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NEW DIRECTIONS IN  
POPULATION COMMUNICATIONS  
FOR THREE DEVELOPING COUNTRIES

A Report Prepared By:

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Background

The U. S. Agency for International Development has played a dominant role, for more than a decade, in assistance to Population/Family Planning programs in less-developed countries around the world. Throughout those years, AID has maintained a central organizational capability for supporting a wide variety of efforts that sought to inform, educate and stimulate great masses of the populace of those countries (especially the rural poor) in the practice of effective fertility control. Through the Information/Education Division within its Office of Population, AID has used its own staff and the specialized talents of private and public institutions and individuals to build or strengthen the motivational elements of those LDC programs, both Governmental and non-Governmental. No aspect of what has been called IE&C (Information, Education and Communication) has been ignored, whether it be research, training, documentation or equipment and educational materials. And AID's concern has ranged across all of the known techniques that can be considered to fall under the rubric of IE&C -- from the mass media and interpersonal communication to incentives and leadership indoctrination.

With help from an array of international development agencies and specialized population organizations, scores of LDC population programs have matured beyond the stages of organizing, demographic stock-taking, gearing up, spreading awareness, and experimenting. In many places, rising acceptance curves leveled off as programs captured those who were more accessible or already inclined toward family planning practice. A number of persistent, if not seemingly immovable, barriers to program success were discernible, in varied shapes and combinations, from country to country. Prominent among them are: lethargy or veiled unconcern among some political and program leaders; an insufficiency of public communication and transportation; a lack of trained and dedicated professional program personnel in the field; and deep-seated, age-old traditions that are inimical to deliberate personal action limiting family size to demographically acceptable numbers.

Partially in response to that condition, and as an additive to its continuing efforts on many fronts, the Office of Population attempted, as far as its budget would feasibly permit, to make oral contraceptives and condoms widely available, where appropriate, through sources as close as possible to where eligible couples live or work. This strategy continues today. It has proved itself in other programs, especially in marketing of commercial products.

The basic premise is simple: a commodity without high intrinsic appeal is not likely to be widely coveted and sought if it is hard to obtain; if it is readily available, a commodity that is perceived as (or known to be) useful or pleasurable will enjoy wider acceptance and use. The premise is generally unassailable, for non-clinical contraceptives can be compared, in some measure, with aspirin or tea, in terms of demand/availability.

But for many in the population community (and indeed for some outside observers) the "availability concept" seemed risky and uneconomical. Unfortunately, the strategy was termed "inundation" in the days following its inception; visions of condoms and pills raining upon LDC villages drew seemingly valid criticism from several quarters and on several self-evident counts. Much of that opposition to the availability strategy was grounded in the argument that contraceptive products are not popular soft-drinks; their use demands high motivation, a radical distortion of accustomed behavior in a highly personal matter. It was argued that although the very presence of contraceptives carries with it a certain amount of information, education and communication, it was nonetheless incumbent on a benevolent donor, such as AID, to insure that prospective consumers know and understand the use and possible implications of contraceptives -- let alone those of family planning itself. In short, it seemed to some that AID was ignoring IE&C as an obviously needed concomitant of contraceptive availability.

In early 1977, in conversation with Dr. Reinert T. Ravenholt, Director, Office of Population, AID, this writer raised that issue. "It is not that we are ignoring IE&C," said Dr. Ravenholt. "It is simply that we have not seen any evidence thus far that IE&C has any appreciable direct effect on the volume of contraceptives used."

"I think," replied the writer, "that's because nobody has tried the right kind of IE&C." The writer expressed his belief that conventional "Western" IE&C techniques -- characterized by posters, pamphlets, flipcharts, films, radio programs and visiting field workers -- are impotent in changing the fertility behavior of village people in traditional societies. That there are established traditional forces in the developing countries, that are effectively used to gain public participation in urgent national programs other than family planning. Those forces may be political, or they may be religious or administrative. They work through hierarchies that descend into the village, and they are brought effectively into play for national elections, military emergencies, lotteries, censustaking, disease control, patriotic demonstrations -- wherever, in short, a country's topmost authority desires public action that it considers to be in the national interest. In such cases -- wherein a national program is considered a "must" rather than a "should" program -- conventional IE&C

media and techniques may be used as incidental reinforcement, while the interpersonal "chain of command" carries the primary persuasive message. And because the chain of authority is strong at every link, the message is carried, undiminished, to the farthest corners of the country, into the villages.

There must be ways, the consultant suggested, in which the sources of both contraceptive supplies and their accompanying IE&C can be activated within villages, through such organized networks of formal and informal leaders. And yet, he explained, all countries differ widely in the nature and condition of their social, political and administrative structures, as well as in the state of their population programs and the forms of family and community relationships. Each country must be studied for what it is --for its own communication resources and potential -- and not for the opportunities and obstacles it may present to the introduction of a particular mix of conventional communications media.

Out of that conversation (here freely paraphrased), came a challenge: "Select three or four likely countries, visit them and see whether you can introduce in at least one of them, an IE&C program that will result directly in a significant increase in the off-take of orals and condoms". In a later memorandum (see Appendix A), the goal for the Consultant's assignment was restated, adding that the entire value of this assignment will be judged, according to whether clearly effective information programs are implemented in at least one and preferably several countries during the next year or so. (See Appendix B)

#### Modus Operandi

There began then, in Washington, a process of grossly reviewing the Population programs and their IE&C elements in the 56 LDCs that receive Population assistance from AID. This was achieved chiefly through discussions with PHA/POP staff familiar with programs in the candidate countries and through study of documents. The criteria for country candidacy were: (1) that a program of non-clinical contraceptives delivery be substantially operational; (2) that at least a minimal IE&C unit had been established in the national Population structure; and (3) that there be a clear national commitment openly to promote family planning in the country. Above all, the Consultant felt, it would be absolutely necessary that the national program leadership understand the purpose of the Consultant's visit and welcome it.

Preliminary screening narrowed the candidate countries to Indonesia, The Philippines, Thailand, Tunisia, Egypt and Ghana. Concurrences were received first from Indonesia and Thailand. The AID Population Officer in Manila declined to participate, having before him a massive critical evaluation report of the Philippine program. At the same time, the

Population Commission was still digesting a large set of IE&C recommendations left behind a month earlier by another American consultant.

Each of the AID Population Officers contacted in the field were asked to be sure that the appropriate national program person understood the purpose of the visit and concurred in it. In the case of Ghana, the Consultant had the good fortune to meet Dr. A. A. Armar, Executive Director of the National Family Planning Program, in Washington. (See Appendix D)

On July 31, the Consultant left for Indonesia and Thailand, leaving in PHA/POP/IE hands the completion of negotiations for one more country, out of the remaining three candidates (Ghana, Egypt and Tunisia). Concurrence from Ghana materialized later, and it was decided that three countries would suffice for the allotted time remaining.

As far as would be possible, the Consultant's approach was to concentrate in each country on unearthing the major true reasons, in the minds of eligible men and women, for acceptance and non-acceptance of modern contraception. Many reports of KAP studies in LDCs have attributed a great deal of non-acceptance to "acceptable" but superficial reasons (such as "no need", "health", "religion", "physical", "emotional", "intend to practice", "no reason", and "other"). Experience has shown, in fact, that many of such declarations to interviewers are disguises for "unacceptable" reasons (such as non-specific fear, distance from health center or clinic, husband domination, lack of knowledge, embarrassment and loss of time at clinics, rumors, and plain lethargy in the absence of illness, pain or other perceived urgency).

Second, the Consultant needed to understand the existing and planned condition of IE&C support in the official Population program, as well as that of major non-governmental programs, where such might exist. This would involve a rapid survey of IE&C facilities, personnel and programs; identification of persons able or prepared to modify IE&C strategies as might be deemed necessary; and the study of IE&C operations and effects at public-audience levels. Instead, he spent as much time as he could in villages and towns, talking with "eligible" men and women and local family planning officials and workers. Thus, the Consultant attempted wherever possible (with due sensitivity to local pride) to avoid the standard tour of pilot projects and lengthy official briefings. (See Appendix E, "Report of visit to Karanganyar and Surakarta").

Third, it would be necessary to understand in each country the attitudes and actions of the AID Mission, as well as those of pertinent other donor agencies in the area of assistance to IE&C support of government and/or private Population efforts.

A list of persons contacted during this consultancy assignment is not included in this report. It can be made available on request. It includes virtually all of the professional staff of PHA/POP in AID/Washington; Mission Directors; the heads of government and private national Population/Family Planning programs and their IE&C staffs; relevant officials of other donor agencies; medical, paramedical and motivational personnel who deal directly with the public, and approximately 200 male and female family planning acceptors and non-acceptors in villages and towns.

### In The Field

In the three sections that follow, this report will deal separately with the Consultant's visits to Indonesia, Thailand and Ghana. The development of IE&C strategy, totally or in part, proceeds from knowledge of both country-specific political-economic-cultural conditions, as well as from knowledge of national public and private Population/Family Planning programs themselves and existing and potential IE&C capability and practice. While it was necessary for the Consultant to gather those kinds of general intelligence, there is no attempt here to provide detailed and complete pictures of either the countries or the national programs. Such background is more than adequately set forth in voluminous existing documentation from AID and other institutional sources. As has already been explained, the Consultant was asked to attempt suggestions for modification or enhancement of IE&C strategies that could result, within a year or two, in marked boosts in the offtake and use of oral contraceptives and condoms. The following country-visit reports, therefore, will attempt as far as possible, without sacrificing essential supporting information, to relate succinctly those actions taken by the Consultant in each country and the impressions and new thinking he may have left behind.

Finally, it should be pointed out that while the Consultant was asked to focus on IE&C support for the non-clinical contraceptives, he could not help but consider seriously the broader frameworks of the country Population programs studied. Thus, in Thailand, for example, while orals and condoms presently provide the major basis for both the government and private family planning effort, there are strong moves into sterilization, and injectables hold promise of assuming a large role. It would have been less productive under those circumstances to consider community-based distribution of contraceptives in isolation.

## I. INDONESIA

### A. OVERVIEW

There is little question that among Asia's developing countries, Indonesia has gone farthest in taking the sources of both contraceptive supply and information-education to the villages. (We choose to disqualify The People's Republic of China, Singapore, Hong Kong, Taiwan and Korea from the status of "less-developed country"). And yet, even as the BKKBN (National Family Planning Coordinating Board) begins to move actively into programming in the more difficult Outer Islands, it is clear that prevalence rates for pills and condoms in the "easier" regions of Java and Bali, while admirable, are too low, and dropout rates too high, for Indonesia's population managers to rest on their IE&C laurels.

That is not to say that the BKKBN (notably in the person of its extremely able and imaginative Deputy Chairman III, Dr. Haryono Suyono) does not energetically continue to monitor its program closely and re-examine its strategies and results continually. The visit of this Consultant, however, provided an opportunity for discussions that led to confirming the validity of the underlying Village Contraceptive Distribution Center approach, but more importantly to seeing new IE&C steps that might make that approach even more effective in terms of increased contraceptives use.

As of May 1977, the prevalence rate for all contraception methods in Java, Bali and the new (partial) Outer Islands program area was reported as 19.4% of MWRA. For Java and Bali alone it was 24.9%. The drop-out rate for oral contraceptives as a first method in Java, Bali was reported to be 67.7% after 36 months. Similar figures for condoms are hard to come by, since the sample becomes too small after 24 months at which point the adjusted cumulative continuation rate for condoms as a first method in Java/Bali is reported as 52.1%, representing a drop-out rate of approximately 48%.

It is important to note that the picture of Indonesian birth prevention runs the gamut of virtually all known methods. The IUD, which had suffered its usual decline, is receiving BKKBN attention and appears now to be recovering significantly. As long ago as November 1975, BKKBN stressed the IUD in an intensive family planning drive in East Java. The result: the IUD accounted for 25% of new acceptors in the campaign, against 10% in the regular program. In Yogyakarta, 38% of current users have IUD's against 36% on pills and

22% for condoms. Nationwide, where the family planning program is active, the IUD-pill ratio was a little better than 1:2. In places where Depo-Provera and female sterilization are offered, the results bode well for those methods, especially among Christians. In one Christian village in North Sulawesi, where 317 out of 352 eligible couples were said to be using modern contraception, the method breakdown showed: orals, 112; IUD, 80; condoms, 40; and injectables, 51.

None of the foregoing is intended as a complete reflection of the current state of contraception in Indonesia. The point to be made is that over the long range there appear to be considerably fewer method-related obstacles in the way of real program success for Indonesia's well-organized, well-planned, well-implemented population program than one would expect in a country that must, after all, be considered truly to be an LDC.

But program performance is merely the backdrop for four major sets of observations, or issues, that contributed to the IE&C conclusions arrived at during the Indonesia visit. Those four principal issues relate to: 1) the husband's position on contraception, 2) the national political-administrative hierarchy, 3) reasons for non-practice of contraception, and 4) public understanding and public talk concerning contraception.

### The Husband

We know that throughout the world, in less developed areas or not, it is indeed the rarest of married women who can act openly upon a desire to prevent her next pregnancy or curb her fertility with a contraceptive drug, device or surgery without the advice and consent of her spouse-in-residence.

Indonesian husbands, taken as a mass, are by no means homogeneous in their life styles, philosophies, worldliness, or their knowledge and attitudes concerning contraception. Differing religions and ethnicities, of course, play a large role in all of those characteristics. It seems, for example, that among Christian families in the eastern portion of North Sulawesi, wives can generally express and explain to their husbands a desire to contracept and can win their concurrence. In the western area of the same province, a Moslem wife dare not speak out on the subject. Indeed, as one of perhaps four wives in a polygamous marriage, she is not likely to jeopardize the protection and security provided by husband and community by attacking the institution of prolonged fecundity. Thus, in varying degrees and intensities, the Indonesian husband consciously decrees -- perhaps without have ever to say a word -- that childbearing shall go on and on and on.

### Political-Administrative Hierarchy

We have already mentioned the political-administrative hierarchy, reaching from the capital city to the villages, that is used with such unmitigated efficiency (in virtually every LDC) in the achievement of a variety of goals perceived by top leadership as necessary for the "national good". While it is true that the Government of Indonesia has given high priority to its Population program, and has given program responsibility to provincial governors, the program is conducted largely through non-political public entities, without the strong non-nonsense push that characterizes programs involving national security and political survival. Family Planning, as we have noted, is a "should" program, rather than a "must" program.

### Reasons for Non-Practice of Family Planning

As in other countries, the Indonesian program, despite its relative success thus far, faces the twin challenge of a sizeable "hard core" of non-acceptors and large masses of persons as yet unreached in remote, often isolated, areas. Like other programs, the Indonesia program has had to aim its face-to-face IE&C at eligible women, partly because of the limited availability of effective male methods and wherever tradition and male dominance work strongly against the adoption of male sterilization. It would appear, therefore, that in Indonesia it will be necessary to explore ways in which those barriers might be overcome, if the program is to reach its stated goals in time.

### Public Consciousness of the Program

To what extent does the idea of family-size limitation occupy the minds of Indonesia's rural millions? The answer, in Bali at least, is a credit to BKKBN's strategy of taking both contraceptives and IE&C into the village and of placing responsibility for program execution in local hands. And there are areas in Java where the handy availability of contraceptives keeps the subject of family planning in the public eye and ear. But Indonesia has yet to achieve widespread, continuing consciousness of family planning and of the family planning program. What is needed as a condition for individual acceptance of contraception is open community acceptance of the central family-size limitation idea and a dispelling of embarrassment, where such might exist, about contraceptive devices and methods and how they work. Later, we will discuss a simple, low-cost, trouble-free device that holds promise of achieving such an "airing" of family planning ideas in villages.

The BKKBN, with responsibility for coordinating the entire population program, has already recognized the validity of putting into local hands the twin tasks of contraceptives-delivery and IE&C:

"....the ultimate success or failure of the family planning program....depend(s) on the degree to which fertility control and the small family norm are accepted by the community itself and on the degree to which the community bears the ultimate responsibility for motivating, recruiting and maintaining family planning acceptors and for supporting and reinforcing the small family norm."

"....Tailoring the program to the community requires the complete involvement of community forces to assist in the attainment of what are hoped will become essentially community-defined goals and objectives. Harnessing these forces consists of a step-by-step procedure of identifying and training those key individuals who have the capacity to organize and positively influence others. Such individuals include formal leaders to whom the people traditionally turn for guidance and advice in personal and community matter, such as the village chief, his staff, the local religious leaders and the school teacher."\*

Those statements of program strategy represent an all-important giant step toward program success for Indonesia. Indeed, it must be acknowledge that wherever that strategy of community involvement has been instituted, the results are solid and significant. Nonetheless, while social pressure within each community may eventually generate a radiating effect to those who, for one reason or another, practice modern contraception ineffectively or not at all, the motivation of eligible couples to terminate fertility at demographically acceptable levels -- certainly at fewer than three or four children -- will continue to be relatively weak and sparse. The BKKBN strategy document goes on to say:

"It is the community and its residents who are expected (emphasis supplied) to shoulder the responsibility for encouraging married couples to accept and practice family planning, for sustaining the motivation and participation in the program, and for educating, through the socialization process, the youth in the community in the small-family norm."

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\*Badan Koordinasi Keluarga Berencana Nasional: The Indonesian Family planning program: Basic Strategies; Oct. 1976

"The task of transferring these functions and responsibilities to the field is enormous. The government does not consider such a transfer to be possible without a simultaneous improvement of other aspects of the life of the individual and his community ...For this reason family planning is working in close conjunction with the national development program for the rural areas and is striving both to make population and family planning a component of development and development a component of family planning."

"In short, the family planning program...is working in concert with other programs to create a community network information system which will create a dynamic responsibility for disseminating, maintaining, institutionalizing and culturalizing the small-family norm in the community".

Again, in comparison with a majority of other LDC programs, the Indonesian program must be applauded for the insight and logic of its strategy. During the Consultant's visit, however, it became clear that the present mechanisms for energizing in-village leaders to win new acceptors and re-supply them with contraceptives must in some way to be reinforced, extended or supplanted with a powerful and persistent local stimulus that can prod eligible non-acceptors into contraception and assure the widest possible continuation of effective contraceptive practice. That is especially important now that BKKBN is moving into the Outer Islands, where logistics and motivation will prove more difficult than they are on Java and Bali, and also as the program increasingly emphasizes the more lasting of available methods.

Discussions with Dr. Haryono Suyono and provincial BKKBN officials indicated that need. Indeed, Dr. Haryono has revealed that BKKBN has begun studies and project experiments looking toward such an intensification and improvement of IE&C activity.

B. . NEXT IE&C STEPS FOR INDONESIA

The Consultant devoted most of the Indonesia visit to talking with acceptors and non-acceptors in villages and hamlets and with program persons at all levels -- national, provincial, regency (district), sub-district and village. Possibilities for more effective IE&C efforts were discussed with Dr. Haryono and other program officers at several points. The thinking that emerged during those discussions related to the desirability of embarking on an IE&C operation whose principal feature will be the employment of the existing political-administrative hierarchy to influence resistant rural husbands toward permitting their wives, as a beginning, to practice effective contraception. That strategy, if successfully "sold" to Indonesia's leaders, is not only the best response to current insufficient rates of birth preventions attributable to orals and condoms; it can also provide the basis for later IE&C efforts that will be needed to boost the acceptance of sterilization, both male and female.

Also discussed were two preparatory steps that need to be taken before BKKBN can institute an effective male-targeted IE&C effort through the political-administrative system. One is the careful orientation and instruction of three levels of local political-administrative leaders. The other is the conduct of special short-lived studies to uncover the most prevalent of reasons in the minds of husbands (especially Muslims and Christians, with Chinese possibly to be studied later) for failure or refusal to accept the notion of contraception, either for spacing or fertility termination.

In order to make more comprehensible our later explanation of the proposed use of a portion of the important political-administrative structure, let us first look more closely at the two preparatory steps. In doing so, there is no value in conjecture by any non-Indonesian about the specific ways in which those steps -- nor, indeed, the use of the political-administrative system itself -- should be executed. We are dealing with uniquely Indonesian institutions and traditions; only Indonesians will be able sensibly to proceed from planning to implementation.

For convenience, the two preparatory steps may be regarded as the "research" and "training" elements of the proposed IE&C technique. However, neither bears much resemblance to its label.

### Research

Standard KAP survey techniques, characterized by interviewers administering written questionnaires, would be inappropriate and subject to distorted results in an attempt to unearth from the depths of the rustic male mind the true underlying reasons for the avoidance or rejection of modern contraceptive methods. There is abundant, if as yet unrecorded, evidence that significant numbers of Indonesian men harbor inchoate feelings of repulsion to deliberate prolonged contraception. Asked to justify those feelings, most such men tend to declare, and perhaps consciously believe, that they are restrained by their religion or by anticipated side effects. Some give no reason at all.

One might hypothesize that (especially for a Muslim man) the family planning program, in the form of visiting field worker or mass communication message, represents an unwelcome interference with his unquestioned right to direct the daily behavior of his own family and, more important, his right to originate and decree any change in that behavior. From the comments of some village Indonesian men, it might also be hypothesized that messengers of family planning represent an assault also on his unquestioned right to conduct his own sexual affairs as he sees fit. He seems to be saying: "If anyone is to tell my wife to travel to a clinic and subject herself to the insertion of a strange plastic thing in her most private part, then it will be I who tells her and not a stranger".

While such "reasoning" may not be programmatically acceptable to those concerned with national rates of contraceptive prevalence and population growth, experience has amply shown that such "reasons" are nonetheless powerful deterrents to contraception and have withstood the relatively mild probings of field workers and family planning motivational films. So it will be necessary first to understand better the nature and extent of male resistance to family planning that appears frequently to rest on varying combinations of inertia and what has been called machismo.

It should be obvious that research designed to accomplish those ends -- as a prerequisite for shaping the special communication described below -- will have to rely on a form of dialogue lacking many of the visible tools of the interviewer. Indeed, those who conduct such informal talks with village husbands must be persons who are identifiable as

being as "local" as possible. The size of the sample need not be large, and the persons selected to sit and chat with village husbands can be District and sub-District program persons who themselves originate from the locale being studied and who "take" to the brief orientation that will be necessary to prepare them for their work. They should probably be married men. As appropriate, both "group" and "one-to-one" talks would be conducted. There seems to be a willingness on the part of most village husbands to speak their minds with a "local" person who merely dropped in for a light-hearted chat.

### Training

The second step preparatory to the launching of the IE&C operation itself is the orientation and instruction of sub-District heads (camat) in their task of instructing and directing village chiefs (lurah) and sub-village chiefs (bayan) in their task of bringing eligible husbands (suami) to acceptance of the notion of modern contraception.

Before this "training" can be accomplished, there will necessarily have been a decision, taken at high level, to use this powerful communication channel in the cause of population growth management. The role of each camat will be largely to transmit to the lurah (from 6 to 20 such village chiefs, roughly, for each camat) the government's expectation that all eligible couples who have reached a certain parity level will adopt and sustain an effective method of contraception.

The camat, the key person in assuring the success of the program, will need more to be imbued with the importance of success than to be instructed in the details of contraception. As such, the indoctrination process for him may be relatively brief, but it should be conducted in an atmosphere that suggests to him the importance of the role he is being given. The camat may be brought to provincial capitals in groups of 100. Of utmost importance is the involvement of the Governors in the opening session of the "training", which could be completed in as little as one full day. Those who speak to the gathering, especially in outlining the camat's specific functions, must be dynamic officers of the national and provincial BKKBNs.

The camat will assume primary responsibility for arranging the training of his lurah and for being present while the district and sub-district program personnel explain the benefits and necessity of family planning, as well as appropriate details of contraception, rumors and motivational methods.

#### The "Ca-Lu-Ba-Su" Channel at Work

While the President, the Governors and Regency heads (bupati) will play an important role in launching the IE&C program, the essential operational roles will be played at the "lower" three levels of the hierarchy: the sub-district (kecamatan), the village (desa or kalurahan), and the hamlet, or sub-village (dukuh). And the central function of this compact system will be to persuade eligible rural husbands (suami) to choose one of the effective contraceptive methods, either for their wives or for themselves. (Special programs usually fall victim to a tendency to invent acronyms. This IE&C activity seems to lend itself to the acronym, CALUBASU, representing the human motivational chain, from CAMat ("C" pronounced "ch") to LURah to BAYan to SUami).

The CALUBASU technique should not displace the existing excellent BKKBN system of village-level motivation by program personnel and outspoken informal village "leaders". Nor does it involve large expenditures of funds. Its attractiveness lies, as we have pointed out, in its persuasive strength. No element of coercion should be inferred; the CALUBASU chain of authority is an effective way to strengthen the public information and education process, and it has worked for other national movements.

#### The Hand-Powered Movie Viewer

Most short-term observers of the Indonesian family planning program, who quite naturally spend their time with program officials and ongoing projects, come away with the impression that modern contraception enjoys a place of prominence in village life today. Indeed, as we have already noted, there is general high awareness of family planning wherever BKKBN is active. The program in Bali, to cite the best example of such success, has achieved extraordinary "airing" of the subject in most villages, through monthly meetings where rosters of acceptors are read out and updated, and through the marking of acceptor's houses.

The fact remains, however, that BKKBN now faces the more difficult task of bringing family planning into the open in the Outer Islands and even in some areas of Java. As a possible aid to achieving such an airing of family planning, the Consultant discussed with Dr. Haryono and the Mission the use of a new hand-operated movie viewer known as the Ortho Health Communicator. Both Dr. Haryono and the Mission were already familiar with the device, and the Consultant's visit may have served to examine its potential more closely.

The "Health Communicator" is made of rugged plastic. It is hand-held, and a crank is turned to activate an endless loop of 8mm color film that runs up to three minutes. The film is contained in a cassette, making it possible to interchange different films by simple insertion of the cassette. The machine is used by one person at a time. The film can be stopped at any point and run at varying speeds and backwards. The device seems to be virtually indestructible and trouble-free and can be operated by anyone without instruction. Purchased in quantity, the unit price may be as low as \$5.

As we envision the use of this device, a village chief could permit it to circulate from person to person and then returned to him. Obviously, it would take only a few days for it to complete the village circuit, and it certainly would get into the hands of everyone, including children. The village chief might have three different cassettes, and would circulate one at a time.

The content of the films is the most important feature of this little system. The purpose would not be to preach family planning or to explain methods, but rather to present simple, light-hearted, even humorous, sketches, perhaps in cartoon form -- films that would evoke interest, laughter and conversation -- with a basic small-family theme.

#### Prospects for Implementation

Among those BKKBN program officials with whom the Consultant spoke, there was general interest and acceptance of the four IE&C elements described above. It will be necessary, of course, for the Indonesians to further explore their feasibility.

Dr. Haryono Suyono said the BKKBN program already had "given responsibility" to the Governors and local political-administrative leaders, and that

it would be worth considering a specific intensification of that approach through the kind of structured educational process suggested. Winarno Wiromidjojo, BKKBN Chairman for DI Yogyakarta, said he saw no reason why such an IE&C program aimed at husbands could not be mounted in that province. The UNFPA Coordinator, Ms. Petra Osinski, briefed at the suggestion of the Mission's Charles Terry and Bill Johnson, was keenly interested in the research suggestions. (See Appendix F).

The Ortho Health Communicator, the hand-operated movie viewer, was already known to both the Mission and to Dr. Haryono. In fact, it was in Indonesia on this visit that the Consultant saw it for the first time. It was reported that the Mission had asked AID/W for price details, but had not yet had a reply. (In Washington, the Consultant again brought this to AID's attention). In any case, the Consultant sees a significant role for this seemingly indestructible device --but only if the films to be produced present family planning in an entertaining context. (For a view of the less formal aspects of one Consultant's activities in developing his conclusion, see Appendix G).

## II. THAILAND

### A. OVERVIEW

If anything is clear in the Thai national population program, it is that the path to certain demographic success lies chiefly now in combining (and coordinating) the delivery of both information about family planning and the availability of contraceptives and contraceptive services.

It is true that the Thai program has tested and is using a variety of techniques, both for IE&C and for making available virtually every major modern contraceptive method. This report, however, based on discussions with Thai program personnel at many levels and with acceptors and non-acceptors in several separated rural areas of the country over a period of 19 days, sets forth a specific IE&C approach that is not only appropriate for Thailand but is feasible and, indeed, has been successfully tried, in part, in that country.

#### The Present Situation

We are concerned here with the roles of USAID and of two major Thai agencies as they seek to apply most effectively funds intended to inform and stimulate eligible Thai couples toward sustained contraception. Two separate AID grants to the Ministry of Health are involved. One is a contribution of \$8,340,000 to the Ministry's Population Planning Project over the period FY 1976-81; the other is earmarked for the private sector's Community-Based Family Planning Services and provides approximately \$850,000 for a four-year project designed to determine the relative effectiveness of four modes in the delivery of orals and condoms in 80 Districts (population approximately 5.6 million).

The Population Planning Project envisions the use of approximately \$7 million for commodities, \$862,000 for training, \$450,000 for local research, and \$100,000 for completion of a multi-year effort to incorporate family planning information into the RTG's functional literacy training program. The FY 1976 Project Agreement contained no discernible provision for IE&C support of contraceptives distribution and other elements of the project. The FY 1977 ProAg (Revision 4) provides for a USG contribution of \$170,000 and an RTG contribution of the equivalent of \$60,000 for direct IE&C support of the voluntary sterilization program. It includes the procurement of

audio-visual equipment for 40 mobile motivational teams and materials production. An additional joint contribution totaling \$234,000 is provided for: (1) regular meetings of provincial health officers, mobile service teams and NFPP program coordinators (\$80,000); (2) a study to determine the effectiveness of traditional puppet shows in family planning motivation (\$20,000) (see Appendix H), and (3) per diem costs of 40 motivators and 40 drivers in the mobile motivational teams (\$134,000). While these latter items may be considered under the rubric of IE&C, their relevance to the task of increasing demand and promoting sustained contraceptive practice is only indirect.

In the second project, implemented by CBFPS in 80 districts, USAID appears to have committed \$41,000 toward IE&C support for FY 1977, the first operational year and approximately \$177,000 over the life of the project. However, because of the inclusion under IE&C of all project items labeled as "documents and materials", only as little as approximately \$5000 may be available for direct IE&C needs in the first year. The intention is to assist CBFPS in fielding motivational teams armed with films and printed materials, borrowing the audio-visual equipment that is being provided to the IE&C unit of NFPP under the larger Population Planning Project.

The IE&C Unit of NFPP, headed by Ms. Patama Bhiromrut, a conscientious and imaginative person, operates ten mobile motivational teams. In vehicles equipped for 16mm film projection and public address, these teams are normally coordinated in their village visits with the movements of the 17 mobile sterilization teams. With funding from AID, the RTG and other sources, the NFPP's Population Planning Project calls for an eventual 37 service units and 37 IE&C units. The IE&C teams precede the service teams in pre-selected villages, conduct daytime meetings for leaders of two or three villages and announce the evening film show. Typically, the team projects two or three short family planning motivational films and one full-length Thai feature film. Local family planning program officers frequently join the team and talk to the crowd about contraception and family planning.

That basic pattern is followed also by CBFPS, the private organization headed by the renowned and daring Mechai Viravaidya, but with two important differences. CBFPS maintains a network of distributors and supervisors engaged in the sale of contraceptives. These persons, well trained and continuously supervised and helped,

are of local origin; they and their points of sale are known to villagers. CBFPS has three mobile motivational teams that have usually to rely on NBPP and its Provincial and District officers for equipment. Local buses are used extensively in CBFPS field operations. Dedicated personnel from the Bangkok headquarters personally supervise field operations, including the village motivational meetings and evening film shows.

Because it is obvious, especially from the Mechai experience, that the most effective carriers of family planning messages are persons who are known and trusted neighbors, NFPP is moving purposefully into programs to enlist teachers, religious leaders and "village volunteers".

Both the NFPP and Mechai programs also utilize a variety of other IE&C media, in addition to the village-level use of films, talks and meetings. They include television and radio, posters, pamphlets, the press, and educational kits in the hands of clinic extension workers. Mechai, as is well known, has gained nationwide (and international) attention for family planning with the sale of such items as family planning tee-shirts, a family planning song for school children, a challenge to Mohammed Ali to undergo a vasectomy on television, and family planning "boutiques" in Bangkok. In addition, some 13,000 midwives have been trained, albeit briefly, in family planning, with some attention to techniques of face-to-face motivation.

There is, of course, a firm national government commitment to control population growth. Provincial and District officials -- at least wherever the program is well established -- are supportive. Health officers at those levels, charged with population/family planning program responsibility, seem generally knowledgeable and eager to make a good showing on the acceptor charts. Mechai's field supervisors seem to have gone farther (with their empathetic person-to-person approach) than NFPP has in stimulating the interest, even zeal, of village heads and of the country's upper-echelon political, civic and religious leaders.

There are still other factors and circumstances in the present Thai situation that are relevant to this appraisal of opportunities for increasing the demand for orals and condoms and generally hastening program success through the application of an improved IE&C strategy. Where the program has been active, it is not uncommon to find the practice of several methods (IUD, female sterilization, pills, rhythm, Depo Provera, foam, condoms) prevalent in areas as small as a village. That is unusual, as Population programs go in the developing world, and it bespeaks not only the maturity and breadth of the Thai program but also the independent

thinking of a great many village women.

Nevertheless, over the entire country, it is clear that levels of contraceptive-method knowledge and, more importantly, levels of method availability play foremost roles in determining relative levels of acceptance of the various methods than can be provided by the program. Thus, while Mechai's Annual Customer Survey for 1975-76 reported that 46 per cent of villagers were not interested in the injectables as a method, one could conclude that the reported 42 percent who were "not sure," represent an astonishingly high acceptance of the method -- especially at a time and place where sound knowledge of the method was low, availability even lower and its price relatively high. Easy availability and personal knowledge (both sound and faulty) must be considered, then, in examining the "method preference" percentages reported by the same survey: pills, 75%; tubal ligations, 12%; injectables, 5%; vasectomy, 2%; and condoms, 0.7%. One need only see the results of work with Depo Provera at McCormick Hospital in Chiang Mai to understand the meaning for program success of personal familiarity with a method and its availability.

In remote villages method-defeating rumors abound, notably among men, but not as rampantly as in developing countries where mass media are less prevalent and less used by the national program. In many places in Thailand, where inter-village communication flows fairly well and talk of sex and family planning, even in mixed groups, is relatively free and easy, it would behoove the IE&C strategist to approach his non-acceptor with respect. In talks with village men and women, this observer encountered "rumors" decrying methods that were based on sound first-hand knowledge of convincingly undesirable ill effects. In one area, widely differing patterns of method acceptance in two villages close to each other aroused our curiosity and we sought to determine why tubal ligation dominated the pattern in one village while in the next there was only one case of female sterilization. In that second village, one woman in a mixed group spoke up to condemn tubal ligation as "very painful".

"It can't be all that painful", we argued. "Millions of women have undergone surgical sterilization without serious complaint".

"I know it's painful, because I was the first to have the operation in this village, and it was so painful that I've told all the other women to use pills instead", she stated.

"But surely it wasn't as painful as giving birth", we countered.

"That's what you think", she said. "I suffered great pain for three or four days. When I had babies, at least I knew in advance that the pain would last a few hours at most, and then it would be over. With the sterilization, I thought I'd die".

In IE&C terms, apart from the obvious need for quality surgery and post-operative care, no posters or radio jingles, no declarations from Bangkok or Washington, will bring another woman from that village to that same hospital for a tubal ligation.

As for male attitudes toward family planning, there is only one surprise, a major one. While one encounters the classic rejection of vasectomy for the classic reasons of machismo and indifference to the program, one also encounters, with unexpected frequency, a high male tolerance of the idea of spacing and limiting childbirth. And more so than in most rural developing societies; they are listened to and permitted to take the time for family planning.

Nor is it surprising, therefore, that despite some existing male indifference to and ignorance of the details of contraception, it is already obvious in Thailand (unlike Indonesia and Ghana) that availability of male sterilization services, together with imaginative local-source information, can bring significant numbers of Thai men to the vasectomy table. In December 1975, in the province of Mahasarakham (which ranked 47th among Thailand's 71 provinces), the Government program was performing vasectomies at the rate of approximately 50 a year. In December 1976, Mechai conducted a vasectomy campaign there, and the result was 717 operations in 14 days.

#### B. NEXT IE&C STEPS FOR THAILAND

It must be said that the two principals in the engineering and execution of IE&C support for Thailand's Population Program -- Patama of NFPP and Mechai of CBFP -- are fully cognizant of the need for reenforcing whatever motivational work is now going on in a variety of ways, with a variety of personnel and in varying degrees in various geographical program areas. More than that, both are sensitive to the obvious need for building a system of communication to villagers and speaks in village terms with a voice that is local. Beginnings have already been made -- by Patama, hampered by the obstacles inherent in bureaucracy and more so by Mechai, whose independence, influence and soaring dynamism have turned the taboos of sex and family planning into subjects of open light-hearted conversation virtually throughout the land.

It must also be emphasized that the strategy and revised techniques and logistics discussed with Patama and Mechai represent neither a drastic renovation of present IE&C activities nor the significant addition of new funds, if any. In fact, the basic idea of using evening films and public-address talks in villages, practiced to some extent by both NFPP and CBFPS, is the heart of the system discussed and outlined during the Consultant's visit. At present, however, the film materials being used are poor, insufficient and inappropriate -- although, as will be seen below, excellent, sufficient and meaningful film materials are available in Thailand, consonant with present and future fund commitments, both from the RTG and from foreign assistance agencies. In addition, vehicles and necessary audio-visual equipment will be sufficient for at least the next year or two of operations. Secondly, the present mobile motivation effort by NFPP is conducted routinely, merely as another of the several IE&C techniques being carried on, and it is insufficiently supported because of insufficient supervisory staff at the central IE&C Unit of NFPP.

Appendix H describes the IE&C approach to which Patama, Mechai, and this Consultant subscribe. Its basic approach was mobile motivational presentations in villages, highlighted by the showing of a Thai full-length feature (commercial) film, one family family planning film, and brief talks between reel changes by a dynamic motivator.

All of the films that will be used in that techniques are available in Thailand, Sixteen-millimeter prints in color and wide-screen image of the popular (and typical) adventure/romance films are purchasable in local currency. Projection in Cinemascope presents no problem, since each print purchase includes the use of an anamorphic lens adaptable to the 40 projectors in the mobile audio-visual sets being purchased by USAID under the Population Planning Project. Concerning family planning motivational films, it is this Consultant's conviction, from field observation, that most of those available -- especially those made in other countries -- are of minimal value in the Thai village situation. It is recommended, and both Patama and Mechai appear to agree, that the only useful family planning film is the one recently made by the Development Support Communication Service in Bangkok in collaboration with NFPP and with UNFPA funding. It was produced in three versions -- one each for the North, Northeast and South -- each with a story and message appropriate to each of those geographical areas.

Although Thai villagers, like villagers anywhere, will gather en masse for a film showing, they are rather selective about film content. The Government's 16mm "informational" and "educational" films pale in interest before the 35mm Cinemascope color films brought to villages by two other institutions, both commercial. One is the itinerant cinema, which erects its temporary enclosure and charges admission; the other is the mobile unit selling household and personal products. Both arrive with heavy-duty vehicles capable of generating power for the heavier 35mm projector and producing a movie-house-sized image in Cinemascope. They project popular commercial Thai feature-length films, the same as those shown in Bangkok theaters.

Because NFPP and its foreign donors are committed to standard mobile-unit vehicle types and to 16mm projection, it would not be feasible --logistically or economically -- to try to compete with those two commercial film sources. In any case, using similar entertainment films and wide-screen projection in 16mm, the result will be satisfactory. The image will be smaller and less bright, but an audience soon loses awareness of those differences in the first few minutes of an entertaining film.

The key to success in the arrangement, of course, is the dynamism, good humor, language and general magnetism of the motivator. The pegs on which he hangs his between-the-reels presentations are: (1) the impending visit of the services team to the area, and (2) the methods that are appropriate to the contraceptive history of the villager-audience. Wherever possible (as has been done by Mechai) local program officials and village leaders join the motivator in making relevant points to the audience. Local program administrators will have been advised in advance, naturally, of the forthcoming schedule of both the services and motivation teams, and supervision of field operations by Bangkok officers must be conducted as frequently as possible. During the morning and afternoon preceding the film show, the motivator (and hopefully at least one local program officer) will have met with village leaders and at least one group of villagers.

Distribution during the evening show of a simple coupon entitling the holder to services has been tried and should be used more widely.

That is the simple package that Thailand is ready and able to implement as the major IE&C concentration throughout the active districts. By no means does it mean an end of other mass and interpersonal communication already being conducted. Those that will continue to be programmatically profitable are (1) radio, for its reinforcement value;

(2) the press, for its powers to influence the influencers, and (3) the family planning demonstration kits carried by clinic-based field workers, if indeed they are inclined to use them. Posters and pamphlets will have extremely limited effect on the country's population growth rate.

So enthused is Mechai over the potential of an intensified system of mobile presentations in villages that he declared himself prepared to return to AID any funds used for that IE&C work if he could not boost sales of orals and condoms combined by 25 percent using that technique. Specifically, he has in mind the introduction of the technique in half (or possibly only one-fourth) of the 80 AID-supported District programs (ten for each experimental mode) to see the results in comparison with the other half. He would add, using non-AID funds, a few additional IE&C "gimmicks" -- such as (1) conducting lotteries for acceptors; (2) bringing to villages the stars of movies shown by the program; (3) convincing a movie star or other luminary to undergo sterilization and publicize that event widely; (4) packaging sample condoms individually especially if the low level of condom offtake produces a surplus; and (5) using CBFPS contraceptive distributors more widely as motivators for vasectomy, now that demand for tubal ligation has far exceeded the program's capacity to provide that service.

An important additional IE&C channel to the village are the widespread and influential "Village Scouts", a national movement begun as a grass-roots counter to Communism. Known as the "Blue Guards", they are composed of men, women, and children, trained also to carry on rural improvement works. In some provinces, they have already been used to assist the family planning program. Since they, in fact, are villagers and have official status, their value to the program, if they could be enlisted for motivation, would be inestimable.

There continues to be a strong need to stimulate and orient leaders of all kinds throughout the country -- including officers of the national population program, particularly in the Ministry of Health down to the District level. There is ample opportunity to do so, and in a rudimentary and scattered way it has been done. The simplest and most economical medium is a set of slides that: (1) describes the program, including that of Mechai; (2) tells why there is a program; (3) shows how motivation can be carried out through informal channels, and (4) describes generally the contraceptive methods available. Such a set is easy to edit for specific audiences. Mechai has produced a videotape that covers the subjects, but it is angled toward the private program. Patama maintains one set of slides that she uses in different formats for different audiences.

Design and production of an all-encompassing set of color slides, with accompanying sound track and music (much in the style of the set used so effectively by Haryono in Indonesia), would not be difficult for Patama and Mechai, but there must be sufficient copies of the set to put one or two permanently in each District and others in teacher training and in major institutions that deal with leaders or potential leaders. It is useful also in training of all categories of program personnel and in briefings for visitors. Before the Consultant left Thailand, he arranged for Haryono to lend a copy of his slide set to USAID/Bangkok for examination by Patama and Mechai.

Mechai's role in the coming success of the Thai Population program is unquestioned. Cooperation and coordination between his CBFPS and the Government's NFPP is a sine qua non in the achievement of that success. It is said that Mechai's boldness, resulting naturally in frequent splashes of personal publicity, has created a rough interface between him and those who manage the official program. Because it will be necessary -- and officially agreed -- that there will be joint use of some of the vehicles and audio-visual equipment of NFPP, smooth dovetailing of schedules will be necessary. While some jealousies and competition may be inevitable, this Consultant believes that both sides, at higher levels, will insist on a strategy of cooperation. At provincial and district levels, Mechai's personnel and those of NFPP and the Ministry of Health appear to have good relations. As Patama proceeds with the decentralization of her mobile IE&C teams by assigning them to the provinces, problems of jurisdiction and equipment use will, hopefully, be minimal at those levels.

### III. GHANA

#### A. OVERVIEW

In the town of Swedru, only 20 miles or so from Ghana's capital city of Accra, six women appear at the Government Health Center seeking IUD insertions during the few hours when the family planning clinic is open every week. They are turned away, because, as the clinic midwife tells us, "the nurse hasn't shown up from Accra." "In fact", she says, "the nurse hasn't come to Swedru for the past year."

- In the United Nations General Assembly's session of 1962-63, Ghana co-sponsored a resolution on Population and Economic Development. "Again in 1967", a publication of the Ghana's National Family Planning Program with pride, "Ghana became the first sub-Saharan African nation to sign the World Leaders' Declaration on Population".

In the village of Pong-Tamale, along the main road north from the northern city of Tamale, the Planned Parenthood Association of Ghana conducted a community-based family planning pilot project. In nine months the project sold 20 packets of foam tablets, 12 tubes of jelly, 3 gross of condoms and 12 cans of Emko foam.

- "The past year has been another year of great activity for the PPAG", declared its President in a message to PPAG's annual meeting in late 1976, read by the Vice President in the President's absence abroad. "We... have associated ourselves with the work of all agencies, both government and non-government, in the effort to bring family planning education and services to the people of this country. Our field workers carried out over 85,000 home visits during the last year, and contacted nearly 170,000 persons in the process. They also organized some 275 film shows and over 3,200 lectures and meetings for the public up and down the country, involving a further 60,000 people. These activities have surely helped in spreading knowledge about family planning, and increased this awareness of the public about available family planning services... Our Association, which was established in March 1967 will be 10 years old in March 1977. It has been decided that this anniversary should be celebrated in grand style, and branch Associations will be expected to mount appropriate activities during 1977 to mark the occasion. It is hoped that, as part of the celebrations, a Seminar on an appropriate Family Planning Theme, can be organized, in collaboration with the Ghana Medical Association...The climax of the 10th Anniversary Celebrations will, of course, be the Annual General Meeting next year; we all look forward to that occasion with joy and expectancy. A Short History of the PPAB over

the past 10 years is nearly completed. It will be published early next year to coincide with the Tenth Anniversary Celebration".

In a town in the Northern Region, a well-dressed Muslim in his thirties of dubious but apparently profitable occupation, shoos some boys away from touching his shiny motorcycle as he chats with us in the marketplace. "What's wrong with having eleven children? he asked. "I have four wives; I take care of them, and they take care of me. It's good and right to have as many children as Allah sends. I'm looking for another wife".

- In Tamale, at provincial headquarters, the Regional Social Welfare and Community Development Officer believes there should be more coordination of family planning with community development and social welfare, but that family planning is still a private matter and the program cannot therefore utilize "satisfied customers". "And we have to be careful because women who practice family planning could be unfaithful to their husbands," he says. The office has one UNICEF motorcycle, but it's "broken down".

At Bolgatanga, headquarters of the far northern Upper Region, the regional family planning coordinator has received from Accra his copy of the all-Ghana results in family planning for May. (It is mid-September) From it, he learns that out of 193 registered family planning clinics, 103 report a total of 2560 "new acceptors". Ministry of Health facilities have accounted for 1380; PPAG, 623; Christian Council of Churches, 390; and "Other", 167. Pills account for 56% of the "new acceptors"; IUD, 9%; and "Other", 35%. An IE&C officer of PPAG informs us that female sterilizations are performed usually after seven to nine children, "never after four or five".

At a provincial hospital in the North, Depo Provera is prescribed for a woman recently widowed, with ten children. A tubal ligation is performed on a woman who has delivered her eleventh child and who is motivated by "economic reasons". Another patient comes secretly to the hospital family planning clinic because her new second husband (her first has died) wants to have "his own children" in addition to the four born in the first marriage. She is given an injection of Depo Provera. The clinic is open twice a week from 8 a.m. to 1 p.m. and sees 10 or 12 clients per session.

- In Ghana, 40 percent of all children die before reaching school age. Of the 200,000 deaths of all kinds every year, 130,000 are preventable or controllable. The ten leading diseases are malaria, measles, diarrhea, pneumonia,

malnutrition, tetanus, tuberculosis, leprosy, whooping cough and intestinal parasites. Estimates of the total population differ; it is around 10 million. Nor is there unanimity in estimates of the crude birth rate (around 49-51) or the death rate (19-20). One study showed the desired family size in rural areas to be 7.5 children; in the urban centers, 4.3 to 6.1.

- In Winneba on the Gulf of Guinea, as in Swedru not far inland, the family planning nurse from Accra has not been making her visits for the weekly family planning clinic. The resident public health nurse and her six community health nurses simply turn away women coming for family planning, telling them to try a clinic in Accra.

The 13 clinics of the Christian Council of Churches, mainly in the Volta Region, are open daily from 6 to 12 and 2 to 5. The CCG carries on a family planning program and provides family counselling and family life education. There are some 200 voluntary family counsellors with CCG. Talks are given to students, youth groups and others. Films and flip-charts also are used. Quarterly reports are sent to NFPP. The report for April-June 1977 showed 1670 "new acceptors" and 4,933 "continuing acceptors". Pills accounted for 50%; IUD, 30%; and condoms and "other", 20%. CCG receives assistance from FPIA. Field workers conduct case follow-ups. They have been trained for 2 to 3 days.

- An animist husband may have five or six wives, we are told in Tamale. "They used to wait three or four years before going back to a wife who has delivered a child. Now it may be only a year". One animist husband said: "My wife was resisting me until the new baby would begin to walk, so I took a second wife".

If a wife becomes pregnant when it is not her turn, she may live with her parents and come home again after the delivery. One woman said she practices family planning one way or another because "I have only one set of breasts; I must work, and anyhow the next child too soon will be very lean".

At the University of Ghana in Legon, we are impressed by the look of efficiency in the modern, well-equipped offices of the Danfa Project, the Regional Institute of Population Studies and the Institute for Statistical, Social and Economic Research. But it is lunch time, and there is no one in authority with whom to talk.

- Around Koforidua in the Eastern Region, it is said that the number of abortions is increasing because of the unavailability of pills.

The Westinghouse/AID project for commercial distribution of contraceptives is off to a good start, although still in stages of local negotiation, testing brand names, mapping a "mind-KAP" study and other planning. The Westinghouse Project Director is considering the packaging of individual sample condoms, using a container in the shape of a Red Triangle, the symbol of the program in Ghana.

DANAFCO, a Danish-controlled distributing company in Accra, seems ready to take on the tasks of packaging, storing and sales. It will use its distribution system through 300 outlets and try to promote other channels, such as lottery kiosks and village trader women.

Last year, condom supplies were given to the Government-operated Ghana National Trading Corporation for commercial distribution, but most of the stock stayed on the shelves or in storage. Under consideration is a plan to replace those stocks with fresh condoms, one for one, and then sell condoms directly to GNTC.

- A village woman speaking: "Why do I take the pills? Because I want to rest. I have five children, and another died when he was a year and a half old. But I will soon stop the pill. Why? Because the other wives in the family also have four".

A visiting IPFF evaluator says it is "useless" to launch contraceptive programs without inputs into such longer range efforts as in-school education and the stimulation of the country's leaders. The spreading destruction of plant cover in Ghana is bringing about disastrous soil depletion. Ironically, he believes, the worsening food situation is likely to bring on significant increases in contraceptive prevalence. Equally tragic, he says, is the non-existence of a political structure that could stir the villages to family planning action. Nor are there sufficient non-government organizations with representation in the villages. Tanzania, he reports, has created village committees of influential persons and development workers to promote the family planning program. In Ghana perhaps two generations will be needed to overcome the population problem, he thinks, but the time to start is now.

- As time permits, we stop at small drugstores in the towns and find "Blue Lady" pills and Tahiti condoms at prices considerably above those of the Government and of PPAG.

In Accra, the USAID Health, Population and Nutrition Officer arrives late at an American colleague's home for a late evening informal meeting on family planning with a small group of knowledgeable Ghanaian scholars. He explains he has had trouble with his car --the only one he has for his work and his family -- and had to attend an emergency American patient in his role as "Embassy Doctor" on duty.

- At a national transport depot six modern buses, looking brand new, sit without tires.

Family Planning in Ghana, a pamphlet produced by the NFPP's Materials Production Unit, says, "The Ministry of Economic Planning being responsible to the Government for the Programme, has a Secretariat...within the Ministry to be responsible for planning, coordinating and maintaining the activities of the National Family Planning Programme, which has been designed to maximize the use of existing institutional facilities and personnel both in the public and private sectors.

"The National Family Planning Council, a policy-recommending body and not an operating agency, links the National Family Planning Programme through a Programme Advisory Committee made up of the Heads of all participating agencies.

"The Secretariat has two operating divisions...the Services Division...(and) the Information and Education Division...(which) works with the participating agencies, such as the Information Services Department of Social Welfare and Community Development, the Christian Council of Ghana and the Planned Parenthood Association of Ghana, which have large numbers of personnel actively engaged in information and communications work among the local population".

- Notes of conversations with women waiting in family planning clinic:

Client A: Catholic, motivated two years ago by another village woman. She is 38, ten pregnancies, 7 living children, youngest, three years old. Wants no more. "My health won't stand another pregnancy". Husband is farmer.

Client B: Illiterate, 32, five pregnancies, four living children, motivated by a friend, found unsuited for pill, took IUD in October 1976. Wants to wait four years after birth of last child. Husband is Border Policeman, stays with her one year, with Wife No. 2 one year. She stays with parents that year. Before he

took second wife, she lived with him steadily. Other wife has two children. If No. 1 had choice, she would have only one more child. The two wives don't know each other.

Client C: A voluntary field worker helping at the clinic; has five children and an IUD; motivated by field worker. "Fed up with having kids; we just can't afford them...Yes, Moslems come to clinic, but sometimes secretly".

Client D: Another volunteer FP worker; Methodist, has two children; youngest 7 years old, and IUD. (Laughs: "I have no maid.")

Client E: "Men don't like Emko; it's too slippery. They don't like Tahiti' it's too hard. They like foam tablets."

Others are there seeking Depo Provera, and one for sterilization. But there's no nurse.

Field worker says she doesn't need doctor to tell if woman is suitable for pill. "I could do IUD insertions, too, if they'd train me."

"We moved into the community-based approach in IE&C a year ago", a high NFPP official says. "We're using existing associations and groups, co-ops and village chiefs. The services are lagging behind the IE&C."

- At the Materials Production Unit in Accra, all is quiet. A new pamphlet on Family Planning in Ghana is out, having been printed commercially under contract in five hundred copies. It is intended for leaders. There is a film entitled, "Family Planning in Ghana", produced by the National Film Board of Canada. Earlier in the program, the press was used intensively with advertising for family planning. At least a dozen different posters have been produced, but they are to be seen only in family planning offices and clinics. Radio is said to have been used, too. A set of slides exists.

The Northern and Upper Regions of Ghana cover nearly half of the land area of Ghana. The PPAG coordinator for those two regions has 19 field workers (11 male, 8 female) and four clinics in the major urban centers. During the period January to June 1977, 23,460 persons were reported to have been contacted during 9,027 clinic visits and house calls. New acceptors were said to total 1,632; continuing acceptors, 2,571. There were no vasectomies; 4 tubal ligations; 9,128 pills (apparently by number of cycles); injectables, 120, but only 12 new acceptors were reported for May to October,

all of whom later dropped out); condoms, 667; foam, 1,329, jellies and creams, 261. The PPAG Field Work Supervisor in the Northern Region has a 16mm film projector, but it's not working.

- Along the roads, rural buses are colorfully decorated with sayings: No Time to Die; Fear God; Now is the Hour; Respect; Travel and See; Ani Get Your Gun; Good Never Lost; Good God; A Day Will Come; Dynamite Joe; Suffer to Gain.

At the PPAG's clinic in Bawku, one of four PPAG clinics in all of the North, there are two field workers and a nurse. Monday is clinic day. A doctor comes once a month from the Bawku Presbyterian Hospital, where there is no family planning nurse right now. The PPAG nurse at Bawku has done more than 50 IUD insertions. She removed ten of them, usually to permit another pregnancy. Two were expelled. It was said that it is a PPAG rule to give no more than one cycle of pills per client per visit.

- It is sunset. In a Navro-Pungu village near Bolgatanga in the North, the cattle are re-entering the village, mindless of the boy shepherd as he is of them. As the cattle, the sheep, and the chickens settle into their accustomed sleeping quarters, one of the chief's sons mounts the hard clay-mud steps to the roof of this house and he points out his fields of millet, yams and cassava. An educated man, he and his wife, a family planning field worker with 15 years of "social service", have returned to the simplicity, peace and security of the village. "This", he tells us, sweeping his hand across the darkening scene toward two other villages silhouetted against a red sky, "is where life is best." He and his wife will have no more than two children.

#### B. NEXT IE&C STEPS FOR GHANA

Thus goes family planning in the world that is Ghana -- a kaleidoscopic picture without pattern. A people wonderously warm and lighthearted amid ever-worsening economic conditions. Where death is part of life, and reality becomes indistinguishable from the imagined. If there is tragedy in Ghana it may be that the march of time -- with its population explosion and a "better life" -- poses an inescapable choice between the safety and tranquility of the village and survival itself.

No one can question that Ghana needs help, intelligent help, in finding a painless and acceptable way to stem the tide of population that is sure to destroy this country. Thoughtful Ghanaians will agree that in the nature of things social and political, Ghana may not be

ready and able by herself to carry on with efficiency, speed and thoroughness the many tasks required by the strong (but necessary) national population policy engineered largely by foreigners.

It is foolhardy, for example, to talk of reaching the villages -- or, for that matter, carrying out much else of the program -- without uni-purpose vehicles. But it is equally foolhardy to provide such vehicles in the absence of an expert (or experts) and of material for maintenance depots as sophisticated as those modern automotive vehicle require, if they are to keep running. A larger task, and more imperative, is the training of Ghanaians to operate such systems themselves. There is danger for Ghana in the realization by development assistance planners that much of the developing world no longer has need for foreign experts -- true as that may be.

But until Ghanaian leadership itself speaks up for and insists on the highest quality of Ghanaian program administrators (and foreign helpers) and the committed participation of all political and social agencies, the definition and launching of large long-term Population-related programs will end in frustration and high cost.

Fortunately for Ghana and the United States, AID has managed to put in place (1) a Population Officer whose demeanor is approximately restrained while he searches for those doors that can safely be opened, and (2) assistance to opening one of the right doors at this time: the Westinghouse project for commercial marketing of contraceptives, led by a wise and cautious resident expert.

From what this Consultant has seen in 16 days (and reported here in a rush of glimpses), it is obvious that Ghana is no place for what this Consultant has come to call "traditional IE&C", with its trappings of audio-visual equipment, design and production units, posters (especially those that emulate the standards of a U.S. training course) and anatomical drawings that are incomprehensible, even were they used. And long-term studies that tell us in the end that villagers are inclined to believe someone they know rather than someone they don't.

IE&C for the Population program in Ghana today (and for some years to come) means such actions as:

1. Revealing to Ghana's topmost leadership the alternatives to population growth abatement -- together with a truthful picture of births prevented thus far by the present program effort. Thereafter, whether commitment and action are forthcoming or not, AID's role in the program will be clear -- and likely to be productive.

2. Concentrating the village availability of non-clinical contraceptives in the commercial distribution project -- even if at greater expense to AID. In the absence, for years to come, of vasectomy and the inability (for some years) of the program to provide sufficient and sound clinical services, it is clear that pills and condoms can at least spread the contraceptive habit. They carry their own family planning IE&C with them, but a logo for condoms and pills must be made ubiquitous in Ghana through distribution.
3. Letting the Ghanaians themselves (if they wish) try the enlistment of village women traders as purveyors of contraceptives -- without the sophisticated laboratory accoutrements and know-how of a U.S.-university-run pilot demonstration project.
4. Using radio to dispel male ignorance of the meaning of contraception and family planning to men themselves.
5. Convincing the country's traditional healers that illness from excessive births can be cured more easily with herbs when they are used with the Blue Lady medicine.
6. Enlisting the military and police authorities in a strict program of contraception (injectables?), for the rank and file and their wives.

UNITED STATES GOVERNMENT

APPENDIX A

# Memorandum

TO : PHA/POP/I&C, Dr. Gerald Winfield  
PHA/POP/FPS, Dr. Harald Pedersen

DATE: June 28, 1977

FROM : PHA/POP, R. T. Ravenholt

SUBJECT: Consultative Assistance for Creation of Much Improved Information Programs in Support of Family Planning Activities, especially Oral Contraception, in Several Countries

While amenable to the proposals that we employ an experienced consultant to assist with development of I&C programs, I wish to emphasize that the goal of such consultative assistance and related activities should be the creation and implementation of a strong informational program in at least one and preferably several countries. Such informational programs should be fashioned to provide the strongest possible support for the availability and use of oral contraceptives.

Please keep me apprized from time to time of the progress of this project and be aware that I will judge the entire value of this exercise according to whether clearly effective information programs are implemented in at least one and preferably several countries during the next year or two.

JUN 28 1977



5010-108

Buy U.S. Savings Bonds Regularly on the Payroll Savings Plan

TASK ASSIGNMENT  
CONSULTATION AND TECHNICAL ASSISTANCE  
AID/pha/C-1100

APPENDIX B

Date June 24, 1977

TO: APHA Project Director  
FROM: AID Cognizant Technical Officer

*Gerald F. Winfield*  
Gerald F. Winfield  
(Signature)

Consultation and/or technical assistance is requested to fulfill the following:

1. Purpose and scope of work: \* A principal element in the U.S. contribution to stemming world population growth is the provision of contraceptive commodities, notably pills and condoms, in 56 developing countries. In the face of widespread illiteracy, poor communications and deep-set tradition and mores that are inimical to the adoption of modern fertility control methods, it is clear that targeted population growth rates will not be achieved in time without the earliest identification and application of  
(See continuation sheet)
2. Locations (country and city) in which services are to be performed: Washington (2 to 3 weeks); Chicago (3 days); Thailand (3 weeks); Indonesia (3 weeks); Bangladesh (one week); Philippines (2 weeks)\*
3. Date on which services are expected to start July 15
4. Estimated duration of work schedule Ninety days
5. Type of personnel and special skills required: \* Population Communication generalist; 10 years of experience in assisting national and institutional I&E programs in support of Population programs in at least ten LDCs; long-term familiarity with I&E components of AID Population assistance and of other international donor agencies.
6. Special funding (ECC) or working conditions: \*\* Report required for final 3 days in Washington.

~~\* Append additional information, cables, etc.~~  
~~\*\* include briefing and/or debriefing requirements.~~

\* Subject to revision during preparatory work in Washington.

Number 1 (continued)

public (especially rural) information/education schemes that can both boost the numbers of new acceptors and insure sustained family planning practice.

For more than a decade the Office of Population has invested substantially in a wide variety of undertakings designed to establish, improve or expand LDC capability (both public and private) to reach and influence appropriate audiences. In many places such efforts have achieved dramatic success in spreading awareness and indeed have contributed, in some places, to lowered birth rates. However, experience thus far reveals the insufficiency (and apparent ineffectiveness) of what must now be considered "traditional" communications media alone -- such as films, posters, flipcharts and extension workers - in overcoming the resistance of hundreds of millions of parents who seem to acknowledge the need for family-size limitation, who should be contracepting for both individual and programmatic reasons, but who fail or refuse to take that final step of adoption. The reasons for that may vary from place to place, and they may be rooted in one or more of several factors -- from a lethargy of leadership to the absence of community sanction to plain old individual inertia. In short, the so-called hard core of non-practicing couples in the LDCs is larger than its yielding shell. And it presents a challenge to Information/Education expertise that has nowhere been successfully met on a national scale.

The Office of Population intends to assist concerned and amenable governments in finding new and culturally appropriate communication keys to the widest possible spread of effective contraception among the rural and urban disadvantaged.

In this much-needed addition to its Information/Education strategy, the Office of Population wishes to avoid the costly and protracted mechanisms of workshops and seminars, graduate studies in the U.S., task forces, surveys and sophisticated audio-visual equipment. Instead, we intend to enlist the services, for a relatively short term, of a person with intimate and wide experience in LDC Population and Population Communication programs. That experience should have been gained largely from outside the AID structure.

Out of preliminary consultation with the Office of Population and through communication with selected Missions, no more than four countries will be identified, where prospects are most promising for the development of new systems for extending persuasive messages far and wide. The candidate will evaluate ongoing I&E efforts and AID's involvement in them. He or she will identify communications channels and systems that may never have been used to promote contraceptives. Specific attention will be paid to the mobilization of existing in-built communication networks, such as the military, commercial product channels, private organizations of women, youth and farmers, and official administrative and political systems. The goal is the continuing permeation of contraceptive habit among the poor.

ITINERARY

Day 1 - July 10 (Sun)	Travel SFO-Wash.	Day 46 - Aug. 25	Bangkok
2 11	AID/Wash.	47 26	
3 12	"	48 27	
4 13	"	49 28 (Sun)	
5 14	"	50 29	Bangkok-Ang Thong
6 15	"	51 30	
7 16 (Sat)	"	52 31	Bangkok-Khon Kaen
8 17 (Sun)	"	53 Sept. 1	Kohn Kaen-Mahasarakham
9 18	"		Bangkok
10 19	"	54 2	Bangkok
11 20	"	55 3	"
12 21	"	56 4 (Sun)	"
13 22	"	57 5	"
14 23 (Sat)	"	58 6	"
15 24 (Sun)	"	59 7	"
16 25	"	60 8	"
17 26	"	61 9	"
18 27	"	62 10	Bangkok - Cairo
19 28	"	63 11 (Sun)	Cairo-Accra
20 29	Travel Wash.-SFO	64 12	Accra
21 30	SFO	65 13	"
22 31 (Sun)	Travel	66 14	"
23 Aug. 1	Travel	67 15	Accra
	Int'l Date Line	68 16	Nswam-Suhm-Koforidua
24 3	Jakarta	69 17	Accra
25 4	"	70 18 (Sun)	
26 5	"	71 19	Tamale
27 6 (Sat)	"	72 20	Tamale-Bolgatanga
28 7 (Sun)	Full work day	73 21	Bolga
29 8	"	74 22	Bolga-Tamale
30 9	"	75 23	Tamale-Accra
31 10	Jakarta-Semarang	76 24	Accra
32 11	Semarang-JogJa-Jakarta	77 25 (Sun)	"
33 12	JogJa-Jakarta	78 26	"
34 13 (Sat)	JogJa-Jakarta	79 27	Swerdu-Winneba
35 14 (Sun)	Full work day	80 28	Accra
36 15	Jakarta-Manado	81 29	Accra-N.Y.C.
37 16	North Sulawesi	82 30	N.Y.C.
38 17	Manado-Jakarta	83 Oct. 1	Wash.
39 18	Jakarta	84 2 (Sun)	"
40 18	Jakarta-Bangkok	85 3	"
41 20	Bangkok	86 4	"
42 21 (Sun)	"	87 5	"
43 22	"	88 6	"
44 23	"	89 7	"
45 24	Bangkok-Villages	90 8 (Sat)	

July 28, 1977

Dr. Fred Zerzavy  
Development Officer  
USAID/Accra

Dear Fred:

I hope you will remember me from Vietnam days. I was then with The Asia Foundation, you may recall, working in Population with local private institutions, although I came to Saigon only from time to time from my home base in Singapore. I left the Foundation about a year ago. Now I've come on board with AID under a 90-day consultancy at the request of Ray Ravenholt for a specific and special (if not impossible) assignment. And that's what I'm writing about.

My task is to select three or four countries where AID-supplied contraceptives are at work and to see what appropriate kinds of mechanisms might be suggested to give meaningful information/education support to those pill and/or condom distribution programs.

We are not talking about instituting a long-term step-by-step program of research, training, materials production, and audio-visual equipment procurement. Frankly, I don't know what it might be, if anything, in Ghana. But I think my 25 years of work in this field in LDCs would help to surface feasible and practical ideas. Above all, it will have to be something that key Ghanaian Population people themselves will understand and be enthusiastic about. And something that is essentially Ghanaian -- hopefully an existing force or system through which people are persuaded to act.

Dr. Armar was here the other day, and I had the privilege of meeting him ever so briefly. Having had some responsibility for creation of the Red Triangle, I couldn't help but know that Ghana has used that symbol quite widely and with good effect in the early days of awareness-creating. So I gave him a copy of a recent monograph I'd done on the story behind the original Red Triangle and pinned a small Red Triangle on his lapel. I told him briefly about my assignment, and he had time only to say that a visit to Ghana might prove interesting. That's as far as we got, because he was rushing off to dinner and a plane to Chapel Hill.

I've also discussed this with Lou Gardella and Ray Martin, as well as Jerry Winfield, and they think it's a good idea. But, of course, it will have to be a Mission decision.

Ghana is a prime candidate in this assignment. I will be going first to Indonesia and Thailand and possibly to Egypt after September 1. If you agree that we might give this a try -- I am very gentle in countries new to me and I will do more observing than talking, and no elaborate reports or

recommendations -- then I must suggest an unusual procedure. Since I have only about eight more weeks in which to accomplish something, I am leaving here in the next few days for Asia. Therefore, I wonder if you would be good enough to cable Jerry Winfield, who heads the PHA/POP/IE Division, your reaction (concurrente, I hope), using this letter as reference. Jerry will then cable me in Jakarta. I should think anytime after around August 25 would be good for such a visit to Accra, but I can easily delay Egypt if early or mid-September would be better for you. And I should think we would want at least a week together.

With warmest regards.

Sincerely,

Frank Wilder  
Population Consultant  
PHA/POP/IE

cc: PHA/POP/IE: G. Winfield  
PHA/POP/AFR: L. Gardella

PHA/POP/IE:FWilder:sms:July 28, 1977



BADAN KOORDINASI KELUARGA BERENCANA NASIONAL  
(B.K.K.B.N.)

PROPINSI DAERAH TK. I JAWA - TENGAH

Jl. PEMUDA 79 SEMARANG

Telp. 27207 - 26937

No. :  
Lamp. :  
Hal : Report of visit to Karanganyar and  
Surakarta 11<sup>th</sup> August 1977

Semarang, 12<sup>th</sup> August 1977

BEST  
AVAILABLE

At 8.00 we picked up Mr. Frank Wilcier at Telomoyo Hotel and directly went to B.K.K.B.N. of Central Java Province in Semarang. At 9.00 we left for Surakarta and Karanganyar.

A. We arrived at Surakarta B.K.K.B.N. about 11.00 and first met the Mayor of Surakarta, Mr. Soeman Wongso prawiro for a few minutes.

The target area is Serengan subdistrict in Paguyuban K.B. R.K. III s.k.d. Danukusuman village.

We were accepted by the Camat, Mr. Muchson B.A, the hwarah, Mr. Harjo Sukarto and all the ladies acceptors which are members of Paguyuban K.B.

Serengan subdistrict is divided into 7 villages.

The Danukusuman village's spacious : 3 km<sup>2</sup>.

Population : ± 61.000.

Density : ± 20.000/km<sup>2</sup>

There are 3 R.K. : R.K. I consists of 18 R.T

R.K. II consists of 20 R.T

R.K. III consists of 16 R.T.

The execution of Family Planning is successful but there are problems that need our attention.

1). Especially the Chinese population is still difficult in accepting Family Planning; they are merchants, so when the field-workers come during the morning they have no time and when the Camat holds a meeting, they send their servants.

2). In one of the villages, Jayengan there are Banjares from Kalimantan who still hold tight their tradition.



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Hal :

Semarang, .....

BEST AVAILABLE

3). In the other village, Jayotakan is a minus area. They want to use I.U.D. but they require for free transportation to the clinic.

Till July 1977 there are:

.. Elco	2200.		
.. Acceptors	1915:	Pills	915
		I.U.D.	35
		Condom	925
		Vasectomy	5
		Injectable	35

Some examples:

- 1). Mr. Hasan is using I.U.D. since 1966, has 6 children the youngest is now 6 years old.
- 2). The Camat's wife is a pill acceptor since 1973.
- 3). The secretary of the lurah's wife has 3 children; the intervals between the first child and the second is 3 years and the second child and the third is 4 years. At first her husband used condom, now he wants to change it into Vasectomy.

The husbands are not interested in seeing family planning film. They are bored to hear about motivation of it. Some of them don't allow their wives become I.U.D. acceptors.

The reasons why the women don't want to become acceptors:

- .. their husbands don't allow them
- .. some of the families still hold tight the tradition or religion
- .. they feel lonesome if they have only 2 or 3 children
- .. some of them have the opinion why only the Indonesian population should do Family Planning, whereas the



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Chinese people should not..

There is a family who has 5 children and all of them are girls, so they want boys.

The Camat requires :

- a) motivation on the T.V.
- b) motivation to all the officials of the Departments

At 1.00 in the afternoon we continued our trip to Karanganyu Regency and directly went to the B.K.K.B.N. office.

B. The target area is Ngargoyoso subdistrict, Girmulyo village in Sgejring and the following hamlets.

Ngargoyoso subdistrict is divided into 9 villages and there are 6 hamlets in Girmulyo village.

We were also accepted by the Camat, Mr. Gunawan B.S. the lurah, and the members of the Saguyuban who are mostly I.U.D. acceptors.

In Sgejring hamlet : Population 432

House holds 61

Elco 45 (the others are too old)

Acceptors 41 (the 4 women are still pregnant).

Pills 5

I.U.D. 35

Injectable 1

The problems are :

- 1) They are too shy.
- 2) Some of them are afraid of doing Family Planning.
- 3) The husbands don't like a small family.
- 4) The communication with husbands cannot be as close



BADAN KOORDINASI KELUARGA BERENCANA NASIONAL

(B.K.K.B.N.)

PROPINSI DAERAH TK. I JAWA - TENGAH

Jl. PEMUDA, 79 SEMARANG

Telp. 27207 - 26937

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Hal :

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BEST AVAILABLE

as with women.

- 5). Usually a husband feels that he is the boss in his family so every body can not force his family to do something.
- 6). In Selowik hamlet, the people still hold tight their principle (old fashioned Islamic).

All the acceptors who came in that meeting consists of :

- a). 5 women have a child only, because they can only take care of a child.
- b). 10 women have 2 children.
- c). 8 women have 3 children.
- d). 6 women have 4 children.
- e). 2 women have 5 children.

According to their opinion if they have more than 3 children they cannot take care of them well. They prefer to use I.U. because it is only once for ever. When they use pills they are afraid that they forget to take it.

Some examples :

In Selowik hamlet :

Mrs. Harim Amun (the religion teacher's wife), has 5 children and the youngest is 13 months old. She told us that they are using the calendar-system, but it always fails.

In Mungur hamlet :

There is a woman that had used I.U.D. for 3 years after her fourth child. Because of some side effects the I.U.D. was pulled out. Now she has a baby of 2 months. But she promised us to use I.U.D. acceptor again when the baby is 3 months old.



BADAN KOORDINASI KELUARGA BERENCANA NASIONAL  
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Telp. 27207 - 26937

No. :

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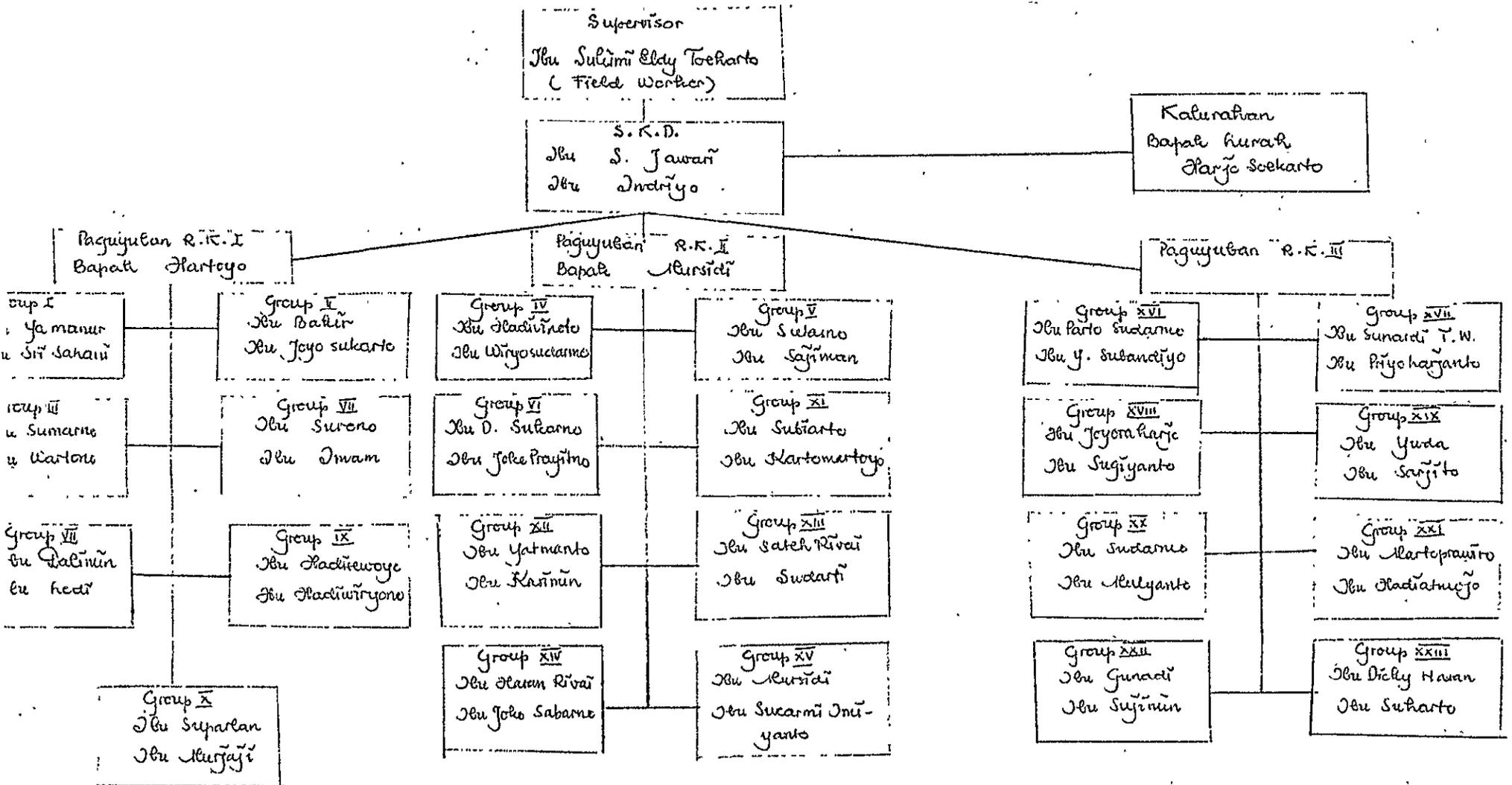
Semarang, .....

We finished our visit at 04 00 in the afternoon and continue  
our trip to go back to Salatiga.

BEST  
AVAILABLE

(Nitis Soesilawati Koesoemo)

# STRUCTURE ORGANIZATION S.K.D. DANUKUSUMAN VILLAGE



Mgargayoso Subdistrict

Girimulyo Village

NO.	HAMLET	TOTAL	(ELIGIBLE PEOPLE)				TOTAL
			ELCO	I. U. D.	PILL	INJECTABLE	
1.	Klunggur	456	78	26	16	5	47
2.	Puton	443	64	17	16	3	36
3.	Selountik	403	58	13	9	-	21
4.	Gadungan	895	111	51	26	-	77
5.	Plawan	601	91	31	34	2	67
6.	Mgejring	432	45	35	5	1	41
			447				289

or 64.7%

CENTRAL JAVA PROVINCE

Consists of :

1) 29 Regencies = Kabupaten (rural area)	Bupati = Regent
2) 6 Municipalities = Kotamadya (urban area)	Walikota = Mayor
3) 492 Subdistricts = Kecamatan	Camat
4) 8466 Villages = Desa / Kelurahan Each village is divided in	Kuruk
5) Hamlets = Dukuh = Rukun Kampung (R.K.)	Bayan

18 Agustus 1977

Dear Hari:

Before I leave for Bangkok tomorrow morning, I thought I should report to you on what followed this morning after your meeting with me last night.

First, I met with Charles Terry and Bill Johnson to brief them on the results of my visit to Sulawesi Utara and to let them know that I had similarly reported to you, with special reference to our meeting of minds on the idea of investigating the possibilities for carrying out a special kind of research that would unearth the real inner hidden reasons for non-practice (and termination), especially in the minds of ~~dominating~~ dominating husbands under varying geographic circumstances. The purpose would be to provide information that could help BKKBN to forge an economical and truly effective motivation strategy aimed at specific audiences. All of that would then, of course, lead in to easier selection of interpersonal (and perhaps even mass media) channels of communication, such as Camat-to-lura-to-husband (Camat-IUra-SUami) and of the most telling kinds of appeals, arguments and messages.

Both Bill and Charlie thought I should not come back so soon -- I had told them it would be after September 21 or 22, as you said -- because things would not move ahead fast enough. They thought funding would have to be found. (My own feeling is that you would want to go ahead with the task of brainstorming the idea, putting together some ideas about research design (which is so important here to avoid the traps of traditional KAP studies), talking about the scope of the study, how it could be carried out, and what it might cost. That process could start, even if only to have something to present to a donor for funding. However, I told them they had to decide, and I would abide by that decision, unless you specifically saw the need for me to return.

Charlie and Bill also thought Petra Osinski would be interested and asked me to brief her on the idea. She was all tied up, but she listened very interestedly to an outline on the telephone. She sounded quite interested and may be approaching you for further discussion.

That's where the matter stands. If there's anything I can do to help you, Bill Johnson will know how to reach me. Keep up your good work.

Sincerely,

Frank Wilder

Jakarta: Sunday 14 August 77

Dear Ray:

Last night, here in my hotel room, having just returned <sup>(by plane)</sup> from village visits in Central Java, I talked for about an hour and a half with Haryono Suyono, Deputy Chairman III, as he is called, of the BKKBN -- (But I think of him as the engine that has driven this Indonesian Population Program to the phenomenal heights you have already heard about officially.)

It was Saturday night, he had been at home, and I didn't expect him to come. But I had learned that all high public officials had been asked to remain in Jakarta until after August 17 (next Wednesday), Independence Day, in anticipation of possible student demonstrations. Through Bill Johnson (whom I had called at home as soon as I returned here) Haryono had sent word that he would not be able to accompany me to North Sulawesi. I was to go ahead alone as scheduled tomorrow morning. Sulawesi, just below the southernmost tip of The Philippines, is, as you know, one of the Outer Islands where the Indonesian program now faces its real test in winning village acceptors. Outer Islanders can be expected to be substantially more resistant, for a variety of reasons, than Javanese and Balinese. Communications, both physical and social, are relatively underdeveloped in the Outer Islands. Our purpose, then, in having me make this second field trip was to see if we could discern some openings for an appropriate kind of people-motivating technique, knowing what we know about the capability of the program in that critical IE&C component on Java and Bali.

(Bear with me a while longer through this dull introduction; it's the necessary and important background for the point of this letter.)

Obviously, I needed Haryono with me on the Sulawesi trip. But there was no way to override the order that would keep him in Jakarta. I needed now to talk with him before I left for North Sulawesi, for more than one reason. Tomorrow's flight is fully booked; there was some problem on a Saturday night and today (a Sunday) in getting confirmation; ~~the~~ The Sulawesi BKKBN had already been advised I would be coming along. But most important, I am due to leave for Bangkok the very morning after my return from Sulawesi, and there would be no time to discuss with Haryono what had emerged and seized my mind (on the Central Java expedition) as the only and most surely productive course for the Indonesian Village Contraceptives ~~Delivery~~ Distribution Centers system to pursue now: a motivational technique that can push prevalence rates to where I am convinced they can and should be -- at no less than 80 percent of couples programmatically eligible to contracept.

And that is what I am writing you about now.

The idea that revealed itself to me as I began to talk with village women in the Central Java area of Semarang the other day is so simple that -- like the concept of contraceptives-availability -- it will be considered to be self-evident, nothing new. And given as we are to applying abbreviated labels to our program concepts, there is the risk that this motivational strategy will be ~~misunderstood~~ misinterpreted and misunderstood -- just as many have read mindless inundation into your strategy of availability. But that's not important; here is what has

18 75 MAFIOSOVO 'AOGAKARIV-INDONESIA PHONE 3113 - 2115

WALIBBE HOTEL



taken firm root in my mind:

As you probably know, the major (and doubtlessly the only fruitful) IE&C element in the Indonesian program involves the harnessing of an existing political-administrative system to stimulate village individuals -- leaders and other socially acceptable extroverts -- to believe in the rightness of contraception for nation, village, ~~and individual~~ family and individual, and thereby to instruct and persuade eligible women to take pil (oral contraceptives) or accept spiral (the Lippes Loop.) All that is done in an atmosphere of commodity and service availability. A great deal more contributes to this program's achievements, of course. But I need not here detail the character of communal life on Java and Bali; the role of an approving head of state; the use-efficiency of resources; thoughtful, cooperative planning; the plain hard work and pride of countless program persons at every level; the sparkling drive of Haryono, a Bogue Ph D supported in large part, I guess, by AID.

In fact, although you had suggested Indonesia as one of four Asian countries where I might search for and succeed in encouraging the adoption of a fresh piece of IE&C that would actually directly result in OC/IUD/Condom use/with neither time nor money, he laughed -- Indonesia seemed a bad choice. Prevalance curves and new-acceptor data told us that things were going more than reasonably well, if not phenomenally, if one de-certifies Hong Kong, Korea, Singapore and Taiwan as bona fide developing countries, as we must. What is much more, Indonesia was already doing what I'd been suggesting for years as post-awareness IE&C: mobilizing established politico-administrative structures and age-old family and community relationships in the same way in which they are used for anything else that is, or has to become, a part of daily living. Tom Reese knew all that, too, when I called him in Jakarta from Washington. It was my luck and his magnanimity that led him finally to say, in effect: "OK, why don't you come and learn something from the Java/Bali programs, but what can you tell the Indonesians that they don't already know? "

So Indonesia became my first stop. (Thailand comes next. As for The Philippines, Lenni Kangas, in the dark wake of the Clinton Report and a set of recent Bogue IE&C recommendations that PopCom "still hasn't digested," begged off, and rightly so. The fourth country you suggested was Bangladesh, but I was no sooner out your door than I dropped it from consideration as barren for my purposes for the next 90 months, let alone 90 days. From a consensus of your relevantly-specialized staff people, Egypt, Tunisia and Ghana emerged as other candidates. Jerry Winfield is pursuing negotiations we began with those while I was in Washington, and I would take on one and no more than two of those -- if indeed any at all respond affirmatively.)

Now let's look at the Indonesian program another way. I'm sure I'm not alone in believing that it is time to think about actually reaching growth-rate goals. That means we should be aiming directly at numbers of births averted, and not primarily at new acceptors and use-prevalance levels. (I say "we," but I mean the ~~max~~ Indonesian managers of the program.) Not that nobody here or in Washington is not thinking about growth rates and births averted; I just think that if it is said loudly enough, then certain program emphases will change, some may be added, others diminished or discarded. Sustained effective contraception has ~~simply~~ just got to be boosted ~~to~~ three- or four-fold ~~by~~ the next five years or so. Please forgive that statistical imprecision; I've not had time to see if anyone has estimated present and projected births averted by the program, but just look at some prevalance and continuation rates, and it should be easy for you to figure out the job ahead -- remembering that these figures are for Java and Bali alone; in a contraceptives mix that suggests a significant amount of pregnancy slippage. In May of this year, 24 percent of ~~WRA~~ were using program-offered contraceptives

and services. All-method continuation rates for as late as June or July ~~range~~ seem to range between 43.7 and 45 percent after 36 months, revealing a dropout rate on the order of 56 percent, if I read the figures correctly. FOR PILLS ALONE, THE DROPOUT RATE AFTER 36 MONTHS IS 67.7%!!

(Let me interject here that nothing I say or think can possibly diminish in any way the outstanding job that has been done here by the Indonesians and by the AID Population staff who have ~~worked~~ worked and are working here. I don't mind saying that twice or more.)

Now an important, if not indispensible, factor to understand before any meaningful piece of IE&C strategy or approach or technique or mechanism can be found and appropriately applied consists of the dominating reasons for non-practice by persons who can and (from both the personal and program viewpoints) should practice seriously and with ~~effect~~ sustained effect. In other words: Why is it that in a long-established community like an Indonesian village, where people are indeed tied greatly as family, we find such a divided pattern of good practice, poor practice and no practice?

also/

There has been at least one investigation here of reasons for termination of practice by method and rates of termination by method. Also studied were "rates by reason for termination by parity and age." To a great extent, I'm sure, these data can be a valid reflector of reasons for failure or refusal to contract using the program's methods.

For IE&C purposes, we are naturally interested in termination rates by method, but we are primarily interested in the reasons themselves for termination and, from the ~~implication~~ implications of those figures, the reasons for non-practice, of non-adoption if you will. I want to leave aside (but only in this letter) the rates by both method and reason, and tell you only that the reasons ~~declared~~ declared and recorded were these:

- Want Child
- No Need
- IUD Expulsion
- Health
- Physical, Emotional
- Accidental Pregnancy
- Other

Look them over. Consider each one. From any point of view -- program, family, mother, community, country -- which ones can you accept all the time? Which some of the time? Which not at all? Of course you don't know for sure, or with any accuracy, until you could talk a little more with each mother. You would be left, I am sure, with a rate of "valid" reasons that is shockingly lower than one would assume from the study.

Now leave all that aside, and I'll make the principal point concerning reasons for termination and non-practice: There is virtually no village mother in Indonesia who dares take an IUD or collect her first cycle of orals as long as her husband ~~doesn't~~ doesn't want her to.

What's more, none of the respondents seems to have revealed that to any interviewer, for obvious reasons. Unless a few are hidden in the "Other" column.

A third critical hypothesis suggested itself in the discussions I have had here: That a large number of Indonesian village men -- I guess conservatively more than half, taking all of Indonesia and not only Java/Bali -- cling to an inchoate rejection of, at least, the commodity methods that are offered. I think few of those men would be able to express and explain that rejection (especially to an interviewer with a clipboard), but imbedded deep in their consciousness are two proud attitudes: (1) "I and I alone am responsible for this woman and these children; nobody is going to tell her what to do, especially when it comes to my private personal sex relations with her; you are interfering with my masculine authority in this house; if anybody is going to tell her to have an IUD, it will be me; and just because ~~summarized~~ it is you, an outsider, who wants her to have one, I say 'No' and don't ask me why;" and (2) that IUD, those pills, and that condom constitute ~~another~~ another kind of interference, this one a physical interference with what I do physically to her."

I will grant to you and to the Research Division that by its sheer meagerness my sample is unreliable. I confess that I stand by these "hypotheses" that are ~~my~~ actually my convictions out of a combination of long experience in the countries of Asia (excluding Burma and The People's Republic) and common sense. Nonetheless, when Haryono last night made clear sounds of agreement with me, I suggested the outline of the beginnings of a different kind of study that might unearth the truth of the matter. Such a study won't be easy, but it could be done in about two months. I think Haryono would go ahead with it, with the slightest of nudges and some technical help, advisory help.

I'm sorry to have kept you in suspense, necessarily, for so long, but the essence of what I have discussed with Haryono as a "new," added-on IE&C technique should now be obvious. It is not a drive toward male contraception, such as we hear about in Korea and elsewhere. Rather it is, in its barest essentials, an intimate man-to-man chain of instruction and persuasion that runs from the camat (who is responsible for, I don't know, six to 20 villages) to the lura (village chief) to the recalcitrant husband.

Honestly, I would have to make you read another two pages to show you why this approach will produce results in Indonesia. Nor have I run through the details of how the system would be set in motion, the role of BKKBN, the kinds of content for the persuasion of the husband, and so on. But I did with Haryono, and he feels that I have confirmed his own feelings. He says also that he has already started some kind of male-oriented IE&C program in two places in the country. Virtually nothing else in the present program would be changed. This IE&C chain would run alongside what is being done now, and by existing personnel. If you like acronyms, Haryono can probably come up with something like "The GLS Program," or "CALUSU" (from Camat-Lura-Suami.) Funds? Definitely; but I think much of it can come out of uncommitted existing funds in the USAID project. In any case, it probably will present no difficulty.

Again, I believe Haryono will at least begin the process of deeper thinking, planning and discussing. He and I will have a final discussion when I return from North Sulawesi the day before I leave for Bangkok. And the irony of all this is that Haryono, Bill Johnson and I agree that we should be looking for a possible enhanced strategy for the Outer Islands, rather than Java/Bali. And I haven't even visited North Sulawesi yet! It's either very good or very bad that I am this pressed for time.

There is one element in the CALUSA that I must mention and explain, because it represents what may be regarded as a violation of my thinking about IE&C. In programs that are well over the stage of public awareness of family planning, FP methods and FP programs, I want to see the role of mass media and of audio-visual equipment subordinated to that of all of the known (and as yet unknown) mechanisms of social communication that are actually seen and heard first-hand in the normal course of life in the developing countries. (Each country must, of course, be regarded individually.) I have resisted the sunlight projector, the Crusader battery-operated slide/filmstrip projector and several other more conventional machines as wasteful of money, ~~and~~ unworkable under field conditions for many reasons, and low in productivity. But the other day for the first time, I was shown a plastic gadget that effectively shows a short film to an individual viewer ~~much more conveniently~~ with no power other than the hand-turning of a little crank. It takes a film cartridge. It looks nearly indestructible: I ran it back and forth, threw it on the floor and kicked it. It could pass through the hands of every villager (including, ~~in~~ unavoidably, every child over four) in a matter of days and come back to the village chief, ready for another film. Haryono is already interested. The expense would not be great. I want to pursue this further. It's built by Ortho, you've doubtless seen it, and Chuck Ausherman seems to be involved. The trick is going to be to make a new kind of film: one that surprises the viewer into laughter and a wholesome feeling about family planning and gets across one major important point. I know it can be done in Indonesia, and I believe Haryono will try it, possibly on a wide scale.

by Bill Johnson

Some final highlight thoughts:

1. I think the Indonesia program needs some international attention beyond the professional community's newsletters, journals and reports. The purpose would be to boost further the pride and confidence of the Indonesians. I can't think of a way that we might contribute to this, other than to ~~please~~ see that President Suharto is nominated for a Draper Award. I can quickly think of a couple of reasons against it, but maybe you can think of three for it.

see Magsaysay

2. You may have noticed that ~~in my opinion~~ as a technical adviser or as a grant-maker or a project development helper, I tend to concentrate on the personality first and the concept second. I have always believed, from my first experience in The Philippines 25 years ago (with MSA-now-AID) that real program successes in development come usually out of the minds of somewhat mad individuals. They're the ones who have made those reckless end runs around bureaucracies and meticulous scientists, dashing wildly for the end zone, rather than for that first down. I can think quickly of a few: that crazy Dr. D. N. Pai in Bombay; the young lady doctor in The Philippines, a Catholic country, ~~being~~ ligating a vas under a single naked bulb; Mechai of Thailand, once officially blacklisted by the U. S., now the recipient of a substantial AID grant; the ~~wacky~~ nutty Indian who, without much authorization, splashed The Red Triangle across that vast <sup>land</sup> country. Indeed, you yourself are that kind of nut, so I think you'd make that <sup>final</sup> touchdown -- some would say you've made several already -- if the Right-to-Suffering people don't trip you up with their groping long white canes.

3. Please see that Jerry Winfield sees this too.

Sincerely,

Frank

Frank Wilder



UNITED STATES GOVERNMENT

*Memorandum*

TO : Mr. Vernon R. Scott, PO/SCOTT      DATE: September 9, 1977

FROM: Frank Wilder, AID/W-APHA Consultant on Population

SUBJECT: AID Support in IE&C for NFPP and Mechai Projects.

As you asked me to, I've gone back for further discussions with both Patama and her staff and with Mechai and his staff to try to sort out more exactly and rationally what would be needed as the USG input for IE&C equipment and supplies and other support to make the Thai IE&C strategy work.

I. The NFPP Project

The IE&C component in the ProAg totals \$170,000 for equipment (\$160,000) and "audio-visual materials" (\$10,000). The Mission's draft equipment list, adapted from the NFPP request (both attached), totals around \$120,000, including estimated transportation charges of \$3,800. However, in what appears to be an oversight, our draft list does not include the needed amplifier. (The movie projector amplifier cannot effectively be used with the crowd sizes they'll be dealing with. Indeed, our list includes the necessary external loudspeakers, so everyone seems agreed that there was no intention to omit the amplifier). Patama's estimated cost per amplifier is the equivalent of \$500, but she included microphone and speaker, which we take care of elsewhere. So taking an estimated unit cost of, say, \$300, I come up with a total of approximately \$132,000 as a raw figure as the list now stands, against the ProAg's \$170,000.

That gives you some \$28,000 of elbow room on equipment. Note, however, that you have included in your list the cost of film prints--looking like \$48,000 for a total of 160 prints of 3 or 4 titles, all short FP motivational films, about which more later). Then there is the \$10,000 set aside in the ProAg, presumably for printed materials, about which also more later.

DIST:  
SCOTT  
CR

First, let me clean up the specifics in the equipment list as it now stands:

1. Movie Projectors

NFPP now has Bell & Howells (made in Japan), as well as two

other Japanese types. They have been satisfied with the B&H projectors, for reasons I need not go into. The point is that the Kalart-Victor machine -- one of those for which you'll be inviting bids and which has been tried and tested over 30 years in LDCs -- should serve perfectly well. Whatever machine is finally accepted, Patama's people and I are agreed that it must have the following:

(a) Manual load; rather than automatic -- This is because (1) the Thai operators can thread a machine blindfolded, and (2) film that is old, frayed and frazzled can jam in the automatic threading mechanism, necessitating the removal of the front plate, cleaning out the debris, trying again and praying it won't do the same a second time.

(b) Halogen lamp as light source -- This is a matter of preferred low-wattage and light intensity. And on that score, you should specify the highest intensity model projector (without danger to condensers over long operation), because of the wide screen requirement, which I'll mention next.

(c) Anamorphic lens (which is used for "Cinemascope" projection)--There is just no future anymore in Thailand for the use of regular 16 mm projection in the villages. Before you scream, I hasten to add that we need not go into 35 mm equipment and film. Indeed, there seems to be an easy way for Patama to get the anamorphic lenses locally, without resort to a PIO/C. While there are many places in Thailand where villagers may still flock to a regular 16 mm showing, the experience recently indicates that this is increasingly not so. In addition to Government, there are two other institutions, both private, who come to villages with movies. One is the itinerant commercial movie, set in an enclosure and for which viewers pay one, two or three Baht. The other is the company (or companies) selling consumer products, including medicines. Both of these have graduated to the grandeur of 35 mm wide-screen projection. They use a vehicle with a heavy-duty engine and an adaptor as the power source. The projector is a 35 mm high-light-intensity arc machine. The result compares with the quality of a city cinema. Add to that the fact that Bangkok film processing labs are virtually out of the business of reducing 35 mm wide-screen prints to regular 16 mm. Reduction prints in 16 mm "Cinemascope" are, however, available. And the normal arrangement is for inclusion of an anamorphic lens in the purchase price of the film. Getting these lenses with a mount compatible with the Kalart-Victor should be no trouble, but this whole arrangement should be assured in advance.

(d) Power Compatibility -- The projectors should be suitable for operation on 220 Watts 50 Cycles. And those specifications should be built into the machine without external transformers or rectifiers.

2. Slide Projector (Item 2), Cassette "player" (Item 3) and Cassette "player" (Item 5).

One of the little cassette tape machines is intended for use in conjunction with village movie showings. Its sole useful role is to pipe music through the PA system (amplifier and loudspeakers) to attract the crowd and keep things lively before the show starts. As such, this machine need not have a recording capability, and I suspect you could save some money if you purchased a good rugged cassette tape deck compatible with the amplifier.

The other cassette machine is intended to provide a synchronized commentary with training and motivational slide sets for the slide projector (Item 2).

Now the intention is to move the control and management of all of the 40 sets of equipment to the office of the PCMO. That is good, and I'll come back later to the implications of that shift. As for the slide projector, with its accompanying multi-purpose cassette machine, there is this to consider:

The use of slides, with or without accompanying sound track, can be effective in several circumstances, and I am sure they will be used. Patama has a few slide sets for training and what I believe is an incomplete presentation about the program for leadership information and indoctrination.

Let's leave training aside, because I believe NFPP will be in good shape by themselves on that software. Equally important is the need to increase greatly the exposure of leaders at all levels to the rationale, nature, purpose and workings of the National Family Planning Program. The evidence thus far is that there are interest and demand for this exposure from the universities, private organizations and a wide variety of official formal groups -- In short, anyone from village chiefs upward, including visitors from abroad. Both Patama and Mechai see the need for this kind of canned presentation, and I have arranged for Dr. Haryono Suyono, Deputy Chairman of the Indonesian Family Planning Coordinating Board, to send one slide set with English cassette narration, to you through Bill Johnson, so that Patama and Mechai and their appropriate staff members can see an excellent format for this kind of presentation. You are to return the materials via the same route.

But there are questions: One of the five FP motion picture films now being completed by Patama (with production by DSCS and funding by UNFPA) supposedly does exactly what I'm saying the slide set should do. The film should be coming back soon from processing. At the same time, as you know, Mechai has a videotape that does the same kind of job, but confined to his own program.

I prefer the slides-with-sound approach because (1) it can be used more expeditiously and under nearly all conditions; (2) it's easier to haul around and to operate without the need of a technician; (3) the slides can be arranged in a variety of formats for varying audiences; and (4) they're easier to update. I think Mechai can fend for himself without any hassle, if he wants to do his own kind of presentation, but I believe that NFPP needs one good presentation that includes the Mechai strategy and operations as part of the national picture.

So the new film needs to<sup>be</sup> looked at when it comes back, with an eye to the many and varied audiences (including training) that Patama has in mind. If the film serves the purpose, I'd be the last to say they need a slide set as well. But a decision will have to be made, and it might help to see what the Indonesians did. (More on films later).

3. Rear Projection Screens (Item 4A and 4B)

These are presumably for use with the slide projector. Only after you've settled the issue of the slide projector itself, with an understanding of the audiences for which it will be used, will you be able to ask Patama why there should be two rear projection screens -- one for "Groupshow" and one "collapsible".

4. "Hand Blow Horn and Microphone" (Item 8)

This is what is called a "bull horn" in the U.S. It is hand-held and one talks into one end. Batteries and a small amplifier send the sound out the other end, a lot louder. Police use them in crowds and whatnot. I thought this item could be useful in some circumstances outdoors, or even in large training sessions indoors where a PA system might not be readily available. However, Patama and her people had not ordered it, and they see no need for it. On the other hand, this item could be useful in the kinds of spontaneous situations into which Mechai motivators get themselves, and Mechai thought a few, but not 40, would be handy. They're not expensive.

5. Speakers (Item 10)

These are fine, and the specs will be available from Patama's people. There are two for each set of equipment. Just be sure that when ordering the amplifier, you ignore the speaker and microphone in Patama's list under "PA Amplifier," as I mentioned in para 2 page 1 above. There are two speakers for each equipment set, and the microphones and stands are shown as Item 7.

6. Spare Parts (Item 12)

You can ask Kalart-Victor for their recommended spare parts list, but if indeed you go for Kalart-Victor, I would be sure to have Patama's people go over the list. Your list calls for 400 spare projector lamps, or 10 per projector. I had one report that a motivation team used two lamps in 12 days of operation, 5 hours a day. Exciter lamps are another important item, but there are several others that Kalart-Victor specifies.

7. Accessories to make large outdoor screens.

You will find this as the last item on the third page of our list, numbered 2. The only point to be noted is that the price is listed as \$400 for each, while I am told that these are put together here for 5,000 baht each, or \$250.

Now we can consider the matter of films to its end.

A total of 160 prints are shown on our list as Items 9 and 11 on the second page and Item 1 on the third page. It's not exactly clear what was agreed to, if any agreement was reached. It looks like four separate titles: two local FP films and two imported, but each running about 20-30 minutes, priced at \$300 a print, 40 copies per title.

Here is at least part of the existing picture as I could hastily put it together:

As far as short family planning films are concerned, NFPP has five of them completed or nearly completed. All have been shot, and three should be coming back soon from final processing and copying:

1. Motivational film (villagers) for northeast; 20 prints ordered.
2. Same, but angled for South; 20 prints ordered.
3. Same, but angled for North; 20 prints ordered.

4. Contraception (training and selected leader information); 75 copies ordered.

5. Program Orientation (training and for leaders, other formal groups, as mentioned in Paras 4, 5, and 6 above); five copies ordered.

First, if the equipment is to be based in the provinces and shared by all, 20 prints each of the village films and five copies of the orientation film will be insufficient.

Second, I hope you will reconsider in its entirety the matter of what films your funds will support, in the light of this information:

The Thai motivational strategy, especially as it supports the growing shift toward vasectomy, as well as the ongoing pill program, is absolutely the only way to go, in my view. The trick that has been proved effective is to bring together a crowd -- and they sometimes come from as many as four and five surrounding villages -- with the lure of a shoot-em-up Thai film in 16 mm cinemascope, which is preceded by an FP motivational film or two, and with the all-important dynamic motivator giving the FP spiel through the PA system during reel changes.

I think you will agree that it would be folly to invest in mobile motivation teams that can offer only talk and serious motivational films -- and they are serious, although quite good. There are perhaps many places in rural Thailand where film showings are a rarity, where anything will be looked at eagerly, although not necessarily resulting in vasectomies. But I would guess that most Thai villagers have seen commercial feature films, now in wide-screen, and they love them. To come with a film featuring well-known Thai stars is to face an audience of up to two thousand. The mere identification of the Family Planning Program as the source of entertainment films is itself good for family planning.

Now since the USOM draft list of equipment includes those 160 film prints, I presume the \$10,000 item in the ProAg for "audio-visual materials" must be for printed materials. The total cost of the FP films in our list comes to \$48,000, at \$300 each. However, if we were to purchase 160 prints/a<sup>n</sup> particular mix of the five films made in Thailand -- and I would prefer all of those over most anything from the U.S. -- the price is now nearer to \$350 per print. That would come to \$56,000. If one were to opt for the purchase of 40 full-length Thai Cinemascope entertainment films in 16mm, the cost would be \$60,000 estimating the average cost per film at \$30,000, or \$1,500, including the anamorphic lens.

The point is that Patama will have to go the route of using both commercial and FP films. (Mechai might opt to use the commercial film only). But there is no way to go the FP film - only route. These commercial films must be regarded as a legitimate, if not indispensable, IE&C tool to take the Thai program straight and fast to its goals. Like the USG, the RTG tends in its archaic way to frown on the use of public funds for what has to be called entertainment. Patama has one or two prints still remaining usable from ones that were purchased by UNFPA (selected by NFPP), as a means of avoiding DTEC scrutiny. I would strongly urge you to explore that method if it develops that this software for the equipment USOM is purchasing cannot otherwise be obtained. Patama does have some funds for film purchase, and, in fact, needs more to have enough prints of those five FP films to meet the expanded need.

If anyone happens to question the proved effectiveness of feature films for family planning, both Patama and Mechai can tell stories. In Mahasarakham, you will recall, Mechai's people garnered 717 vasectomies in 14 days in an area where the Government had been doing about 50 a year!

You may be interested in looking over the list of 61 film titles held by NFPP. It's attached. We went down the list and find that the greatest number of films exist in one copy only and that there are only two films -- of which only one copy of each exists, and those are worn -- that are still useful for FP motivation work. Both are Thai feature films purchased by UNFPA locally. They are Nos. 59 and 61.

#### Research on Puppet Shows Among Muslims

Just a word about this item in the ProAg, which sets aside \$20,000 to study the effectiveness of traditional puppet shows as a vehicle for FP motivation in the South.

I understand you are not yet finally committed to this item, and you will doubtless look into it more carefully when the time comes to discuss details of implementation with Patama, Mechai and whatever appropriate research facility might be pulled into the discussions.

Ed Muniak tells me you are already supporting a study by NESDB of Thai Muslim attitudes toward Family Planning. That's good, very important to the formulation of an IE&C approach in the South. I can also appreciate that on the face of it, the idea of using established traditional folk media will always be appealing to program planners. (A dozen international and national workshops have been conducted on the subject).

Until you have explored this further yourself, I should probably withhold any judgment, but it may be helpful if I risk airing my suspicions, based on experience elsewhere and from what I've seen and heard about Thailand:

1. Patama says some work has already been done in studying the effectiveness of the puppet-show medium. She comes up with the feeling that (1) it is the older traditional persons -- and children -- who are likely to flock to and become thoroughly immersed in a traditional puppet show with a Family Planning theme, (2) rustic itinerant puppeteers are difficult to stimulate to excitement over family planning, and (3) what Patama calls the "hard core" of the program's clientele are more likely to be movie fans than Ramayana fans.

2. As I say, arguing against folk media with IE&C planners is like attacking their mothers. But this is Thailand. I prefer to think of puppet shows in terms of their absolute value in preventing births, rather than in the interest they may create in the desirability of having fewer children. Whether they can focus, in a Muslim village, on the desirability of vasectomy and its actual adoption, is problematical, to say the least.

3. I confirm Patama's conviction that puppet-show troupes are a headache to administer on a wide scale. And trying to couple a puppet show with an entertainment film is bit much more, from the logistics point of view. By themselves, the cost-benefit ratio is likely to be unacceptable.

## II. The Mechai Program

I had a little problem understanding with some measure of clarity how the IE&C budget will be actually applied. That's probably because (1) Mechai wasn't in a position to think out the details of his motivation program, (2) in the necessary process of translating Mechai's budget breakdowns into AID breakdowns, items like "transportation," "documents and materials," and "per diem" lost their original meaning, and (3) I ain't too good with figures.

Therefore, we should note, for example, that in Budget I (USOM Contribution) attached to your May 20 Letter of Agreement to Mechai, \$32,000 earmarked for "Documents and Materials" under Information & Education in Year One is actually the sum of three such items intended for use under Monitoring and Distribution. These "documents and materials," Mechai points out, are non-IE&C items.

Thus, perhaps in the confusion of regarding "documents and materials" as including films, Mechai's \$8,000 item for "Movie" (which included only per diem, transportation and other costs in his

submission) was submerged.

The Thai program is especially (perhaps uniquely) fortunate in having vigorous public and private IE&C chiefs (Patama and Mechai) who happen to agree on the basic means for motivating Thais toward contraception. This not only economizes on USOM and RTG inputs but, in my view, is going to go far toward insuring the application of the best IE&C techniques.

I don't know how to suggest a way, within the present terms of the Letter of Agreement, for you to help Mechai into the smoothest coordination with those 40 mobile audio-visual sets that we are giving to the provinces. One healthy sign is the decision to move Patama's present staff of mobile motivators out to the critical provinces to act as trainers and in a kind of supervisory capacity. I think these people (all men) will get along well with Mechai's supervisors and motivators. At the level of the PCMO, Mechai's record for productive cooperation is generally good. As demands for the equipment mount -- from Mechai, from the training people, the NFPP program and "outside" institutions -- I foresee inevitable conflicts in scheduling, aggravated by more frequent equipment breakdowns resulting from too many different hands and more frequent transport.

If I had my druthers, I would like to see the Year One IE&C budget revised (even at the expense of later years, if necessary) to focus sharply on the technique that both Mechai and Patama want to pursue -- the use of entertainment films backed by a lively motivator and a "free vasectomy certificate" that precede the arrival of the service team. At the same time, Mechai intends to take further much-needed steps to boost the effectiveness of distributors as active motivators, rather than passive merchants. His fertile mind will have no problem finding ways to stimulate them toward such activity as catching the pill drop-out before she drops out, promoting increased sales, and spotting vasectomy candidates for referral.

Here is some other information you will need in order to finalize how and where you and Mechai can best allot whatever IE&C funds can be scraped together from the prescribed pot:

The PIO/T (932-11-570-632) for the project provides for only one piece of equipment out of the larger list submitted by Mechai -- an IBM typewriter, apparently intended for the Mahidol research task. There is some evidence that the RTG is not aware we are expecting them to provide 8 movie projectors, 8 public address systems, two video tape recorders and eight family planning films -- the IE&C items I've extracted from the original list. I'm

told this arrangement pre-dates the decision to provide 40 audio-visual sets to the NFPP.

Since you and I had no opportunity to discuss this in detail, I should not venture any conclusions. But quite apart from that list, Mechai and I talked on several occasions in an attempt roughly to design a working strategy for IE&C support of his program. Motivation looms as large in Mechai's program as it does in NFPP's, and perhaps larger, given Mechai's style. What both he and I are saying is that if he were to realistically, systematically and economically attack the IE&C problem, he would be able to hit approximately 2,100 villages in the 80 "AID" districts, or 25 per cent of the total (8,000) villages in the project areas in the first year of operation using three mobile motivational teams. (He swears that each of three teams will do 20 showings a month, and each showing would cover three villages.) From his experience, he's so sure he can pull this off, that he could pledge to return AID funds if he could not increase vasectomy acceptance by 25 per cent with this IE&C approach. The question is: can Mechai move freely and quickly enough, at the right times, to run such a program using NFPP equipment that will be heavily in demand elsewhere?

My reason for having written this much to you is that I saw no profit in having you wait for the APHA report that I am required to write at the end of this assignment. I have left out, therefore, much of the IE&C philosophy and some of the conclusions I've come to about this program, as the result of my visits to villages concerning resistances to FP success in Thailand and (happily) the opportunities for more profitable delivery of commodities and services.

I've enjoyed this look into the program more than I can tell you. I think that, given the brief time I was here, the openness and honesty displayed by you, your staff and the Thai program people account for my feeling that what I've learned is true. Good luck.

FW/cb