

PN 7744 087

42821

Meeting the Family Planning Needs of the Urban Poor

Malcolm Potts, MB, B Chir, PhD

Pouru P. Bhiwandiwalla, MD, MSPH, FCPS

International Fertility Research Program
Research Triangle Park, North Carolina USA
1981

Other reports published by the IFRP:

RAMOS

**SURGICAL FAMILY PLANNING METHODS:
THE ROLE OF THE PRIVATE PHYSICIAN**

**TRADITIONAL ABORTION PRACTICES:
THREE STUDIES OF ILLEGAL ABORTION IN THE
DEVELOPING WORLD**

RURAL HEALTH AND BIRTH PLANNING IN CHINA

Library of Congress Cataloging in Publication Data

Potts, Malcolm.

Meeting the family planning needs of the urban poor.

1. Birth control—Government policy. 2. Poor.

I. Bhiwandiwala, Pouru. II. International Fertility

Research Program. III. Title.

HQ766.P6759

363.9'6

81-7184

ISBN 0-939704-03-X

AACR2

International Standard Book Number: 0-939-704-03-X



The International Fertility Research Program is a nonprofit organization dedicated to improving the quality of life for women, children and their families. Since 1971 the IFRP has provided essential support and training to those whose need for family planning and improved maternal and child health care is greatest. Our staff collaborates with an international team of highly competent investigators to make realistic fertility regulation choices available to all groups of people, but most especially to people in the developing world. The IFRP's efforts are concentrated in Contraceptive Development and Evaluation, Operations Research and Distribution of Family Planning Services and Information.

Partial support for this publication was provided by the International Fertility Research Program with funds from the US Agency for International Development and from The Hewlett Foundation.

Acknowledgment

The International Fertility Research Program is grateful to the following persons, who participated in the September 1980 meeting held in Juarez, Mexico, and who served as reviewers of this publication: Gonzalo Echeverry of Pro-familia, Bogotá, Colombia; Merle Goldberg of the International Women's Health Coalition, Washington, DC; Alfredo Guzmán of ALAFARPE, Lima, Peru; Genoveva Mora de Hamilton of the Asociación Pro Salud Maternal, Mexico City, Mexico; Marcia Jaffe, International Fertility Research Program, Research Triangle Park, North Carolina; Mustari Khan of the Concerned Women for Family Planning, Dacca, Bangladesh; Fred S. Mayer of Pharmacist Planning Service, Inc, Sausalito, California; Indumati Parikh of Streehitakarani, Bombay, India; Isabel Rosario of Neighbors Population and Development Services, Inc, Zamboanga, Philippines; Sunarti Sudomo of the National Family Planning Coordinating Board (BKKBN), Jakarta, Indonesia; Maria Guadalupe de la Vega of Centros Materno, Infantil y de Planificación, Juarez, Mexico; and Mohamed Zarouf, Médecin-chef of Marrakech Province, Marrakech, Morocco.

Contents

Preface	vii
Introduction	3
Family Planning in the Urban Slum	7
Promoting Family Planning	39
Managing a Family Planning Effort	49
Using the Urban Structure	61
Family Planning and Human Welfare	75
Opportunities and Barriers	89

This publication is the fifth in a series of reports published occasionally by the International Fertility Research Program on selected topics of interest to those concerned with population, family planning and the ultimate well-being of all people. Copies are available from the IFRP Publications Unit on request. Series Editor: Patricia M. McCarthy; Associate Editor: Candee P. Ellis; Graphic Design: Marcy McKaig, Elizabeth Smith.

Preface

The largest migration in human history is currently taking place. Over the past 15 years, 600 million people—almost equal to the population of India—have left a traditional way of village life to live in the exploding cities of the developing world. By the end of the century, they are likely to be joined by another 1500 million, the estimated number of people who will be born in the cities and who will migrate from the countryside during the next 20 years.

The changes in life-style resulting from rural-to-urban migration tend to reduce desired family size, but economic growth is slow and the urban poor often have limited access to those services normally associated with city living. Rapid urbanization results in unemployment, poor housing with unsanitary conditions and overcrowding. To ameliorate the problems of rapid urbanization, it is essential to provide people with family planning choices that will allow them to control the natural population growth that occurs in areas with rapid inward migration. However, the lack of an established infrastructure and the multitude of social and physical problems that surround life in shantytowns often result in a wide disparity between needs and services.

In September 1980 the International Fertility Research Program (IFRP) sponsored an international meeting to evaluate the most appropriate ways to deliver family planning services to the urban poor in the peripheral slums and shantytowns of rapidly expanding cities of the developing world. The participants met specifically to review current technologies and to:

- document successful urban family planning programs,
- analyze common factors that help identify and replicate successful programs,
- review those problems and opportunities that distinguish urban from rural family planning programs and
- compare cities with and without successful programs to determine factors that limit fertility in the design and implementation of family planning programs.

viii

Shortly after the IFRP meeting, the United Nations Fund for Population Activities (UNFPA) held an International Conference on Population and the Urban Future, where among the participants were the mayors and administrators from 41 cities whose populations are projected to reach five million or more by the year 2000 A.D.

**“Over the past 15 years,
600 million people—
almost equal to the
population of India—have
left a traditional way of
village life to live in the
exploding cities of the
developing world.”**

That meeting reviewed the numerous policy decisions that must be made to secure any sort of reasonable urban life in the future.

The recommendations of the two meetings dealing specifically with services were in full accord. As expressed by the Rome Declaration, Recommendations 18 (c) and (d), September 1-6, 1980¹, these recommendations were:

- Encouraging the full participation of the population at large and their community organizations in the urban development process both at the planning and the implementation stage of policy and programme development.
- Establishing or strengthening measures to enable all couples and individuals to have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so.

This report summarizes the information and inspiration exchanged during the IFRP meeting. It is hoped that the report will in some measure help the growing numbers of urban poor to obtain the family planning services they desire.

¹ *Rome Declaration on Population, and the Urban Future*. Issued by the International Conference on Population and the Urban Future, 1-4 September 1980. United Nations Fund for Population Activities, New York, 1980.

Introduction

Introduction

Throughout the world's urban areas, there has been a remarkable, consistent and demonstrable reduction in desired family size. Many surveys from a large number of different countries demonstrate that women in urban areas do not want as many children as they are currently bearing. For example, in Peru, a country with strong pronatalist traditions, 95% of all women with three or more children do not want another child.

3

When family planning services are made available, wives usually express a desire to control their fertility before their husbands. In fact, during the early stages of adopting family planning, the husband may object to contraceptive practice. However, after a brief interval, the men become less opposed to family planning and begin to support the availability and use of contraceptives.

In the last decade the understanding of family planning has deepened. Experience has shown that easy access to contraception is essential for its adoption. When a community is undergoing rapid change and adopting family planning practices, those who first use contraceptives need to be sustained and nurtured. Although repeated household visits may be needed to launch contraceptive use, in two or three years even the most unsophisticated and underprivileged communities begin to make an autonomous, self-sufficient response to the availability of family planning services. When this happens, the need for fieldworkers to attend to individual couples declines.

Family Planning in the Urban Slum

Family Planning in the Urban Slum

Family planning programs are defined by the population they serve—urban or rural. This, in turn, determines the most appropriate and successful channels through which contraceptives and other family planning services can be distributed, as well as the most needed, suitable and acceptable methods of family planning to be offered.

The Urban Population

Family planning in urban areas presents special needs and opportunities. Although certain changes in life-style that result from rural-to-urban migration, such as a switch from breast-feeding to bottle-feeding, may increase fertility, the social and economic pressures to control fertility are stronger in most urban situations than in rural areas.

In urban areas the approach to controlling fertility has often been merely to provide a number of family planning clinics and to rely on these clinics and on the local hospitals to meet the needs of the urban population. Although the upper and middle classes have always been able to turn to private physicians, pharmacies and retail sales outlets, relatively few programs have been developed to fulfill the particular needs of the urban poor. However, there are sufficient urban programs tailored to the needs of the poor from different social, religious and cultural backgrounds in different countries and in different types of slum environments to demonstrate that tailor-made services can be highly effective in improving the health of women and in lowering birthrates.

The urban setting offers family planning programs many potentials for the delivery of services that do not exist in rural areas. By definition, slums are areas of high population density, making door-to-door service delivery easier and cheaper. In addition, an increasing number of slum dwellers are having their babies in maternity hospitals, which provides another opportunity for offering family planning not found in most village areas.

The difference between the rural and urban economy also influences the access to contraceptives. Slum dwellers usually operate in a cash economy and have easy access to small shops and pharmacies. In virtually all developing countries, medicines of every type are usually available without a prescription. Because slum dwellers often spend a significant portion of their disposable income, sometimes purchasing nonessential items, exposure to and information about family planning methods could channel some of this money to the purchase of contraceptives.

The mean age at marriage is usually higher in urban than in rural areas. In the People's Republic of China, a new marriage law was adopted by the fifth National People's Congress in September 1980. This new law sets the minimum marriage age for men at 22 years and for women at 20. However, few countries have made systematic attempts to raise the marriage age although it is an im-

portant variable in achieving lower fertility rates. In many cities, and particularly in the Indian subcontinent, women often marry during their early teens. Efforts to change such traditional social patterns are difficult, but not impossible. Nearly all countries have laws specifying the minimum age of marriage, but they are difficult to enforce and are commonly broken. The education and employment of women seem to be the most powerful incentives for delaying marriage until a later age.

One of the most important differences distinguishing rural from urban family planning programs is the opportunity for the urban programs to involve the community. The non-slum urban population can provide leadership, professional skills, concerned volunteers and usually a more highly developed and effective municipal administration than exist in remote rural areas.

Channels for Delivering Services

9

The very nature of city life affords a broad range of options for taking family planning to the urban poor. Different channels of service delivery are available to accommodate the needs that arise at different levels of contraceptive acceptance and program development.

HOUSEHOLD DISTRIBUTION. In most urban areas, there is already some use of modern contraceptive methods, and if left to their own devices, communities would probably adopt contraceptive use and voluntary sterilization with increasing frequency. However, distribution of contraceptives directly to the household provides an opportunity to accelerate the adoption of family planning. The population density of slums makes it logistically possible to establish these door-to-door services, which provide the opportunity to take modern methods of family planning to a large number of couples in a cost-effective and culturally acceptable way. The need for household distribution is in many ways greatest in the less sophisticated communities

where migration from rural areas and a traditional way of life is most recent.

The actual management of household-distribution systems is achieved through various methods. In a few countries commercial agents who already visit slum areas are subcontracted to distribute samples of contraceptives door-to-door. Such campaigns usually involve teams of women who make a very brief visit to each household and systematically indicate visited households by marking each house, or at least each street, with chalk. Such subcontracting has been used successfully by Profam, a social marketing program in Mexico, with the support of the country's national family planning organization. Household distribution through subcontracted commercial agents is most appropriate for more developed slums, where there are few cultural barriers to the adoption of contraception. Distribution of this type must be integrated into a comprehensive family planning program, with the availability and active promotion of the same products in local pharmacies or shops.

10

A second method of door-to-door contraceptive distribution involves field-workers specifically trained in family planning who are able and willing to spend more than a few moments in each household. They are organized by a government or nongovernment organization and are trained to promote the concept of family planning, as well as to answer a broad range of questions, distribute supplies and offer advice and instructions on the use of specific methods. Teams of individuals visit community members and usually make a follow-up visit a month or so after the initial contact. Such urban programs have been well developed in the Philippines by the Iglesia ni Cristo, a nongovernment religious organization. Programs that depend on field-workers must offer follow-up supplies of contraceptives through retail outlets and/or selected depot holders within the community.

In cultures with a traditional way of life, such as in the shantytowns of the Indian subcontinent, a home visit may be particularly important and may have to be repeated

An Experiment in Door-to-Door Family Planning

A recently completed project begun in 1977 in Marrakech City to test the acceptability and effectiveness of distributing family planning services door-to-door has been found to be highly successful in increasing the use of contraception. Launched in 1977 under the direction of Dr. Zarouf Mohamed, Médecin-chef of Marrakech Province, Visites à Domicile de Motivation Systématique (VDMS) recruited and trained field-workers from existing public health personnel.

Marrakech, a Muslim city, has a population of about 480,000. Of the 200,000 women in this city, 85,000 are aged 15-44 years. Many of the people live in an area with low standards of hygiene and have little contact with the health care infrastructure provided by the provincial government. During the first of two visits, 81 trained health workers (57 female) visited nearly 50,000 households. Their goals were to identify all women eligible for family planning services, to collect basic information on the reproductive background and contraceptive status of each woman, to offer oral contraceptives or condoms to all eligible women and to refer those desiring IUDs to a health facility.

The purposes of the second visit, three to five months later, were to assess the acceptability of the door-to-door delivery system, to provide additional pills or condoms to initial-visit acceptors, to encourage others to accept a method offered by the VDMS program and to record additional information about attitudes toward the use of contraception by Marrakechi women.

Findings from the project demonstrate conclusively that household distribution is a highly acceptable and effective means of increasing contraceptive use, even in a society in which the traditional belief in large families is deeply rooted. The increase in contraceptive use among the women visited twice was dramatic: Overall use of contraception increased from 49% to 64% in urban Marrakech.

For Morocco, a country of 172,000 square miles with a population of 21 million, the average completed family size of 6.8 children and the youthfulness of the people (47% under age 15) are concerns of vital importance for national development. The country's population growth rate is among the highest in the world, and Morocco will double its current population in less than 25 years. With 40% of Marrakech Province's 1.2 million people already living in urban areas, the future for the urban poor is dismal.

The idea of family planning, almost unheard of in Morocco 15 years ago, is now officially recognized as an integral part of the national health policy. As a means of spreading knowledge about family planning and of offering effective methods of contraception, household distribution as implemented by VDMS has proved a valuable strategy toward the goal of reducing the country's population growth rate.

several times. Rapport needs to be developed between the home-visiting team and the members of the community, particularly with women who, for religious or social reasons, are confined to their homes or to very physically limited areas. For example, in Dacca, Bangladesh, women are visited every month for three months and then once every three months for several years, if necessary.

When individual homes are visited, it is common to find a large number of couples who wish to adopt voluntary sterilization. A referral system for surgical services and free transportation to a local hospital or clinic, if necessary, are a valued element in such door-to-door programs. The field-worker can give objective information about voluntary sterilization that the woman may never have had and can accompany the woman to surgery, helping to overcome barriers of fear and the difficulty of getting around in a large city, which can be real deterrents to obtaining services.

12 Programs go through phases. There is a short phase when intensive door-to-door visiting may occur and substantial support is required. Subsequently, programs enter a maintenance phase that requires an adequate and continuous supply of contraceptives. Selected inputs need to be made to respond to new opportunities or previously unforeseen problems. It may be necessary to reinforce messages that have already been expressed and services that are well established.

**“It may take two minutes
to give a cycle of pills,
but ten minutes to talk
of other problems.”**

HOUSEHOLD DEPOTS. One of the secrets to successful adoption of family planning is to reduce the barriers of physical access, cultural unfamiliarity and economic cost that surround the purchase of contraceptives. To achieve this, many programs establish local supply depots. Com-

monly, the depot holders are satisfied contraceptive users who belong to the community and are often older married women who have children. Often their home is identified as a supply depot by a sign board.

Frequently, the depot holders are respected community leaders and may be in prominent locations. For example, in Howrah District, the poor end of Calcutta, mosques have served as contraceptive depots, and in the Philippines the deacons of the church often become depot holders. In many cases the depot holders sell the contraceptives, which is one motivation for their providing this service, and members of the slum neighborhood can approach them at any time of the day or night to obtain contraceptive supplies or advice about family planning.

The depot holders usually do have some basic training, but it rarely lasts more than two days. Although it is not practical to reward distributors with a regular salary, it is reasonable to permit them to keep part or all of the selling price of the contraceptives and to take steps to raise their status within the community. Because the supply depots are convenient and are closely linked to life in the community, they provide a culturally acceptable means of distributing contraceptives.

COMMERCIAL OUTLETS. The ability to purchase contraceptives through commercial outlets alleviates the fear of modern methods of contraception by associating them with everyday domestic items. For example, Mechai Viravaidya's Community-Based Family Planning Services (CBFPS) in Thailand has opened a "Clothes, Cabbages and Contraceptives" store for the urban population. Mechai's philosophy is that contraceptives should be bought in the same way a person buys other essential items. The convenience offered by the first shop attracted such response that CBFPS is pursuing the possibility of opening a chain of CC&C shops where nearly all the basic necessities—food, clothing and contraceptives—can be bought in one-stop shopping. Making contraceptives commercially available also assists in the diffusion of new tech-

nologies through slum areas, and not only helps the people who are directly served but contributes to the overall adoption of contraception in the community.

The retail sale of contraceptives is a major source of contraceptive supplies in nearly all urban areas, excluding those in the People's Republic of China and Cuba. It is also the channel of service provision that was historically significant in the fertility transition of the Western World. In the 19th century, every town in Europe and North America had a variety of commercial outlets for condoms and spermicides.

Pharmacies and other shops that sell contraceptive products are usually open six and sometimes seven days a week. Even in developed countries, the health professional seen most frequently by the population is the pharmacist. For example, in the United States every person enters a pharmacy on an average of once every three weeks.

In the contemporary developing world, pharmacies nearly always sell oral contraceptives, commonly have injectable contraceptives and usually provide condoms and spermicides. Although some developing countries require a medical prescription for the purchase of pills and injectable contraceptives, it is a requirement that is rarely, if ever, observed, and for slum dwellers, the main barrier to purchasing contraceptives from retail outlets is their price. Generally, over-the-counter contraceptives sell for about \$1 per cycle of pills and \$1-\$4 for injectable contraceptives, making commercially available products beyond the reach of most of the urban poor.

In addition to pharmacies, a number of other small shops sell simple medicines and contraceptives. Shops are an important part of the slum economy, and usually shop owners know everyone in the local community and will extend credit to their neighbors. The fact that the shop owner is well known in the community can be an advantage in the provision of contraceptives. Often the husband will purchase oral contraceptives for his wife, as in Bangladesh, or the parents will send their child to obtain contraceptive supplies.



15

In Sri Lanka, a display of *Preethi* condoms makes them easily accessible to the customer.

Reproduced with permission from *People*, the development quarterly published by the International Planned Parenthood Federation.

The volume of trade in a small shop is low and items are purchased in small amounts. In extreme cases, and when no formal urban family planning program has been created, people sometimes buy only four or five contraceptive pills at one time. Because of the low volume of trade, shopkeepers are not visited by retailers or wholesalers and often have to visit other shops or outlets to obtain the goods they sell.

In many countries there are also retail outlets for traditional medicines. In Taiwan, many pharmacies have one counter for Western medicines and one for herbal and other traditional medicines. In the Indian subcontinent, Southeast Asia and Africa, some shops specialize in the sale of herbal remedies for a variety of ailments, herbal contraceptives and herbal agents to induce a late period and to treat infertility and loss of libido. In the Philippines and Peru, abortifacients can be bought from stalls located immediately outside Catholic churches. In other countries vending machines are used to dispense contraceptives.

16

Although vending machines have not been systematically explored as outlets for modern medicines and contraceptives, there is every reason to believe that they could be an effective channel for the distribution of contraceptives because use is not restricted by clinic or shop hours and accessibility is convenient for those who are embarrassed to purchase contraceptives. The disadvantage is that vending machines are sometimes vandalized (although no doubt the contraceptives will get used!), and some countries may not have a suitable denomination of coins appropriate for vending machines.

SOCIAL MARKETING. To overcome the economic barriers to the access to contraceptives and to increase their visibility and availability, a number of social marketing programs have been established. The oldest is in Sri Lanka.

Since its inception, the sale of condoms has increased from about 500,000 in 1972 to more than 6 million in 1978. The social marketing program in Bangladesh supplies about 40% of all the contraceptives used in the country.

and as of 1979 provided contraceptive protection to 2.7% of the country's couples. In Mexico, the Profam social marketing program was launched in early 1979 and by March 1981 had supplied 4.4 million condoms, 1.3 million cycles of oral contraceptives, almost 100,000 containers each of spermicidal cream and foam and approximately 700,000 packets of spermicidal suppositories.

Social marketing programs have several elements. They select the contraceptives to be marketed, develop a brand image with carefully designed packages, determine prices, identify appropriate distributors and launch a promotional campaign. Selected products are often extensively pretested within the community to assess the effectiveness and acceptability of the method, packaging, brand name



An important element in the Profam marketing strategy is the open exchange between the pharmacist and customer.

Credit: R. Ciszewski, Population Services International, 1979.

“Basically, social marketing projects in family planning promote, distribute and sell a contraceptive product to consumers through an existing sales outlet at a relatively low, subsidized price to achieve a recognized social goal—expanding contraceptive use.”¹

18

and price. For example, in Mexico oral contraceptives were offered in a variety of colors. This was changed as the majority of the people wanted a white pill because it was associated with purity and cleanliness.

Effective promotion of the selected products is an essential element of effective social marketing programs. Some countries, such as Mexico, permit radio and television advertising of contraceptives, including references to specific brands. Policies should be established in all countries to allow brand-name advertising through the use of billboards, radio, television, newspapers and magazines.

CLINICS AND HOSPITALS. Urban areas are always better served by private and government hospitals than rural areas. In some countries, a disproportionate amount of the health budget is allocated for urban services and private physicians are invariably concentrated in urban areas. Even government and nongovernment family planning programs tend to open clinics in urban areas before they reach into rural areas. For example, in Indonesia there is approximately one clinic per 50 square kilometers in Java and Bali, but only one clinic for every 850 and 6400 square

¹“Social Marketing: Does It Work?” *Popul Rep [J]* No. 21, January 1980.

kilometers in the two groups of the more remote Outer Islands.

Unfortunately, the advantages of having appropriate medical facilities in urban areas are not always fully exploited. For example, many urban maternity hospitals do not provide postpartum contraceptive advice. For many of the urban poor, the moment of childbirth may be their only contact with a physician or other health care professional. Thus, the occasion offers many women a rare opportunity to obtain family planning advice and contra-

Prices to Consumer of Contraceptives Available
Through Commercial Retail Market and
Through Social Marketing Programs
in Selected Countries (in \$US)

Country	Contraceptive	Commercial Retail Price ¹	Price Through Social Marketing Program ¹
Bangladesh	Condom	.08- .12	.01
	OC	.80-1.50	.05
Colombia	OC	.50-1.10	.25-.45
Costa Rica	OC	1.50-2.50	.35
El Salvador	Condom	.10-.30	.04
	OC	1.00-3.56	.40
Indonesia	Condom	.07- .20	.016
	OC	2.00-2.25	.17
Korea	Condom	.50	.05
	OC	.60	.30
Mexico	Condom	.30	.11
	OC	1.00	.39
	Foam	4.25	1.91
Nepal	Condom	²	.013
	OC	.50-1.10	.13
Sri Lanka	Condom	³	.013
	OC	.85-1.50	.15

19

¹Price (in \$US) per cycle of oral contraceptives, per condom, or per container of pressurized foam

²None available before social marketing program

³Negligible sales of brands other than *Prothi* since 1974

Population Reports, Series J, Number 21, Population Information Program. The Johns Hopkins University, Baltimore, MD 21205 USA.

ceptive services. Maternity hospitals also have an important role in sustaining an appropriate level and duration of breast-feeding, both to improve the welfare of the infant and to extend the period before ovulation resumes.

Perhaps the women most in need of help are those who come to hospitals with the consequences of a poorly performed illegal abortion. After an abortion, there is evidence that most women are receptive to the idea of planning their families and want a reliable method. And, women who accept contraception at this time often have the best rates of continued contraceptive use. It should be mandatory hospital or clinical practice to provide these women with contraceptive advice. Before leaving the hospital, they should have the choice of obtaining a supply of oral contraceptives, having an injectable contraceptive administered to them or having an IUD inserted concurrently with the treatment of incomplete abortion.

20

Family planning clinics run by government or non-government agencies are an important but sometimes misunderstood element in urban services. They should rarely be allowed to operate as an isolated entity, but should be regarded as the center for reaching out to the community—a place where patients with special problems are referred and where particular procedures, such as voluntary sterilization or menstrual regulation, are provided. Clinical facilities are staffed with personnel who can provide good health care and a variety of services and supplies. Also, the provision of contraceptives in a clinical setting associates them with routine medical care and increases the likelihood of widespread acceptance.

However, there is always a danger that a network of urban family planning clinics will be regarded as an end in itself, and administrators may not clearly see their limitations. Women are often deterred by the prospect of the routine clinic procedures, such as a pelvic examination, that are commonly associated with family planning clinics. Clinics are often open only at limited and inconvenient hours and are commonly situated at some distance from the poorest slum areas. The distance becomes a problem

The Indonesian Experience

Family planning activities in Indonesia have developed quickly and smoothly in the ten years since the creation of the National Family Planning Coordinating Board (BKKBN). Once the government assumed responsibility for managing a nationwide program in 1970, family planning became an integral component of the country's overall development program. A specific goal was set to reduce the 1971 fertility rate by 50% by the year 2000.

The process of institutionalizing family planning in communities has also begun to develop. In provinces where 15%-35% of all eligible couples use contraceptives, community participation in family planning has increased significantly. Some of the provinces in Java and Bali have reached 50%-70% of eligible couples. By the end of 1977, it was estimated that 20% of all Indonesian couples were using some method of contraception. After the first six years of the BKKBN program, Indonesia's birthrate fell from 43/1000 to 36/1000, and the growth rate declined by 10% from 2.1% to 1.9% a year.

Throughout Java and Bali, family planning posts and hamlet acceptor groups have been established, largely on the initiative of the community itself. In provinces where the number of contraceptive users is high, the hamlet acceptor groups have broadened their activities to encompass a wide variety of programs from those that provide education on nutrition and primary health care to those that provide new economic opportunities for women, further stimulating village development efforts.

21

To achieve acceptance of small family size, the programs plan to establish and consolidate family planning groups consisting of all eligible couples in the community. It is expected that such groups will become increasingly involved in the motivation, recruitment and maintenance of family planning acceptors in the community.

A program to weigh children younger than age 3 will also be instituted. The trained field-worker will provide information and education on family planning, will distribute contraceptives, will train local contraceptive acceptors to weigh the children and keep simple records, and will give advice to mothers on nutrition, child spacing, breast-feeding and family planning.

In 1978 the BKKBN employed over 7000 paid field-workers, had established 20,000 Village Contraceptive Distribution Centers and 25,000 village family planning groups that depend on local volunteers. The program provides oral contraceptives and condoms and refers those who desire an IUD or sterilization to the appropriate health facility.

because of transportation costs and because it takes women away from their families and, in some cases, away from a job. These reasons contribute to the situation in which the same contraceptive can be sold more readily in the slum itself than it can be given away free at a clinic.

REFERRAL SYSTEMS. Effective family planning requires access to a variety of contraceptive choices. Although it may not be physically possible to offer all choices within a slum area, it is essential that effective referral systems exist for those who want to switch from one method to another as the need arises, for those who experience problems with a particular contraceptive, and for those who desire a surgical method of contraception.

In Morocco, there is a new element to family planning called the reference center. This center is usually located near a maternity hospital and helps women choose an appropriate contraceptive. Unfortunately, the maternity hospitals and reference centers are usually too far from the slums to be of use to the urban poor.

22

The principal challenge to providers of family planning services is to develop acceptable channels of distribution that effectively reach the population. After the second World War in Japan, the Family Planning Association needed to extend services to millions of citizens in a highly urbanized country where the economy had been shattered by a disastrous war. Because outside aid was practically nonexistent, they had to strive for self-sufficiency. The Family Planning Association entered into an imaginative promotion and sale of condoms, using both special staff and midwives as distributors. Their work led to a number of innovations in condom sales and packaging, including the use of teams of women who made, and continue to make, door-to-door visits promoting condoms to women. Although the major outlet of condoms in Japan continues to be through pharmacies with sales directly to men, one important lesson was learned from the Japanese experience: Different channels of distribution need to be developed, targeting both men and women.

The Range of Methods

Three basic categories of contraceptives are available to those who provide family planning services:

1. Nonappliance methods, which include coitus interruptus, periodic abstinence (rhythm method) and breast-feeding;
2. Chemical and mechanical methods, which include oral and injectable formulations; IUDs; condoms; diaphragms; cervical caps; and spermicidal creams, jellies, foams, foaming tablets and suppositories; and
3. Surgical methods, consisting of voluntary female and male sterilization, menstrual regulation and abortion.

Among the many variables that affect the methods offered by family planning programs are:

- the life-style, economic status and cultural traditions of the population served,
- the degree of information and education about and acceptance of contraception that already exists in the community, and
- the legal status of particular contraceptives in the country involved.

23

Some methods are not very suitable for developing country populations because of existing family planning facilities and life-styles. Thus, the diaphragm and cervical cap have been excluded from our discussion of the range of methods likely to be used on a large scale. Use of the diaphragm or cervical cap requires trained personnel to fit the devices and to instruct the woman on proper insertion techniques. Effectiveness of these methods requires a high motivation for their use. Also, few contraceptive distribution programs have subsidized these two devices.

Periodic abstinence requires intensive instruction by trained personnel and meticulous record keeping by acceptors. Calendar rhythm is usually not promoted by family planning workers because it is difficult to identify accurately the time of ovulation and is not practical for women who have irregular menstrual cycles. Use of the temperature method affords a more reliable means of pre-

dicting ovulation, but the woman must have a thermometer and must be able to read it correctly. Although the ovulation method has been tried in slums, it is too early to assess its effectiveness.

COITUS INTERRUPTUS. Coitus interruptus, or withdrawal, is often, and probably unjustly, criticized as a poor method of family planning. The evidence that is available concerning its effectiveness suggests that it can be almost as effective as a mechanical method, and during the demographic transition in Europe, coitus interruptus was the single most important method of fertility control. Family planning workers should know that this method exists and should not discourage its use unless they have sure evidence that people will move on to adopt a more effective method of fertility control.

24

BREAST-FEEDING. It is estimated that current patterns of breast-feeding in the developing world provide approximately 34 million years of protection against pregnancy. The exact physiologic mechanisms controlling the return of ovulation in lactating women are not fully understood but are thought to depend upon patterns of suckling. The introduction of supplementary feeding, breast-feeding according to a strict schedule rather than on demand, and the separation of the infant from the mother at night probably all increase the likelihood of an earlier return of ovulation during lactation.

Bottle-feeding is spreading rapidly in many urban areas. In some poor urban areas, the loss of the natural protection against conception that lactation provides may occur more rapidly than the adoption of artificial methods of family planning. Clearly, there are reasons why women who are employed may adopt bottle-feeding. However, from the viewpoint of family planning programs, it is important to emphasize steps that can be taken to resist any unnecessary switch from breast- to bottle-feeding.

First, medical professionals need to be more fully educated on the role of lactation in suppressing ovulation and



breastfeeding is
an integral part of the
reproductive process,
the natural and ideal
way of feeding the infant
and a unique biological
and emotional basis
for child development.

-WHO/UNICEF Meeting
on Infant and Young
Child Feeding
Geneva, 1979



Breast-feeding poster designed by the WHO for use in medical schools and nursing institutions.

Credit: World Health Organization, Geneva, 1979.

in reducing the incidence of infant gastroenteritis. More and more slum women are having their babies in large, usually busy, and often overcrowded hospitals. Among the steps that should be taken to improve the chances and success of breast-feeding is to allow the mother to suckle her infant *immediately*, or at most within 30 minutes, after birth. Once out of the delivery room, the baby should be with the mother, either in her bed or in a bassinet at the end of the bed and not in a separate nursery.

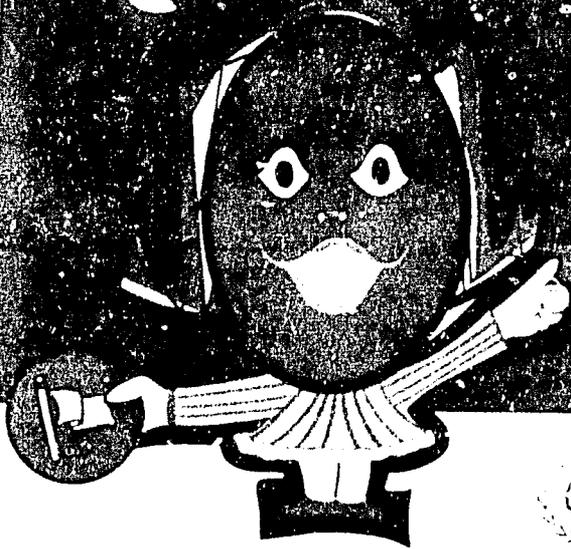
Second, because the sale of commercially prepared infant formula represents a significant part of their income, pharmacies and other stores are unlikely to cease promotion of artificial feeding. However, pharmacists must be taught about the side effects and dangers of infant formula in exactly the same way they are taught about the side effects and dangers of other drugs they dispense.

26 Third, in many countries there is no valid reason why the advertising and promotion of infant formula should not be regulated, without any disadvantage whatever to individuals. Those women who want or need to bottle-feed their babies would still do so. In some countries, such as the Philippines, Indonesia and Mexico, efforts are made to promote breast-feeding through posters, billboards and television advertisements. Last, governments should be reminded that infant formula often involves high import costs and serious strains on foreign exchange.

In short, to maintain and fully improve the prevalence of breast-feeding in urban areas, a concerted strategy must be aimed both at those who provide infant formula and at mothers who are caring for babies. It is better to provide extra food to the *mother* rather than to provide infant formulas to the baby.

ORAL AND INJECTABLE CONTRACEPTIVES. The pill has proved an acceptable, popular method of contraception wherever it has been made available in an urban situation. An increasing number of countries have recognized that it is responsible to distribute oral contraceptives without a prescription. In countries where prescription laws still

soy la
pildora!



**METODO SEGURO
PARA PLANIFICAR LA FAMILIA**



PROFAMILIA



27

A poster used by Profamilia, a family program in Colombia, to promote use of oral contraceptives.

Reproduced with permission from *People*, the development quarterly published by the International Planned Parenthood Federation. *People* 2(4):8, 1975.

exist, it is difficult for family planning programs to subsidize pills for sale in slums, and the situation arises where the middle and upper classes can purchase the pills without a prescription from pharmacies, but the poor are denied access to this method because of lack of money. One of the most important steps that can be taken to improve family planning services, and to prevent maternal death due to abortion and unwanted pregnancies, is to remove the prescription requirement for the distribution of oral contraceptives.

Shopkeepers, pharmacists and community depot holders can be taught to use a simple checklist to ask women about their age, smoking habits and any recent history of jaundice before distributing oral contraceptives. In sophisticated communities, questions can also be asked about hypertension and diabetes.

28 Unfortunately, the media in developing countries often pick up Western attitudes toward oral contraceptives, repeatedly emphasizing the drawbacks of this method and rarely publicizing the positive effects. It should be noted that in poor communities, a majority of the women are anemic and use of the pill decreases menstrual blood loss and raises the hemoglobin levels. Epidemiologic evidence shows that use of oral contraceptives may reduce the risk of developing ovarian cancer and breast tumors. There is also a suggestion that endometrial cancer may be reduced by using oral contraceptives.

Injectable contraceptives are popular in many developing countries, partly because diseases are commonly treated with a shot, causing injections to be associated with safe, effective modern medicine. Wherever injectable contraceptives have been made available, program managers have found them a useful addition to the range of contraceptive methods. There is often a considerable over-the-counter trade, although at a relatively high cost, and strong evidence that wide availability of injectable contraceptives through social marketing programs and government-supported programs would expand their use rapidly.

Unlike the use of oral contraceptives, injectable contraceptives appear to be suitable for women of all ages, including those who are lactating and those who smoke. Urban slums always have a number of people who can give injections, including pharmacists.

IUDs. One of the most cost-effective ways to provide IUDs is to encourage private practitioners to insert IUDs by supplying them with free devices that can be sold at a low price to acceptors. Perhaps the single most successful use of IUDs has been in Taiwan. In 1964 the government established training programs for private physicians, and nationwide use of IUDs occurred in a short interval. An effective coupon system for government subsidy of the IUD insertion was developed, and no capital had to be invested into building family planning clinics. From 1964 to 1974, the birthrate in Taiwan decreased from 34.0/1000 to 23.4/1000, and the number of IUDs inserted (including reinsertions) increased from 46,449 to almost 1.5 million. It is notable that prevalence of IUD use is considerably higher in Taiwan, where private practitioners were used, than in the Philippines, where 4000 family planning clinics were created but private practitioners were not explicitly involved in the government program

29

The use of IUDs is generally secure in clinical terms, but sometimes it is a choice that reflects social and cultural factors. In Muslim communities, some women fear that their husbands will divorce them if they plan their families. One woman with five children who asked the physician why IUDs have strings was told that they make it possible to check if the device is in place and make it easy to remove it. "Could a device be removed if the tails were cut off?" she asked. "It would be more difficult, but it would be possible." The woman requested that the threads be removed so that she could be completely sure her husband would not discover that she had an IUD. Subsequently, she brought 25 other women to the same clinic, also asking for devices with the threads cut off.

BARRIER METHODS. Condoms are usually available in cities, although in many situations they are associated with prostitution and a means of preventing the spread of venereal disease. This relationship often creates a stigma, causing the use of condoms to be associated with venereal disease rather than with family planning. This stigma can be removed by a more concerted effort to promote condoms as an effective family planning method and by associating them with basic, everyday commodities. In Thailand, condoms have become a form of currency, and arrangements have been made for women who must travel to obtain a sterilization to pay for the ride on the local bus with condoms.

The use of colored condoms can sometimes increase acceptance. Recently, in a very poor slum in Lima, Peru, the advent of colored condoms caused not only greater acceptance, but also discussion and joking about family planning, which increased the general adoption of contraception within the community.

Encouraging results have also been obtained with the marketing of spermicides, particularly foaming tablets, and there is reason to believe that the use of this method could be expanded in several situations. Again, marketing techniques can be useful because spermicides are easy to use and have no systemic side effects. In some countries, such as Brazil, where it is illegal to advertise contraceptives, or where social or political conditions prohibit their advertisement, spermicides are often promoted as feminine hygiene products.

31

VOLUNTARY FEMALE STERILIZATION. Voluntary sterilization has become the most universally popular method of contraception, and its acceptance continues to grow rapidly. It is estimated that 90 million couples use sterilization to control their fertility, and that by the end of the century, another 100 million will choose this method.

Sterilization can be performed between pregnancies or immediately postpartum. The fact that increasing numbers of women are delivering their babies in hospitals in-

Evolution of Attitudes in Peru

In 1977 the Peruvian government was aware of the socioeconomic problems created by rapid population growth and permitted family planning, provided it was integrated with other aspects of health care.

Twenty-five percent of Peru's population lives in cities, and the average urban couple has 6.3 children. With an annual population growth rate of 2.9%, the country will double its population of over 18 million in less than 25 years. Five million people live in the capital city of Lima, and half of them live in the abject poverty of the urban slums. In 1977 the Association of Pharmaceutical Laboratories of Peru (ALAFARPE) set up four family planning health centers in the southern zone of Lima, serving 200,000 people in an area where the nearest hospital is an hour-and-a-half drive.

Twenty-three field-workers were recruited and trained for four months by the Ministry of Health in the areas of first aid, vaccinations, the treatment of dehydration and family planning. A door-to-door survey was conducted and maternity care and family planning were promoted. Services were provided for small fees, appropriate to the slum economy.

Swing: in government policy, Marxist opposition in the slums, illiteracy and the traditional attitudes of the people all slowed the adoption of family planning. Eighty percent of the people were unaware of any possibility of contraception, and of those who knew about contraception, 80% knew only of a traditional method. Although the population was a young one, most women had already exceeded their desired family size. Nevertheless, husbands were opposed to their wives using contraceptives.

Simple records are kept of the client's age, parity, desired family size and previous knowledge of family planning. Satisfied users, who are mostly women with IUDs, refer others for services and provide resupplies of contraceptives. Such depot holders receive a three-day training course.

Despite the adverse circumstances, the program succeeded and grew rapidly. The husband's opposition to family planning waned, and contraception has become a joint decision of the couple.

tensifies the need for promotion of postpartum sterilization. It is the most technically simple sterilization method for a physician to learn and to perform safely, is the most convenient procedure for the woman and can be performed within 24 hours after delivery.

Once again, private practitioners represent a cost-effective, culturally acceptable channel of provision for sterilization services. In Korea and Taiwan, coupon systems have been used for government subsidy of the operation. In Korea the 1978 medical fee for female sterilization was US \$30, and in Taiwan the 1979 fee for tubal ligation was US \$26. When selected physicians have been appropriately trained, a high volume of service can be offered.

VOLUNTARY MALE STERILIZATION. Vasectomy is an easier operation to perform and to provide than tubal ligation, and both physicians and auxiliary personnel can be easily trained in the technique. No special facilities, other than a clean room, are required, and the instrumentation is simple and inexpensive.

However, there are many people in poor urban areas who regard any operation with a great deal of fear. For example, when vasectomy was first made available in Bombay, men were required to attend hospitals or family planning clinics. Relatively few came. However, when the same operation, performed by the same physicians, was offered in booths at a railway station, more men accepted it in a month than had adopted vasectomy in the previous year. Many hundreds of thousands of operations were subsequently performed at railway stations, in converted buses and in temporary booths of bamboo and tarpaulins erected on streets in the busiest areas of the city.

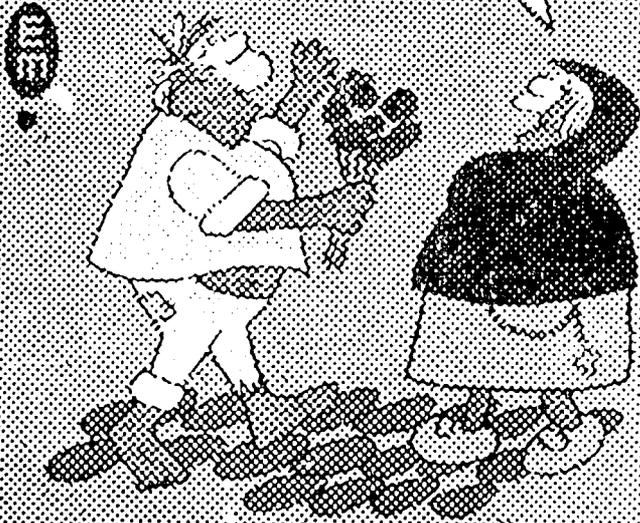
MENSTRUAL REGULATION. Menstrual regulation is performed within 14 days of the missed menstrual period and is usually done on an outpatient basis. Uterine evacuation using a hand-held gynecologic syringe and a flexible plastic Karman cannula has proved a safe, easy-to-use, inexpensive procedure. In some urban areas, this new technology has been rapidly adopted; individual cases can be quoted of private practitioners who have performed several thousands of menstrual regulation procedures. Professional counseling is valuable before the procedure to explain it to the woman and afterwards to provide informa-

LOS SUPERMACHOS

LA VASECTOMIA

LECCION
ELEMENTAL
DE EDUCACION
SEXUAL

LO ACOMPAÑARÉ AL CINE,
CUANDO SE HAGA LA
VASECTOMÍA, CHONI



34

Inexpensive comic books can be effective in providing needed information on family planning methods.

Reproduced with permission from *People*, the development quarterly published by the International Planned Parenthood Federation. *People* 6(2):33, 1979.

tion and advice about effective family planning methods. There is evidence that women will use menstrual regulation if it is available.

ABORTION. Whether abortion is legal or illegal, it is an intrinsic variable in fertility control. There is evidence that abortion is most common when a society first attempts to control its fertility. Therefore, abortion is a particular problem in urban areas and is likely to become more of a problem in the remaining years of the 20th century.

“From 30 to 55 million abortions are estimated to take place annually throughout the world. About half of them are illegal; more than half take place in developing countries.”²

35

Experience demonstrates that many women who have second-trimester abortions made the decision to terminate the pregnancy soon after missing their menstrual period but were unable to find appropriate services, needed time to gather money for the sometimes high cost or were put on a waiting list at a government service. When abortion is to be performed, every effort must be made to perform the procedure as early as possible.

“One estimate, based on data from the International Planned Parenthood Federation, is that in 65 Asian, African, Middle Eastern and Latin American countries about 84,000 women die each year from induced abortion.”²

²“Complications of abortion in developing countries.” Popul Rep[F] No. 7, July 1980.

In areas where menstrual regulation and abortion are not legally available upon request, many women turn to traditional abortion practitioners who bring age-old methods from their village backgrounds. (For more information, see M Potts, M Gallen, T Narkavonkit, J Tomaro: *Traditional Abortion Practices: Three Studies of Illegal Abortion in the Developing World*. IFRP, Research Triangle Park, NC, 1981.)

Promoting Family Planning

Promoting Family Planning

39

Before people can adopt family planning, they must have access to services and information about those services. A wide variety of channels exists in urban areas both for promoting the concept of family planning and for providing information about scientific methods of fertility regulation. When family planning is first being introduced, the most effective way of informing and educating people about services and methods is often by word of mouth. Once the idea of family planning becomes more familiar and acceptable, mass-media advertising can be a valuable tool for increasing awareness.

Field-Workers

Personally committed field-workers should be carefully selected to sincerely and enthusiastically promote family planning. They must be acceptable to the community, meeting the people's expectations in such areas as marital status, age and sex. An effort should be made to enhance

the image and visibility of the field-worker within the community. In Dacca, field-workers can usually be identified by the effects of better nutrition and their dress: Each one wears a button with the logo of Concerned Women for Family Planning, a group of women who distribute contraceptives door-to-door. Those who provide services under the auspices of the Iglesia ni Cristo in the Philippines wear attractive, bright uniforms, and in the Howrah District of Calcutta, field-workers carry a bag sporting a distinctive logo.

Volunteers can be recruited from slum communities. Although there is often considerable willingness to help, lack

40



Each field-worker of the Concerned Women for Family Planning in Dacca wears a button with the organization's logo on it.

of time can limit their effectiveness. If consistent, effective work is to be secured, field-workers need to be paid. In Pakistan in 1975, government-sponsored door-to-door distributors were paid US \$20 a month. In the Philippines, Iglesia ni Cristo field-workers receive a small salary and are reimbursed for transportation.

Health Care Personnel

The nature of family planning is such that people often turn to those in their own social group for advice. A physician may be perceived as a remote, busy, even unsympathetic person by the urban poor. And, although a physician may have a certain amount of influence, many of them have had no training in family planning. Sometimes the custodian in a family planning clinic has more influence than the doctor.

To obtain the maximum use of family planning, all members of the health profession need to understand the advantages of contraception and to have a basic knowledge of the techniques available. Only then can they promote family planning in all appropriate situations, respond to questions from acceptors and potential acceptors and refer women and men to appropriate facilities for obtaining surgical procedures.

41

Pharmacists

The goal of a retail outlet is to make a profit by providing a service to the community. In poor communities retail outlets should have access to free or subsidized contraceptives from the government so that they can sell them for a low price and still enjoy some profit.

Shops will promote those items that sell best. But many shopkeepers also have a social conscience and will work hard to promote contraceptive products. Usually, the shop's salespersons earn the same average wages as the

area's slum dwellers and are well aware of the need for family planning at an affordable cost.

Point-of-purchase display racks holding contraceptives and promotional materials attract attention and make contraceptive products accessible to the consumer. Some customers may be too shy to ask for a contraceptive, but if they can pick it up and hand it to the salesperson, they may buy it.

Family planning and public health issues should be included in the training of pharmacists, and refresher courses should be held for those already in practice. In the United States, a systematic attempt to enroll pharmacists in courses on family planning and the control of venereal disease quadrupled condom sales.

Community Leaders

42

In many urban communities the members who are influential, either because of administrative, political or religious reasons or because of sheer charisma, can make or break the acceptance of family planning. Community leaders may influence people against adopting family planning by promoting and reinforcing traditional, conservative attitudes toward contraception. But, they are also in a position to play a particularly creative role in achieving the acceptance of family planning.

Often, by virtue of the slightly higher income they may enjoy and by an appreciation of the merits of education, they themselves may be more likely than average to be practicing family planning. Nearly all structured family planning programs that have been effective in slum areas have begun by engaging the interest and by involving the sympathy of local community leaders.

General Service Providers

Some people are particularly well placed to influence their neighbors, and certain situations are tailor-made for dis-

seminating family planning information. In Arab countries, bathing establishments are very common, and the attendants have great power in spreading information. Conversations about family planning could easily be carried on and would serve to disseminate information to a great number of people.

In the United Kingdom, barbers are a major outlet for the sale of condoms. After a man has his hair cut, the barber asks, "Is there anything else, Sir?" The man either says, "Yes, please," and gets a package of condoms, or says, "No, thank you," and continues with his business. The situation in which contraception is positively offered to people, allowing them to accept or decline, is often a more effective way to distribute family planning methods than the situation in which people must overcome their embarrassment or shyness and summon up the courage to purchase a contraceptive.

When those who provide services offer their customers contraceptives, the situation is mutually beneficial. The service provider earns a little extra money, and the customer can purchase contraceptives in a relaxed, familiar environment. In Thailand, taxi drivers distribute referral coupons to sterilization acceptors. If a driver refers 50 acceptors in one year, the sponsoring program, CBFPS, pays the insurance on his cab for one year.

43

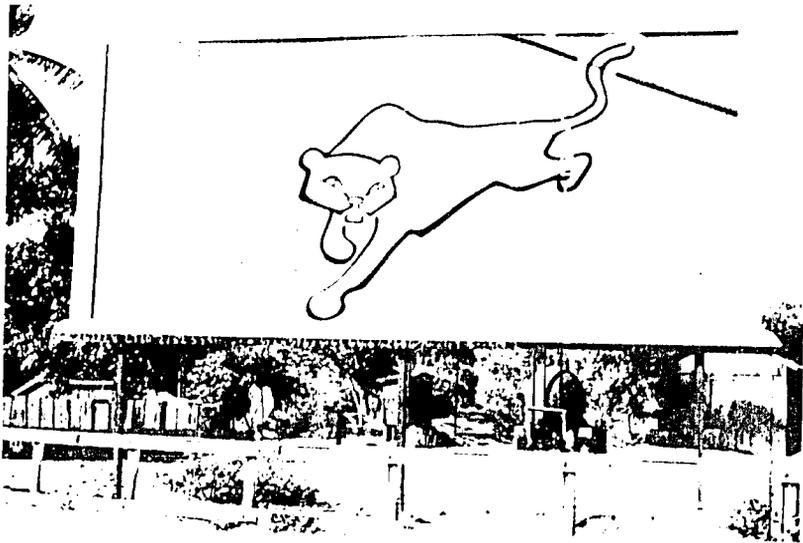
Mass-Media Advertising

Many low-cost commodities, such as soft drinks and cigarettes, are actively promoted in slums. The same straightforward advertising of contraceptives has been successfully carried out in a variety of different countries, including Bangladesh, Sri Lanka, Colombia and Mexico. Advertising has also been used to promote breast-feeding. In certain situations, the commitment to family planning is so great that advertising agencies have donated their skills and prepared promotional material at no charge. On the whole, professionally designed materials have proved

more cost-effective to produce than material put together by the employees of family planning organizations, who rarely have the necessary experience and training.

Pamphlets, prepared both for the literate and illiterate, describing the methods and philosophy of family planning can be distributed through a number of outlets to shops, pharmacies, hospitals and private practitioners. Billboards displaying the *Panther* (condoms) trade name, slogans and logo are common in Jamaica, radio jingles and slide shows shown in theaters are popular in Bangladesh, and television spots are a major part of Mexico's social marketing program. However, in some countries laws or internal media regulations prevent the advertising of contraception, particularly of specific brands.

The significant role of the pharmacist in the urban area can be enhanced by the production of flip charts and magazines deliberately aimed at the pharmacy and its employees. In one country, a very expensive glossy publica-



Billboards displaying the *Panther* trade name, slogans and logo are common in Jamaica.

Reproduced with permission from *People*, the development quarterly published by the International Planned Parenthood Federation. *People* 2(4):21, 1975.

Managing a Family Planning Effort

Managing a Family Planning Effort

The goal of a family planning program is to provide all people who want to control their fertility with the information, supplies and services needed. Programs must be efficiently managed, realistically staffed and designed to reach all the special groups in the population to be served.

Government Sponsorship

The need for family planning in urban areas can only be met by significant government involvement. However, municipal and national government resources are almost invariably overstretched in trying to meet the numerous needs of poor urban areas: Resources are drastically needed to provide educational and vocational opportunities and to improve health care, housing conditions, transportation and sanitation.

Although government resources are likely to continue to meet the major part of the needs of the urban poor, non-government agencies play an important role in experimenting with pilot schemes to provide sensitive services that respond to the needs of the community and to handle needs that receive the sympathy of government officials but are too controversial and politically sensitive to allow government involvement.

One of the simplest ways in which the government can help is by subcontracting services to the private sector of the urban structure. The subsidizing of sterilization procedures and IUD insertions performed by private practitioners has been successful in Korea and Taiwan. Social marketing programs are relatively easy to administer and can be implemented rapidly by subcontracting to advertising agencies and wholesalers and by using the technical skills of the private sector for appropriate activities. The senior administrators in hospitals and public health services usually control an important portion of resources and can either facilitate the implementation of successful family planning services or inhibit progress, depending on the priority they give to this particular topic.

50

Strong political backing for effective family planning programs is one of the most significant variables affecting their success. Some cities around the world have made impressive progress in the field of family planning because of support of the local mayor.

Selection of Staff

While no universal guidelines can be established, the selection of staff is of key importance. Among the criteria that must be considered for staff to be accepted by the community are marital status, educational level, sex, personality and degree of commitment. In some areas, as in Dacca, it is imperative that field-workers be married women. In other areas, as in Morocco, men may be more suitable, and in still other areas, as in Thailand, the sex of

Success in Mexico

In 1959, the year that the Mexican Sanitary Code (article 24) defined both birth control and abortion as illegal, Mexico's first family planning service, the *Asociación Pro Salud Maternal*, was organized. The *Asociación* was started initially as a pilot project to determine if Mexican women of the lowest socioeconomic group could be motivated to practice contraception for a prolonged period, and if so, which methods were most effective. For six years the *Asociación Pro Salud Maternal* was the only organization offering contraceptive advice in Mexico, and, as such, was the target for those who were opposed to birth control.

When Echeverría ran for President in 1969, he used the slogan "to populate is to govern." But in 1974, he drafted a law stating that every person has the constitutional right to receive free family planning services. Today, the National Population Council is headed by the Minister of the Interior, and free services in family planning are provided by government health institutions. It has even become possible for a sterilization procedure to be obtained without consent from the spouse.

Since 1965 the *Asociación* has provided intensive training and educational programs in family planning and currently maintains a comprehensive book and film library. Recently, the program opened a clinic at the National University of Mexico where students can obtain contraceptive services, sex education and general counseling.

The *Asociación Pro Salud Maternal* continues to thrive in a country where the government codes outlawed birth control only 22 years ago. It has survived the times of the worst opposition successfully and serves as a center of information, education, communication and training in family planning.

the field-workers and other staff seems to be secondary to other characteristics. What is essential is that the selected criteria do not exclude employing people from the community that is to be served.

Nongovernment agencies have a significant advantage over government services in that they usually have much greater freedom to hire and fire staff. Staff employed by nongovernment agencies are also likely to become more involved with people in the community than are government employees. Government services usually employ peo-

ple within a strictly defined framework, and unfortunately, the structure of many government and municipal services does not encourage outreach into a community: Workers commonly spend the day inside a building. Government employees are sometimes shifted around to meet administrative concerns quite beyond the needs of local communities, making it difficult to create a situation in which local staff help people in their own community.

Training

52

The technical knowledge necessary for field-workers to take family planning into poor urban areas can usually be taught in one or two days. The basic training should cover the goals and policy of the program, the different methods of family planning and their potential side effects, the distribution of contraceptives and appropriate record keeping. Training can be accomplished through a variety of techniques, including lectures, demonstrations, group discussions, slide shows and role-playing. Role-playing prepares field-workers for situations that are likely to arise in their daily work.

It is often most advantageous to assign new workers to a small team of more experienced colleagues so that they can serve an apprenticeship, learning the subtleties of communication and reinforcing and consolidating their knowledge by practical experience. Periodic refresher courses are as important as the initial training session, and some programs, such as the one in Dacca, provide an opportunity for field-workers to exchange information and discuss cases once every two months.

Supervision

The supervisory structure of a family planning program must be strong if the program is to be effective. Invariably, the supervisors with the strongest leadership qualities are



A Moroccan field-worker from the Family Planning Association calls on the keeper of a *hamman* (bath house).

Credit: Jeremy Hamand/IPPF

concerned professionals from outside the slum community who already have a strong background in health care or medicine. They must be able to select and train field-workers and other staff; answer questions about methods, side effects and distribution techniques; obtain adequate supplies of contraceptives; keep proper records; and assist in whatever other way is necessary.

In one way or another, every successful program reaches into the community and involves the slum dwellers themselves in the program. The role of the supervisor is to encourage this involvement. This is sometimes accomplished by paying members of the community or establishing depot holders who sell contraceptives and keep a small financial return for the work they do. The ratio of supervisors to field-workers in programs that successfully serve urban slum areas is high; in Dacca and Bombay, it is one to four.

Record Keeping

Most family planning programs collect more information than is analyzed or is useful for managerial purposes. As programs evolve and become more successful and as channels of service broaden, so the true role of record keeping becomes easier to understand

When excessive detail is required, it not only consumes valuable time that could have been given to the direct care of individuals, but it also causes anxiety among clients. When it is necessary to record data on a patient's characteristics to manage and evaluate a program, then age, parity, number of living children and age of the youngest child are the essentials that need to be collected.

Staff at each family planning program must determine their need for record keeping and devise systems that will allow them to record only the information that is useful. Collection of unnecessary data requires too much staff time and can undermine the effectiveness of a program.

Budget

Government-sponsored programs are subject to government procedures. It is common for the approval of a project and the transmission of funds to take a year or more and to involve numerous departments, particularly for activities targeted for urban areas. Every effort should be made to simplify such bureaucratic situations. Awareness by influential politicians can enable priority to be given to family planning.

In Asia, Africa and Latin America, the people in a slum community can probably afford to cover approximately half the cost of the reversible methods of contraception. While voluntary sterilization, by virtue of the years of protection it gives against pregnancy, is a cost-effective method of family planning, most people in a poor community cannot raise the money to pay the full cost. Even when programs are moving toward some degree of self-sufficiency, outside subsidy through government and non-government sources is needed to help meet the costs of administration, promotion, supply of contraceptives and voluntary sterilization (Fig. 1).

55

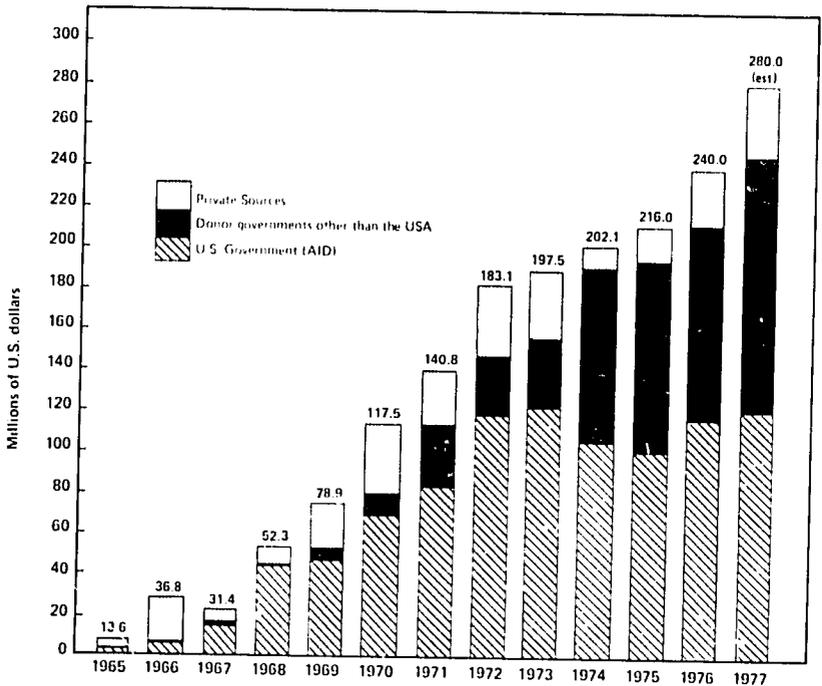
To some degree, most programs depend on donations from individuals and agencies. Although it is important for donor agencies to support and encourage innovative projects, the fact that this has become fashionable has left some highly successful urban family planning programs without funding while money remains unspent in other areas. After a while, program managers exhaust the range of innovations designed to intrigue and capture the interest of donors, and eventually it is the well-designed, successful programs that need the most money. The policy of donors should be to evaluate programs in objective, numerical terms, paying attention to cost-effectiveness, and then to *support success*. Currently, success in family planning programs can be self-defeating, as this can trigger the curtailment of funds.

As programs become larger and more successful, so the continuity of funding becomes increasingly important. Al-

though self-sufficiency should be encouraged, it is not probable that most realistic services in urban slums in the developing world will become totally self-sufficient within the next 10-20 years. The uncertainty in the continuity of funding that is offered on a year-to-year basis is destructive to programs. Plans cannot be made realistically and progress may be severely hindered. Although urban programs are always likely to require some degree of support, start-up costs are much larger than maintenance costs.

Those who manage successful urban programs require continuity of contraceptive supplies even more than continuity of funding. They need to receive donated supplies so that they can sell them at a low price and use the income to help defray program costs.

Fig. 1. International population assistance from primary sources of grant funds, 1965-1977.



Population Reports, Series J, Number 15, Population Information Program. The Johns Hopkins University, Baltimore, MD 21205 USA.

As programs move toward some degree of financial and technical self-sufficiency, the possibility of receiving loans and grants increases. Although most population assistance has been provided through grants, experiments have been made in advancing loans to general practitioners to improve clinic facilities or to set up specialist family planning

**“Donor agencies do not
last forever—especially if
you succeed.”**

mini-hospitals. Since 1968, the World Bank has extended over \$123 million in long-term loans to governments of or private organizations in developing countries to strengthen their family planning programs. In one country, national banks extended loans to general practitioners who offered the surgical methods of family planning, and in another, banks were encouraged by an outside agency who served as an underwriter to extend loans to young practitioners. Governments might also consider the role of extending loans, particularly to those involved with family planning in urban areas.

57

Programs should be managed by objectives. Clear management policies and competent staff performance are essential, both for local and international organizations, and they are the only basis on which an efficient and trusting relationship can be built between those who provide resources and those who implement programs.

Evaluation

Evaluation is an essential part of management, but like any other element within a total system, it can become an overworked word. The success of a program is usually relatively easy to measure by the number of people served, cost-effectiveness and personal knowledge of the morale and integrity of the staff at all levels. The best evaluators

of a program are the people it serves: Their response and the ability of the program to respond to and respect their needs are critically important.

Outside professional evaluators can be useful, but they should work to help rather than destructively criticize. They must have practical field experience and be able to understand the human response of the community being served as well as be able to review such data as quantity of contraceptives delivered or sold, number of new and continuing acceptors, number of distribution points, cost-effectiveness and impact of the program as measured by prevalence of use and fertility rates.

Using the Urban Structure

Using the Urban Structure

The factor distinguishing urban family planning programs from rural services is the variety of institutions, professional skills, physical facilities and social groups that can be used to carry the family planning message and provide services.

61

Schools

Most families who live in poor urban areas are aware of the advantages of education for their children, and they will struggle, often against considerable economic odds, to ensure some type of education for their children. Unfortunately, they are often defeated in their effort before the education is complete.

The years during elementary school can be an excellent time for beginning education on family life and population. High schools and universities also need such information and, in many situations, require family planning services.

Adolescents are exposed to many pressures in the poor urban environment, and their world changes more rapidly than most, often confusing family planning administrators and society as a whole. Legislation, policies and social attitudes commonly lag behind the reality of urban life for young people, both in developed and developing countries. Policies that were reasonable a few decades ago, such as only offering family planning to the married, may no longer apply in the rapidly changing urban environment. Certain aspects of urban life present a unique challenge, and adolescents in the poor and deprived urban environment often become sexually active at an earlier age than their peers who remain in the countryside. The growth rate of urban slums, the density of populations and the exposure to the influence of films, television and other components of modern living that are an integral part of urban life

62



The Iglesia ni Cristo in the Philippines is a nongovernmental religious organization that supports family planning programs.

Reproduced with permission from *People*, the development quarterly published by the International Planned Parenthood Federation. *People* 4(1):23, 1977.

place new and only partially understood pressures on family life in general and on adolescents in particular.

Adolescents are a target population that should receive special attention in relation to the dissemination of family planning information and, where appropriate, to the provision of services. Because many children in slum environments go to school for several years then drop out before completing their education, it is essential that population and family planning education be started at least by the sixth grade. The record of Mexico in providing family life education is particularly impressive. Textbooks approved for school use have a carefully written chapter on reproduction, providing needed information in a straightforward but acceptable way. In Thailand, family planning education is introduced early in the school years, and children can be heard singing family planning songs whose themes center on the ancient Buddhist slogan "too many children make you poor."

63

Religious Institutions

All the world's religions strongly support the philosophy of responsible parenthood and can be a major outlet for the transmission of information. Although some well-publicized differences exist in the theological interpretation of certain aspects of family planning technology, most people make pragmatic choices about the method of contraception they will use, following their consciences even if this conflicts with the formal teaching of their religious group.

Some churches, such as the Iglesia ni Cristo in the Philippines, have strongly supported family planning, using the pulpit to preach the benefits of contraception, the church buildings as sites for voluntary sterilization and the church members to hold depot supplies of contraceptives. Many groups are attempting to teach the fertility awareness methods to people in poor communities, but it is too early to evaluate the success of these programs.

In the situation where conflict does arise between religious leaders and those attempting to provide family planning services, it should not be automatically assumed that negative criticism will harm the family planning program. There is evidence from a number of sources that the reverse can happen. Criticism may very well draw attention to a service and increase the number of acceptors.

Many people, perhaps particularly those subject to the tensions of 20th-century urban living, appear to be able to face in more than one direction at the same time: At one level they may condemn the adoption of family planning, but the same people may find themselves providing services, even using the disapproved method themselves when they are placed in certain situations.

Private Physicians

64

Most private practitioners in urban areas have facilities appropriate for inserting an IUD, many have the ability to perform menstrual regulation procedures, and some can offer vasectomies. Hospitals, private practice clinics or family planning clinics are essential for the provision of a surgical method of family planning. Many obstetricians and gynecologists have small nursing homes where they can perform female sterilization and first-trimester abortions. Unfortunately, many government and nongovernment family planning programs do not adequately utilize private practitioners to provide family planning services.

Using a coupon system to subcontract private practitioners to perform voluntary surgical sterilization procedures is an administrative technique that governments have inadequately used. Systems must be devised to ensure the maximum ease of referral and cooperation among the complementary systems that are represented by government and municipal hospitals, family planning clinics, commercial outlets and community-based contraceptive distribution programs.

The Provincial City

Zamboanga in the Philippines is a typical provincial city in a developing country. It has doubled its population in the last ten years, and many of its 350,000 people live in the extensive slums in the low-lying areas.

In the early 1960s, family planning was a very controversial topic and could not be discussed openly. Arrangements were made with private hospitals to accept clients who were referred to them. Because of the increased demands on medical and clinical services, in 1968 World Neighbors supported the organization of Neighbors Population and Development Services (NPDS), a private, nonsectarian family planning association.

The first family planning program established in the region, NPDS is open six days a week and offers oral and injectable contraceptives, IUDs, spermicidal foams, condoms and male and female sterilization. The program publicizes contraceptive services through the use of radio, television, the press, posters and films. Family planning counseling is available through a hot line that enables people to ask questions over the telephone, and premarital counseling is broadcast over the radio.

The organization's urban program is supervised by a project physician and is staffed by three full-time community outreach workers/family planning motivators, one midwife trained to insert IUDs, one part-time physician and ten volunteers who distribute contraceptives. These volunteers are satisfied family planning acceptors and are trained in family planning, dispensing pills and record keeping.

As in many parts of the world, the political and religious leadership of the Philippines was initially opposed to family planning and still raises critical questions occasionally. Despite the campaign against artificial contraception launched by some of the Catholic clergy, the number of family planning acceptors recruited by NPDS continues to increase. Because the multifaceted problems faced by the program require a multidisciplinary approach, NPDS has organized classes teaching basic nutrition, food preservation, sanitation, food production and family planning.

In Taiwan, government subsidy of voluntary sterilization is controlled through the use of such a coupon system. Both government-employed and private physicians are contracted to perform the operation. Field-workers give couples eligible for the subsidy a coupon with a list of hospitals and clinics that provide sterilization services. After

the operation is completed, the hospital or clinic sends the coupon to its local health bureau for payment and notifies the appropriate health organizations that the operation has been performed. Thus, the coupon serves as:

- a referral between the health agencies and the contracted hospitals and physicians;
- a means of indicating that the operation has been performed and payment is due;
- a tool for evaluating the field-workers' performances and the follow-up by the acceptor; and
- a device for obtaining feedback on the program. (For more information, see M Potts (ed): *Surgical Family Planning Methods: The Role of the Private Physician*. IFRP, Research Triangle Park, NC, 1981.)

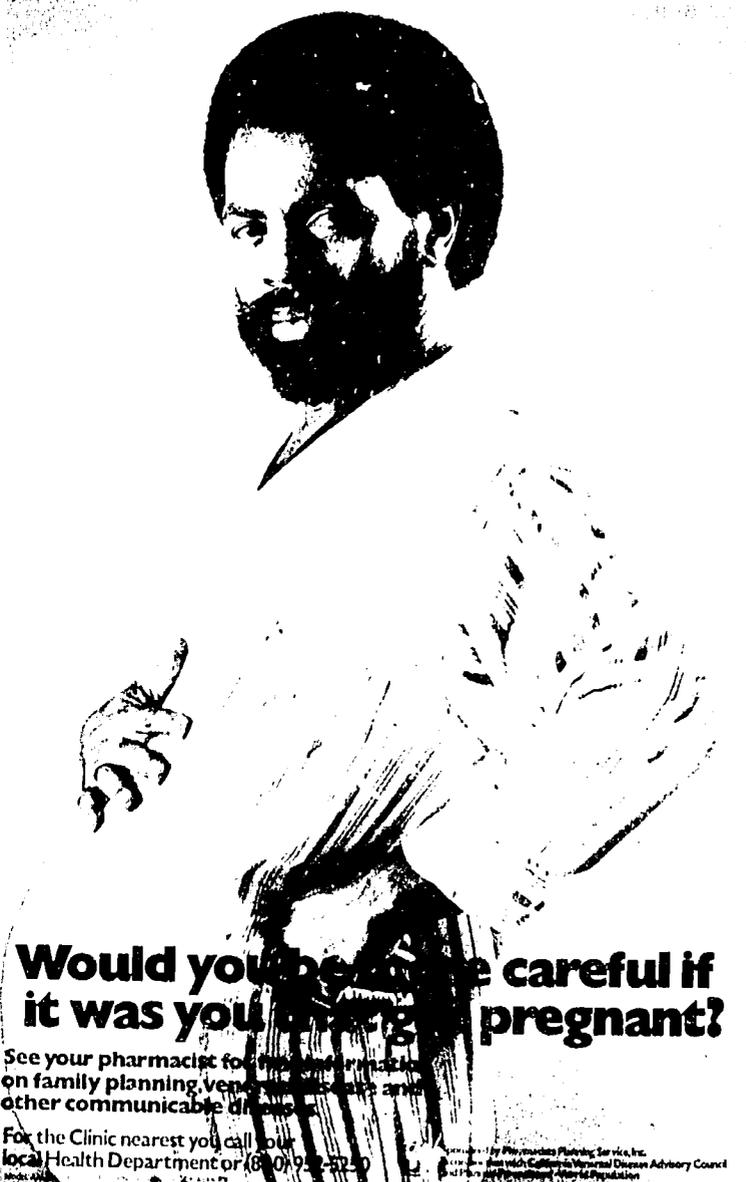
For better or worse, the private practitioner is often perceived to provide a better quality of service than staff at a busy government or municipal hospital.

66

Industry and Labor Unions

Industry, particularly the labor-intensive industries that tend to be characteristic of urban environments of the third world, concentrate large numbers of people in one place. Many employers, through a sense of social responsibility or an eagerness to conform to government policy, will make time available for the dissemination of information and the provision of family planning services to their employees. Large industries often have their own medical services and welfare centers, and family planning can be part of the range of services provided. Follow-up of family planning acceptors is virtually 100% certain in an industrial situation, and high continuation rates can be expected as an outcome of well-designed programs.

In the cities men are commonly concentrated in factories, making it possible to approach large numbers at the same time and to disseminate information about ser-



**Would you be as careful if
it was your wife pregnant?**

See your pharmacist for information on family planning, venereal disease and other communicable diseases.

For the Clinic nearest you call your local Health Department or (800) 932-5230

Sponsored by Pharmacists Planning Service, Inc.
Approved by the Health Communicable Venereal Disease Advisory Council
and the National Pharmaceutical Association

This poster, designed for the male population, is a useful tool in promoting family planning services.

Reproduced courtesy of Pharmacists Planning Service, Inc, PO Box 1336, Sausalito, CA 94965. Posters are available upon request.

vices through special arrangements with employers. Although men are usually more mobile and are exposed to a wider range of urban situations, they are not as likely to visit health centers as are women.

The Centro Materno, Infantil y de Planificación Familiar in Juarez, Mexico, has been developing a model program to zero in on the male population. They have recruited a male "promoter force" to work as community distributors and to work through the labor unions and other male-dominated organizations. Another aspect of their work is to capture the interest of the recent and still unemployed migrants.

In poor urban areas men often outnumber women; because they are usually the first migrants from village areas to seek employment in cities. The involvement and cooperation of men in family planning is clearly essential. Men can often introduce modern methods of contraception to their wives and facilitate their acceptance and use of these methods. Experience in several areas has shown that men may resist family planning when programs are first initiated, but this is usually short-lived: Before long, men, like women, become enthusiastic about the choices offered by modern family planning methods.

It is in the self-interest of employers, as well as part of the broader welfare of individual employees, to offer realistic contraceptive services to women. Time lost from work because of pregnancy or abortion and loss of staff after an investment in training has been made can all be reduced if unwanted pregnancies are prevented and time off due to sickness of children is reduced.

Some employers allow those who select voluntary sterilization to have time off from work with pay to recover from the operation. Many countries require employees to participate in some type of social security system, and often the employer has to contribute toward the cost of the employee's insurance. Wherever private, government or medical insurance programs exist, policies should be set that ensure that money spent for contraceptives and surgical family planning methods will be reimbursed.

The Leadership of Juarez

In Juarez, Mexico, promoters from within the slum areas and leaders from within the city formed a group that invited discussions with others and began giving talks on the needs of family planning. As the project formed, the promoters were trained and materials were provided. After training and 30 days of probation, each satisfactory promoter was given a certificate to display in a prominent place in the house to give the person status within the community. As the work proceeds, it is continually evaluated and new ideas are fed back into the system.

The system has matured and there are five social workers serving as coordinators who conceive the strategies carried out by 11 promoters. The promoters supervise and encourage 210 distributors, who live in the slums and are close to the people they are trying to help.

An important part of the total service is a maternity hospital, which is also equipped to offer voluntary sterilization. The total team in Juarez is staffed by 14 part-time physicians, nine full-time nurses, five social workers, one pharmacist, four maintenance men and an administrative staff of six.

Every elementary school in the Juarez slums is included in the informational program so that the children receive family life education in the sixth grade. The physician who teaches the course observes that the school children ask an outsider questions more freely than they might ask the teachers they must see again the next day. Typical questions have included: "How does a woman find out that she is pregnant?", "Why are children born ahead of time?", "How does a woman develop breasts?", "Why does the voice change in men?", "Why do men have mustaches?", "What do adults do not to have children?"

69

In many Asian countries, labor unions support family planning programs. In parts of Latin America, this strategy has proved more difficult because of the politicization of labor unions, some of which regard family planning as being politically imposed by Western countries. However, a more objective review shows that Cuba, like other socialist countries, has an active and successful family planning program in both urban and rural areas.

Unfortunately, well-intentioned legislation to improve the lives of slum dwellers sometimes backfires. In one country, industries that employ more than 50 women are

required to provide separate lavatories, a nursery and other facilities for women. The result from this legislation has been to reduce job opportunities for women: Industries are very careful never to employ more than 49 women at one time.

Nonslum Urban Dwellers

Slums do not exist in isolation; they invariably develop close to areas with some industrial and commercial prosperity. The upper and middle classes, who are the economic base of the cities to which poor migrants move, must be those who provide the policies and the professional and logistic leadership for urban programs that take family planning to the poor. The key to success lies in bridging the gap between the needs and the perceptions of the urban poor and the willingness of other groups within the city to help the poor find their own solutions, contributing only those external resources that are necessary and appropriate for this task.

70

Motels

In those urban societies where premarital and extramarital sex is relatively common and where prostitution is prevalent, there are usually a number of motels that provide rooms for short-term use by couples. On some occasions married couples may also visit such places to secure privacy away from their overcrowded homes. Such motels are usually readily identified, and the operators should be encouraged to install vending machines to make contraceptives easily available. Motels that dispense condoms can help prostitutes control their fertility and deal with sexually transmitted diseases.

It is sometimes difficult to make family planning advice and methods available to prostitutes because they are a mobile group and those who manage them often resist an

outside agency that tries to approach the women who work for them. In one country where the police raid prostitutes at fairly regular intervals, the time of their arrest and incarceration has been creatively used as an opportunity for providing family planning advice and for offering IUDs and tests for venereal diseases to those who want them.

Mail-Order Services

Ordering contraceptives through the mail has proved successful in some situations. People can respond to newspaper advertisements, filling out coupons to get condoms, spermicides, pills or informational pamphlets. In developed countries there is a long tradition of the purchase of condoms through mail-order businesses. However, in other countries the postal system is not adequate, and any letter with an enclosure is likely to be opened and the contents to be stolen.

Family Planning and Human Welfare

Family Planning and Human Welfare

75

Many urban programs go beyond the mere provision of contraception and referral for sterilization. Some of the most effective programs began as community development programs and added family planning as an essential element in the process. Other programs began with the provision of family planning and added such measures as nutrition education, parasite control and income generation for women.

Family planning should be regarded as an essential element in a spectrum of activities essential for community development. The type of community involvement that establishes a family planning program has proved an appropriate base for other aspects of development. Usually those people who provide the leadership for urban family planning programs are sensitive to other needs and are capable of promoting other aspects of development. The promotion of a total package of family welfare is called a "Happiness Package" in Indonesia.

Maternal Welfare

By preventing unwanted pregnancy and subsequent abortion, contraceptives do a great deal to reduce maternal mortality. The risk of developing diabetes and complications of pregnancy all increase with parity.

Some family planning services provide antenatal care, referral to hospitals and clinics and sometimes even maternity services. A two-way relationship can be created when established maternity institutions make the provision of family planning advice mandatory and when family planning programs set up their own maternity services. On the whole, the most concerned people who create some of the most successful family planning programs also have the skills and the administrative ability to provide excellent maternity services. In Juarez, Mexico, the

76



Indonesian poster illustrates the problems faced by parents with too many children.

Reproduced with permission from *People*, the development quarterly published by the International Planned Parenthood Federation. *People* 2(3):24, 1975.

Bombay's Streehitakarani

Bombay is the most industrialized city in India. Already overcrowded with a population of 8 million, the city continues to swell as 1500 new migrants arrive every day. Many of the homes share a common water supply and a few makeshift latrines serve an entire group of hutments. Most of the people work in the textile mills and small industries of the city. There is a high illiteracy rate, particularly among women, and there is not a single high school in the area.

In 1964, the Streehitakarani (women's welfare) was founded by people from outside the slums. A number of services were offered, and since 1972 comprehensive family planning and development services have been provided to a population of about 50,000. As in Dacca, the Streehitakarani is built around women. But in contrast to the Concerned Women of Dacca, the field-workers come from within the slum itself.

The organization has 24 married, part-time field-workers who have four to eight years of education, are aged 23-40 years and earn 35 rupees (US \$4) a month. Many of them are satisfied contraceptive users or are women who were particularly successful in bringing children in for immunizations. The area served by Streehitakarani is divided into six sections with just under 10,000 people each. Each section has four field-workers and one group leader, and there is competition among the groups for the best performance.

Small fees are charged for services and commodities, even though the same things may be available at no charge from government centers. However, if women cannot pay, they receive free services. There is a small clinic accommodated under the seats of the local sports stadium that provides IUD insertion, pill distribution and menstrual regulation. Women are referred to government institutions for voluntary sterilization procedures and medical termination of pregnancy.

In this exceptionally poor and underprivileged area, the prevalence of contraceptive use is comparable to that of many cities in the industrialized world. Between 1969 and 1973, 67% of the women in the most fertile age group were using a contraceptive method; between 1976 and 1979, the number had grown to 82%. When women with three or fewer children were surveyed in the earlier years, 28% were sterilized, and by 1979, 43% had accepted voluntary sterilization.

The work in Bombay began in a broad development context concerned with immunization, nutrition and income generation for the women. Although family planning was then incorporated into the system, the community development aspects of the program continue to be exceptionally important. The organization's activities include adult education; sewing classes; kindergartens; immunization and nutrition programs; a juvenile delinquency center; a library, a book bank and film shows; a pathology laboratory; and clinics for dental care, well-baby care, gynecologic care and the treatment of infertility.

“The message needs to be transmitted that the poor are better advised to give a lactating mother more food than to purchase infant formula.”

clinic set up by the nongovernment family planning group, received exceptionally good ratings on the care and concern for patients extended by the staff.

Infant Welfare

Family planning, of itself, also improves infant welfare. The chances of a child surviving are increased when optimal birth intervals are achieved. In the United States it

78



A clinic in Morocco has instituted a program to weigh infants on a regular schedule.

has been calculated that the adoption of family planning could lead to a 29% reduction in infant mortality. This figure would be even more marked in countries where infant mortality is higher.

Family planning programs have a particular responsibility to ensure the welfare of children who already exist. The type of door-to-door service that can be provided in slums to distribute contraceptives is well suited to the provision of immunization to infants and children. Fieldworkers can teach oral rehydration for infants who have gastroenteritis—the most common killing disease in urban slums. Once a family planning program has been set up, it is usually easy to modify it to include information and education on adequate nutrition. The most realistic approach is to use the type of food and cooking utensils currently used in the urban slum household, showing that nutrition can be improved without additional expenditure, but merely with better utilization of the available resources.

79

**“We have a moral
obligation to do as much
as we can to protect
the child.”**

Every effort must be made to prevent the premature adoption of bottle-feeding, as adequate intervals of lactation are perhaps even more important in a poor urban environment than in a rural one. However well-intentioned the mother, it is often impossible to prepare infant formula without the risk of infection and to store it for any length of time without it becoming an ideal substrate for the multiplication of bacteria.

Recent scientific studies have shown that the relationship between the mother and child during lactation is even more complex than was originally understood. Breast-feeding assists in the bonding of the infant to the mother.

The content of breast milk is finely adjusted to the needs of the growing infant and changes as the infant's brain develops. Breast milk also provides antibodies against infection.

The density of population in urban areas makes it easy to organize day care for infants, and work opportunities for women make it doubly useful to do this. Once again, those engaged in family planning programs can be a suitable group to carry out work of this type.

Improving Nutrition

Poverty and urban living both tend to reduce the quality of nutrition for the urban poor, which may already be at a lower level than for an agricultural community in the same country. Food may be carried in by relatives from the countryside, but inevitably an increasing amount is purchased in the city. Sometimes food is adulterated, and at other times the urban poor respond in a misguided way to modern advertisements and packaging when purchasing their daily food needs.

80

Fortunately, it is usually possible to improve the diet without substantial increases of expenditure, even though there may still be serious shortcomings. Nutrition classes have proved a useful part of community development in many countries.

The message needs to be transmitted that the urban poor are better advised to give a lactating mother more food than to purchase infant formula. Education should be directed toward ensuring that a pregnant woman gets more than an average share of food. The tradition of the urban poor is often to feed the man of the household first, sometimes at the expense of women and children.

Income Generation

Fertility control changes the status of women in many ways. One of the most important is the freedom it pro-



আপনার শিশুর যত্ন নিন এবং তাকে
 পাঁচ মাস বয়স থেকে
 এসব কিছু কিছু নরম করে
 খেতে দিন

The Concerned Women for Family Planning in Dacca use posters to help promote better nutrition.

vides for women to engage in employment outside the home. Sometimes it is poverty alone that forces women to earn additional family income, and sometimes it is also a response to a freedom of choice and a desire for a wider variety of experiences.

Several successful urban family planning programs provide vocational training to women. Sewing classes can be organized and sometimes credit is extended for the purchase of sewing machines. Women can be trained for the increasingly wide variety of jobs available in cities from domestic service to assembling microcomputers.

Improving the Environment

82

Family planning programs succeed when the people working in them respect those they serve and have a sincere desire to help. Usually, staff in family planning programs are well placed and strongly motivated to help improve the life of the urban poor, from securing legal advice to organizing refuse disposal. Families who adopt family planning are often seen to progress in a variety of ways, from improved dress to greater marital harmony. A mutually reinforcing system of events occurs when the field-workers influence the people who in turn become role models for the less privileged. Spacing children and limiting family size affects each family, and new opportunities and skills are brought into the whole community.

The Poorest of the Poor

Dacca is the capital of Bangladesh, the world's poorest and most crowded country. Since the 1974 famine, the city of Dacca has grown rapidly and now has a population of 1.8 million, many of whom live in the worst of the slums.

Women in the slums are almost always illiterate, marry at very young ages and after marriage are physically confined to the boundaries of their homes and the narrow alleys in the immediate neighborhood. Except for occasional visits to their parents or because of grave sickness, they are unlikely to leave the collection of hutments to which they belong. It is the husband who buys the food and other necessities and conducts any business outside the home. The woman rarely goes beyond the water tap at the end of the alley ten or 50 meters from her home. This is *purdah*, the Muslim seclusion of women that is virtually universal in Bangladesh.

The way of life for women in the Dacca slums is perhaps summarized by the case of a 15-year-old girl who was the third and youngest wife of a Muslim rickshaw driver and was pregnant for the first time. When visited by a field-worker from the Concerned Women for Family Planning, she was so anemic that she was taken to the hos-



Just slightly larger in area than the State of North Carolina, USA, Bangladesh had an estimated 1978 population of 84.6 million.

Reproduced with permission from *War on Hunger*, A Report from the Agency for International Development, July 1975. Washington, DC, US Agency for International Development, 1975.



AN ORGANISATION

FOR

WOMEN

BY

WOMEN

84



Cover of the Concerned Women for Family Planning's brochure describing their program and services.

pital for a blood transfusion. Her husband refused to pay the fee. On inquiry, it was discovered that she ate only one small meal a day at 4:00 p.m.

Childbirth is regarded as an unclean process and always takes place in the dirty environment of the floor rather than on a bed. The woman is expected to remain with her child on a mat for 40 days after delivery, when she is considered unclean. Tetanus and postpartum infections are common in both mother and child. Death during childbirth is regarded as natural and is accepted as a sad but everyday part of life. One woman whose husband was a *haji* (a man who had been to Mecca on pilgrimage) and who was pregnant for the 15th time was asked why she was not using family planning. The mother replied dryly, "If I die from childbirth, I sacrifice myself."

In 1976 the Concerned Women for Family Planning began to offer family planning to the Dacca slum dwellers. This group of volunteer women travel door-to-door distributing oral contraceptives and condoms and referring women to one of ten health facilities to have an IUD inserted or an injectable contraceptive administered. Initially, women were sent to government family planning services for voluntary sterilization, but more recently, the Concerned Women have opened their own clinic and now provide the full range of contraceptive methods, including female sterilization and menstrual regulation.

The Concerned Women administer vaccinations, treat eye infections and skin diseases such as scabies and promote better nutrition, teaching the best use of resources by using the food and cooking utensils that the women normally use. They also provide information and education on the oral rehydration of sick children and the treatment of diarrhea in infancy.

85

The work of the Concerned Women depends on 90 field-workers. The field-workers must be married and must have a minimum education, but beyond these two factors there are no definitive criteria for selection. The woman's dedication to and belief in family planning is the single most important consideration, and there are always more applicants than there are places to be filled. The field-workers receive one day of training and then join a more experienced worker to form a team of two. Two teams (four people) work under a supervisor, who is trained to help rather than discipline. New recruits have a second day of training in the office, and all team members meet every two months to discuss cases. Team supervisors meet monthly to discuss their problems.

Field-workers earn 550 taka a month (US \$35), of which 400 taka (US \$25) is salary and 150 taka (US \$10) is for transportation. Team supervisors are paid almost twice as much. Staff remain with the program for long intervals, and out of ten new recruits, eight or nine are usually found to be satisfactory.

The Concerned Women work systematically through each slum area. Because community leaders may harass women who work in the

streets, literally throwing stones at them, they are approached whenever a new area is chosen. The team starts at the periphery of a new area and slowly covers the entire area, providing door-to-door delivery of services to every household. Each acceptor is visited every month until she feels comfortable and confident using the method she has chosen. Women are then visited once every three months and eventually are referred to a depot holder for supplies whenever possible. When this occurs, it is usually the woman's husband or son who picks up the contraceptives. However, if it is necessary, the women are visited for as long as they stay in the program.

The organization maintains a simple record system. Attention is paid to accurate and practical recording of an address, the number of children delivered, the number of living children, the number of sons and the age of the youngest child.

In the environment in which the Concerned Women work, it would be inappropriate to provide a clinical examination before prescribing oral contraceptives, although questions from a checklist are asked. Women are told about possible side effects and are given encouragement in the use of the pill. Field-workers ask to see the used packet of pills to check up on the consistency of their use.

The Concerned Women also run an extension program in business offices and factories. A volunteer in the institution, who serves as an outlet for condoms or pills, is given one day's training and is then visited once a month by a supervisor.

Since the Concerned Women began working in the poor urban areas, they have recruited approximately 60,000 users of family planning methods. Women are referred to the organization's clinic for voluntary sterilization or menstrual regulation as the need arises, and about 8-10 voluntary sterilizations and 10-12 menstrual regulations are performed daily. In these cases, the field-worker accompanies the woman to the clinic. If a woman undergoes tubal ligation, the field-worker visits her everyday for ten days, removes the stitches and refers her to professional help if any problems arise.

Opportunities and Barriers

Opportunities and Barriers

89

By the year 2000, more than half of the world's population will live in cities, and 80% of the cities with 5 million people or more will be in the developing countries of the third world. For example, by 2000 Mexico City will contain an estimated 31 million inhabitants, slightly more than double its current population. The world has never experienced such a density of population before, and it is inevitable that there will be many unknown and unpredictable aspects of life in the supercities of tomorrow.

Perhaps the theme of social development is a particularly apt way to promote the overall goals of family planning. Programs should respond to the needs of a community and not be imposed from without. Summarizing the Indonesian objectives, the BKKBN program encourages team work for the solution of community problems, promotes economic development and secures action based on consensus and respect for the individual.

Successful family planning programs depend on the support of two different networks of leaders. On one hand, it is essential to understand the social structure of the slums and to work with and provide support for the natural leaders of slum communities. On the other hand, it is equally essential to involve the leadership of the non-slum community within a city. The mayor and municipal authorities can contribute greatly to the success of a program. Industrialists and property owners can contribute skills and money toward the solution of their own city's problems. Professional groups, such as teachers, lawyers, physicians, nurses and dentists, all have skills that are essential to solving the problems of slum areas.

The motivation of the nonslum groups to solve slum problems is twofold. Many people are moved by the unhappiness, exploitation and suffering that they observe in slums. But there is also the motivation of human self-interest, which need not be concealed or diminished. It is in the best interest of everyone in the city that marginal areas be upgraded and that the social problems of begging, prostitution, unemployment, disease and illiteracy so often associated with slum life be eradicated.

One of the secrets of success in Dacca has been the dedicated and consistent involvement of middle-class women. In the Indian subcontinent, women have equal access to school and college educations, but many husbands still do not like their wives to work. However, social work of the type represented by the Concerned Women for Family Planning in Dacca is not perceived as earning money to supplement the family income but rather as a way of helping the community. Therefore, the kind of work that the Concerned Women offer provides interest and satisfaction, which many middle-class women do not get in their daily lives. They have an opportunity to serve other people, join a team of like-minded people, see a way of life that was previously unknown to them and earn a little extra money in a socially acceptable way. There is a waiting list of women who want to join the Concerned Women, and very few who begin to work for the group

The Refugee Phenomenon

The 20th century has seen a massive displacement of populations as a result of war or natural catastrophe, and the fleeing refugees form a unique urban situation. Large numbers of poverty-stricken refugees are almost invariably concentrated in a small space with minimal accommodations—all of which are components of slum living. Commonly, they have endured physical, emotional and mental hardships immediately before they became refugees, and usually they find themselves in an environment of considerable uncertainty, unhappiness and insecurity.

Under these stressful conditions, there is almost always a strong desire to control fertility: Couples rarely want to cope with pregnancy and a baby while they are in a refugee camp. At the same time, refugee camps are places without employment opportunities where people are often trying to overcome recent starvation and illnesses. Families, together after previous strains and tension, may need the warmth and affection that sexual relationships bestow.

For all these reasons, it is essential that family planning be made available in refugee camps. On the few occasions when adequate family planning services have been provided, there has been a remarkable response from the community involved. For example, when contraceptives were offered to Cambodian refugees in Thailand, up to two thirds of all the eligible women adopted a method of family planning in one week. However, all too often those managing refugee camps either forget about this important element or are too shy to offer it.

Some of the generalizations concerning promotion and provision of services to people in urban areas also apply to refugee camps. It is often possible to attract a very large number of people with a simple promotional technique, such as showing a film (on any topic), and usually the existing health services can be expanded to cater to the needs of family planning.

give up or become disillusioned. There is no reason why similar groups should not evolve throughout the Indian subcontinent from Pakistan to India to Sri Lanka.

In Latin America and Southeast Asia, and probably also in Africa and the Middle East, somewhat different social and economic patterns may apply. From the point of view of the client, there is not the absolute necessity for

women to serve women in the way that is essential in the Indian subcontinent. An experiment in Marrakech, Morocco, demonstrated that men can be as effective as women as contraceptive distributors. There is, perhaps, a larger constituency of people who can leave their own homes for a modest economic reward and undertake the necessary work. In many countries, as in Mexico, there is a greater gap in income between the wealthy and the slum dwellers than in parts of Asia. In these circumstances, the upper classes and industrialists may not give much of their time to work in the slums but may instead donate money.

At first glance, a slum community often appears to be rather homogeneous. But on closer investigation, it becomes apparent that even the poorest group of pavement dwellers in India have their own social structure. In the Indian subcontinent, the caste system survives among the slums and one group may not eat with another. Social structures are often defined by economic exchange, and slums often have their own internal regulations. For example, in some Latin American cities, the police may be excluded from their own areas. Even in a refugee city, there will be a "mayor" who controls many thousands of people. The natural leader may not always be immediately apparent: It may be the gang leader rather than the civic appointee to whom people turn for authority.

Discussions among the participants at the IFRP-sponsored meeting in Juarez, Mexico, yielded a plan of action that includes the following recommendations to help meet the family planning needs of the urban poor:

- make oral contraceptives available without a physician's prescription;
- provide greater access to injectable contraceptives and voluntary sterilization;
- promote condoms through advertisements and point-of-purchase displays and encourage their distribution by people with considerable public contact (e.g., barbers, bartenders and motel desk clerks);
- regulate public advertising of infant formulas;

- make realistic family planning services available to prostitutes;
- where abortion is illegal, upgrade the hospital treatment of incomplete abortion to include vacuum aspiration and provide immediate post-abortal contraceptive advice;
- where abortion is legal, provide early abortion services as an integral part of family planning clinics along with immediate postabortal contraceptive advice;
- establish Social Security and/or health insurance payment for sterilization procedures;
- establish systems whereby family planning commodities and services are sold for at least a nominal price to encourage self-sufficiency, although no one should be denied services because of an inability to pay;
- introduce family life education in schools;
- involve pharmacists by including family planning in their training and by providing practicing pharmacists with promotional material;
- enhance the status and visibility of field-workers;
- involve industry and businesses in the distribution of family planning materials;
- increase the involvement and responsibility of men in family planning; and
- establish community-based distribution of contraceptives, backed up by additional services from family planning clinics and/or private physicians, clinics and hospitals.

93

In an area as subtle and private as fertility regulation, some people will exert great influence, but it will take time and wisdom to identify these people and involve them in a program. To identify such people and to win their cooperation is an essential prerequisite to launching a service program or to engaging in other aspects of community development.