

Stinson, W.S.; J.F. Phillips, M. Rahman, and J. Chakraborty
1982 "The demographic impact of the Contraceptive Distribution Project in Matlab, Bangladesh"
Studies in Family Planning 13, No. 5 (May): 141-148.

Van de Vall, Mark and Cheryl Bolas
1980 "Applied social discipline research on social policy Research: The emergency of a
professional paradigm in sociological research" *The American Sociologist* 15:128-137.

BARRIERS TO IMPLEMENTING AN EFFECTIVE NATIONAL MCH-FP PROGRAM

Marjorie A. Koblinsky, Ph.D.¹

Ruth Simmons, Ph.D.²

James F. Phillips, Ph.D.³

Md. Yunus, M.B.B.S., M.Sc.⁴

Introduction

In its effort to transfer lessons from the successful Matlab experiment into the public sector program, the MCH-FP Extension Project uses an intervention strategy which derives from the literature on organization development and planned change (Phillips et. al., 1984). Improving an organization's problem solving and management capabilities entails several steps. One of these is the diagnostic effort by which operational barriers to program functioning are identified. Such diagnostic effort has been an ongoing process since project inception. This paper identifies and analyzes major impediments to implementation which have been identified at the operational level of the national health and family planning outreach program.

A variety of research methods have been utilized: participant observation of field activities and joint ICDDR, Bangladesh Government Project Implementation Committees, field notes from focused interviews with counterpart support fieldstaff, in depth interviews with community health workers and program staff, and government documents. The discussion we present here focuses on the field activities of the program as represented by the fieldworker and field supervision.

Fieldworkers

In community-based, outreach programs, fieldworkers are the critical link to the client population. They anchor programs in the community, ensuring that any existing demand for contraceptive services is met and increasing that demand through educational and informational strategies. If this link is strong, programs have established a major prerequisite for success. If it is weak, programs are likely to founder. In the Matlab Family Planning and Health Services Project, this function has been most effectively performed by young, educated, married and concepting women from respected families (Phillips, et.al., 1982). By now, these community health workers have worked for seven years in the Project. They have acquired an impressive competence to explain the concept of family planning to village women, to motivate them to practice and to handle minor ailments and conceptive side-effects. They interact with all segments of their community in spite of pockets of continued resistance to family planning and utilize, under the guidance of their supervisors, service statistics to plan work routines and to solve the problems they face in their work.

1. Operations Research Scientist, International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B.)

2. Assistant Professor, Center for Population Planning and Department of Health & Administration, School of Public Health, University of Michigan.

3. Associate, the Population Council, and Scientist, ICDDR,B.

4. Associate Scientist, ICDDR,B.

At the time of designing the MCH-FP Extension Project, it was clear that in the public sector program, the fieldworker component of the family planning effort was weak. Several problem areas had been identified in the literature: lack of cooperation among health and family planning workers, inadequate training, low quality and quantity of work performed, etc. (Planning Commission, 1983; Hussain, 1983). However, the exact nature of these weaknesses and their specific characteristics in the project upazilas had to be established.

Worker Density

A low worker to population ratio is a major impediment to the implementation of an effective outreach strategy. In the Matlab Project, there is one Community Health Worker (CHW) for a population of 1,100. For the public sector program, the ratio is much lower but its exact dimension is not as readily established.

Workers are recruited on an areal, not a population basis: three female family planning workers and four to five male health workers per union. Since wards differ in population and size, this entails considerable variability in the number of households and size of the geographic area for which workers are responsible. The average worker to population ratio is approximately one per 2,500 population for study upazilas. That is, a government outreach worker is responsible for slightly more than twice the number of people a Community Health Worker in Matlab must contact.

However, this ratio is misleading. Health and family planning workers have been assigned to overlapping areas. The work area of the female MCH and FP worker is based on the ward, a political subdivision of the union. There are three wards per union, with an average population of 6,000, typically distributed over 5-6 villages. In practice, however, wards differ, both in size and population density. An FWA, for example, may have anywhere between 1,500-3,000 households to cover. Work areas of the health workers are based on a revenue division, the so-called jurisdiction line. Their work area is slightly smaller than that of the FWA. The health and the FP workers each cover a population approximately 4-6 times that of the Matlab CHW.

One might argue that because there are two workers in the same area, what cannot be accomplished by the female FWA from the Population Control Wing of the Ministry, might be attained by the male Health Assistant from the Health Wing. The level of coordination and functional integration between health and family planning implied in such an assumption, however, does not exist. According to a recent government order for "functional integration", both health and FP fieldworkers are to provide household services for the nonclinical FP methods, pills and condoms, with referrals for the clinical methods, plus distribution of ORS for diarrhoea and vitamin A capsules. In addition, female fieldworkers are to provide follow-up services for contraceptive clients and antenatal and postnatal care. The duties of the Health Assistants include epidemic surveillance, reporting of communicable diseases, health and nutrition education, and malaria identification.

This functional integration has been superimposed onto a tradition of separate and uncoordinated activities in the Health and Population Control Wings of the Ministry. Bureaucratic procedures and work routines structured during the time when government policy called for separate health and family planning functions have not been altered. Male workers under the authority of the Health Wing of the Ministry continue to be primarily health workers; female workers from the Population Control Wing are concerned with family planning. In fact, male Health Assistants have actually written to the Ministry officials stating that they will not carry family planning methods since this is not part of their job. Given the failure of functional integration and the resistance of health Assistants to work in family planning, the relevant worker density to consider in regard to the MCH-Family Planning program is one female worker for an average population of 6,000.

Implication of Worker Density for the Quantity and Quality of the Outreach Effort

Female worker density and size of her geographic area have major implications for the quality and quantity of the FWA's work.

Given the number of households of the FWA, it would take 3-5 months to complete one work cycle if she works at a rate of approximately 20 households per day. Twenty households per day is roughly comparable to the work schedule of CHWs in Matlab, — yet this is where the similarity ends. The CHW finishes one round every fortnight, while the FWA would require 3-5 months.

The work effort required by the FWA to visit 20 households per day is greater than that of the CHW. The 20 households of the CHW are within reasonable proximity of her residence. The FWA, however, must walk a considerable distance, frequently several miles, before reaching the work area for a given day since she covers the population of a whole ward. This requires time and effort and may explain in part why her actual work day appears so short. Several sources of information — informal conversations between government and Matlab fieldworkers, reports of upazila health complex officials, and direct observations — confirm a working pattern of no more than 3 hours per day (Simmons, et.al., 1984). When observed, fieldworkers often seem in a hurry, eager to contact as many households as possible and to put their signature on a family planning card kept at the household level, to indicate they had made their rounds.

A work cycle of 3-5 month does not allow the worker the frequency of visits to establish rapport with the client, an ingredient found necessary by Matlab CHWs. It also does not allow for the possibility of follow-up care for an acceptor or for intensive motivation for a borderline client. Frequent visits have been found vital to continuation of method use in Matlab.

Implications of the size of the female worker's work area must also be understood in a cultural context. In the traditional Bangladesh village society, women, especially those from respected families, can leave their homes only for clearly defined, culturally accepted purposes. To walk from house to house in one's own community and other neighboring villages is highly unusual. Matlab CHWs encountered considerable initial hostility from their neighbors and other villagers when they began to make their rounds. If moving about in one's own community is considered a radical departure from tradition, working in neighboring villages is even a bigger step. One of the consequences may be that workers do not venture out to the farther villages as frequently as prescribed.

Since the amount of work to be done by a worker varies with prevalence, low worker densities are especially problematic in programs where contraceptive acceptance is low. After seven years of running the program in Matlab, contraceptive prevalence is 42%. According to senior project staff, CHWs are not as busy now as in the initial years of the program. Contacting satisfied acceptors does not take much time. As the number of those still to be persuaded declines with increasing program success, the CHW finds her daily work load reduced. The public sector program, on the other hand, is characterized by relatively low contraceptive prevalence; thus much of the work remains to be done and the effort required of the fieldworker is extensive.

Nature and Quality of Services: The Matlab FPHSP started as a comprehensive family planning program with basic MCH back-up. It has always had a strong family planning message, but CHWs have learned to adjust that message to the needs of the individual woman, and to deliver it in a context where the family's well being and health have been the focus of attention. CHWs have from the beginning of the program emphasized a broad range of methods — IUDs, pills, sterilization, condoms and injectables. With the exception of sterilization, all methods are administered in the home either by the CHW or the paramedic. The availability of doorstep services is important as Bangladeshi women are not accustomed to leaving their households. Also, the availability of multiple methods has proven instrumental in the project's success as it allows method switching when clients experience side-effects. The regular presence of the CHW at the villager's doorstep, her constant emphasis on family planning, her ability to provide assistance with minor ailments and to arrange referrals, have created the trust as well as the pressure necessary to persuade women to adopt contraception.

In its official version, the government program has many similarities with the Matlab approach. Multiple methods are available; MCH back-up exists at the union level Family Welfare Centre, staffed, as in Matlab, by a female paramedic; the health and well being of the population as well as the need to control population are emphasized. The female village worker is to carry pills and condoms as well as ORS and vitamin A capsules. She is supposed to refer clients for sterilization, injectables and IUD insertions, follow-up all acceptors, register eligible couples, advise and monitor pregnant women and postnatal cases, refer cases for TT and DPT and keep contact with villagers through the Union Council.

However, similarities in the official versions mask stark contrasts in the program's village reality. In practice, the FWA stresses sterilization to the neglect of other methods. Follow-up visits are not done nor are they easily possible given the size of the FWA's work area. Other prescribed activities are not

performed. The fieldworker's focus stems partially from the monthly method-wise targets imposed by government as a strategy to achieve demographic goals. Monetary compensation has been added to motivate workers, doctors, and clients to fulfill sterilization and IUD targets. The importance of sterilization is further emphasized by special contingency funds provided to ensure consistent and continuous service. Rewards and punishments are also now linked to the targets, and specifically to sterilization performance: the reward being a monetary bonus and the punishment being job termination.

Another reason for the FWA's limited focus is that she has very little to offer a client during her visit. In Matlab, the CHW carries basic medical supplies and has access to medical back-up. For the FWA in the government program, medical supplies are a persistent problem not only because they are often inadequate to meet demand but also because access is limited to certain personnel. Minor medications to manage contraceptive side effects are in the hands of the Family Welfare Visitor located at the union level clinic. Government policy does not allow FWAs to carry these medications. To procure an aspirin to soothe the headache of an acceptor may mean walking up to 5 miles each way for the fieldworker as well as the client. The FWV is supposed to make domiciliary visits for contraceptive follow-up at the request of the family planning worker. This assumes these two workers are in regular communication with each other, but they usually work in complete isolation. Hence, the worker who provides the contraceptives is not in a position to manage its side-effects. If she makes an effort to procure medications, she may find the supply exhausted because supplies are inadequate and irregular. Her credibility with the client is lost either way.

When asked why government will not allow FWAs to carry these minor medications or provide more doorstep services, officials will often refer to her credentials. Like the Matlab CHW, an FWA must be female, have 8-10 years of education and be at least 18 years old. Unlike the Matlab CHW, however, she need not be married nor contracepting — two qualifications found important in the credibility of Matlab workers. Preservice training is provided by a district level training team under the Population Wing for a period of 4-6 weeks. Refresher courses are also the responsibility of this team but they are short and do not involve extensive field practice. FWAs in the experimental upazilas had been generally working since the inception of the program in 1976 and had received up to 5 refresher courses since then. That FWAs don't have the credentials to provide many services appears more limited by the lack of trust in them by Ministry officials than by her personal credentials.

Supervision

Supervision is a critical and integral part of the management process. It means planning, directing, organizing and controlling the work of others. Close supervision and support are a major prerequisite for program success. This has been shown in the Matlab FPHSP project which, it has been argued, was successful because of an effectively supervised staff of female fieldworkers (Phillips, et.al., 1982). A similar argument has been made for projects in Pakistan (Rogers, 1973), Thailand, the Philippines, Korea, Indonesia, Guatemala, and India (JOICEP, 1979).

Administrative Supervision at the Union Level

In the MOHPC program, supervision of the frontline staff is vested in male workers based in the field and recruited locally. Both the Health and Population Wings of the Ministry have field supervisors for their respective village level workers. The tasks of these two supervisors were recently combined in an effort to increase supervision over the "integrated" health and family planning duties of fieldworkers. Both the Assistant Health Inspectors of the Health Wing and the Family Planning Assistant of the Population Wing are responsible for implementing the programs of primary health care, nutrition, immunization, malarial care, follow-up and MCH-FP in each union, supervising the field staff according to their pre-planned schedules, checking their supplies and equipment, and collecting and compiling their monthly records. This effort to integrate field supervisors has not resulted in strengthened program management but in resentment from both the FWAs and HAs. Supervisors from each Wing of the Ministry have continued to relate to their own staff — family planning supervisors to the female family planning worker and health supervisors to health workers.

According to formal plans, the male family planning supervisor (FPA) is the immediate or field level supervisor of the family planning fieldworker. Posted to the union level, he is, in theory, responsible for directing and controlling the work of three FWAs. In practice, the FPA's role as supervisor is neither clearly articulated nor effectively exercised. According to reports from ICDDR,B fieldstaff and government workers, their field presence is minimal and they do not organize union level meetings. Hence fieldworkers and upazila level supervisors tend to relate to each other directly, bypassing the FPA. They command little respect and have essentially no authority. In one of the experimental areas they have provided assistance to their supervisor with non-field-related activities. Frequently they have other jobs to augment their low salary. They do not perform the critical linkage function between the upazila health complex and the fieldworker. In no sense do they manage front-line performance.

Technical Supervision at the Union Level

If male workers are not providing the supervision to the fieldworkers, who is? At one time, the female paramedic, the Family Welfare Visitor (FWV) located at the union level clinic was to provide technical guidance to fieldstaff. The FWV is trained for 10 months in MCH and FP care and is to provide the back-up support to FWAs and HAs. However, the responsibility for technical supervision of all field staff now resides with the Medical Assistant (MA), a new cadre of workers dominated by males, trained for 4 years in medicine under the Health Wing. For MCH-FP clients, the MA has limited value as males do not usually have access to female clients in this society. Also there are very few MAs posted in the field. As a result, no technical supervision from the union level is forthcoming.

Technical and Administrative Supervision at the Upazila Level

With neither administrative nor technical supervision at the union level, who then provides supervision to the field program? At the upazila level there are two persons involved in the MCH-FP program: the Medical Officer in charge of MCH-FP services and an administrator, the Family Planning Officer (FPO). The FPO presently issues the paychecks of all staff of the Population Wing from the upazila level on downwards. This means he is in charge of nearly 40 fieldworkers, providing services to a population of approximately 200,000. However, supervision of field staff is only one of the many functions of an FPO. Consequently, the number of days available for field supervision are limited. One FPO indicated he has no more than 4-5 days per month available for this function, although, according to government regulation, he is required to spend 22 days in the field. When workers were questioned about the presence of the FPO in their area, those working close to upazila health complex saw the FPO very occasionally, whereas those in more distant unions had not seen the FPO in the field for a long time, if ever.

The Medical Officer in charge of MCH-FP is to provide technical support to the field program. Until mid-1982, he also held the drawing and disbursing authority over the MCH-FP field staff. When this authority was given to the FPO, the Medical Officer in one experimental upazila stated he would no longer go to the field as no one would pay any attention to him. Consequently, there is a complete lack of medical supervision of field activities.

Technical and Administrative Supervision in Matlab

This dearth of actual supervision in the government program and its confused lines of authority contrast with the Matlab FPHSP project where coordinated administrative and technical supervision is provided from the union level clinic. Every two weeks at the end of one work round, all CHWs from one union meet at the union clinic with their supervisors, the male Senior Health Assistant (SHA), and the female paramedic, the Lady Family Planning Visitor (LFPV), to report their performance and discuss field problems. Each CHW presents her "complaint list" to the LFPV which includes requests by clients that require the LFPV's attendance (e.g., IUD insertion or antenatal care) or need for medications for minor illness (e.g., worms, scabies) which she must prescribe and distribute. The LFPV then spends most afternoons of the ensuing two weeks attending the CHWs' clients in the presence of the CHW. While attending one patient, the LFPV will check all eligible women in that bari to ensure accuracy of the CHW's reporting and services provided as well as to provide a motivational session to promote the CHW's family planning message. In this manner, the LFPV checks each of the 20 CHWs in her union at least once per month. The SHA is also responsible to the requests of CHWs for motivational support to husbands as

well as for liaison with community leaders. However, most of his day is spent checking the attendance of CHWs in the field according to a preplanned schedule and spot checking the accuracy of her reporting and drug distribution. The lines of authority through this dual supervision therefore are clear to the CHW. The Matlab supervisory scheme is supportive and responsive to CHW needs; at the same time, its high field presence provides control over fieldworkers. This dual function of supervisors fosters accuracy in reporting and discussion of field problems.

Field Records in the Government Program

From a managerial perspective, field records are part of a mechanism whereby supervisors elicit performance by establishing reporting systems, developing performance standards, measuring results, and exercising their prerogative to reward and punish. In the public sector programs, however, field records have not been part of such a managerial process. The FWA keeps multiple records in response to government regulations. She is required to list all eligible couples, keep numbers of acceptors by method and supplies given out, as well as report on births and deaths. The FWA does not use these records in managing her clients. Biweekly, these figures are reported to upazila officials where they are supposedly aggregated with others and forwarded to the Ministry. According to one of the FPOs, however, workers' records are "unreliable" and his report on sterilization and IUD acceptors are therefore taken from hospital and clinic records; but he must accept the worker's report on pills and condom users. Neither are their records used by supervisors to assess worker performance. For this the FPO depends on the sterilization record kept at the health complex which lists the referral worker's name. The FPO states that he has no reliable means to assess her performance for other contraceptives or MCH services. Record-keeping activities of the fieldworker are a ritual in response to government orders rather than a tool for supervisors and workers in the management of the field program.

Field Records in Matlab

The Matlab record-keeping system was developed to help CHWs monitor and manage their clients over time. Each eligible woman in her area is listed, with all her reproductive and contraceptive events. This tool provides the CHW with a quick reference to the history of each woman so that she can address the uniqueness of her present needs. It provides the memory needed to strengthen the CHW's ability to address clients' needs. It also signals those women who need more attention, either for follow-up, antenatal or postnatal care. Evolving from these histories are lists of acceptors by method or services similar to those required by government. The major difference is the history file of each eligible woman served. This vital element reflects the difference between the target orientation of the government and the client orientation of the Matlab project.

From a supervisor's viewpoint, CHWs' records of services linked with a specific woman provide the means of checking their accuracy. This contrasts with the FPO's statement that his fieldworkers' records cannot be similarly linked. Because the CHW's records provide the history of a woman, a supervisor is also better able to support the efforts of the CHW in dealing with a complicated client or her relatives. In the aggregate, these records identify areas for programmatic action to address deficiencies. They pinpoint areas where CHWs may need more training and where supplies have not been adequate or appropriate.

Meeting in the Government Program and in Matlab

Meetings can be a forum for goal setting, problem solving, strategizing, decision-making and dissemination of information. However, this is not the tradition among the MOHPC staff from the upazila level downwards. One day a month is set aside for a meeting at the health complex attended by all 80-100 MOHPC staff. Field staff come in primarily to pick up their salaries and supplies. Upazila officials may use the time to criticize workers for inadequate performance, or to set an epidemic management system in place. With the exception of a narrow focus on family planning targets, there is no emphasis on goal setting, and little instrumental dialogue amongst officials and workers or even between health and family planning officials. Monthly meetings are devoted to the bureaucratic procedures of personnel administration; they are not a tool in the management of frontline performance.

The Matlab project has used meetings as a vital component of supervision and planning. At the union level clinic, the two supervisors conduct a meeting at the end of the fortnightly work round of the 20 CHWs in their area. CHWs report their performance, the LFPVs diagnose client complaints; both supervisors distribute medications and contraceptive supplies; and supervisors and CHWs discuss the field problems and possible solutions. A physician attends the meeting to provide medical input and treat clients referred by CHWs. Plans for supportive visits to a CHW area by supervisors are made. Once per month a part of a meeting is used to train CHWs on specific issues determined to be problematic. The biweekly meetings provide peer and supervisory support to a CHW. Their openness is also a means of using social pressures to assure accuracy of reporting.

Monthly, supervisors from each of the experimental unions in Matlab join with senior officials to discuss union performance, problem areas and to request supplies. The presence of both administrative and technical supervisors assures coordination.

The Matlab meetings, which are designed to coincide with the fieldworkers' work cycle, serve several purposes simultaneously. For CHWs, the meetings provide: (1) access to a responsive audience to help solve field problems; (2) a forum where individual CHWs can see their contribution to the total and can compare their performance with that of peers; and (3) a place where CHWs can participate in and even initiate plans for the project in response to community needs. For supervisors, the meetings: (1) determine their work program in accordance with the needs of CHWs and hence the clients; (2) provide a forum for discussion of problems and possible strategies jointly and a means to alert staff of their decisions; and (3) are used for training and instructing staff in new program activities.

Conclusion:

We have identified barriers to implementation at field and supervisor levels in the MOHPC program. Barriers at the field level are:

- Low worker density
- A narrow focus on sterilization
- Infrequent contacts between fieldworkers and villagers
- Poor rapport
- Absence of medical supplies, medical back-up and technical supervision
- Ritualistic record-keeping
- Lack of training
- Inadequate field supervision

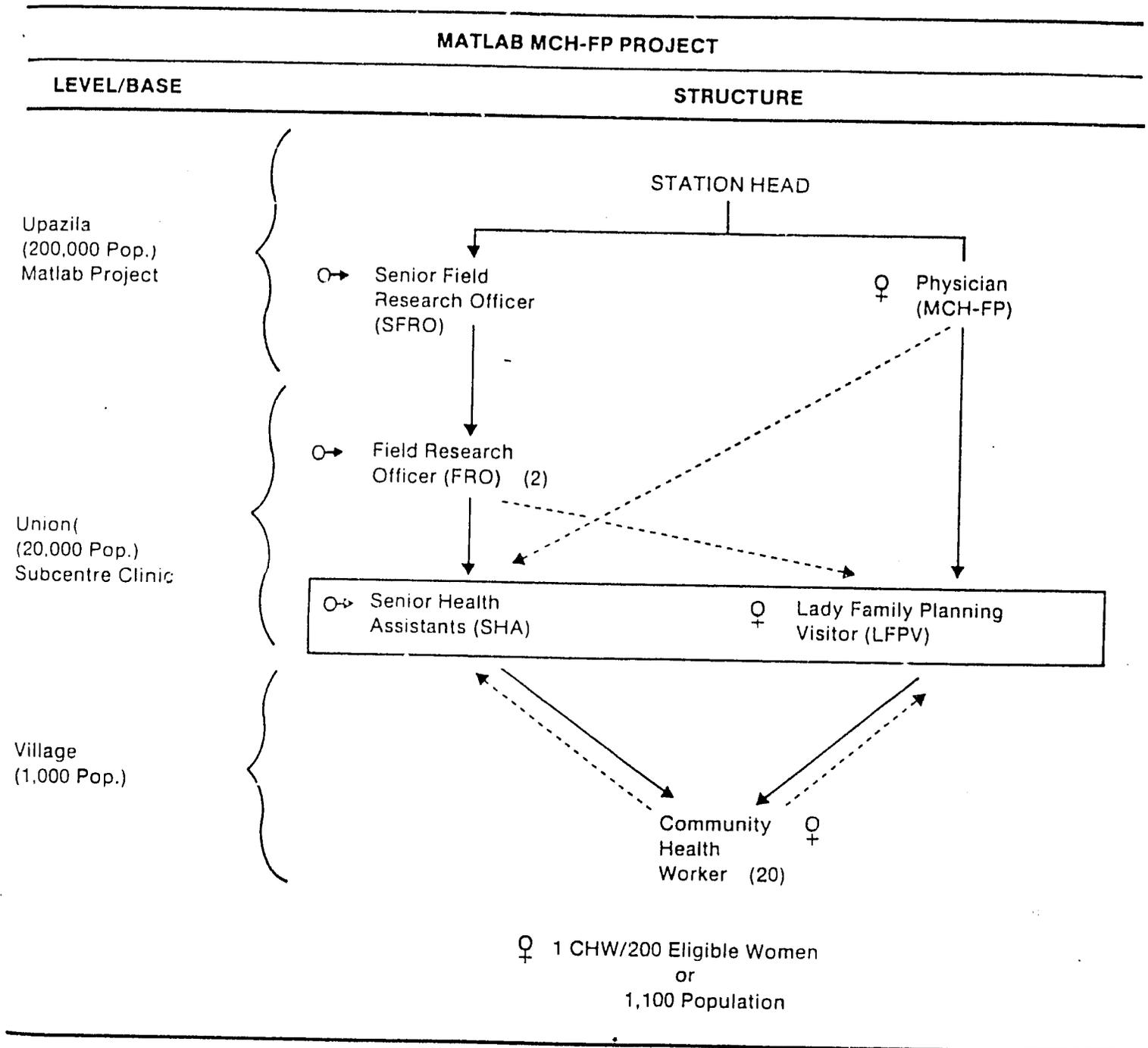
These barriers are interrelated. Jointly, they amount to a field program which has failed to establish the female worker as a trusted, helpful village agent with enough credibility to persuade clients to adopt family planning. Variations among individual workers exist but broad parameters identified here hold for everyone.

Barriers to effective field supervision are identified as:

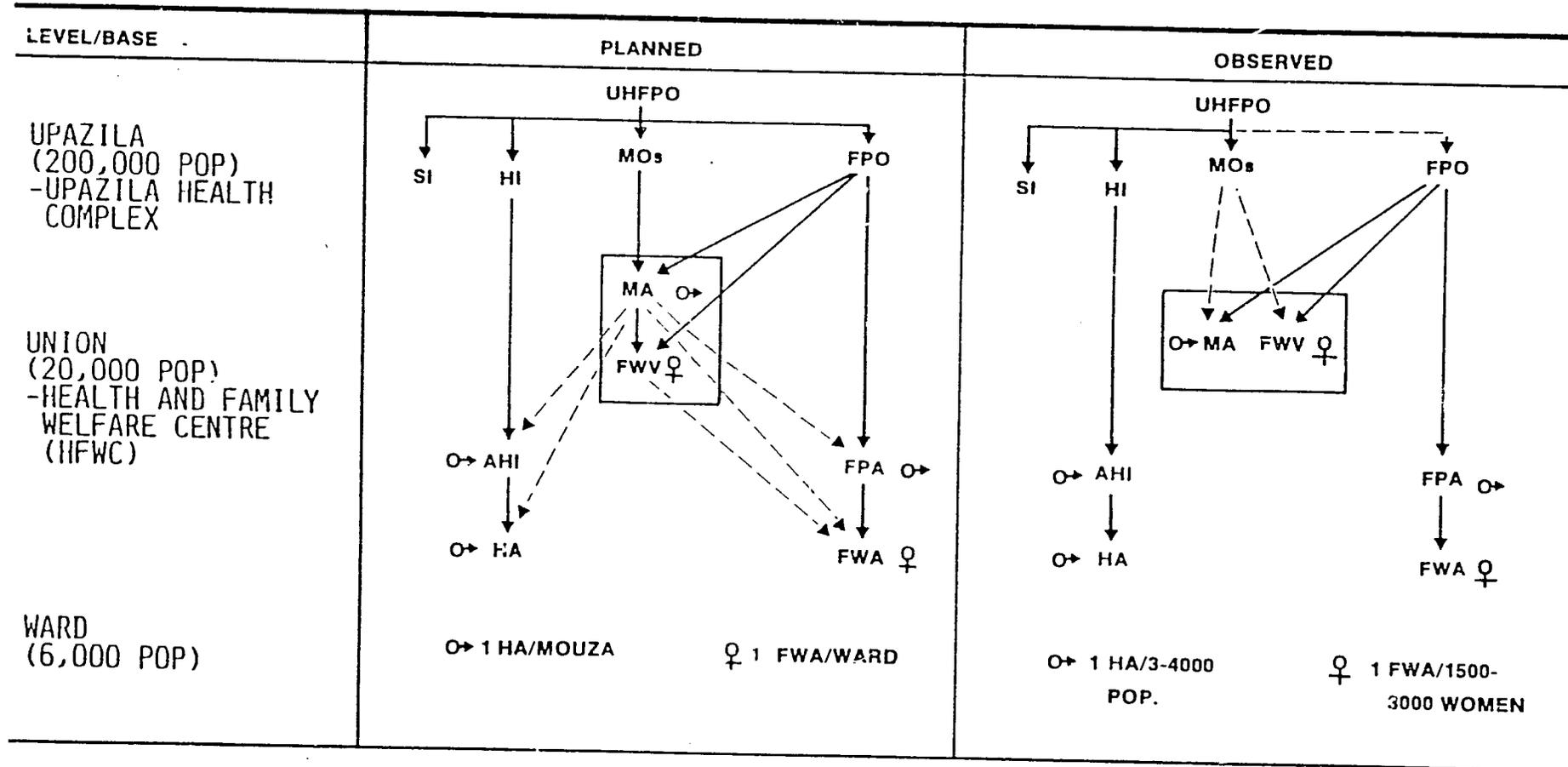
- Absence of planning and problem solving strategies
- Lack of coordination amongst officials as well as between officials and workers
- Supervisory styles and activities focused on inspection and adherence to bureaucratic procedures rather than on guidance, support and performance oriented controls
- Record-keeping system not utilized for managerial purposes at fieldworker and supervisory levels
- Low field presence of supervisors; and
- Role ambiguities and lack of authority

We do not feel that these barriers are unique to the experimental upazilas nor do they exist in a vacuum. The outreach program described here must be seen as part of a larger whole. It functions in an organizational context which does not reward its fieldworkers and supervisors for the client centered performance which characterizes all levels of the Matlab project. Individual fieldworkers or supervisors in the public sector who have a client orientation do so in spite of, rather than because of, the bureaucratic culture or management system within which they work. Some of these barriers, therefore, are outside of the control of the present project, but others are being addressed through various interventions.

MATLAB MCH/FP PROJECT STRUCTURE AT CLIENT-PROJECT INTERFACE



PLANNED AND OBSERVED MOHPC STRUCTURE AT CLIENT-PROGRAMME INTERFACE



-----> Supervision without Authority
 -----> Supervision with Authority

OBSERVED DOORSTEP MCH/FP SERVICES — MATLAB PROJECT AND MOHPC PROGRAM

	Family Planning	Antenatal Care	Post-Natal Care	Mother Care	Child Care
Matlab Project	Pills	Screening and Monitoring If all Pregnant Women	Postpartum Contraceptive Counselling	Aspirin	ORS
	Condoms				Deworming Medicine
	Foam	High Risk Pregnancy Screening and Monitoring	Nutrition Education		Scabies Medicine
	Injectables		Breast Feeding Probiems (FWV)		Vitamin A & D
	IUDs	Tetanus Toxoid Immunization	Delivery Complications Follow-up (FWV)		Skin Ointment
	Contraceptive Follow-up and Continuous Care	Iron Tablets			Vaccination (Measles)
	Referral of Complicated Cases (FWV)	Nutrition Education			
		Safe Delivery Kit			
MOHPC Program	Pills				ORS
	Condoms				Vitamin A
	Foam				

BARRIERS TO IMPLEMENTATION — MOHPC FIELD PROGRAM

FIELD WORKER LEVEL	FIELD SUPERVISION LEVEL
1. Low worker density	1. Absence of planning and problem solving strategies
2. Narrow focus on sterilization	2. Role ambiguities and lack of authority
3. Infrequent client contact	3. Supervisory styles and activities focused on inspection and adherence to bureaucratic procedures than on guidance, support and performance oriented controls
4. Poor rapport	4. Lack of coordination amongst officials as well as between officials and workers
5. Lack of medical supplies, medical back-up and technical supervision	5. Record-keeping system not utilized for managerial purpose
6. Ritualistic record-keeping	6. Low field presence of supervisors
7. Lack of training	
8. Inadequate field supervision	

BIBLIOGRAPHY

- Hussain, Z., **Correlates of Effectiveness of Field Supervision in Family Planning Programme**, Monograph, Centre for Population Management and Research, IBA, Dhaka University, Bangladesh, 1983.
- JOICEP, Report on the study team visiting 5 countries implementing the IPPF/JOICEP Program, 1979.
- Planning Commission, People's Republic of Bangladesh, **The Second Five Year Plan**, Dhaka: Planning Commission of the Ministry of Finance and Planning, People's Republic of Bangladesh, 1983.
- Phillips, J.F.; Simons, R.; Simmons, G.B.; and Yunus, M., "Transferring Health and Family Planning Service Innovations to the Public Sector: An Experiment in Organization Development in Bangladesh," **Studies in Family Planning**, 15(2): 62-75, 1984
- Phillips, J.F.; Stinson, W.; Bhatia, B.; Rahman, M.; and Chakraborty, J., "The Demographic Impact of the Family Planning Health Services Project in Matlab, Bangladesh," **Studies in Family Planning**, 13(5): 131-140, 1982.
- Rogers, Everett, **Communication Strategies for Family Planning**, 1973.
- Simmons, R.; Phillips, J.F.; and Rahman, M., "Strengthening government health and family planning programs: findings from the field-trial of an action-research project in rural Bangladesh". To be published, **Studies in Family Planning**, September/October, 1984.
- Yunus, Md.; Simmons, R.; Koblinsky, M.; and Phillips, J.F., "Strategies for Implementing Change in a Rural Health and Family Planning Program in Bangladesh," paper to be presented at the 1984 Annual Conference of the International Health and Family Planning: Controversy and Consensus, June 11-13, 1984.

EVALUATION OF THE FAMILY PLANNING PROGRAM IN TAIWAN, REPUBLIC OF CHINA

T.H. Sun, Ph.D.¹

Taiwan's family planning program is one of the most intensively evaluated programs in the world. The main sources of data for evaluation are household registration statistics, program records (especially the "coupon system") and related surveys. The excellent household registration system provides monthly data on births, deaths and marriages, and annual data on population composition. The data are used for program planning and evaluation of changes in fertility levels and to measure program impacts on population quality.

Service statistics that are collected from the program include:

- **Program Inputs:** Budgets and actual expenditures; manpower; number of clinics; volume of contraceptive supplies and educational materials; number of home visits made; and number of meetings organized.
- **Program Outputs:** Number and characteristics of contraceptive acceptors by method.

Table 1 indicates the specific program inputs and outputs for the years 1964 to 1982.

The surveys carried out include follow-up surveys of contraceptive acceptors of IUDs, pills, condoms and sterilizations. Survey results are used to evaluate the effectiveness of contraceptive practice. KAP

1. Director, Taiwan Provincial Institute of Family Planning