cash economy with discretionary money do not have to choose between, for example, a pack of cigarettes and a pack of condoms. Lastly, availability is not influenced by negative changes in the individual's economic situation.

Administrative: There are numerous administrative barriers, which range from inconvenience to exclusion of the potential acceptors for nonmedical reasons. Examples of incon-

veniences are: limited opening hours, long queues, and lengthy intake forms. Examples of exclusion are age/parity requirements for certain methods. While it is utopian to believe that all administrative impediments can be done away with, they can be kept to a minimum.

Geographic: The time and effort required to reach family planning services can be a major barrier to acceptance of family planning. It is crucial that potential acceptors have easy physical access at least to nonclinical contraceptives.

Cognitive: It is assumed that there exists a demand for family planning among the vast majority of people living in the developing world and that this desire to limit family size could be better realized with availability of modern fertility regulation technology. People, however, need knowledge about such methods and how the distribution system works. By definition, effective participants in any system must have knowledge of how the system works.

Ideally, a perfect delivery system should remove all of the barriers, or at least minimize their impact. This is precisely what most CBD programs hope to achieve. While some, such as the Chinese program, attempt to remove all the barriers and more, others, such as the India Nirodh program, have a less ambitious goal. If the Chinese program may be termed a maximally feasible CBD program, the India Nirodh program may be called a minimally feasible program. The rest lie along the spectrum, somewhere in between, as we shall elaborate later.

Except for India's Nirodh program and Kenya's Kinga program, all other CBD programs recruit and train local villagers (who are usually influential or respected because of their occupation or status in the village) to serve as village depot holder or distributor. Assisted and supervised by the field workers, they distribute the oral pills (and sometimes condoms) to the fellow villagers, keep simple records, refer the I.U.D. and sterilization (and induced abortion where legal) cases to the nearest clinics, and do IEM work among the villagers on a casual or sustained basis, with or without the support of village leaders. By thus deploying the local residents as distributors, the CBD programs at once remove some of the barriers, referred to above, and enhance the effectiveness of the on-going family planning program.

1. Remove the geographical barrier. By bringing the service to the village instead of requiring the villagers to come to the clinic for service, the CBD program spares the villagers the time, money, and efforts (e.g., find someone to baby sit and cook the meal for the family). The convenience

and saving thus offered presumably would induce many a woman not strongly motivated to give family planning a try; they will also presumably sustain those discouraged by the inconvenience, cost and effort to continue the practice of family planning. In other words, the CBD program presumably reduces the motivation threshold for those women not strongly motivated to practice family planning, whatever the reason. Given strong motivation, as in Western Europe in the late 19th and early 20th century, the couple would practice whatever birth control method known to them in order to limit family size, irrespective of whether it was legal or illegal to do so. In the overwhelming majority of contemporary Third World countries, such strong motivation presumably does not exist, especially among the vast rural population. The convenience, saving, and effortlessness offered by the CBD program will go a long way to induce a substantial proportion of the target population to practice family planning.

2. Achieve greater communication effectiveness. The use of local villagers to do I.E.M. and distribution work, in effect, puts to practice the Rogerian theorem that using homophilous peers as achieves greater communication effectiveness when the innovation concerned is generally regarded as a taboo.

3. Amplify the program's effectiveness at lost cost. Under the field (extension) approach, the field workers are expected to do a superhuman task. In South Korea, each field worker is expected to serve a population of 10,000 scattered around a large geographical area. In West Java, the ration is 1:11,700; in Bali, the ratio is 1:10,000. Furthermore, in one study of South Korean program, it was found the field worker spent 46 percent of his (her) time in office doing paper work and performing other duties. All this means that the load of field workers is unrealistically heavy. No wonder they had a hard time recruiting new acceptors once they skim the cream, i.e., exhausting all the strongly motivated women and men. In contrast to the field (extension) approach, the CBD programs deploy the field workers to resupply the depot holders, supervise them in keeping records, and render whatever assistance is needed. In so doing, the CBD programs put the salaried field workers to task that better utilize their trained skills and at the same time achieve greater outreach coverage. Furthermore, this efficiency is achieved at very low cost. Unlike the field workers who are on the program's payroll, the depot holders as a rule either volunteer their service or receive a small sum of payment for their service. They do not depend on income derived from the family planning work as the main source of income.

To illustrate our point, let us take a look at the Bali CBD program. In my opinion, this is the best CBD program outside of China. In 1974-75, the BKKBN of Bali decided to co-opt the banjur system into the service of family planning program. The program called for recruiting one kelian (leader) of each of the Bali 3724 banjurs to serve as the depot holder for each banjur. Previously each field worker was expected to serve a population of 10,000. Since then, each field worker on the average resupplies, supervises and assists 16 kelians. The result has been spectacular. The Bali program has by the end of 1977 realized the target set by the Indonesian BKKBN for the whole country for the year 2000. Bali has achieved a current user rate of 65 percent-- this in spite of the fact that the island remains very poor, the population is mostly illiterate and in farming, there is no industrialization to speak of.

4. Rationalize the utilization of scarce resource. The shortage of health facility and physicians as well as paramedics are a familiar, perennial phenomenon in the Third World. Furthermore, the uneven distribution of this scarce resource is legendary. As for remedy, none is in sight in the foreseeable future. Within the organized program, the shortage of medical and paramedical personnel is not as bad. However, the shortage remains very acute in the countryside. By deploying the trained villager to prescribe the oral pills, the CBD programs can utilize the scarce medical and paramedical manpower to perform other tasks, such as IUD insertion, sterilization, and induced abortion and treatment of complications.

#### Toward a Classificatory Scheme of CBD

It is obvious from the above that the term CBD has been used to refer to different types of family planning programs. The common denominator is the distribution of contraceptives without required attendance at the clinic, and through channels other than the regular health delivery system. Apart from this, there is little commonality. In view of this, it seems desirable to construct a classificatory scheme, or typology, with certain pre-agreed criteria with which to assign the various CBD programs to certain categories. This section purports to do this.

We propose to classify the various CBD programs according to (1) the degree to which the supply is community-based, and (2) the degree to which demand-generating activities is community-based. First, on the supply dimension, there exists no single accepted index for measuring the extent to which the distribution of contraceptives is community-

based. And it is difficult to settle upon an "ideal" measure. We propose to measure the extent to which the distribution of supplies is community-based by an index of availability of various types of modern contraceptives at the community (village) level. The index is derived from answers to the the following programmatic inputs, namely the availability of the following modern contraceptives right in the village or within 30-minute walking distance:

1. Non-clinical methods:

Condoms?

Spermicide or foam tablets?

2. Semi-clinical methods:

I.U.D.?

Oral pills?

3. Clinical methods:

Tubal ligation?

Vasectomy?

Induced abortion?

Answers to each of the above questions produce a score ranging from 3 to 0 according to the following criteria:

- 3 = supplies are available right in the community, or delivered to the clients at home, or within a 30-minute walking distance;
- 2 = supplies/services are available beyond walking distance, but the CBD program provides transportation and other supports (e.g., bus fare, baby-sitting, cook the meal for the woman's family, etc.) to the clients, or bring the mobile service to the community on fixed schedule or when sufficient demand warrants unscheduled visits;
- 1 = supplies/services are available beyond walking distance; no transportation or other assistance are provided by the CBD program to the clients;
- 0 = supplies/services are not available either for legal reason or for all practical purposes and intents.

These ratings produce an overall index score for selected CBD programs, ranging from 18 for China's three-tier health care/birth planning program, to 3 for Bangladesh household distribution scheme or India's Nirodh project. (See Table I) These indices are

**Table 1. Community Participation in Providing Contraceptive Supplies and Service in Community-Based Distribution Family Planning Programs**

| Types of Supplies and Services   | China | Bali | W. Java VCDC Scheme | S. Korea Euiryong Household Distribution | Thailand CBFP Village Program | S. Korea Mothers Club | Columbia Profamilia Village Depot System | Northeast Brazil C.B.D. | Bangladesh Household Distribution | Bangladesh Shopkeeper Project | India Nirodh Project | Kenya Kinga |
|----------------------------------|-------|------|---------------------|--|-------------------------------|-----------------------|--|-------------------------|-----------------------------------|-------------------------------|----------------------|-------------|
| <b>1. Non-Clinical Methods:</b>  |       |      |                     |  |                               |                       |  |                         |                                   |                               |                      |             |
| Condoms                          | 3     | 3    | 3                   | 3  | 3                             | 0                     | 0  | 0                       | 0                                 | 3                             | 3                    | 3           |
| Spermicide                       | 3     | 3    | 3                   | 0  | 0                             | 0                     | 0  | 0                       | 0                                 | 0                             | 0                    | 0           |
| <b>2. Semi-Clinical Methods:</b> |       |      |                     |  |                               |                       |  |                         |                                   |                               |                      |             |
| I.U.D.                           | 3     | 2    | 1                   | 2  | 1                             | 1                     | 0  | 0                       | 0                                 | 0                             | 0                    | 0           |
| Oral Pills                       | 3     | 3    | 3                   | 3  | 3                             | 3                     | 3  | 3                       | 3                                 | 0                             | 0                    | 3           |
| <b>3. Clinical Methods:</b>      |       |      |                     |  |                               |                       |  |                         |                                   |                               |                      |             |
| Tubal Ligation                   | 2     | 2    | 1                   | 2  | 1                             | 0                     | 0  | 0                       | 0                                 | 0                             | 0                    | 0           |
| Vasectomy                        | 2     | 2    | 1                   | 2  | 1                             | 0                     | 0  | 0                       | 0                                 | 0                             | 0                    | 0           |
| Induced Abortion                 | 2     | 0    | 0                   | 0  | 0                             | 0                     | 0  | 0                       | 0                                 | 0                             | 0                    | 0           |
|                                  | 18    | 15   | 12                  | 12                                       | 9                             | 4                     | 3  | 3                       | 3                                 | 3                             | 3                    | 6           |

Note: The scores used in the above table are defined as follows:

- 3 = supplies/services available right in the community or within walking distance (i.e., 30 minutes walk or less), or delivered to the clients at home;
- 2 = supplies/services available beyond walking distance, but the cbd program provide transportation and other supports (e.g., baby-sitting) to the clients, or bring the mobile service to the community on fixed schedule or when there are sufficient demands for such service;
- 1 = supplies/service available beyond walking distance; no transportation or other assistance provided to the clients;
- 0 = supplies/service not available for all practical purposes

Table 2. Community Participation in Demand-Generating Activities in  
Community-Based Family Planning Programs: Types of Inputs

|   | China 3-tier<br>Health/Birth<br>Planning<br>System | Bali<br>Bandjur<br>System | W. Java<br>VCDC<br>Scheme | Thailand<br>CBFPS<br>Village<br>Program | S. Korea<br>Mothers<br>Club | Columbia<br>Profamilia<br>Village<br>Depot System | Northeast<br>Brazil<br>CED | India<br>Nirodh<br>Project | Kenya<br>Kenga | S. Korea<br>Euiryong<br>Household<br>Distribution | Bangladesh<br>Shopkeeper<br>Project | Bangladesh<br>Household<br>Distribution |
|---|--|---------------------------|---------------------------|---|-----------------------------|---|----------------------------|----------------------------|----------------|---|-------------------------------------|---|
| 1. Local people used as distributors?   | 2  | 2                         | 2                         | 2                                       | 2                           | 2   | 2                          | 2                          | 2              | 2   | 2                                   | 2                                       |
| 2. Mass and folk media utilized?  | 2  | 2                         | 2                         | 2                                       | 1                           | 1   | 0                          | 2                          | 2              | 0   | 0                                   | 1                                       |
| 3. Do the local leaders endorse and encourage F.P.?   | 2  | 2                         | 2                         | 1                                       | 0                           | 1   | 2                          | 0                          | 0              | 0   | 0                                   | 0                                       |
| 4. Do the local leaders assume the responsibility of running the local community I.E.M. program?                            | 2  | 2                         | 1                         | 1                                       | 1                           | 0   | 0                          | 0                          | 0              | 0   | 0                                   | 0                                       |
| 5. Do the local leaders provide leadership by personal example?   | 2  | 1                         | 0                         | 0                                       | 0                           | 0   | 0                          | 0                          | 0              | 0   | 0                                   | 0                                       |
| 6. Are the local grass-roots communal or social organizations utilized for I.E.M. program on a regular and sustained basis? | 2  | 2                         | 1                         | 1                                       | 1                           | 0   | 0                          | 0                          | 0              | 0   | 0                                   | 0                                       |
| 7. Do the local community support the practice of F.P. through financial and other contribution?                            | 2  | 0                         | 0                         | 0                                       | 0                           | 0   | 0                          | 0                          | 0              | 0   | 0                                   | 0                                       |
| 8. Do the communities intervene on behalf of lowering fertility at the point of:  |  |                           |                           |   |                             |   |                            |                            |                |   |                                     |   |
| Age at marriage?  | 2  | 0                         | 0                         | 0                                       | 0                           | 0   | 0                          | 0                          | 0              | 0   | 0                                   | 0                                       |
| Birth spacing?  | 2  | 0                         | 0                         | 0                                       | 0                           | 0   | 0                          | 0                          | 0              | 0   | 0                                   | 0                                       |
| No. of children?  | 2  | 0                         | 0                         | 0                                       | 0                           | 0   | 0                          | 0                          | 0              | 0   | 0                                   | 0                                       |
| 9. Do the local communities plan and enforce communally drawn-up births plan?   | 2  | 0                         | 0                         | 0                                       | 0                           | 0   | 0                          | 0                          | 0              | 0   | 0                                   | 0                                       |
| 10. Is the community F.P. program integrated and supported by other development projects?                                   | 2  | 1                         | 1                         | 1                                       | 1                           | 0   | 0                          | 0                          | 0              | 0   | 0                                   | 0                                       |
|   | <u>24</u>  | <u>12</u>                 | <u>9</u>                  | <u>8</u>                                | <u>6</u>                    | <u>4</u>  | <u>4</u>                   | <u>4</u>                   | <u>4</u>       | <u>2</u>  | <u>2</u>                            | <u>3</u>                                |

Note: The rating of each of the above demanding-generating activities undertaken by the local communities ranges from a score of 1 to 0, depending upon the answer to each of the questions:

2 = unqualified yes;  
1 = qualified yes;  
0 = partial or no.

nothing more than ordinal measures and should be treated as such, no more and no less. They enable us to rank order the degree to which the various CBD programs are community-based with respect to the supply dimension.

As in the case of supply, there is no accepted single index of community-based demand-generating activities. Likewise, it is difficult to settle upon an "ideal" measure. It is suggested that community-based demand-generating activities be defined in terms of the I.E.M. activities conducted by the CBD program. While the structural and development variables generate demand for family planning and are most likely to determine the level of demand, they have to be ignored because they are largely beyond the control of the CBD program managers. An index of community-based (or more properly, community participation in) I.E.M. activities for each CBD program is derived from answers to each of the following questions:

1. Are local people used as distributors?
2. Are mass and/or folk media utilized to promote family planning?
3. Do the local leaders endorse and encourage family planning?
4. Do the local leaders assume the major responsibility of running the local community I.E.M. program?
5. Do the local leaders provide leadership by personal example?
6. Does the local community support its members practicing family planning through financial and other contribution (e.g., using the community chest fund to provide subsidies for transportation, to compensate for income lost while away seeking family planning service; provide baby sitting and assist in cooking meals for the women who go away to seek service)?
7. Are the local grass roots communal or social organizations utilized for conducting I.E.M. program on a regular and institutionalized basis?
8. Do the local communities intervene on behalf of lowering fertility at the point of (a) age at marriage? (b) birth spacing? (c) number of children?
9. Do the local communities plan and enforce communally drawn-up communal births plan?

10. Is the community family planning program integrated with and supported by other development projects?

Answers to each of the above questions produce a score ranging from 2 to 0 according to the following scoring system:

2 = unqualified yes;

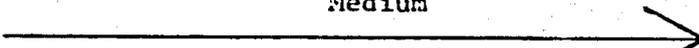
1 = qualified yes;

0 = partial or no.

These ratings in turn produce a composite index score for each of the selected CBD programs, ranging from a high of 24 for China's program, to a low of 3 for Bangladesh household distribution scheme.

With the index thus obtained for both supply and demand-generating activities, one could construct a two dimensional typology of CBD programs as presented in Table 3. Included in Table 3 is a cross section sample of the better known CBD programs. According to Cuca and Pierce, as of early 1977, IPPF had initiated CBD experiments in seven countries, and the U.S. AID had developed eleven of these projects, which were centrally funded and monitored, plus a number of others initiated by country AID missions. Presumably with more information about these recently initiated CBD programs, one may classify them using the criteria suggested here. The use of the typology, together with the data about program performance and the fertility trends, should presumably allow one to do correlational and regression analysis to determine whether program performance and its impact on fertility are indeed correlated to and attributable to the extent to which the CED program is community-based in supply and demand-generating. This is, however, a task beyond the scope of this report.

Table 3, a Two-dimension Classificatory Scheme for Community-based Family Planning Program

|   |   |  |  |  |  |
|---|---|--|--|--|--|
| Increasing community participation in demand-generating activities<br> | High  |  |  |  | China's 3-tier Health care/Birth Planning System |
|   |   |  |  |  | Bali's Bandjur System                            |
|   | Medium  |  |  | W. Java's VCDC                           |  |
|   |   | Columbia Profamilia<br>N.E. Brazil CBD   | Thailand CBFPS'<br>Village Program<br>Korea Mothers Club | S. Korea Euiryong household distribution |  |
|   | Low   | Bangladesh household distribution Project<br>India Nirodh Project<br>Kenya Kinga Project |  |  |  |
|   | Low   | Medium   |  | High                                     |  |
|   | Increasing availability of supplies/services at grass-roots communities<br> |  |  |  |  |

## Appendix I: Bali

### A Brief History of Family Planning in Bali up to 1974

A province of Indonesia, Bali is an island of 5,700 square KM, with a population of 2.3 million in 1971 and 2.4 million in 1978. Administratively, Bali is divided into 8 regencies, which in turn are subdivided into 50 subdistricts. Below the subdistricts are villages, or desas, which number 564 in total. Each desa comprises on the average 7 banjurs. A ubiquitous social organization among the Balinese Hindi, the banjur is a traditional communal organization, whose size ranges from 40 to 120 households, but averages about 100 households. In 1978 there were 3,727 banjurs on the island encompassing over 95 percent of Bali's 2.4 million population. The banjurs have been in existence for centuries, for the purpose of performing vital religious and communal functions.

Organized family planning services on Bali began in 1961, with the establishment of the Bali branch of Indonesian Planned Parenthood Association (IPPA). Until 1968, the IPPA of Bali was the sole provider of family planning services on the island. Due to its limited resources and lack of national policy regarding population planning, the IPPA did not do well in these earlier years. During this early period, less than 9,000 acceptors, amounting to about 3 percent of the eligible population, were recruited.

The turning point came in 1969, when the government established National Family Planning Institute, and charged it with the responsibility of assisting and integrating the efforts of private organizations and some governmental agencies, such as the Ministry of Information and Ministry of Health. The year 1970 saw the establishment of the Indonesian Family Planning Coordinating Board (BKKBN). The Bali BKKBN has been entrusted with the responsibility of coordinating the activities of four government and four private agencies. The government agencies consist of the Armed Forces and the Ministry of Religious Affairs, the Ministry of Health, and the Ministry of Information. The private agencies are: the IPPA which maintained some clinics and assisted in training, Dharma Dutta (Hindu), the Indonesian Council of Churches (Christian), and Muhammadiyah (Muslim).

The Bali BKKBN has operated both clinical services and information, education, and motivation (I.E.M.) programs. As of 1978, the Bali BKKBN operates a total of 156 family planning clinics. There is one clinic for every four desas (villages) on the average. Most of the clinics are manned by one trained midwife (bidan), one assistant midwife (pembatu bidan), and one clerk. All of the midwives have been trained in IUD procedure,

Family Planning Organizational Set-up in the  
Province of Bali, Indonesia

| <u>Province</u>                | <u>No. of Units</u> | <u>F.P. Personnel</u>      | <u>No.</u> | <u>No. of F.P.<br/>Clinics</u> |
|--------------------------------|---------------------|----------------------------|------------|--------------------------------|
| Province                       | 1                   | Bali BKKBN<br>Headquarters |            |                                |
| Regencies<br>(Kabupatans)      | 8                   | Supervisors                | (8)        |                                |
| Sub-districts<br>(Kecabnatans) | 50                  | Group Leaders              | (50)       |                                |
| Villages<br>(Desas)            | 564                 | Field Workeys              | (231)      | 156                            |
| Banjur                         | 3727                |                            |            |                                |

and they do most of the IUD insertions and prescribe oral pills. Of the 110 or so physicians on the island, about 70 or more live and practice in Denpasar, the capital of the province, and are therefore unavailable for village clinic work for all practical purposes. The family planning clinics are open for service for an average of 67 hours per month. Physicians are available for only a quarter of this time. The other regular staff are, however, on duty during all clinic hours.

There are 231 field workers working for the BKKBN full-time. Each of them is responsible for serving about 10,000 population, or about 1,165 eligible couples on the average. They are grouped into 50 teams of four to five field workers each. Each team is supervised by a group leader. The group leaders in turn come under the supervision of 8 regency supervisors, one for each of the 8 regencies in the province. In addition, there is one supervisor for field workers serving the armed forces. The supervisors perform their duties under the supervision of one provincial coordinator. The field workers are not required to work fixed hours. Instead, they are given a monthly quota of new acceptors. The majority, or about 80 percent of the field workers, are male. Most have high school education.

#### Program Performance up to 1974

Every since its inception in 1970, the Bali BKKBN program has been a story of success. Between 1970-71 and 1973-74, the acceptor rate rose from 3.7 percent to 36.6 percent. (Year after year the target set by BKKBN has been overfilled.) The 1974 cumulative acceptor rate of 37 percent achieved in a short period of time is very impressive by all criteria. It is more impressive if one takes into account the method preferred by the acceptors. Up to 1974 the acceptors who adopted IUD comprised 67 percent of the total acceptors!

#### Factors Contributing to Program Success

According to Astawa, Waloeyo, and Laing, the success of the Bali program up to the end of 1974 might be attributed to the following three sets of factors:

##### Cultural Factors:

1. Religious tolerance. "Although religious leaders in Bali have not become notably active in promoting the use of contraceptives, they have not opposed it in any way."
2. Traditional naming system. In the Bali culture there has been a custom of giving a child a name identifying his (her) birth order. The most common names for the first four births are as follows:

first born: Wayan, Gde, Putu (literally, "great")

second born: Made, Nengah ("middle")

third born: Nyoman ("youngest")

fourth born: Ketut ("extra")

Such naming practice implies that in traditional Balinese culture the ideal family size is three, at most four, children. (The Bali BKKBN program has conscientiously exploited this naming system to promote family planning.)

3. Land tenure. "Shared cropping and tenancy are rare. In keeping with the Balinese tradition of cohesive social organization, much of the agricultural land is communally owned and operated, but the proceeds benefit the local community as a whole rather than enriching only a few persons."
4. Openness of Balinese women and male birth attendants (dukan). The Balinese women work outside the house and do not live a secluded life. Birth attendants in Bali have traditionally been men. Balinese women tend to be less inhibited about pelvic examination and of IUD insertion carried out by male physicians. This was of critical importance to the program's progress up to 1974, when 68 percent of the acceptors chose the IUD and when all IUD insertions were done by male physicians, before the midwives were trained in the procedures.
5. Openness about reproductive functions. "In rural areas a husband also often helps his wife during the delivery, while the delivery itself is witnessed by all relatives of the family."

#### Situational Factors

1. Preexisting decline in fertility.
2. (Perceived) population pressure.

#### Program Factors:

1. Extra drive
2. Use of traditional media
3. Density of Program inputs. "Each field worker in Bali serves a population of about 10,000 on the average compared with about 15,000 in Java."

4. Stretching resources. "The scarcity of doctors is offset by the use of midwives for IUD insertion and pill prescription. The problem of providing clinical services to clients in remote areas is solved by taking the services to them, either through mobile teams or through the midwife's regular rounds outside the clinics."
5. Emphasis on promoting IUD.
6. Use of local social structure. "The local leaders (the kelians of banjurs) assist the program by integrating family planning and related topics into community (banjur) meetings, by setting an example of practicing family planning themselves, and by encouraging community residents in need of family planning to join the program."

#### Search for Better Approach

As indicated before, by the end of 1974, 37 percent of the eligible couples had been recruited to practice family planning. In a sense, the program had skimmed the cream on the top; it reached those who had been motivated to practice family planning on their own accord whatever the reason, and succeeded in motivating others who were relatively easy to be motivated. With the cream on the top being thus skimmed, it became increasingly difficult to motivate what Roger would call the hard-core resisters. Furthermore, there was a relative decline in the percentage of new acceptors choosing the IUD, from a high rate of 78 percent in 1970-71 down to 59 percent in 1973-74. This shift in method preference meant that the field workers would have to devote an increasing proportion of their time to resupply the pills users, leaving less time to devote to conduct I.E.M. activities among the non-users. Moreover, the program administrators found it increasingly difficult to keep track of the current users, the drop-out, and other information vital to the evaluation of the program's performance.

Confronted with this development and anticipating possible plateau, the Bali BKKBN began to grope for better approaches to improve program effectiveness and further raise the acceptor rate in the interest of reducing fertility. This search for alternative resulted in the initiation of a pilot project in late 1974 to test the feasibility of co-opting the banjur system to work for the program. The success of this project convinced the program administrator that the banjur system could indeed be pressed into the service of the family planning program. Beginning in 1975, the Bali BKKBN initiated the phase-by-phase co-optation of banjurs into the family planning program. By 1978 all the banjurs on the island had been thus co-opted. During this period, the acceptor rate has scored great gains. By the middle of 1978, the cumulative acceptor rate reached 65 percent. Obviously, the co-optation of the banjur system has

proved to successful. Before we describe how the co-optation of banjurs works, we have to present a brief description of what the banjur system is all about.

### The Banjur System in Bali

Unlike the rest of Indonesia, the religion of Bali is Hinduism. The Balinese Hinduism is however somewhat different from the Hinduism of Indian subcontinent. It is more animistic. While Hindu gods practices are in abundant evidence in Bali Hinduism and folk art, their significance differs from Hinduism of India.

"The religion of Bali is not a sectarian church system, separate from daily life and used by a heirarchy of priests to control and exploit the people; it is a set of rules of behavior, a mode of life.... The resourceful Balinese have fitted their religious system into their social life and have made it law so that the supernatural forces are brought under control by the harmonious cooperation of everyone in the community to strengthen the magic health of the village.

"The Balinese believe that the magic of evil, the polluting effects of sickness and death, bestiality, incest, suicide and temple vandalism as well as evil forces, the demons and witches that haunt the village, are among those that undermine the spiritual health of the village. But the principal concern of the Balinese is to worship the protecting ancestors who descend to this earth on special holidays and at the anniversaries of the innumerable temples, when they receive offerings and entertainment from the people. Through these ceremonies and temple festivals the populace hopes to entice the spirits to remain among them. The beauty of the offerings, the pleasant music, the elaborate theatrical performances are aimed at keeping them from getting bored and leaving. This cult of belief and practices therefore explains why there are so many temples in Bali. Each village has its own temple where the religious performance takes place, and its own dance group that gives elaborate theatrical performances during the temple festivals.

With these religious beliefs, the Balinese found it necessary to establish a system of communal cooperation to provide for the magnificent festivals that were such an important part of their life. Their spirit of cooperation soon extended to their personal and economic life and developed into a primitive agrarian commune, in which every village was a socially and politically independent little republic with every citizen enjoying equal rights and obligations. The villages were ruled by councils of village members and official who governed as representatives of ancestral spirits."

Traditionally, a village, or a desa, on Bali was economically and politically independent of all others, except for the curious

relation of blood. A number of neighboring desas often grouped together by a strong bond to form an association of related desas, which worshipped a common original ancestor and with a common temple of "origin," located in the oldest desas of the association, recognized as a "head" or "mother" desa. From this "head" desa sprang the other desas, which became independent when they grew in size. Such desa associations cooperated with one another by sending offerings and representatives to the temple feasts of the other desas. Every normal married man who owned a house or a plot of land in the desa boundaries was compelled to join the desa association, and his refusal would be punished by the denial of every assistance, confiscation of his property and possible exile from the desa. Theoretically, all the land in Bali belongs ultimately to the gods, who lease it to the Balinese to work it and live from it; consequently, land ownership in an absolute sense could not exist in the Balinese mind. Much of system, practice, and beliefs described above have remained intact to this day.

As a desa grows in size, it is subdivided into wards, or banjurs. The banjurs are cooperative societies of people bound together for the purpose of mutual aid regarding marriage, home festivals, and cremation preparation, which is imperative in the Balinese Hinduism and enormously expensive and beyond the means of individual household. The various banjurs of a desa take part in the desa activities, assisting in the repair and improvement of temples and contributing to the desa festivals.

Following the conquest of the island the Dutch colonial administration, bent on destroying the desa as a viable social and political organization, arbitrarily redivided the desa, ignoring its traditional boundaries and connections. Consequently, the desa became simply any "big" village which existed in the Dutch official document but not in the mind of the Balinese. One consequence of this development was that the banjur came to capture much of the administrative power, and to perform much of the socio-economic functions, of the desa. Although the banjurs have remained socially independent within their territory to this date, they are subject to civil administration of the Indonesian government.

Membership in a banjur is compulsory. After marriage a man receives summons to join the banjur. He is given ample time. If he fails to join after the third summons, he is considered to have deliberately declined and is declared morally "dead," which means that he will be denied the right to be buried in the communal cemetery, communal assistance of any sort, and excluded from all communal activities.

The banjur owns its own property. It owns its meeting hall, the bale banjur (essentially a clubhouse without special religious significance), with its drum tower to call members to meetings. The bale banjur has a kitchen and cooking utensils, which are lent to members upon request. The banjur also owns

the orchestra and the dancing equipment--costumes, masks, and headdress. The men spend most of their spare time in the bale banjur, gossiping, trying out their fighting cocks, watching a rehearsal of a play or of the orchestra, or just sitting. Nowadays, with the advent of electronics age, they may be seen sitting in the bale banjur watching television. Every member of a banjur enjoys absolute equality, and all are obliged to help one another with labor and materials, often assisting a member to build his house, to prepare his son's wedding, or to cremate a relative.

Most banjurs in farming areas are four groups: the harvesting, planting, squirrel and dancing groups. The harvest group assists members harvesting their rice crops. The earnings from this is divided into two equal halves, with one half divided among those who participate, and the remaining half going to the banjur fund. Likewise, part of the proceeds earned from helping planting and squirrel hunting goes to the banjur fund. The banjur fund also derives its revenue from fines assessed on members who show up late for the meetings, or are absent without good excuse. The banjur often have communal rice paddies, the proceeds from which are used to provide for their banquets and to enlarge the banjur fund.

This fund may be used for temple festivals or lent out at an interest rate of 6 percent to members who need cash. The borrowers repay loans with interest without failure; if they fail to, other members would go to their house and get whatever properties they had that could be sold to liquidate their indebtedness.

The banjur is headed by a kelian, who is elected by the members for a term of five years. The kelian is not compensated for his great responsibilities, except for the honor attached to the position and certain small concessions such as extra rice at banquets, a small percentage of the fines collected, and presents from members who receive special service (e.g., part of the reward offered for lost cattle, for surveys, for assistance in marriages, and so forth). He cannot decline to serve, but may be deposed if found unsatisfactory.

#### The Co-Optation of the Banjurs in the Service of Family Planning

As indicated above, a pilot project initiated in late 1974 convinced the BKKBN of Bali of the feasibility of utilizing the banjur system to work for the program. Subsequently, it organized short-term training sessions, recruiting phase by phase one kelian from each of the 3,727 banjurs on the island. The training programs emphasized the why, how, and what of family planning. Upon the completion of the training, the keliens returned to their respective banjurs and began to work on behalf of the BKKBN program.

The BKKBN of Bali has defined the following three tasks for the kelians to perform:

1. To serve as depot holder distributing contraceptives among the users in their respective banjur and to refer those choosing IUD to the field workers or to the family planning clinics;
2. To institutionalize family planning in the banjur by conducting I.E.M. activities during the regular banjur meetings, and by face-to-face approach;
3. To fill a standardized record form keeping track of certain events (i.e., the acceptors, the drop-out, eligible but not acceptors, live births, deaths), and to draw up an ELCO (eligible couples) map. (The ELCO map lists by residence/location all the eligible couples within the banjur boundaries, using different colors to designate their family planning status, i.e., acceptors, non-acceptors, methods used by the acceptors. This ELCO enables anyone who takes a quick look to determine which eligible living in which house is practicing or not, and if practicing using what method. It is one of the most impressive innovations in family planning record keeping I have seen, the likes of which I am not aware of except in China.)

As of 1978 there are 231 field workers in Bali. Each is responsible for 16 banjurs on the average. The total number of eligible couples is estimated to be 269,168 in 1978. This means that each field worker is responsible for serving 1,165 couples in 16 banjurs on the average. This is a stupendous task, especially if the eligible non-acceptors are not strongly motivated to practice family planning, and the banjurs spread out in a wide geographic area or are located in remote regions not easily accessible. By co-opting kelians to work on behalf of the program, the task of the field workers has undergone not just a quantitative change, but also a qualitative change. Instead of going the round paying visit from one house to another to resupply and/or do I.E.M. work, they now resupply the kelians, who in turn distribute the contraceptives among the users. For those indicating a preference for IUD, the field worker may give her a ride or accompany her to the family planning clinics for the operation. He also shows up during the regular banjur meetings to help the kelian do the I.E.M. work. At such meetings he may explain the plus and minus of each contraceptive method. He is however not supposed to dominate the show. The kelian is expected to play the key role of conducting I.E.M., using his own language to explain the why of family planning. (I was told that some of the speech given by the kelians recorded in tape so impressed Haryono Suyono of

the national BKKBN at Jakarta that he confessed he could not do as well.)

Ninety percent of the kelians have only a primary school education; a few are illiterate. Because of this, many kelians find the duty of filling out the record form and drawing up and ELCO map beyond them. Quite often they made mistakes in filling out the form. In an attempt to remedy this condition, the Bali BKKBN is currently sending mobile teams out to the banjurs to go over the record with the kelian, pinpoint the mistake and instruct the kelians how to do the job right. (I went out with the mobile team on one such mission to a remote section of the island.) In cases where the kelians cannot be trained, a local youth with more education is being recruited and trained to keep the record. They will eventually assist the kelians to fill out the form in the future.

As a result of co-opting the kelians, the field workers now spend most of their time going from banjur to banjur to resupply the kelian-cum-depot-holder, assist the latter to fill out the form and collect the form from them monthly, referring or accompanying the women choosing IUD to the clinic. They use the remaining time to conduct I.E.M. among the eligible non-acceptors.

As I see it, the beauty of this approach is that it achieves not only community-based distribution of contraceptives, but also community-based I.E.M. of family planning. The BKKBN of Bali first sells the why of family planning to the community leaders. The kelians, in turn, try to sell their newly acquired conviction to their fellow peers in their own way and language. Since the kelians practice what they preach (they all practice family planning, if eligible), their attempt at persuasion would carry weight with their peers. As a compensation for their service to family planning, the government recently raised their monthly allowance to Ruppiah 6,500 (about 16 U.S. dollars) per year. The kelians continue to derive their main source of income from whatever occupation they have been engaged in.

In short, in the post-1974 Bali program, the field workers have come to become a link between the provincial family planning program and the community leaders, rendering whatever assistance to the latter needed. This scheme not only amplifies the effectiveness of the field workers, but also institutionalizes family planning at the communal level, thanks to the cooperation of the kelians who have ready, regular access to all the relevant members of the community.

The Bali BKKBN administrators are now looking forward to co-opt the youth groups within each banjur as a mechanism for conducting population education with emphasis on age at marriage and small family-size norm. Success in this undertaking can be expected, with far-reaching consequences in the decades ahead.

### The Results

The following data were given to me by Dr. Astawa of BKKBN of Bali on a briefing:

Population: 2,300,000 (1978)  
 ELCO (eligible couples): 269,168 (about 11 percent of the total population)  
 Acceptors: 17,844, or an acceptor rate of 64.59 percent  
 Drop-out: 2,774  
 Non-acceptors: 81,782  
 Pregnant: 10,768, or 3.84 percent of the ELCO.

| Method                                      | No. of Acceptors | Percent |
|---|------------------|---------|
| IUD   | 120,070          | 69.07%  |
| Oral pills                                  | 29,397           | 16.91%  |
| Condoms                                     | 323              | .19%    |
| Sterilization<br>(mostly tubal<br>ligation) | 6,860            | 3.95%   |

As of March 1978 the cumulative acceptor rate was thus 65 percent. (Not every subdistrict had been equally well: the cumulative acceptor rate for the various subdistricts ranged from 46 to 86 percent.) According to Dr. Astawa, the Bali

program has thus reached the target set by the National BKKBN headquarters for the year 2000. The Bali program has fulfilled the target 22 years ahead of schedule.

The vital statistics for the island is inadequate and judged to be not particularly reliable. No current figures of the vital rates were provided to me. The crude birth rate in 1973-74 was however estimated to be 34.5 per 1,000. At that time, the cumulative acceptor rate was 37 percent. With a cumulative acceptor rate of 65 percent, the crude birth rate must be much lower. While there is not reliable data about the vital rates that would give clue to the pace of the fertility decline, there are other circumstantial evidence indicating downward fertility trend. Dr. Astawa indicated that the pregnancy rate has declined from 5 percent to 3.9 percent between 1971 and 1977. There is evidence indicating a steady and significant increase in the percentage of married fertile women using contraception as a means of spacing births. During the period 1973-77, among those women practicing family planning, the women with four or more children decreased from 44 percent to 32 percent. During the same period, the percent of women with three or less children currently practicing family planning, increased from 56 percent to 68 percent; the percent of women with two or less children currently practicing family planning also experienced an increase, from 36 to 48 percent. All of this seems to suggest that increasing proportion of the women in reproductive age have been resorting to contraception not only as a way of limiting family size after they have achieved the desired size, but also as a means of spacing births.

The Bali experience shows that, in the absence of industrialization, the idea of family planning could spread, adoption of effective contraception could reach a relative high rate, and the crude birth rate could decline substantially. Bali lacks the conditions conventionally regarded as conducive to widespread adoption of family planning. Its population is very much tradition-bound; the life of the Balinese remains very much dominated by the Hindu religion. The overwhelming majority of its population are rural, employed in agricultural sector. Most have little or no formal education. The health conditions remain very poor. Without industrial development, the per capita income and living standard remain very low. The only economic activity that provides some non-agricultural jobs and decent income to some portion of the population is booming tourist industry which has experienced a rapid growth in recent years. In spite of all of this, Bali program has achieved an acceptor rate as high or almost as high as that obtained only in a few developing countries (e.g., Singapore, Taiwan, Hong Kong, and South Korea) where there have been profound socio-economic development and the conditions are much more favorable to the widespread adoption of family planning. While all the three sets of favorable factors pointed out by Astawa and his co-authors undoubtedly all contributed to the

program's success, it is hard to believe that without the co-optation of the banjur system in 1974-75, the acceptor rate could have shot from 37 percent in 1974 to 65 percent in 1978.

The Bali program's co-optation of the banjur system bears striking resemblance to the Chinese approach. They all utilize the lowest communal/social organization in pursuit of the institutionalization of family planning at the grass-roots level. They all place a premium on socializing the grass roots level community leaders into the imperative and desirability of population control, and relying upon them to motivate their own fellow community members to adopt family planning through the mechanism of group dynamics. The social psychologists and anthropologists have long learned the important role played by the group, especially cohesive social group, in preserving and changing the norms governing the behavior of the group members. Individuals do not abandon old norms and adopt new norms in isolation; rather, individuals tend to discard old norms and adopt new norms as a member of a social organization or system. In other words, the individuals tend to anchor their own norms onto that of the group to which they belong, they adhere to or change their norms as the group as a whole do so.

In Bali and China, the family planning program deliberately utilizes the grass roots communal organization not only to distribute contraceptives, but also to effect normative transformation among the members. The experience of Bali and China seems to suggest that without substantial modernization, widespread adoption of family planning may take place and become institutionalized provided that (1) contraceptives, especially modern types, are made easily available free or at subsidized affordable price; (2) certain key elements or elite at the grass roots level are convinced of the imperative and/or benefits of fertility regulation and accordingly persuade their own fellow villagers to avail themselves of the benefits (3) there exists social organizations at the communal or grass roots level, encompassing virtually all the relevant population, that could be utilized or co-opted by the family planning program to promote family family planning.

Appendix II The Village Program of the Community-Based Family  
Planning Service, Thailand

The Community-Based Family Planning Service was founded by the resourceful Mechai Viravidya in May 1974. Funded initially by grants from the IPPF and U.S. AID, the CBFPS has grown rapidly in a short period of time. At present it has a staff of 210 fulltime personnel, and operates three programs covering a population of 13 million, roughly one third of Thailand's total population. In a sense the CBFPS's programs are an attempt to maximize the impact of early Thai government's liberalization of regulations allowing trained midwives and other paramedics to prescribe the oral pills. (Thailand was one of the earlier countries to do so following the success of a pilot project testing the feasibility of using the trained paramedics, assisted by the use of a checklist, to prescribe the pills.) The official liberalization of procedures governing the pill prescription was based on the premise that the physician/population ratio and the distribution of physicians (more than 50 percent reside and practice in the greater Bangkok) are such that without liberalization the oral pills were and would remain inaccessible to the vast majority of population for all practical purposes.

The CBFPS operation has been inspired by the intellectual conviction that distribution of contraceptives through channels other than the state-funded health system will greatly increase the rate of acceptance. At present the CBFPS operates three programs: (1) the sector program, (2) the public institution program, and (3) the village program. The first program aims to provide information and contraceptives to the members of organizations or groups (e.g., factories, labor unions, barber shops, or beauty parlours, etc.) and to recruit and train volunteers to serve as local distributors of contraceptives. It also contemplates launching a mail order component and nationwide distribution of condoms through commercial marketing network. The second program, in collaboration with existing organizations with a medical infrastructure and large members (e.g., the Teachers Council, the Armed Forces, cooperatives, and so on), aims to provide family planning information and services to their members. Members of the organizations will be identified, recruited, and trained to serve as distributors for the organization. The third program, the village program, aims to bring family planning information and contraceptives to the vast rural population through the phase-by-phase establishment of a nationwide network of village contraceptive distribution points. Since this program, if successful, will have the greatest impact on Thailand's fertility, and since it has

attracted a great deal of attention both at home and abroad for good reasons, this report proposes to focus on it.

### The Philosophy of the Village Program

The village program proceeds from the premise that the familiar KAP gap can be reduced by making available contraceptives to the eligible couples, especially in rural villages, right in the community. In spite of a gradual increase in the acceptance of contraceptives, especially the oral pills following the government liberalization of prescription requirement, the overall acceptance remained very low because average couple has no easy, regular access to modern contraceptives. A substantial proportion of the rural population has had no access to family planning because the number of family planning clinics was inadequate to cover the vast rural areas. Access is especially a problem for those living in isolated, remote villages not connected by low-cost transportation to the town, and far away from the nearest family planning. All of this means that although there are family planning clinics in the rural towns, many rural people simply cannot afford the time and cost to go there for supplies and services. If a substantial proportion of the rural population could not go to the family planning clinics in spite of a desire to practice family planning for a number of practical reasons, then the program should bring the contraceptives to them right in the villages. How to bring this about? Mechai's answer is community-based distribution.

A person from each village is recruited and trained to be a distributor for the village, with a population ranging from 500 to 1,000 persons. All the distributors within a district (with a population size ranging from 40,000 to 130,000 persons) come under the supervision of a local supervisor. Locally recruited and stationed, the district supervisor is responsible for resupplying all the village distributors within his (her) district, assisting the latter in filling out the record form and collecting the filled out record forms from them. This private community-based distribution scheme is linked to and medically backed up by a government physician stationed at the District Hospital operated by the Ministry of Health. The government physician provides medical supervision over the distributors and takes care of those clients, referred to by the distributors or the district supervisors, who choose I.U.D. insertion, sterilization, and others. (See Chart I for the organizational set-up and the linkage between the community-based distribution and the government rural health delivery system.) By the end of 1977, the CBFPS operation has covered about 25 percent of the villages in Thailand. In each of the covered villages, there is a local distributor who (1) sells contraceptives to those villagers practicing family planning; (2) guides or refers interested villagers to the government

health centers and family planning clinics for methods requiring clinical attention; and (3) counters rumors.

Underlying the CBFPS village program are the following assumptions:

- 1) wider availability of an easy access to contraceptives, mainly the oral pills, will increase the acceptance rate;
- 2) utilizing the indigenous villagers as distributors rather than sending outsiders into the villagers will increase the acceptance rate;
- 3) significant reduction in time, cost, and effort to obtain contraceptives will increase the acceptance rate.

With the higher acceptance rate the fertility rate would be reduced, it was hoped. Experience of the last few years has sustained the hope. A recent survey revealed that the acceptance rate in the CBFPS villages was higher than in the non-CBFPS villages served only by the government program. It was also found that in 67 districts covered by the CBFPS, with a total population of 6 million persons, there has been a 40 percent reduction in the number of pregnancies in the last two years. The CBFPS has been widely hailed for helping reduce the Thailand natural growth rate to 2.6 in 1976, down from over 30 per 1,000 in late 1960's. The statistical data available are however of doubtful quality, and a careful evaluation of the program's effectiveness and impact on fertility remains to be done, preferably by an outside evaluation team. In spite of this, there seems little doubt that the CBFPS has helped raise the national acceptance rate to where it is. According to those who have followed the Thailand program closely, the single greatest contribution of the CBFPS village program has been its success in raising the family planning consciousness among the Thai farmers, thanks mainly to Mechai's flair for and great talent of publicity at little or no cost to the program. Mechai's publicity stunt such as the ballon (i.e., condom) contest, cracking jokes at condom, and many other ingenious devises including presenting condoms as his visit card or gift even to the visiting Vietnam dignitaries, has been legendary and a frequent commentary subject of the journalists. In his view, treating a more or less taboo subject matter like birth control in such an irreverant manner is the best approach to family planning communication. Judged from his success, he has proved to be right. One of the most remarkable things about this approach to communication is that he has accomplished this without spending the resource of the program; the journalists happily oblige with his wish by writing and joking about Mechai's harmless but attention-gathering mischieves.

## Integration of the CBD with Other Development Programs

Under the leadership of Mechai, the CBFPS has been probably one of the most innovating and exciting family planning programs in the world. It has been in constant search for better ways to induce peasants to adopt family planning. Almost from its very inception, it has cranked out one after another innovative ideas, and put them to trial through pilot projects. Most of such pilot projects come under the rubric of the so-called integrated development approach. These projects package family planning with one and sometimes more development programs designed to benefit and/or appeal to the peasants in the hope of inducing increasing numbers of them to adopt family planning. The following are projects that have been initiated or put to trial by the CBFPS.

- (1) Integrated family planning/parasite control project. In collaboration with the JOICFP, this project has been training village distributors and often selected members of the community in selected villages to serve as local parasite control agents. Upon completion of their training, they are to teach and organize the villagers to control parasites, mainly hookworm, which infect an estimate of 80 percent of Thai population. To the credit of the project managers, the project emphasizes the use of herbal medicine, whose ingredient is obtained from a plant locally available. Western drug is also made available at cost to those who prefer.
- (2) Better Market Program. Under this scheme, the CBFPS offers to buy such non-perishable agricultural products as coconuts, pumpkins, silk, and handicrafts from the farmers who practice family planning at a price 30 percent above what they can fetch from the middleman. The program also buys in bulk such commodities as seeds, chemical fertilizer, dye for silk, clothing, fish sauce, and sanitary towel and retail-sell them to the family planning farmers at a discount rate of 30 percent or more. As Mechai puts it, this is the CBFPS' way of bringing home to the farmers the immediate and tangible benefit of practicing family planning.
- (3) Non-Pregnancy Agricultural Loan. In view of the fact that the rural peasants often have a hard time obtaining needed loans from the bank, the CBFPS negotiates and obtains loans from the bank at an interest rate below the normal. The loan thus obtained is available for lending out to the farmers. A farmer whose wife remains

non-pregnant is entitled to take out a small loan at half the normal interest rate. If the farmer's wife is sterilized, he is entitled to twice as large a loan. If he has himself sterilized, he is entitled to one four times as large.

- (4) Buffalo for Family Planning Program. Under this scheme, buffalo are rented out to farmers who need them to plough their fields. Registered family planning farmers can rent them at half price. The rent thus collected is used to finance the expansion of the family planning program locally, paying for the sterilization operation or for transporting poor clients to the nearest family planning clinic. (In some areas, the buses will now accept condoms as payment for the bus fare, thanks to Mechai's persuasion. As a publicity gimmick, it seems to me, Mechai may well be advised to have all his buffalo carry a cotton cloth on their back with a sign to the effect: "The more I breed the better my boss will be, but the more my boss breeds, the worse he will be." Or something more funny than this. Mechai is very resourceful, and I am sure he can come out with something better.)

In addition to the above pilot projects, the CBFPS has recently initiated the phase one of a program aimed to train the village distributors as primary health providers in the villages. Modelling obviously after the Chinese three-tier health care/birth planning delivery system, this project faces an uncertain prospect. While the idea is sound and intention beyond reproach, the project may not fare well for a number of reasons. To begin with, to erect a nationwide network of family planning/primary health care delivery system is beyond the resource of a private non-profit organization. The success of such an enterprise requires not only determination and imagination, but also government commitment, and the support or at least acquiescence of the medical profession and the government health bureaucracy. I saw no such sign during my short visit. Furthermore, a lot of questions remain unanswered or unsettled. Are all distributors to be so trained? How about those who are illiterate but have a minimum of formal education? (Dedication cannot completely substitute for competence.) Are they going to practice under supervision and to be backed up medically? By whom? The government physicians at the District Hospitals? How closely? How about the financial arrangement? Who is going to pay for what part of service at what percent? Who is going to pay for the referral cases? By group insurance? Who is going to administer the fund? How to strike a balance between more comprehensive coverage and minimum premium? Many more questions can be asked and must be answered before such a project will become viable on a large scale. Given experience through trial and errors a feasible and/or optimal solution to these will be found. Whatever its ultimate fate, the attempt is

most admirable. Hopefully, the CBFPS will work out some pilot project (or projects) which proves to be medically sound and financially viable that it may be able to sell the idea to the government and leaves it to the latter to extend the model on a nationwide scale.

In addition to the above, the CBFPS has also been experimenting with other more orthodox approaches, such as training selected villagers, particularly the village schoolteachers, to provide demonstration on nutrition, and initiating a pilot project to find out the optimal way to teach the villagers the "appropriate technology," in this instance, the making of biogas. Needless to say, all of the above projects have intrinsic merits of their own. They will all help the farmer to improve his lot and need not to be justified in terms of family planning. The government should have undertaken steps to bring them to the farmers who constitute the majority of the population. The fact that it requires a private organization to introduce them reflects something on the Thai government. If proved to be feasible and successful, all the above projects will eventually extend together with family planning to larger areas. In view of the resourcefulness of Mechai and his colleagues, I won't be surprised if the CBFPS comes out with some new integrated development projects in the future.

#### The Lack of Community-Based I.E.M. Activities

Under the leadership of Mechai, the CBFPS has been a truly remarkable organization. It boasts a number of unique features. It is a private non-profit organization, deriving its initial funding from grants abroad. And yet within a few years after it began operation, it has covered one third of Thailand's population. It is a non-profit making organization, but has managed to achieve a remarkable 60-percent self-sufficiency in financing after two years of operation. Although it tries hard to sell the idea of family planning to people, it does not distribute contraceptives free. It sells contraceptives. Revenue derived from the sale of contraceptives is not the only source of income; it also operates some profit-making activities. It runs a Fertility Restaurant in Bangkok. At the restaurant the customers may pay their bill with condoms, and sterilized customers get a sizeable discount. It also runs four Family Planning Supermarkets at one department store and three bus terminals in Bangkok with a combined passenger flow of 500,000 per day. It also runs a Sterilization Parlour (Mechai prefers the term Parlour to Clinic which he believes turns people off) in the Bangkok's famous massage parlour district, Patpong.

The CBFPS' village program is genuinely community-based insofar as the distribution of contraceptives, especially

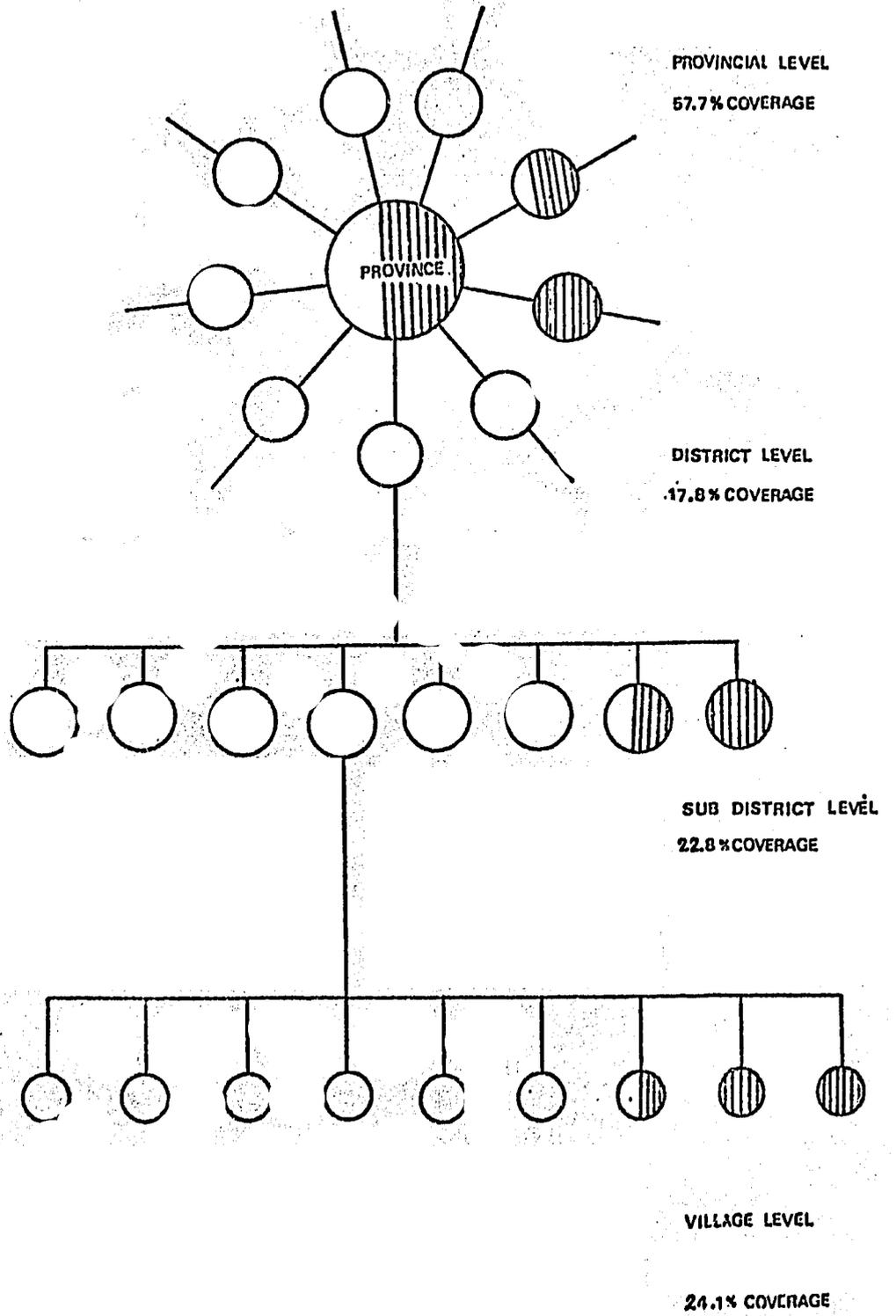
oral pills and condoms, is concerned. It is moving in the direction of integrating family planning with a host of feasible development programs aimed to find out the most optimal ways to raise the farmers' productivity and living standards, and at the same time induce them to practice family planning. With the eventual extension of the village program with its current emphasis on distribution of contraception to the rest of the country, and with the extension of those development programs that prove their worth to increasing number of villages, the CBFPS's village program will undoubtedly contribute a great deal to the spread of family planning and sustain its practice.

However, insofar as the I.E.M. component is concerned, the CBFPS' Village Program has little going for it that is genuinely community-based. It has not involved the local grassroots community leaders (e.g., the schoolteachers, police officers, village headmen, religious leaders, etc.) in the local I.E.M. activities to the extent the Chinese and Balinese programs have. There have been efforts to convert and recruit some local leaders, especially schoolteachers to endorse and legitimize family planning, or to use them as local distributors (and, in the pilot project areas, as nutrition demonstrator and parasite control agent). However, little or no effort has been made to capitalize on the local leaders' influence with their fellow villagers in a more dramatic and/or institutionalized manner. For example, in spite of Mechai's flair for publicity, the program has expended energy to persuade all the relevant community leaders to practice family planning and to publicize this as a device of persuasive communication among the villagers. In other words, the principle of persuasion and leadership by personal example, at the community level, so systematically exploited by the Balinese and Chinese programs, has been ignored by the CBFPS.

Secondly, the CBFPS has no readily accessible social organizations at the grassroots level, such as the banjurs in Bali and small groups and production teams in China, that it may utilize as a forum to conduct I.E.M. activities at low cost and in a sustained manner. In Thai villages, there simply exist no social organizations that encompass all the relevant population within the community and that meets regularly for practical and vital purposes. While no fault of the CBFPS, the absence of such communal social organizations makes it more difficult for the CBFPS to "institutionalize" family planning at the village level. Could the CBFPS find or create the structural equivalent of the Bali's banjurs or Chinese production teams whereby it may achieve the institutionalization of family planning at the village level?

1977

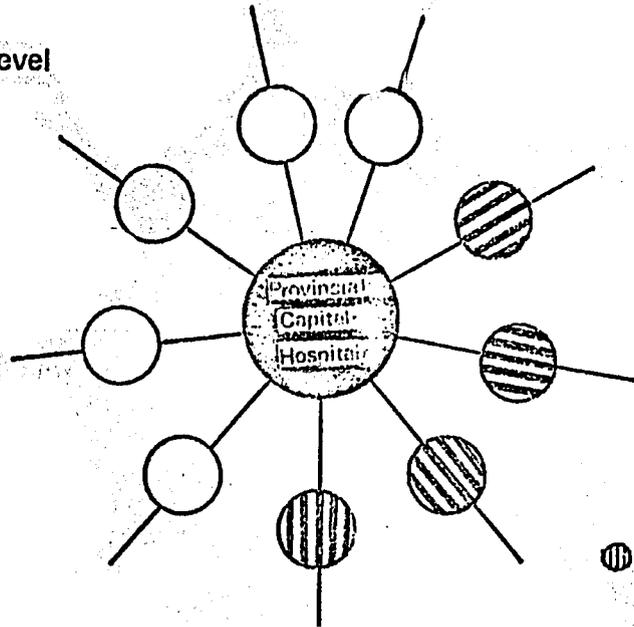
CBFPS COVERAGE IN EACH PROVINCE OF THAILAND



1977

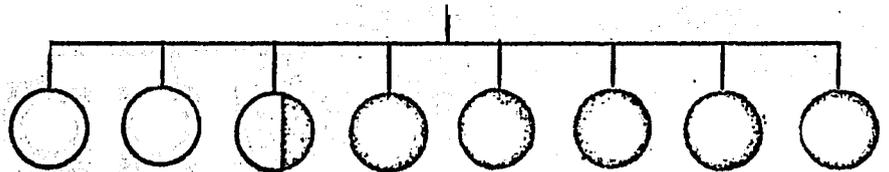
HEALTH SERVICE COVERAGE IN EACH PROVINCE OF THAILAND

District level



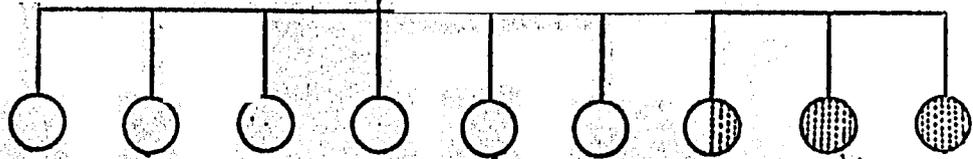
① District Hospital 44.4% coverage.

Sub district level



② 2<sup>nd</sup> Class Health Center 68.2% coverage

Village level



③ Mid-wifery Center 3.7 coverage

④ CBFPS Operation Village 27.8 coverage

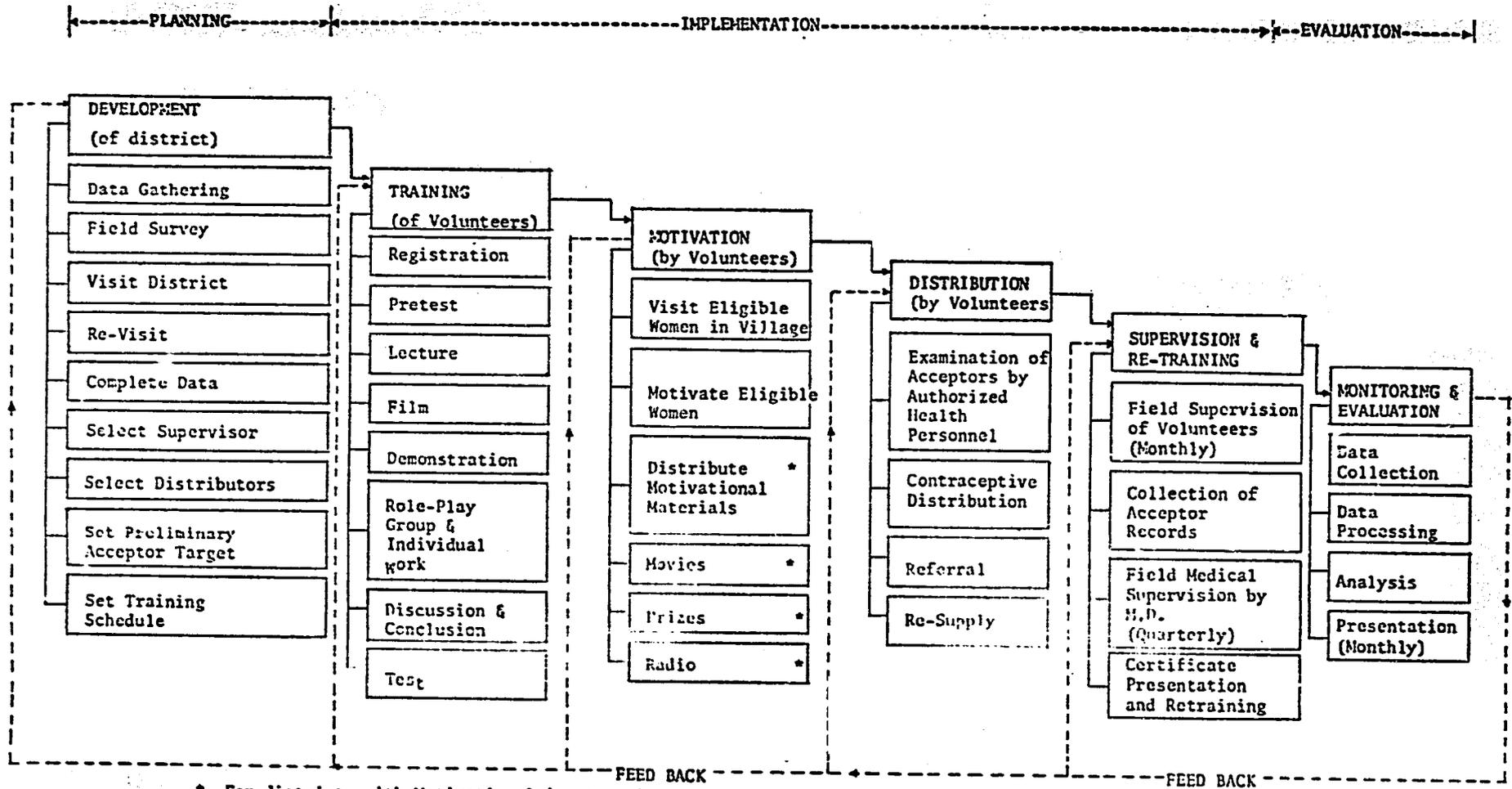
On the average:

1 Province = 9 Districts

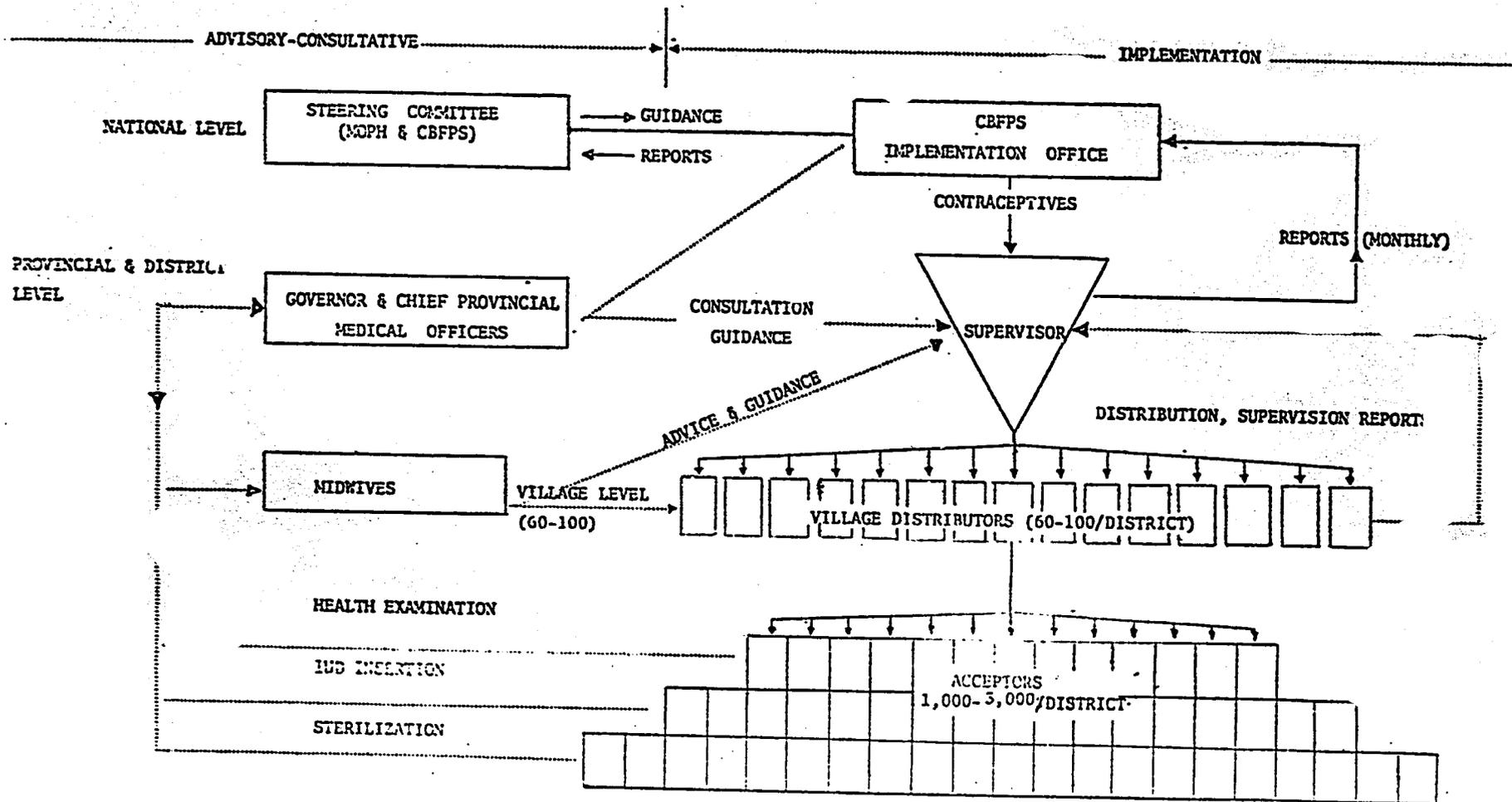
1 District = 8 Sub districts

1 Sub district = 9 Villages

**PROCESS OF COMMUNITY BASED FAMILY PLANNING ACTIVITIES**



CBFPS ADMINISTRATIVE & DISTRIBUTION STRUCTURE



# LOCATION OF CBFPS OPERATIONAL DISTRICTS

