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FAMILY PLANNING
within
PRIMARY
HEALTH CARE



NATIONAL COUNCIL FOR INTERNATIONAL HEALTH



NATIONAL COUNCIL FOR INTERNATIONAL HEALTH

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FAMILY PLANNING
within
PRIMARY HEALTH CARE

Edited by

F. Curtiss Swezy

and

Cynthia P. Green

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INTRODUCTION

This monograph contains the major substantive papers presented during the workshop entitled "Family Planning within Primary Health Care," which was sponsored by the National Council for International Health (NCIH) and held in Washington, D.C. on March 12-14, 1986.

NCIH convened the workshop in order to underscore the importance of family planning as a major primary health care intervention that can have a significant impact on maternal and child health. The goal of the workshop was to familiarize representatives of U.S.-based organizations working in international health programs with the positive health outcomes associated with childspacing and to discuss the program implications for service providers. Participants also had an opportunity to review the practical issues involved in providing family planning information and services, both within existing health programs and in programs being extended to new areas.

Participants at the NCIH workshop included 58 representatives of 40 private voluntary organizations (PVOs) that are involved in the provision of primary health care in developing countries, as well as other internationally known health and family planning professionals.

Results of a survey presented during the workshop indicate that about 60 percent of U.S.-based PVOs working in international health currently provide both family planning information and services in countries which permit them. The remaining 40 percent of the PVOs surveyed expressed support for family planning as a service that should be made available from primary health workers. However, their village health workers do not have adequate training, time, or supplies to provide family planning information and services; referrals are made to the nearest government service or family planning association. This monograph is intended to provide background information, guidance and practical advice for service providers interested in becoming involved in family planning.

The NCIH wishes to acknowledge with gratitude the support of the Agency for International Development, which funded the workshop, and the William and Flora Hewlett Foundation, which provided additional funding to ensure that the results of this workshop are widely disseminated. Appreciation is also expressed for the many contributions of the workshop speakers and participants, especially the authors of the papers included in this monograph. Finally, NCIH appreciates the conscientious efforts of Ms. Korrine R. Fitz who was responsible for the production of this publication.

CHAPTER I

HEALTH BENEFITS OF FAMILY PLANNING

FAMILY PLANNING: THE IMPACT ON THE HEALTH OF WOMEN AND CHILDREN

by Allan Rosenfield, M.D., Dean of the School of Public Health, Columbia University

Introduction

A great deal has been written on the effects of rapid population growth on economies, environment, food production, urbanization and the role and status of women. In Asia, the majority of population and family planning programs were developed to meet demographic concerns such as adverse effects of high rates of population growth on both social and economic development. In addition, such programs also were justified by some as a basic human right of all women and couples to have access to services in order to plan one's reproductive life.

Considerably less attention has been paid to the straight-forward impact of family planning services on health, particularly of women in the childbearing years and children under five. And yet the impact is significant. It is not possible to maximize the health of mothers and children without providing married couples with the means of regulating their fertility.

Generally, in the past, many health authorities also justified family planning programming because of its potential positive impact upon the health of both women and children. Unfortunately, in the 1960s and 1970s there were inadequate data to document the perceived impact. More recently, however, we have learned a great deal from a number of studies of infant and maternal mortality, as well as from extraordinary data emanating from the World Fertility Survey (WFS). Beginning in the late 1970s, surveys were carried out in a large number of developing countries in Africa, Asia, and Latin America. The data generated on fertility and on infant and child mortality have greatly extended our knowledge in this area. This information has been analyzed by a number of scholars in the field and is now reaching print. As a result new insight is replacing "clinical observations" and "hunches" about the relationship between fertility regulation and health, not only of the specific mother and child, but also of other members of the family. This chapter is based primarily on two recent publications of the Center for Population and Family Health at Columbia University in New York City. These publications are Family Planning: Its Impact on the Health of Women and Children (1981) and Birth Spacing and Child Survival (1985). Both these publications are available from the Center for Population and Family Health upon request. (See Appendix C for complete address.)

Overall, it is fair to say that family planning is one of the single most effective interventions to reduce infant, childhood and maternal mortality in the short run. If one is interested in the reduction of infant mortality rates, and probably childhood mortality rates as well, family planning is of the key interventions that can be implemented at the community level. UNICEF's GOBI program was

originally described as GOBIFFF, but the last three letters were dropped. (GOBIFFF is an acronym for growth monitoring, oral rehydration, breast feeding, immunization, family planning, food supplementation and female literacy.) The program is, in my opinion, inappropriately incomplete without at least adding family planning. In the remainder of this chapter the justification for considering family planning as a priority intervention will be discussed.

Maternal and Child Morbidity and Mortality

Infant mortality and maternal mortality rates in the developing world are extraordinarily high. While rates vary from country to country all rates are well above comparable figures for more developed countries. Figure I-1 shows the comparative percentages of children who die under the age of 5 between predominantly developing countries in Africa, Asia and Latin America -- and in predominantly developed countries -- Europe and North America.

Approximately, 15 million children under the age of 5 die each year in the developing world (50,000 per day). A majority of these deaths are caused by diseases that are preventable and/or treatable with existing technology. The primary causes are diarrhea, infectious diseases (particularly respiratory infections) and malnutrition. UNICEF's GOBI program is aimed at prevention and/or treatment of these conditions. Much of this infant death is exacerbated by malnutrition. What is not broadly recognized is that family planning -- more specifically the lack thereof -- is also directly related to these infant deaths.

The World Fertility Survey has provided extremely important data on the impact of spacing (or the length of time between births) on child survival. The least risk exists for intervals of three or more years between births. Children born with an interval of two years or less between births are twice as likely to die as those who are born at longer intervals. The risks also increase for the older child when spacing is short.

Although the impact is less pronounced, it is clear that increasing the total number of births above four also has a negative impact on infant and child health. Studies in India have indicated that among poor populations, protein and caloric intake per person significantly decreases with total births of greater than three. This effect clearly relates to families' limited resources being spread among increasing numbers of children. From the WFS data it has been demonstrated that if all children were born with at least two years of spacing, there would be 10 to 25 percent decrease in infant mortality, the percentage varying depending upon the country studied.

It is interesting that traditional custom in some cultures has, in effect, recognized that spacing is important for the health of the child. In parts of Africa, for example, postpartum abstinence for two to three years is not uncommon. Similarly, prolonged breastfeeding is the general practice and not only has a positive impact on infant health, but also has the effect of decreasing fertility and increasing

the length of time between births. Kwashiorkor is a Ghanaian term, which basically means malnutrition of the next older child caused by removal from the breast too early due to another pregnancy.

Figures for maternal mortality are equally distressing. Approximately 500,000 women die each year in the developing world during pregnancy and childbirth. Pregnancy and delivery are the leading causes of death among women aged 15-19 in the developing world and this gives a hint as to the relationship between family planning -- contraceptive practice -- and maternal mortality. Clearly, if unwanted pregnancies were eliminated for the age cohorts 15-20 and 35-45, maternal mortality would be significantly reduced.

A. Spacing and Infant Mortality

There are similar dramatic data showing a clear correlation between spacing of births and infant survivability. The critical spacing of time appears to be two years. When the interval between births is less than two years, children in developing countries are 50 percent more likely to die than children who are spaced more than two years apart. The risk is increased both for the child at the beginning of the short interval as well as the following child. Figure I-2 shows death rates in selected developing countries for children at the end of birth intervals of less than 2 years, 2 years, and 3 years. A pronounced progression of decreasing infant death can be observed as the space after the previous birth increases. This is clear evidence that in terms of saving babies' lives spacing works.

Why does spacing have such an impact on child survival? In many ways we still do not know. But existing data do give some suggestions as to what is, and is not, related to spacing and infant death.

One common assumption is that "maternal depletion," the strain on women from multiple births in a short time span, may be a factor in child death. This might partly explain the greater risk to infants at the end of a short interval, but does not explain the risk to infants at the beginning of a short interval, a risk that continues up to the age of five even when the younger sibling dies.

Another assumption is that birth spacing is not a causal factor in infant and child death, but a characteristic of families that are high risk for other reasons. But the data do not appear to support this either. One indicator of a "high risk" family is the death of a child. But the effects of a longer birth spacing in these families are only minimally smaller than in families where earlier children have not died. Also, short birth intervals pose a risk to families with the advantages of education and urban residence as well as to rural families with low levels of education.

A common belief is that many children born in a short time interval result in competition for food, including breast milk. This appears to be the case among poor families with more than four children. However, this does not appear to be a major causal factor in relation to spacing and infant mortality, since the risk of death to children with a short

interval between them does not change when one of the children dies. Surviving children are still at higher risk and this risk persists for several years.

Whatever the complex interrelationships are between physical and social factors, it is apparent that child death is reduced with better spacing. This is true whether the contraceptive method employed is a "traditional" method, such as breast feeding, postpartum abstinence or withdrawal, or a "modern" method such as the pill, condom or diaphragm. Naturally, the more reliable the method the greater the impact on child survival. While it is difficult to impute cause and effect to a variety of interacting factors, nonetheless, Figure I-3 presents an interesting assessment of data from Chile documenting increases in contraception and declines in births, infant deaths and maternal deaths. Future research will add insight into the dynamics between spacing and child survival, but existing data clearly document the correlation between the two.

B. Age of Mother and Maternal Mortality

The age at which a woman becomes pregnant and delivers also directly affects her survivability. Between the ages of 20 and 35 is the optimal time for a woman to survive the rigors of pregnancy and delivery. The years above the age of 35 and below the age of 20 are dangerous, and the danger increases for every year beyond those limits. Sixteen is more dangerous than 18; 40 is more dangerous than 35. If women are sexually active outside of the 20-35 age range, the provision of effective contraceptives to prevent pregnancies becomes an important health intervention.

This relationship of age to increased reproductive risk holds true for both developed and developing countries. While mortality rates are consistently much higher in developing countries, the correlation between age of mother and pregnancy-related deaths remains.

C. Parity and Maternal Mortality

In addition to the age of the mother, the total number of children she bears has a dramatic impact on her survivability. For women with more than four deliveries, maternal mortality rises sharply. Further, when we combine high parity (more than four deliveries) with higher age (over 35), women are placed in double jeopardy. Additional risks from high-order births include placenta and umbilical cord damage, uterine rupture, anemia and abnormal positioning of the fetus.

These risks to women presented by age and high birth order are operative across ranges of residence (urban-rural), education, income and occupation and are perhaps easier to explain than the correlation between spacing and infant mortality. Younger women have often not achieved their full physical development. Older women are less able to endure the rigors of pregnancy and delivery. Higher-order births render the mother more vulnerable to hemorrhage, pulmonary embolism and toxemia. Particularly for higher-order births in older women,

contraception is needed, not for spacing, but limitation. In these instances permanent methods, including vasectomy and tubal ligation, are appropriate.

Health Impact of Family Planning

Who are the high-risk mothers? Firstly, any woman under the age of 20. In those societies where women are sexually active in their early teens, concerted efforts should be made to avoid pregnancy. In those instances involving early marriage there may be added social pressures for the young bride to demonstrate her fecundity. Obviously, reliable temporary methods are the most appropriate for early teenage contraception. This is a particularly important age cohort to serve because reproducing teenagers tend to have shorter birth intervals than older women. Combined with their young age, this makes these pregnancies especially risky for both the infant and mother.

Women between 20 and 35 are primarily targets for spacing methods, both for their own health as well as to ensure positive birth outcome and survivability of the child.

Women who are over the age of 35 and have four or more children are another prime target group. Women who are over the age of 35 and have four or more children are the highest-risk group. These women, and their spouses, are the principle candidates for permanent contraceptive methods.

Unfortunately, there continues to be a large unmet need for family planning in developing countries. Many couples want and need effective contraceptive services. But a large proportion of this felt need goes unmet. This is due to a variety of reasons, including Ministries of Health that cannot match resources to needs, policymakers who are reluctant to fully support total effective family planning service provision in their countries, and development agencies that have been successfully intimidated from becoming involved in contraception, reproduction and sex education. Whatever the reasons, the lack of family planning services inhibits the realization of the potential for maximum health of women and children and blunts the other development efforts to raise the status of health in many developing countries.

Figure I-4 shows the proportions of women in selected developing countries who want no more children, and Figure I-5 shows the percentage of women who do not know where to get contraceptives. Obviously, an enormous unmet need exists in the developing world.

What is the potential health impact that an effective family planning component within a primary health program can have? Specialists at the Columbia University Center for Population and Family Health have estimated that in a high fertility country such as Kenya, if spacing were increased to two years for every birth, then child mortality would be reduced by 20 percent.

Innovative Women's Health Interventions

Just as infant mortality is dramatically higher in developing countries than in the West, the same is true of maternal mortality. At the present time, a majority of women living in developing countries, particularly those who live in the rural areas, have their babies at home with traditional birth attendants, relatives or, in some cases, no one in attendance. Maternal mortality rates in the range of 100 to 1,000 per 100,000 live births, depending on the country and the area, are common in developing countries, compared with only 8 to 10 per 100,000 live births in the West. This differential between developed and developing countries is even greater than that between infant mortality rates.

Between 1980 and the year 2000, the World Health Organization has estimated that there will be about 2 billion births to women delivering at home, without modern obstetrical intervention. With an average maternal mortality rate of 400 to 500 per 100,000 live births, WHO estimates 8 to 10 million deaths to women in the 20-year period, or 400,000 to 500,000 deaths per year. The majority of these deaths are also due to conditions that are preventable and/or treatable with existing technology. The most common causes generally include postpartum hemorrhage, toxemia of pregnancy, postpartum infection and obstructed labor. A fifth and tragic cause is related to the complications of illegal abortion. In some parts of the world, particularly in Latin America, it is estimated that illegal abortion is the single greatest cause of maternal mortality. The World Health Organization estimates as many as 200,000 deaths each year occur as a result of complications of illegal abortion.

Clearly those women subjecting themselves to an abortion attempt would be prime candidates for contraceptive services as a preventative measure. Studies in Chile in the late 1960s demonstrated that when family planning services were widely introduced and utilized in that country, there was a dramatic decrease in both hospitalizations for complications of illegal abortions and abortion-related deaths.

The data presented in this paper demonstrate clearly that women who have had four or more children and/or are younger than age 20 or over the age of 35 are at a greater risk of mortality than are women between the ages of 20-35 and/or have three or fewer children. Thus these are the women at greatest risk and also the women most likely to accept family planning services. There are also data that demonstrate a significant decrease in maternal mortality by the provision of contraceptive services to all women who state they want no more children but are not contracepting.

Most of the attention in maternal and child health services has focused on the child health component. The subtitle of a recent Lancet article on maternal mortality was "Where is the M in MCH?" There is a need both to focus attention on women's health per se, rather than as an infant health intervention, and to plan strategies to improve it within the parameters of comprehensive primary health care.

In the past, the international obstetrics and gynecology community has given very little attention to this problem, either at the national level or at international meetings such as those of the International Federation of Gynecologists and Obstetricians (FIGO). Attention instead has been focused on high-technology subspecialty areas, such as endocrinology, maternal-fetal medicine and cancer. In many developing countries as many as 80 percent of women do not have access to any maternity care whatsoever. A few years ago, a WHO/FIGO Task Force was formed to explore social issues in the field of obstetrics and gynecology, such as maternity care and maternal mortality, in an attempt to bring attention to these areas through the tri-annual FIGO meetings, as well as the annual meetings of national societies.

For the long run, universal access to institutionalized maternity care services is of prime importance and the eventual solution. However, at best that goal is at least 25 years away from being achieved, and in the interim other interventions are possible. First and foremost, at the community level, is access to family planning services to prevent unwanted pregnancies. Also at the community level, assessment is needed of new and untested interventions such as the training of traditional birth attendants in the use of antibiotics for the prevention of sepsis, initiating this therapy after 12 hours of ruptured membranes. Similarly such personnel might be trained to use oxytocic or ergotrate drugs to control postpartum hemorrhage. With appropriate training and with the use of checklists, these are possible interventions worthy of testing.

In addition, there is a need to make cesarian section services more accessible to rural women, since in certain conditions cesarian section is the only life-saving step possible. I believe it is possible to train personnel other than physicians to carry out this relatively simple procedure. Studies are needed to demonstrate the appropriateness and effectiveness of such an approach, particularly in areas where there may be a health center or hospital, but where physicians are not available to provide the needed services.

The analysis of WFS data has demonstrated that significant percentages of women want no more children than they already have. In Africa the percentages range from 5 to 50 percent, depending upon the country; in Asia from 35 to 70 percent; and in Latin America, from 40 to 60 percent. The percentages are significantly higher if one asks women who have already had four or more children, reaching levels as high as 80 to 90 percent in some countries. Furthermore, many women who want no more children are not using an effective method of contraception. In Africa this proportion is 83 percent, in Asia, 63 percent and in Latin America, 58 percent.

As mentioned earlier, if contraceptive services could be provided to all women who state they want no more children and are not currently contracting, there could be a dramatic impact on maternal mortality. Current estimates indicate that a decrease in maternal mortality of approximately 17 percent could be achieved in Africa, and 33-35 percent in Asia and Latin America. Based on this analysis, one can stress that access is a key problem in those countries in which family planning

services are least well distributed. Unfortunately, in some countries high percentages of women state they simply do not know where to go for such services, with the highest known rate currently existing in Nepal.

Contraception and Noncontraceptive Health Benefits

In discussing the impact of family planning on health, one must also look at the effects of contraceptive methods. Over the past 20 years, there has been concern regarding complications of oral contraceptive use, particularly cardiovascular complications, including heart attacks, thromboembolic disease and strokes. The overall risks, however, are very small in those women who do not have any risk factors (which include diabetes, hypertension, hyperlipoproteinemia, age greater than 35 and/or smoking over the age of 30).

The risk in screened women is extremely low. Overall, the risk currently in the United States among all pill users is approximately five deaths per 100,000 users. If no women over the age of 35, or women who smoke, were using the pill, it would decrease this rate to 6 per 1,000,000. The risk of smoking alone has a significantly greater impact on the health of women than do oral contraceptives. In developing countries, the risk of complications secondary to pill use is very small, particularly when compared to the much higher risks of pregnancy. The risk-benefit ratio is very positive in the United States and is markedly more so in developing countries.

In recent years we have also learned a great deal about some of the noncontraceptive benefits of oral contraception, in addition to the reduction of maternal mortality among high-parity older women. Among current users of the pill, there is a decrease in the incidence of the following: menstrual symptoms, such as dysmenorrhea, spotting, and hypermenorrhea; ectopic pregnancies; tubal infection or PID; benign breast and ovarian disease; and endometrial and ovarian cancer. The latter is of particular importance because ovarian cancer is one of the most difficult female cancers to diagnose early. The protection against ectopic pregnancy is also of great importance, since this can be a rapidly fatal condition after rupture for women not having ready access to health care services when surgery needs to be performed.

The Centers for Disease Control in Atlanta carried out an interesting study in which they estimated the number of hospitalizations secondary to pill use in the United States among the 10 million women currently using the pill and compared that to the number of hospitalizations prevented. Overall it appears that approximately 6,000 hospitalizations occurred among pill users, while approximately 58,000 hospitalizations were prevented. Based on this and other assessments, one is able to come to the conclusion that oral contraceptive distribution in community-based programs is more than justified, with the benefits far outweighing the risks. Thus, it is fair to state that, for a variety of reasons, the provision of oral contraception is a major public health intervention that can lead to significant improvements in the health of both women and children.

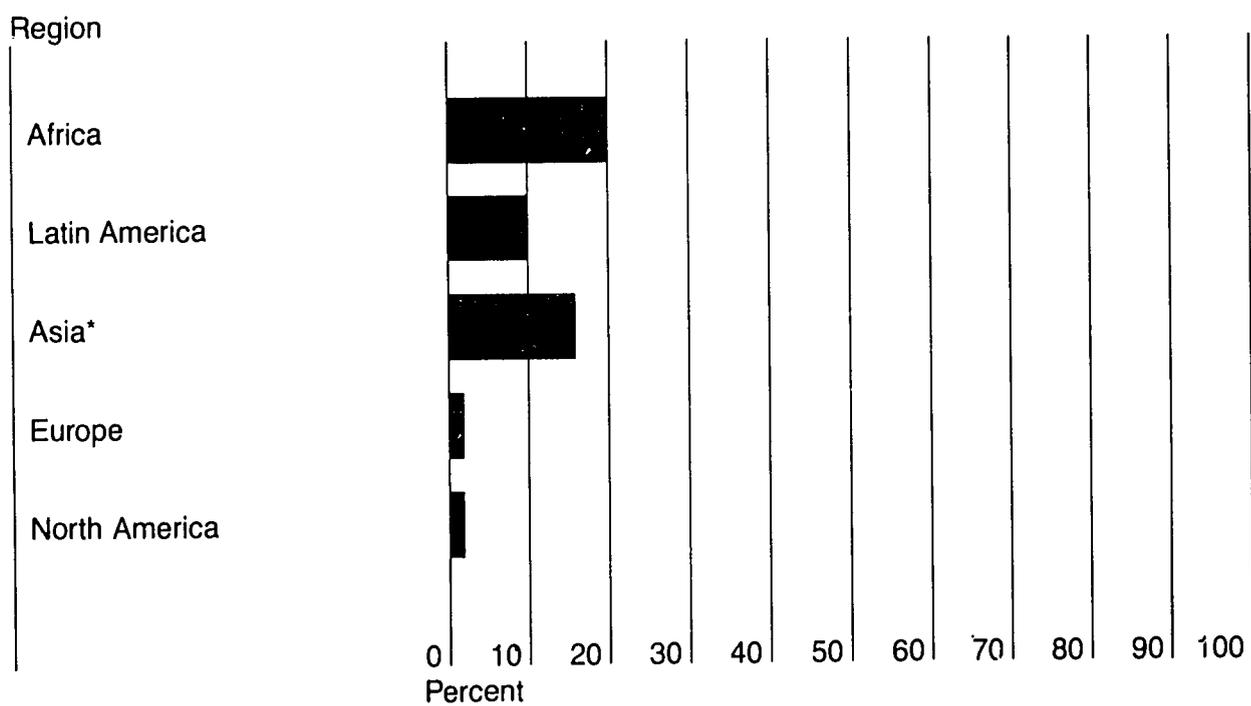
Conclusion

While there has been increasing concern about demographic issues in most of the developing world, and increasing interest in family planning programs as an intervention to help lower high rates of population growth, this paper instead has focused attention on the importance of family planning programming as an intervention which has a significant impact on the health of women and children. Maternal mortality rates in the developing world are dramatically higher than those in the West, particularly among women of parity greater than four and age less than 20 or more than 35. Similarly, infant mortality rates are affected by both the age and parity of the mother, but most importantly by the number of years of spacing between births. For those women giving birth with less than two years of spacing, infant morbidity and mortality rates are significantly higher than for those who delay for more than two years. Thus, the practice of family planning for purposes of either child spacing or limitation can have a very important and significant impact on the health of women and children.

In addition, during the last five years increasing data have been presented to demonstrate a positive impact on health of oral contraceptives, one of the major methods of family planning. Pill users have a decreased incidence of anemia, benign tumors of both breast and ovary, pelvic inflammatory disease, ectopic pregnancy, rheumatoid arthritis, endometrial cancer and ovarian cancer. Thus, it is fair to say that with our current knowledge any program aimed at the well-being of women and children should include a family planning component. Concerns about pill-related complications have been more than offset by both relative benefits in comparison to the risks of pregnancy, as well as a number of the non-contraceptive health benefits.

Figure I-1

Percent of children who will die in the first 5 years of life

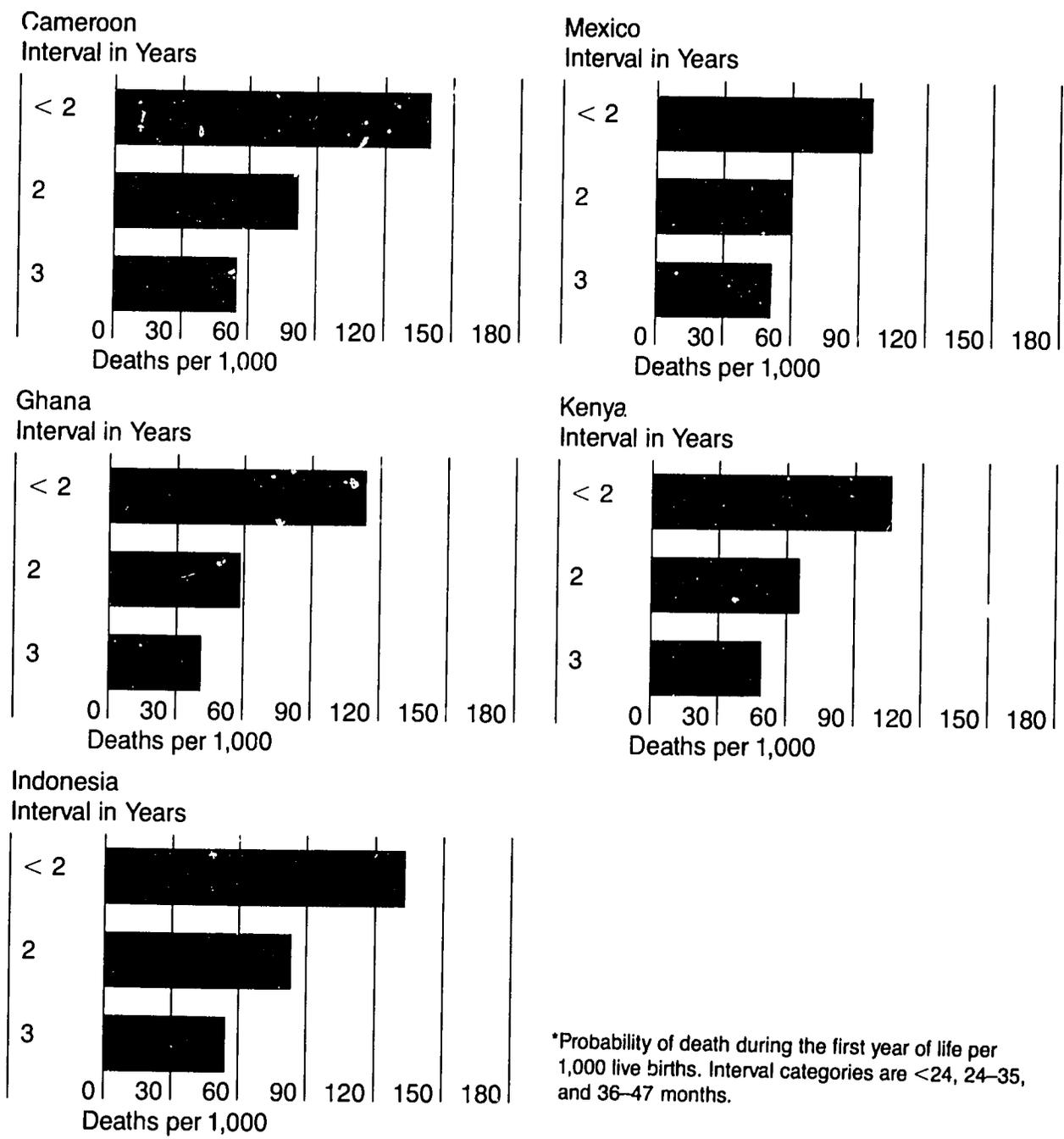


*Not including the People's Republic of China.

Source: Maine, D., and McNamara, R. Birth Spacing and Child Survival. New York: Center for Population and Family Health, Columbia University, 1986, p. 5.

Figure I-2

Infant death rates among children born at the end of birth intervals of less than 2 years, of 2 years, and of 3 years*



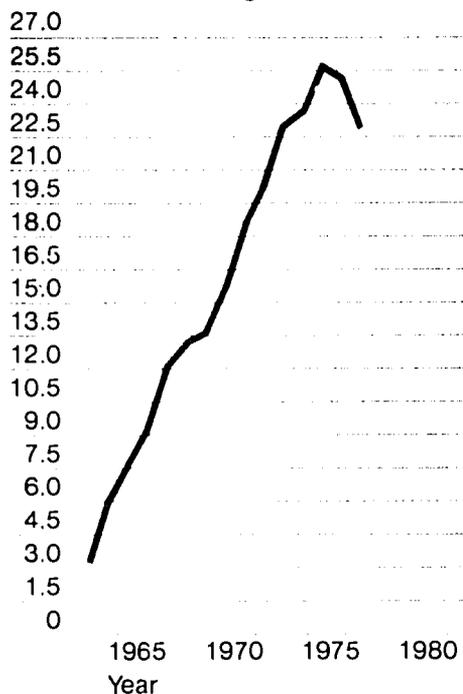
Source: Maine, D., and McNamara, R. Birth Spacing and Child Survival. New York: Center for Population and Family Health, Columbia University, 1986, p. 26.

Figure I-3

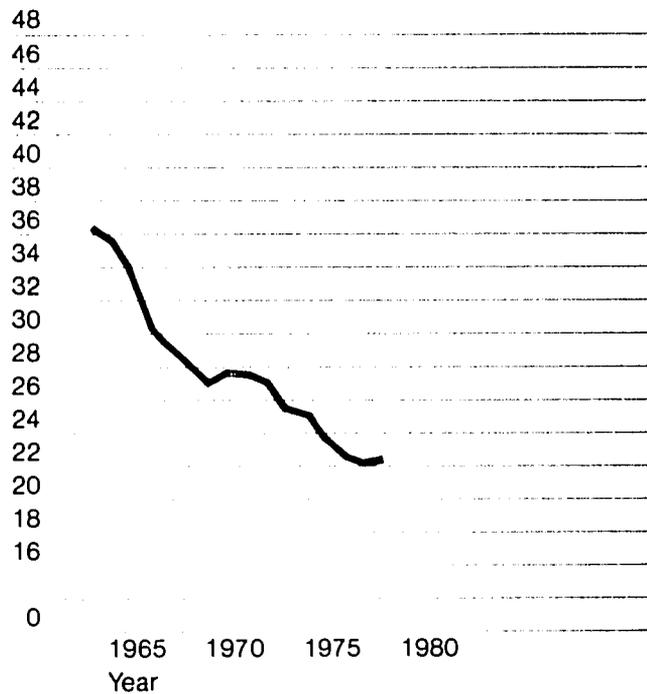
Percent of women using contraception, Chile, 1964-1978

Birth rates, Chile, 1964-1979

Percent of women aged 15-44

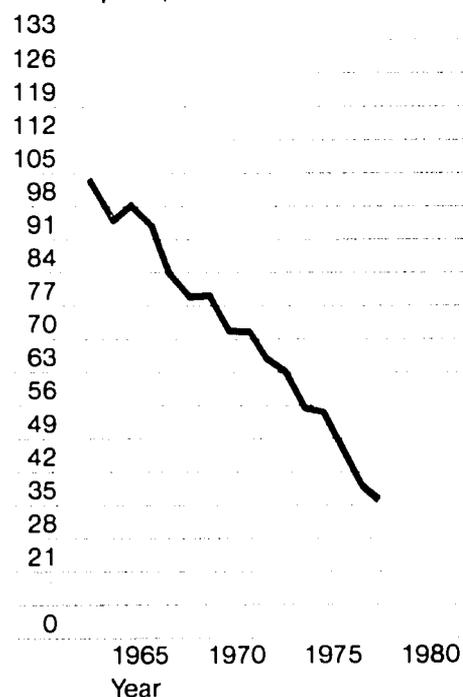


Births per 1,000 population



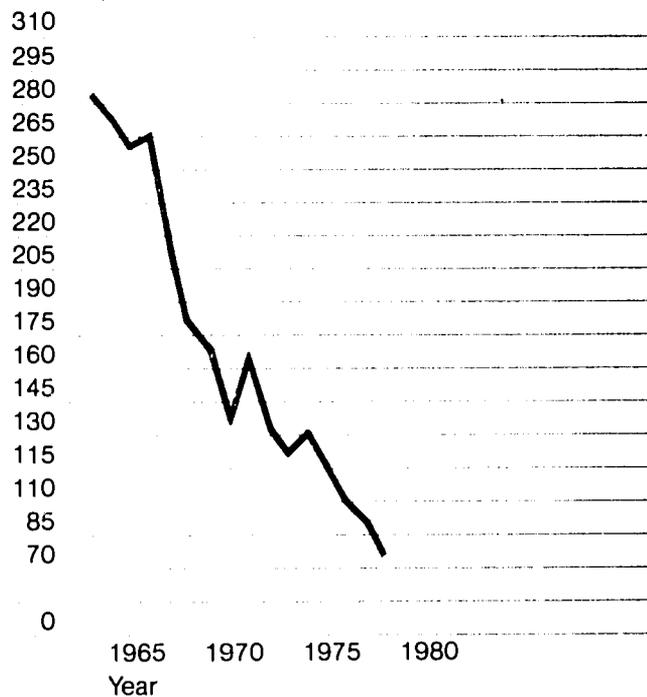
Infant deaths, Chile, 1964-1979

Deaths per 1,000 live births



Maternal deaths, Chile, 1964-1979

Deaths per 100,000 live births



Source: Asociacion Chilena de Protección de la Familia, "Actualización del Documento 'Evaluación de 10 Años de Planificación Familiar en Chile,'" Unpublished, 1978.

Artwork from: Maine, P. Family Planning: Its Impact on the Health of Women and Children. New York: Center for Population and Family Health, Columbia University, 1981, p. 7.

Figure I-4

Percent of women with three living children who want no more children, 1974-1977

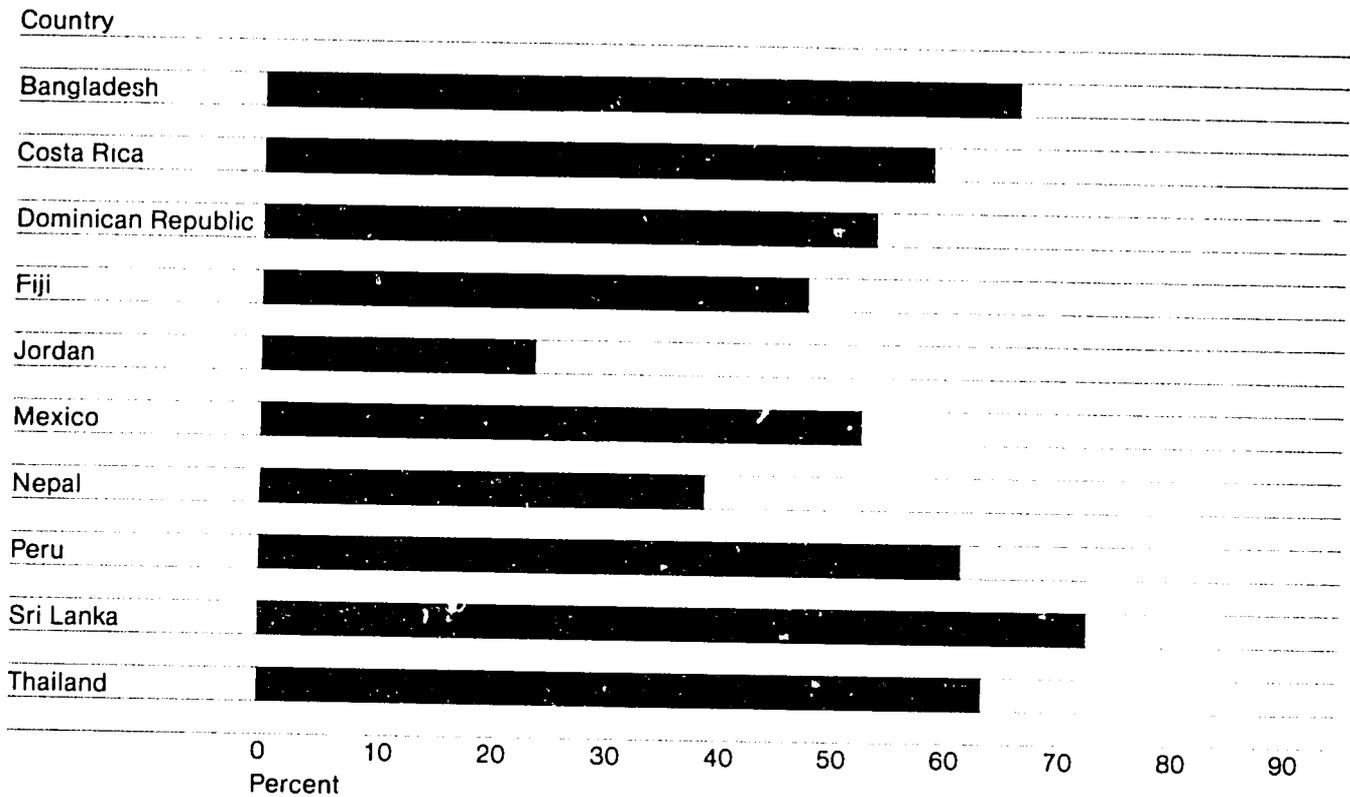
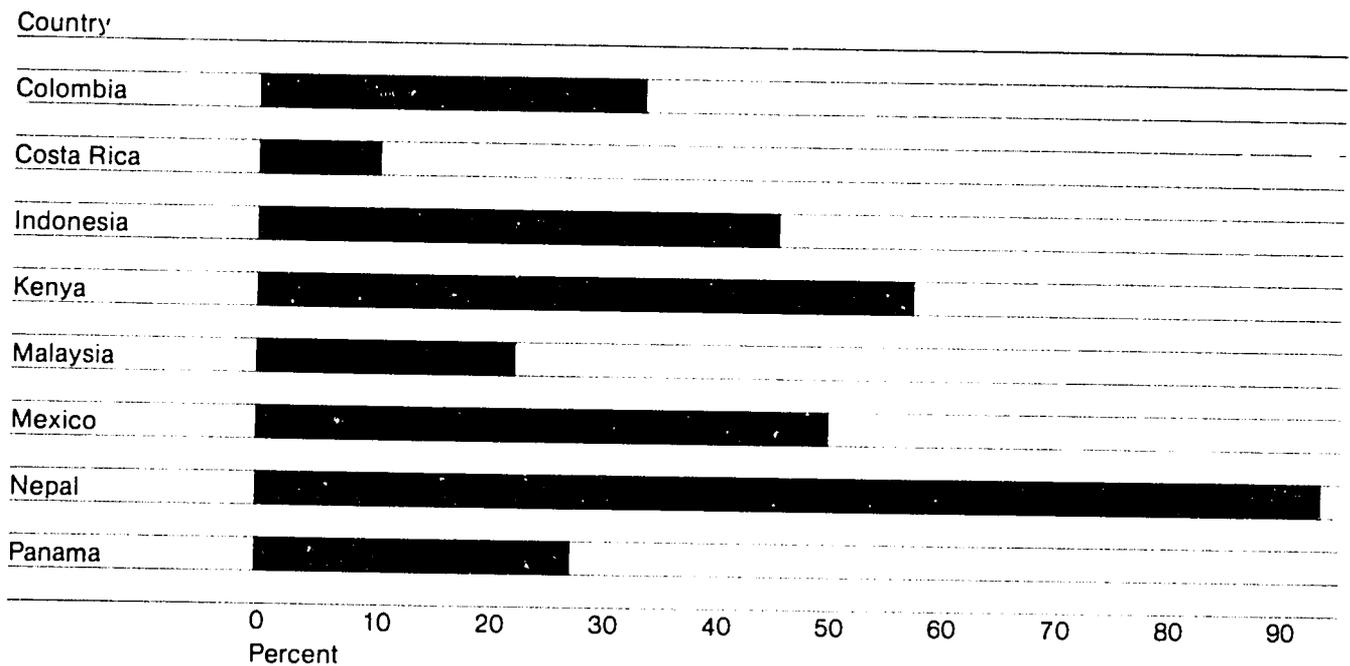


Figure I-5

Percent of married women who do not know where to get contraceptive supplies or advice, 1974-1978



Source: Maino, D. Family Planning: Its Impact on the Health of Women and Children. New York: Center for Population and Family Health, Columbia University, 1981, p. 41 and 45.

CHAPTER II

ETHICAL ISSUES IN PROVIDING FAMILY PLANNING

ETHICAL ISSUES IN PROVIDING FAMILY PLANNING WITHIN PRIMARY HEALTH CARE

by Fred T. Sai, M.D., M.P.H., Senior Population Adviser, The World Bank

Introduction

One of the first questions asked when consideration is given to starting a family planning program is "What are the ethics of providing contraceptives?" No one questions the morality of governments, volunteer agencies or private entrepreneurs providing curative and preventive health services. But as soon as the subject changes to family planning, a large number of traditionalists, religious leaders, and just average citizens immediately question the morality of making such a service available.

In both developed and developing countries, this predictable and persistent attack on family planning has intimidated many organizations from providing this service. Many program managers feel safer by confining their programs to "health" or "development" and staying clear of "controversial" programs like contraceptive service provision. However, it has been clearly documented that family planning -- spacing and limitation -- saves lives. Therefore, the question becomes "What are the ethics involved in withholding family planning from couples who want to control their fertility?" The inescapable conclusion is that it is profoundly unethical to withhold this health service from couples who want to use effective contraception. The essence of a moral decision is to make a decision. By withholding the information and services from couples, program managers are denying the basic right to married couples to make a moral decision on if, and how, they will regulate their fertility.

There have been attacks on family planning in all parts of the world, from various churches and from political organizations. Many of these attacks are based on ethical issues which need to be examined critically. A definition of the word ethical itself may pose a problem. Webster's Collegiate Dictionary defines ethics as "the discipline dealing with what is good and bad and with moral duty and obligation" or "a set of moral principles or values" or "a theory or system of moral values." It would appear, thus, that there is little distinction between what is ethical and what is moral. Perhaps one should also remember that morality and what is moral may change with time and place. Although there may be some issues which are considered universally moral or ethical, even they may undergo changes with time, at least in the responses they generate in societies.

In the arena of family planning, the first ethical consideration is whether or not family planning is a basic human right. Secondly, who has this right and, thirdly, how is this right to be interpreted? It was in 1968 in Tehran where the international community first asserted family planning as a human right. In 1974, at the International Population Conference in Bucharest, the governments of the world

asserted without any equivocation the right of all individuals and couples to family planning.

The relevant Section 14(f) of the World Population Plan of Action states:

All couples and individuals 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. The responsibility of couples and individuals in the exercise of this right takes into account the needs of their living and future children and their responsibilities toward the community.

This declaration was reaffirmed in 1984 at the International Conference on Population in Mexico City, and its Recommendation 25 specifically called upon governments to help with the implementation:

Governments should, as a matter of urgency, make universally available information, education and the means to assist couples and individuals to achieve their desired number of children. Family planning information, education and means should include all medically approved and appropriate methods of family planning, including natural family planning, to ensure a voluntary and free choice in accordance with changing individual and cultural values. Particular attention should be given to those segments of the population which are most vulnerable and difficult to reach.

The Right to Family Planning

The human right to knowledge, information and the services for family planning is thus accepted in these pronouncements of international consensuses. A right cannot be enjoyed if it is not known. Therefore, any effort to withhold information and the services for planning one's family from individuals and couples must be considered as inherently unethical. Governments, for example, that do not wish to make provisions for family planning and those segments of society that would fight against the free and ready availability of family planning, for whatever reason, must be considered in the view of these agreements as acting unethically.

May we ask why so much effort is spent by some organizations and governments to withhold family planning education and information as well as services from either their citizens or certain segments of the society? Firstly, there is the misguided notion that provision of family planning, ipso facto, is making provision for cutting down the size of the population. It can be proven both theoretically and factually that a good family planning program, which ensures a woman starting childbearing at, say, 20 years of age and ending at 35, spacing the children by 3-year intervals, would still be able to assist women to have total fertility of 6 or thereabouts; in that situation the

population would grow at well over 2.5 percent per annum. This would correspond to some of the fastest growing countries in the world.

A second major fear is the separation of copulation from reproduction and the attendant supposition that this will make society less moral. There is no evidence for this. The sexual revolution and all it entails cannot be attributed to contraception per se. The third fear is the fear of the methods themselves. There has been so much adverse media criticism of some of the methods, e.g., the injectables and the pill, that in many societies and among many individuals these are classified as dangerous drugs to be controlled and handled with extreme caution through trained physicians only.

Fourthly, the possible discriminatory application of family planning for political or demographic ends or for eugenic and economic ones has always been lurking in the background for some of the people who criticize family planning. Finally, there are those who feel that family planning gives to women too much power and/or too much freedom. None of these reasons can be considered ethically just or moral, and yet they are among the reasons on which some societies or communities stand to justify withholding family planning education, information and services from their citizens.

An International Planned Parenthood Federation (IPPF) work group, looking at the recommendations from the 1984 Mexico City International Conference on Population, recommended that a clear designation be made in the statement of the right to family planning to reflect two important components of that right, namely:

- o the right of everyone to have ready access to information, education and services for fertility regulation; and
- o the right of everyone to make decisions about reproductive behavior, including whether to have a child, when, and how many.

The group decided that the right of access to information, education and services should be held as an obligation by society and governments for all persons:

This duty transcends population policies and should not be withheld for demographic or any other objectives. On the other hand, the right of everyone to make personal decisions about reproductive behavior is of necessity affected by personal and societal perceptions of responsible childbearing and such perceptions may be modified by knowledge and understanding of the inter-relationships between numbers of children and the resources to meet their needs and on a larger scale, the impact of population growth on development and on the finite resources of the government and ultimately of the planet.

Thus, governments and other authorities on whom society relies have a duty to inform and educate the public about responsible choice in childbearing. They also have a duty to adopt enlightened policies which protect the interests of present and future generations while not violating unnecessarily other human rights of the present generation.

The Need to Know

It is an unfortunate fact that in many countries adolescents and even many adults have practically no knowledge of their own human reproductive systems and how they function. Some will maintain that such knowledge stimulates early sexual experimentation. There is no evidence that lack of knowledge has prevented early experimentation. It is a surprising phenomenon to find that in an area of such great importance as human reproduction, there are people who still maintain that ignorance is the best defense against "doing the wrong thing." All the evidence, when it has been assembled, has shown that those who would start sexual experimentation early would do so and try to gain knowledge of contraception after they have experimented rather than in anticipation of the experimentation.

It is probably necessary to separate three components about family planning and population. First is the knowledge of population in relation to resources, the knowledge of household resources in relation to the numbers of children in the household and how these affect the health and well-being of the household generally. This sort of knowledge ought to be available for children from an early age. Secondly, there is knowledge of the reproductive system and its functioning, reproductive behavior, and what one would call responsible attitude to childbearing. This knowledge which can be combined with the teaching of ordinary science and social studies should be given to children in their later ages. Finally, there is the knowledge of responsible sex and how to plan a family. This probably should come much later and be followed, as considered necessary, by access to family planning methods, including information about the use of contraceptives and their side effects.

Availability and Accessibility of Methods

It is an unfortunate fact that most family planning methods that are now available have been manufactured or discovered in western countries and their availability to countries with different needs and different organizational structures is handicapped, to a certain extent, by requirements and restrictions of their countries of origin. For example, up until now, many countries around the world required that the contraceptive pill be prescribed only by physicians. Even countries where the doctor to population ratio is 1 to 20,000 or 1 to 30,000 still make such a requirement. This effectively withholds a potent family planning method from many persons who are in need. The questions to be asked are, given the state of our knowledge, given the known mortality rate differences between the proper use of the pill and an unwanted pregnancy, or even wanted pregnancies, in those countries, is it ethical to so restrict the availability and accessibility of the pill?

In a community in which maternal mortality rates range from 200 to 800 per 1,000 live births, is it ethical to make women go through one pregnancy after another up to, say, the seventh delivery, from which they die, without their being given the option of spacing their children better or ending childbearing sooner, simply because there is no doctor available to prescribe a contraceptive? The death rate from the pill, even in western societies where these death rates are accentuated because of lifestyles such as smoking and obesity, is no more than 5 per 100,000. In less developed countries this rate is bound to be very much lower. How this rate compares with the death rate from pregnancies ought to give us a risk/benefit ratio, which gives courage to distribute the pill without recourse to physicians. There are experiments which have shown that the pill can be distributed by other health workers and even non-health workers, such as shopkeepers and teachers, when trained properly. They can screen for contraindications and monitor for side effects.

Development and Testing of Contraceptives

The development and testing of contraceptives has been an area of a good deal of controversy which has led in some instances to some developing countries refusing to accept a contraceptive until it has been completely tested in its country of origin. Such attitudes may have originated from the testing of other drugs without due guarantees to the developing countries. There is no reason why such a practice should continue today. The World Health Organization, with its clinical testing centers, which involve both developed and developing countries, is our best guarantee against unwarranted discriminatory testing practices around the world. There have been instances where, although drugs have been tested fully in their countries of origin and indeed continue to be used in their countries of origin, because of adverse newspaper publicity these drugs are not being used or used appropriately in some countries which need them most. The case of Depo-Provera is a sad one. Because of the U.S. Food and Drug Administration's refusal to register the drug for contraceptive use, many developing countries say they would not make the drugs available to their women, although these drugs may fit into their social, cultural and health patterns better than they do those of the United States. (Ironically, the U.S. FDA has approved Depo-Provera as a regimen for endometrial cancer.) It probably would be best if all developing countries, apart from depending on the WHO, would also try to develop either the actual competencies for drug testing or at least the competence for assessing the scientific facts after analyzing results gathered from all around the world, so they will be able to deal with their own circumstances. Ignoring different needs, and different interactions between drugs and user groups in decision-making could also prove unethical.

Voluntary Sterilization

One contraceptive method which has aroused a great deal of controversy is voluntary sterilization. Because of its irreversible nature, sterilization is viewed as something which, by and large, should not be encouraged. Some countries and religions have laws against it. It is an unfortunate fact that coercive sterilization procedures have

been used within some countries in a genocidal attempt to keep sections of the populations down. The world at large has not forgotten the Hitler era, and the shame and guilt still cloud thinking and views about sterilization. It is accepted in some LDC programs only with a number of restrictions. However, for couples who have already completed their families, at the present time, there is no better method than voluntary sterilization. So far, no long-term side effects of any consequence have arisen. Countries and programs that would withhold voluntary sterilization from women or men who wish to terminate childbearing may be considered as not acting ethically in relation to those people's needs and requirements. This is particularly relevant for couples who want no more children and the wife is over the age of 35.

Contraceptive Mixes in Programs

There are a large number of contraceptives at present. In some communities there is a tendency for the government or program managers to restrict the choice of clients by offering only one or two methods. The proper thing to do is to have available what is now termed a cafeteria of methods, to inform potential users of contraceptives about the value, side effects and complications of each of the methods. Then, during the counselling, the client should be helped to make a choice from the information that is given. The idea that "program managers or program operators know best" should be laid to rest. What is ethical is to see to it that the individual or couple is given the fullest possible information and encouraged to make an informed choice. These are the fundamental ingredients of a moral decision.

The Special Case of Minors

One cannot end without referring to the troublesome and agonizing area of contraceptives for minors. Some quite serious and concerned parents ask, "If a minor cannot have medical attendance for a tummy ache or any other ailment and if a minor cannot be put under anaesthesia for appendectomy without the approval of his/her parent or guardian, why should it be possible for the same minor to have family planning service, or in some cases even an abortion, which requires a surgical procedure, without reference to her parents or guardians?" There are no easy answers to this question. Answers must be related to what is likely to prove more beneficial to the individual minor. Secondly, the relationship between the minor and his/her parents or guardians needs to be probed. One can say quite genuinely, as a parent, that perhaps one thing that all parents would desire would be that their children would not actively engage in sex until they are fully prepared for the consequences of sexual activity and are ready to start forming permanent unions within the social and cultural norms of their society.

However, the real world we live in is different. Our children go to school and, in many instances in LDCs, they are away from us for many long hours. In some countries we have situations where children are in school while their parents and grandparents never went to school at all. There are situations where they are not only at school, but at school away from their own communities and away from the cultural and moral influences of those communities. The extent to which such minors need

to have parental control or parental guidance or agreement before they can have help with their needs for a type of life that they are being ushered into should be seriously considered. On the whole, one would say that if a minor is already sexually active it is incumbent on the physician or the family planner to assist that minor to understand the consequences of his or her sexuality and help to make a choice as to whether and what contraceptives he/she should use. The involvement of parents should be sought if this step is in the best interest of the minor and if his or her rights are fully protected. It should be remembered that minors are also people and, in the rapidly changing world of LDCs, often very different people, educationally, culturally, and even morally, from their parents and grandparents.

In the case of minors who are not already sexually active it is incumbent upon all society to make them understand their reproductive health needs and make them appreciate that to say no to sexual advances, and to not enter sexual relationships until one is fully prepared for their consequences, is not a bad thing.

Conclusion

This short paper deliberately refrains from entering into ethical and moral issues related to abortion. Many family planners do not consider abortion a method of family planning, although all agree that it is a method of fertility control. The difference is not merely semantic. Family planning is a preventive and promotive activity, while abortion is a curative one. Abortions have been with mankind for a long time and the evidence is that they will continue. Illegally induced abortions contribute about a quarter of all deaths related to pregnancy and childbirth in all developing countries, and therefore would demand very serious consideration in all health and welfare efforts.

There are, however, some issues within the field of family planning which ought to be considered as more pertinent to health providers. These include the following:

- o How much family planning education and information should be given prior to an individual reaching maturity?
- o What contraceptives should be made available and in what circumstances once the individuals are mature?
- o What role is to be given to individuals in choosing own contraceptives?
- o How accessible are these methods to be?

Issues of this nature need to be resolved before health care providers and family planners can really assist their communities in ways that respond to the needs and circumstances of their communities. All those claiming to give health care to individuals and couples and to their children ought to be prepared to stand outside of their own moral, ethical and religious principles and examine some of these issues

dispassionately so that they may be able to give true information about reproductive health and its needs to all clients and to help in providing, when requested, family planning services. In the final analysis, they should ask themselves what ethical justification they have for withholding from their clients a service which has been proven to be such a potent preventive health tool for the health and welfare of women and children.

Lastly, it must be emphasized that without family planning being freely accessible it is unlikely that women, as individuals, will be able to enjoy to the full other rights and freedoms. Therefore, any attempt to withhold education, information and services for family planning from any woman for reasons outside of her own choice must be considered grossly unethical and a denial to such a woman the right to make an important choice. Every service provider must be confronted with this challenge and needs to examine his or her own ethical views in relation to the client's needs and society's cultural and social consensus and practices.

CHAPTER III

GOVERNMENT POLICIES REGARDING FAMILY PLANNING

FAMILY PLANNING POLICIES, DEVELOPMENT PLANNING,
AND THE CHALLENGE TO NON-GOVERNMENTAL ORGANIZATIONS

by Stephen L. Isaacs, J.D., Director of the Development Law and Policy Program, Center for Population and Family Health, Columbia University

Governments wishing to reduce fertility (and this may be for demographic, health, or human rights reasons) have a limited number of policy and legal options available to them:

1. They can issue population or family planning policies or other wide-ranging legislation.
2. They can focus on the direct means by which people control their fertility by:
 - o Increasing access to contraception; this would include family planning programs, community distribution, social marketing and loosening restrictions on contraceptive distribution, advertising and import.
 - o Increasing access to voluntary sterilization, by legalizing the procedure and removing onerous consent and waiting requirements.
 - o Legalizing and making available abortion services.
 - o Encouraging breastfeeding.
 - o Raising the age of marriage.
3. They can offer social-economic incentives and disincentives for specified fertility behavior. Incentives have been associated largely, but not exclusively, with East and South Asia.
4. They can improve those social and economic conditions that have been associated with reduced fertility. Those indirect measures thought to affect demand for smaller families include:
 - o Improved status of women, particularly female education.
 - o Improved education for the entire population.
 - o Reduced infant mortality.
 - o Urbanization.
 - o Higher per capita income (or more equal distribution).

Over the past decade, more than 50 countries have strengthened laws

and policies related to fertility. Policies, laws, and regulations to influence fertility are now recognized as an integral part of efforts to promote social and economic development. This recognition was reaffirmed at the International Conference on Population, held in Mexico City in 1984. Reviewing the major trends by region in the developing world, the most activity has taken place in East and South Asia, and sub-Saharan Africa leaders have taken a new interest in population growth and family planning.

East and South Asia

The world's first "population policy" was issued by the Indian government in 1952. Since that time, the nations of both East and South Asia, with a few exceptions such as Burma, Cambodia, Laos, and Mongolia, have been concerned with population growth and its effect on economic development and the quality of life of their citizens. Almost all countries of the region have articulated policies to reduce population growth and have implemented family planning programs. Contraceptives are, in general, legally available; sterilization is permitted, and even encouraged; and with the exception of Islamic countries such as Indonesia and Pakistan, abortion is available on liberal grounds (e.g., on demand in China, for contraceptive failure in India). Monetary or in-kind payments are offered to family planning acceptors particularly those adopting voluntary sterilization, in Bangladesh, South Korea, some Indian states, and Sri Lanka. In China, Thailand, Indonesia, and some Indian states, localities which have achieved low fertility or high acceptor rates are rewarded. With its adoption of the one-child family program, based in part on Singapore's "disincentives" system, China embarked on a series of penalties for couples having two children or more.

Indeed, the issue with regard to Asia is whether the demographic problems and pressures are of sufficient gravity to justify the strong program measures that governments have adopted. This issue came up in the context of India's sterilization program in the 1970s, China's allegedly coercing abortions and provoking infanticide in the 1980s, and, most recently, concern about Bangladesh's payments for sterilization.

Latin America and the Caribbean

Since the late 1960s, private family planning associations, and increasingly governments, supported family planning as an alternative to abortion and for its benefits to the health of women and children. Early studies in Chile demonstrating the extent and health consequences of illegal abortions paved the way for the first Latin American family planning programs. Demographic pressures perceived by Colombia, the Dominican Republic, El Salvador, Mexico, and Peru in the 1970s led these countries to adopt formal population policies. In 1985 Peru adopted a new, wide-ranging Population Law. Ecuador (1976), Mexico (1974) and Guatemala (1985) constitutionally guarantee individuals the right to choose the number and spacing of their children. Peru's constitution guarantees "responsible parenthood."

Currently, all Latin American countries except Argentina, Paraguay and Uruguay offer family planning as a part of governmental or social security health services. Latin countries such as Brazil and Colombia (particularly through the family planning associations affiliated with IPPF), led the movement to offer contraceptives at the community level. Brazil, which remains generally pronatalist, changed its regulations in 1985 to permit government health services to offer family planning and to allow copper IUDs to be utilized.

Voluntary sterilization too, has been available in many Latin countries. It plays a major role in Panama and has been widely accepted wherever policy changes permitted its being offered. Lately it has been under attack in a number of countries, ranging from Brazil to Colombia to Guatemala. Perhaps this stems from the more conservative posture of the Roman Catholic Church and the increased strength and militance of the Opus Dei.

Throughout the hemisphere, with the exception of Cuba and Uruguay, abortion is illegal except on relatively narrow grounds such as danger to life or physical health of the woman. Although clandestine abortion is still rampant, apparently efforts to reform the laws in Latin America have failed and there is little likelihood that this will change in the near future.

Sub-Saharan Africa

Attitudes among African leaders have undergone a remarkable transformation. As recently as five years ago, mere mention of the words "population policy" would have been taboo in all but a few locations. Now the development plans of 11 countries express concern about population growth; population policies or legal changes are being considered in Kenya, Liberia, Niger, Nigeria, and Sierra Leone. (Ghana issued the continent's first such policy in 1969.)

Family planning or "birth spacing," the term more commonly used in Africa, is ostensibly offered as part of maternal-child health programs, with the exception of some francophone African countries. However, services are considered weak in all sub-Saharan African countries with the possible exceptions of Botswana and Zimbabwe.

Those countries colonized by France have maintained their conservative legacy: in all but a handful of francophone countries the distribution of contraceptives is prohibited by law; sterilization might be considered a criminal act; and abortion is illegal. However, Cameroon, Ivory Coast, Mali, and Senegal have repealed their laws prohibiting contraceptive distribution. In anglophone Africa, governments generally support family planning because of its benefits to the health of mothers and children and permit voluntary sterilization where it is necessary to maintain the life or health of the woman.

Fertility in sub-Saharan Africa is high and has been rising in some countries. Whether there is much demand for family planning services (at least beyond the major cities) is not yet known. Certainly, high infant mortality, widescale poverty exacerbated by the drought, low

status of women with great value placed on childbearing, tribal rivalries, dependence on agriculture and the labor that it requires, and the influence of Catholicism and Islam (both generally pronatalist) explain the prevalent high fertility and difficulties in lowering it.

North Africa and West Asia

Of the countries located in North Africa, all but Libya have national family planning programs. Tunisia, in particular, has taken strong measures to reduce rapid population growth. These include supporting a strong family planning effort, permitting voluntary sterilization, legalizing first trimester abortions, and taking legal steps to improve the status of women. Egypt too has been concerned about the effects of rapid population growth, but has had less success with its national policies, commissions, and programs.

Most Middle Eastern Arab states limit or discourage access to modern means of contraception; Saudi Arabia, for example, prohibits the possession of contraceptives. Grounds for abortion are generally restricted: either it is totally prohibited or permitted to save the life (and occasionally the physical health) of the woman. Sterilization, too, is largely restricted; its legality depends on interpretations of Islamic law, the most common of which permit it only when another pregnancy would threaten the life or the health of the woman.

Throughout the Arab world, the impact of fundamentalism poses a serious threat to fertility reduction activities. Even governments such as that of Tunisia must worry about the growth of fundamentalist Islam and its restrictive effects -- whether theologically "correct" or not -- on family planning.

Two other countries in the region should be mentioned. Turkey passed a Population Planning Act in 1983 which, reversing years of pronatalist policies, permitted distribution of contraceptives by persons other than physicians, authorized voluntary sterilization, and legalized early abortion. Israel, with its three populations (European Jews, Middle Eastern Jews, and Arabs) growing at different rates and a rift between religious and non-religious groups has developed rather complex fertility policies. Generally, they restrict access to means of fertility regulation (although the abortion law was one of the world's most liberal until the social-economic hardship ground was eliminated a few years ago) and try to encourage, through incentive payments, increases in the growth rate of Jewish populations.

New Momentum, New Constraints

What does this review signify? What does it mean for non-governmental organizations in the health field? I would suggest the following for consideration.

First, there is a readiness around the world, with few exceptions, to do family planning. It is no longer as controversial as it was a decade, or even five years ago. The change of attitude of African

leaders -- particularly those in francophone Africa -- over the past few years is nothing short of remarkable. The words "population control" may still be explosive in some parts of the world but "family planning" or "birth spacing" certainly are not.

Second, the effectiveness of family planning programs is now generally accepted. The almost complete absence of debate at the 1984 Population Conference in Mexico about the value of family planning programs is significant. A recent study by the National Academy of Sciences found that family planning programs do "work" (to reduce family size), and a number of recent publications have demonstrated the health effects of family planning.

Third, just as official interest in family planning has increased, funds have started to dry up. Money from both international organizations and governments is likely to become even more scarce. This is a very serious problem, one that is not yet fully understood. It implies a much more important role for non-governmental organizations in the whole range of development activities, not just family planning and health. In broad terms:

- o The debt crisis, which forces countries to use a disproportionate amount of their foreign exchange to service the debt, leaves debtor countries with less money to fund domestic development programs. Although the situation of Latin American countries such as Mexico, Brazil and Argentina captures the headlines, the size of African debt in relation to income and exports is the highest in the world (World Bank Development Report, 1985, p. 24).
- o The increased pressure on foreign exchange comes at a time when commodity prices are down. Since many developing countries depend on one or two commodities to earn foreign exchange, they have less of it coming in.
- o Austerity measures imposed by the International Monetary Fund to reduce inflation mean that countries must cut their expenditures. The burden falls heavily on social programs such as health and education. Thus, less and less national government budget is and will be available for development programs.
- o Foreign aid from the United States will decrease, perhaps dramatically, over the next few years. Gramm-Rudman is already beginning to take effect, and it may be only the tip of the iceberg. A recent article by James Fallows illustrated convincingly that unprecedented budget and trade deficits, combined with unprecedented borrowing from other nations, are leading to a situation where "Ronald Reagan's successors will find it hard to do anything other than meet the government's interest obligations, and the nation as a whole will have more difficulty investing in education, technology, or other

sources of happiness and wealth." (Atlantic, September 1985, p. 22).

With both developing and developed country funds for social development drying up, where will money for health and family planning (and other) programs come from? Obviously it will have to come from the private sector -- both the for-profit and the not-for-profit side.

Much has been written about the importance of private enterprise in health and family planning. No doubt the for-profit sector will and should become increasingly involved in health and family planning services delivery (as they already are in the United States). Yet, it is fair to ask whether family planning is sufficiently profitable to maintain the interest of these companies over the long run.

Given this, the non-governmental organizations have a critical role to play. It is ironic that just as family planning has become less controversial, money to support policies and implement programs is becoming scarcer. It is this irony that is also the challenge that confronts us.

CHAPTER IV

PVO INVOLVEMENT IN FAMILY PLANNING

PVO PERSPECTIVES ON INTEGRATING FAMILY PLANNING INTO PRIMARY HEALTH CARE

by Christine Burbach, Ph.D., Director, Washington Office, Interaction

A survey was conducted of 16 private voluntary organizations (PVOs) to assess the degree to which they have added or upgraded the family planning component within their primary health care service programs. The objective was to get up-to-date, insightful information of use to PVOs trying to obtain support for family planning services. Each PVO was asked four basic questions:

1. What are the positive PVO aspects most conducive for integrating the family planning/health components?
2. What are the major constraints to integrating the family planning/health components?
3. What advice would you give to PVOs trying to add or upgrade the family planning component into an existing health program?
4. What resources are you aware of that would be helpful to PVOs attempting to accomplish the above?

The general findings include:

- o There is no typical PVO; therefore it is risky to generalize.
- o The primary health care provided by PVOs is focused mainly on mothers and children.
- o All PVOs interviewed support family planning and spacing pregnancy as an important health behavior, and in principle all of them believe at least some type of family planning services should be available from primary health care workers.
- o In practice, 60 percent provide both family planning information and contraceptives in countries which permit them; the services are at least partially integrated into the village health workers' regular schedule.
- o The other 40 percent of PVOs support integrated family planning services but in practice their village health workers do not have adequate training, time or supplies to do so; referrals

are made to the nearest government service or family planning association.

- o It is this symbiosis between separate horizontal PVO health services and vertical family planning specialists which appears frequently to be the best strategy in areas where neither organization works as well alone.

The following sections include PVO responses to the four major questions.

1. Positive PVO Aspects That Facilitate Integration

- o Committed and trusted staffs
- o Encourage community involvement
- o More cost-effective than public-sector workers
- o Concentrate on relatively small impact areas
- o Build primary care outreach programs which utilize existing curative care infrastructure
- o Responsible humanitarian focus
- o Strong values
- o Commitment to host country
- o Less likely to transfer staff
- o Continuity makes them more trusted and credible
- o Control costs and move toward self-sustaining programs
- o Flexible (decentralized decision-making)
- o Significant portion of PVO project resources are contributed by local donors and beneficiaries
- o Capacity to develop infrastructure

2. Constraints That Make Integration of Population/Health Programs Difficult

A. PVO Constraints

- o Health worker overload
- o Resistance to collaboration with governments
- o Weak information systems
- o Must collaborate with separate (vertical) family planning programs
- o Most urgent MCH services often take precedence over family planning
- o Difficult to provide adequate supervision and supplies for family planning
- o Family planning services are too costly to include primary health care
- o Small impact area
- o Lack of planning and management
- o Lack of information and evaluation (documentation and replication)
- o Little sustainability

- o Child survival projects oriented towards ORT and nutrition
- o Generally poor at marketing

B. Government Constraints

- o Majority of funds spent on costly care, centered in hospitals and clinics, not on community-based primary health care
- o Generally serve higher-income urban areas
- o Higher-cost technologies
- o Vertical administration
- o Services in rural areas do not adequately involve the community in planning and implementation

C. General Constraints

- o Family planning is too controversial
- o Difficult to integrate culturally
- o Funders do not always see integration potential and will not fur.
- o Pressure from publicity inhibits funders
- o Politics
- o Too much focus on national program development

3. Advice for Successful Integration

- o Learn to work with governments in order to replicate the successes and spread their limited impact. You need government support.
- o Learn about existing family planning services and needs of the people.
- o Improve institution-building.
- o Do not overlook training; emphasize both family planning and primary health care topics such as nutrition and maternal and child health care.
- o Enhance linkages and coordination.
- o Facilitate participation of health consumers.
- o Improve communications financing.
- o Expand PVO role as intermediaries to government.
- o Make convincing argument for: 1) child protection -- MCH focus rather than decreasing population; and 2) empowerment--potential to get funding.
- o Do not overlook funding possibilities for field offices.
- o Tie into an existing organization with a proven track record (existing health facility and administrative services).
- o Use local resources to integrate family planning. Keep within culture; do not go outside.
- o Pay attention to the clients.
- o Identify village members who are well-respected, active in their villages and have some health

background to be the prime promoters of family planning.

- o Know the policies of the countries you are entering.
- o Focus more on teens and pregnancy. (Do not overlook the male perspective.)
- o Relate to cultural perspectives and heroes.
- o Let programs initiate from the field.
- o Conduct regular meetings to combine feedback, problem analysis, new training and re-education. Include more than the number of recipients in your evaluation. You must also look at counseling and information dissemination components. These are often missing and are hard to evaluate.
- o Collaborate with family planning/population groups that are more involved in the delivery of contraceptives.
- o Make sure the administrators and trainers for the project are professionally competent in their field -- the clinical subjects, training, promotion and management. They should have a "development" attitude, committed to leaving behind a continuing structure with its own resources.
- o Give the program legitimacy. Some kind of official authority for its activities must be granted by the appropriate agencies and local community (the village head).
- o It is often useful to be the pioneer in delivering a service rather than moving into an area where someone else already involved but is not performing adequately.
- o Any outreach program requires close supervision, and thus the better the transportation network is in an area, the easier the supervision will be.
- o For replication, make sure that the project provides workers with the means of independently earning income for services rendered, rather than only a set salary from a project dependent on outside funding. With their "private practice," the village workers have both an incentive for professional development and a basis for continuing their involvement without relying on a central organization for instructions. This is an important step towards self-sufficient community health services.

In conclusion, the above input reflects that PVOs do have substantive experience and assistance to render to other PVOs trying to integrate family planning and health programs. There is no need for PVOs initiating family planning/health programs to reinvent the wheel -- there is a plethora of information available.

Unfortunately, however, the information does not exist in a central data base or location; rather, it exists with specific individuals in many different organizations. With time and patience it can be obtained.

POLICY AND POLITICAL ISSUES IN IMPLEMENTING FAMILY
PLANNING PROGRAMS IN LDCs: A PVO PERSPECTIVE

by David R. Syme, M.P.H., Director of Technical Support, Adventist
Development and Relief Agency International

The political dimensions that surround all primary health care interventions are inescapable. This reality places many humanitarian agencies in a considerable dilemma. Health professionals in particular are generally equipped rather poorly to deal with the more political aspects of their programs. One cannot work very long in rural health programs before the realization dawns that lasting change and human betterment demand approaches that go beyond medicine and health. At this point, most agencies and health personnel succumb to the temptation to ignore or trivialize the socio-political issues. Others pursue the opposite track in attempting to create a politically conducive environment as a first prerequisite to primary health care intervention.

While both of these approaches are perfectly understandable, they are nevertheless misguided. There are no purely technical solutions. Politics intrude into every fabric of society. Conversely, any program that mobilizes the processes of human and community development through health care can and does make substantial contributions to social and political change at the local level and hence has some political effect. An appreciation of this fact is essential to an understanding of why so many PVOs in the rural health arena conduct their programs with little or no emphasis on, or integration of, family planning activities.

The reason for this agency reluctance should be readily apparent. Family planning has been perceived by a large number of people in both the North and South as being more politically oriented than health-attuned. No doubt for reasons of emphasis and management, family planning services, perhaps more than any other activities in the health field, have tended towards sectoral isolation and disintegration from mainstream health programming. Many approaches have favored top-down efforts with their predominant focus at national and governmental levels of administration. Within the context of this paper, it is not necessary to dissect the whys and wherefores of this situation other than to say that these perceptions have contributed to a lack of emphasis on family planning by many agencies which operate health programs in less developed countries. Fear of identification with such vertical-macro approaches has tended to frighten off the smaller PVOs.

There are two basic questions that need to be asked by PVO policy-makers as they consider their position:

1. Is there a need for family planning in their health programming?

To ask such a question may sound axiomatic, for almost everybody in the North at least, knows that family planning is the answer to the world's problem of poverty!

This simplistic naivete is of course offset by the actual complexity of relationships between population groups and the socio-political reality in which they live. For the poor, children are an economic necessity and will continue to be as long as infant mortality rates stay high, access to improved agricultural technologies remains low, and as there continues to be no social and economic support for the aged outside of the family circle.

Nonetheless, the growing need for primary health care in which appropriate family planning activities are an integrated and important part is obvious with some national growth rates now exceeding 3.5 percent (a doubling time of 20 years) and with local rates substantially higher. In addition, it is worthy of note that child spacing did not start with the advent of the "pill." Societies have had traditional methods of birth control for centuries. However, traditional practices have fallen into disuse, and the demand today for safe, low-cost contraception is growing fast in many LCDs. No health program that is really in touch with local communities can afford to ignore this trend or delegate the responsibility for its implementation to someone else. The second question then must be:

2. Are there ways in which my agency can involve itself without the incumbent overlay of overt politics that has tended to surround family planning activities in the past?

As has already been stated, one cannot do any primary health care programming without being political to some degree. One must also accept that there is a continuing need for advocacy and "political conscientization" at higher levels in order to create the environment that makes PHC, and family planning in particular, a possibility. This in and of itself is still insufficient. Much of the weakness of family planning efforts in the past has been due to the failure of large macro programs to provide the right kind of social marketing that enables knowledge about family planning to reach communities in an acceptable fashion.

In traditional cultures access to knowledge is often in the hands of local learning institutions, e.g., the local shaman, village elites and religious leaders. Many of these local institutions often play a major role in shaping of local culture and value systems. Even though modern media messages may bypass such traditional mechanisms for control, they have relatively little impact in reshaping established values and are unable to reinterpret that information within the local sub-culture of beliefs and practices. Choices about family size and contraception are extremely personal compared with choices about vaccination or ORT. In such sensitive decisions, responses more often

than not are determined by traditional values and internal social relationships rather than a mere exposure to outside messages on what is best for health and happiness.

Given the above, it can be seen that PVOs which work at the community level and especially those which have an ongoing presence there are in a much stronger position to deliver sensitive and appropriate knowledge to meet community needs than relative outsiders are.

A classic example of this potential is the rapid growth of religious groups in Africa. These groups, many of them indigenous, comprise a major part of rural and urban society. In the case of the Christian community, rates of growth are in excess of 7-8 percent per year in many places; a large proportion of these members are women. The impact of such groups on local values and culture is grossly underestimated. Through private school systems and health care services, the potential is enormous for introducing and, more importantly, institutionalizing knowledge about family planning.

In order for this potential to be realized, it is essential that PVO policy-makers fully comprehend the scope and implications of family planning activities and recognize that it is possible to implement them in a manner that will appropriately meet local needs while keeping a distance from those more political aspects associated with macro-programming. It is only fair to note here that there appears to be a commonly held assumption that silence about family planning issues on the part of agencies implies lack of involvement. Such is not the case. There are in fact many "silent partners" who are engaged in a considerable amount of family planning activity but who hesitate to identify with it at the macro-sectoral level because of the political and philosophical implications.

If family planning can be presented once again as an integral part of the whole primary health care package and can lose some of its more unattractive political gloss, then I believe it can find more open support from the PVO community at large and a much broader, more appropriate base from which to operate in the future.

Factors for Consideration in Determining PVO Policy

1. The provision of family planning knowledge and appropriate services should be an integrated part of every primary health care intervention if "health for all" is ever to be reached.
2. While there will always be social and political factors surrounding health activities, and especially family planning, there are low profile ways in which family planning knowledge and services can be delivered successfully.
3. PVOs that are closest to and members of rural and urban communities have the best potential to facilitate family planning awareness and practice.

4. The emphasis must be on provision, not imposition.
5. Because there are controversial aspects surrounding some family planning activities does not mean that everything should be discarded. There are a wide variety of suitable activities and approaches which can meet most situations appropriately.

THE DEMAND FOR FAMILY PLANNING

by Nancy P. Harris, Deputy Director, The Enterprise Program, John Snow, Inc.

In every country there is a unique set of political and policy circumstances. PVOs, by virtue of being small, grass roots and in close touch with their "constituency," are especially well placed both to respond to, and to influence, their environment. This has historically been the case in a number of health areas, including primary health care, immunization, ORT, and sanitation. Unfortunately, far too many have dragged their feet in terms of family planning. One reason for this could be the political climate in the U.S., where a highly vocal minority of citizens which opposes international family planning gets more than its fair share of media attention. Another reason could be sometimes cumbersome funding mechanisms, which too often segregate activities and encourage "parallel" programs. Certainly, PVOs must be responsive to these donor or U.S.-based pressures. Nevertheless, PVOs have demonstrated an ability to work well in a complex funding situation and certainly can and will continue to do so, if convinced that their work is important and that it represents a felt need.

Another reason why many PVOs seem to have declined involvement in family planning is that, in the past, family planning was seen as a highly "sensitive" area, unpopular with government bureaucrats and inconsistent with the desires of ordinary people. Nine years of living and travelling in Africa -- the most "conservative" of the developing continents -- has convinced me that this is an antiquated idea, if it was ever valid at all. Indeed, LDC governments are increasingly demanding that PVOs become more active in this area. Governments are also enunciating and taking action on population policies. Even in countries such as Ecuador, which have no government-sponsored services, there is a tacit understanding that PVOs have the government's "blessing" and encouragement to provide services.

PVOs also play a key role in testing new ideas in small, non-threatening ways. In Kenya, for example, PVOs initiated the idea of community-based distribution, again with only quiet encouragement from the government until the idea had been tested and accepted. Just five years ago there were few CBD programs in Kenya; now there is talk of a nationwide government-sponsored program. Because they have a reputation for integrity, PVOs, particularly church-related or religious PVOs, provide the moral force needed to get programs going.

But is there a demand for family planning at the grass roots, village level? Of this I am more sure than anything else, yes! And demand is growing far faster than our ability to respond. From a taxi driver in crowded Mexico City to an isolated rural area in Nigeria, people are concerned with the rising cost of living, with whether they will be able to feed, clothe and educate their children, and with the health of mothers and babies. In a recent village-level "needs assessment" in Western Kenya, the village leaders were asked to name

their most important health problems. They identified a "new disease," one for which there was no name in their language (Luo). It was the "disease of a woman who gives birth every year" -- unheard of in the era of traditional birth spacing.

Men are sometimes maligned as being universally resistant or anti-family planning due to "machismo" and for other reasons, but I am convinced the majority do care deeply about their families. Numerous LDC programs have proven that if men are exposed to well-designed educational components, they often become the strongest supporters of family planning programs.

In sum, the political and policy "constraints" which once seemed important in determining whether a PVO chose to include family planning in its programs are quickly diminishing. In fact, the situation seems to have changed completely. Official policies now support family planning, and public demand at the grass roots is high and growing. More importantly, people want and need family planning. PVOs must rise to the challenge very soon.

THE POLITICS OF FAMILY PLANNING IN DEVELOPING COUNTRIES:
A NOTE FOR PVOs

by F. Curtiss Swezy, Dr. P.H., Program Manager, National Council for International Health

PVOs generally see themselves as apolitical organizations intent on doing the job at hand and not becoming involved with politics, either in the U.S. or, most especially, in the developing nation in which they are working. Such insularity of view is comfortable, but hardly realistic. Development agencies, including PVOs, are involved in a political process and understanding this role will help PVOs to understand the circumstances in which they work and, ultimately, to better achieve their goals.

Whether working with a village council to improve the water supply or negotiating with the Ministry of Foreign Affairs to bring in medical supplies duty-free, development agencies are constantly interfacing with the political system of the host country. Many PVOs, in fact, have considerable skill in dealing with these dynamics. This paper will highlight some of the political processes that a development agency, including a PVO, should be aware of when it desires to implement a change in practice and, ultimately, health status in a traditional society. Reference will also be made to some political issues that pertain particularly to family planning programs.

Development as a Political Process

Changing the health behaviors and outcomes of a traditional society is a political process. PVOs, which are particularly effective at the community level, have developed considerable experience and skill in group dynamics and putting democratic principles to work in autocratic, tradition-bound settings. Community development is a political process, and PVOs are particularly skilled at it. But macro-political forces are also involved in development work even when the focus is on the individual village or local community.

A PVO must receive and tacitly reaffirm permission to enter and work in a country. Some LDCs monitor PVO activities more zealously than others. Within one country, the "permission" to function waxes and wanes depending upon the temperament and politics of host officials who come and go. A repeated problem PVOs have is believing that once initial sanction has been given to their program they are free to continue working in a particular sovereign nation as long as they wish. In fact, a PVO must constantly work at affirming its prerogative to continue working in the country. Otherwise, one is "suddenly" faced with problems of revalidating visas, clearing duty-free goods through customs and the host of actions countries take when one's welcome is wearing thin, if not out. Continuing to maintain sanction from the host government sometimes challenges the PVO's strong desire to maintain an independent program with integrity and high standards for medical care. This is a problem known to all PVOs, but perhaps it bears repeating here.

The Politics of Funding Sources

PVOs generally receive their funding from two sources: money raised from individual contributors and grants from institutions, including corporations, foundations and even the U.S. Government. (It should be noted that, as a matter of policy, some PVOs refuse to accept U.S. Government money, an important political decision in itself.)

The old adage is "he who funds controls." When a large contributor has a particular opinion about a program, she/he is listened to fervently. The situation is escalated in those situations where a large proportion of the funds is coming from the U.S. Government. National policies begin to interface with health development work, and often domestic U.S. political issues impact on foreign development programs. A current example is the restrictions on promoting abortion in developing countries where it is legal, even when using non-U.S. Government funds (abortion is also legal in the U.S.).

Politics of Family Planning

Family planning/population programs were started on an international scale in the post-World War II period. The very populous country of India was the first nation to have a national population policy in 1952. Others quickly followed and today nearly all developing nations have policies supporting the provision of family planning services.

To implement these policies, national family planning programs were launched. Family planning programs were started based on two assumptions: 1) couples have the right to choose the number of children they want; 2) rapid population growth, fueled by modern health interventions, inhibits economic development and makes the raising of standards of living in developing countries difficult or impossible.

Those in the so-called family planning or "population" field viewed these two assumptions as being completely compatible. Couples, without recourse to modern contraceptives, are having more children than they want. So, by making contraceptives readily available couples would have less children, thus promoting the economic and demographic policies of the government.

Non-population professionals, including many in the health field, have always suspected that the two assumptions were inherently in conflict. This, among other forces, has led to a reluctance of many health and development specialists to become involved in family planning programs. Thus, the stage was set for the treating of these two program components as discrete, and even rival, activities. And yet family planning is a subset of health and one cannot maximize the impact on women's and children's health without making family planning services readily available.

In more recent times those in the "population" community have begun to question the assumption that freedom of choice inevitably leads to

dramatic declines in population growth. Furthermore, national policies focusing heavily on population growth at the expense of individual choice have created ethical dilemmas. Not surprisingly, India and China are concerned about the size of their populations and how they are going to feed their citizens, much less raise the standard of living in the 21st century. Spurred on by this concern for survival of the group, zealous local program managers have impinged upon the rights of some individuals. The ensuing international publicity has served to reinforce the belief of some international health specialists that family planning is a separate activity and, in some instances, to be avoided.

How are real-world program implementers to deal with these issues? The major problem arises from the failure of family planning program managers, primarily LDC governments, to offer truly comprehensive family planning service programs. Sexually active couples need different kinds of contraceptives at different periods in their reproductive lives. A program that offers one or two methods simply cannot meet the broad needs of the public to regulate their fertility. This opens questions on the ethical standards of such programs. Acknowledging the limitations of funds, trained staff and facilities, program managers must strive to provide comprehensive programs -- a "cafeteria" of services -- not just methods that are programmatically or logistically convenient.

Second, choice must be truly informed choice. Public education must be education, not propaganda. It can and should inform couples of what is in their interest and also that of society. In addition, a couple should be fully informed of the benefits and risks of each contraceptive method. Side effects must be accurately portrayed. The risk-benefits must be honestly portrayed. This results in a matching of the consumer to the appropriate method. In the reality of scarce resources, this poses hard questions both for policy planners and program implementers. However, in the past short-cuts and "quick-fixes" to meet financial constraints and demographic targets have resulted in resistance.

This is precisely where the PVOs can play a pivotal role. High-quality service is the trademark of PVOs, and this is exactly what is called for in providing an effective and ethically sound family planning program. By adhering to the high standards that typify PVO programs, the seeming conflict between individual choice and demographic imperatives can be reconciled. Truly informed consent with a cafeteria of contraceptive methods will enable consumers to maximize their freedom of choice and improve, not parenthetically, their health and that of their newborn children.

There is ample room for program innovation -- another area in which PVOs have demonstrated ability. While broad-scale national programs have responded to the immediate felt need of much of the community, it will take more persistent and subtle approaches to reach the even greater latent felt need for this service. In early programs expatriate family planners were quick to recruit local charismatic leaders -- superstars -- to lead dramatic programs. But it is now recognized that

leaders to carry on and expand current program initiatives. Once again, PVOs are particularly suited for this role. With their tradition of funding their programs as they go, PVOs are in a better position to create programs that will become financially self-sustaining.

Finally, PVOs can be very instrumental in turning what is often viewed as a coercive program -- population control -- into an enabling program -- self-determined fertility regulation. To accomplish this they must work hard at "rumor control," countering the completely erroneous stories that sweep through communities such as "IUDs are implanted by the government to control the population." The strongest defense is a satisfied customer; this comes down to a case of providing high-quality services with truly informed consent on the part of the consumers. Such a program will lead to turning the rumor network around to support the program: "women who do not want to get pregnant don't."

CHAPTER V

PROVISION OF FAMILY PLANNING SERVICES

PROGRAM ISSUES IN THE PROVISION OF FAMILY PLANNING SERVICES

by Peggy McEvoy, Dr. P.H., Associate - International Programs, The Population Council

The case for the positive health impact of family planning has already been made. An examination has also been made of some of the ethical issues related to family planning service provision. In this paper we will review some of the program issues that arise when adding contraceptive services to an existing primary health care network.

There are many approaches to providing health care, including family planning, in developing countries. A common model is to have a single service program, a so-called vertical program, where the focus is on the prevention of pregnancies. Many national programs are based on this model. Similarly, there are a number of non-governmental organizations which focus exclusively on family planning.

Conversely, there are many primary health care (PHC) projects in operation which do not include a family planning component. This provides an opportunity to integrate family planning easily and economically into an existing service network.

Both integrated and vertical family planning service delivery models have advantages and disadvantages. The individual service provider will have to determine for itself which model it prefers; if the organization is already providing services it is most likely that family planning will be added to the existing network. The papers in this chapter provide some case material on such program additions.

A second perspective on service delivery may be stated as a maternal and child health (MCH) approach versus a family planning approach. In the MCH approach, family planning is comfortably melded with prenatal services, well-baby clinics, post-partum care, etc. This approach fits in very well with a program emphasizing the health benefits of family planning, since they directly and measurably affect the health of infants and mothers.

However, the MCH approach often neglects the role of males in the process. In many countries women say, "I'm convinced, but talk to my husband!" The family planning approach stresses involving the male and provision of contraceptives for this partner as well as the wife. Again, each organization has to assess its current program and decide which approach will be most effective within the community where it is working.

Finally, once the approach is decided upon it is important to note that service must be provided to special groups that would not regularly participate in PHC, much less family planning, programs. It has been noted earlier that pregnancies to women under the age of 20 or over 35 are particularly hazardous. Therefore, all women who are sexually active in these age groups constitute a special population. And, as

noted above, no matter what the approach, a responsible program cannot ignore sexually active males, whether living with a regular partner or as removed as a migrant worker in another country.

INCORPORATING FAMILY PLANNING WITHIN PRIMARY HEALTH CARE

by David D. Nicholas, M.D., M.P.H., Director, Primary Health Care Operations Research Project (PRICOR), Center for Human Services

The Primary Health Care Operations Research Project (PRICOR) takes an operations research approach both in the design of PHC systems and in the solution to operational problems that frequently arise. The approach is divided into three phases. In Phase I an analysis is done of the system to be designed or in which there is an operational problem. This analysis includes the following system components:

- o Goal - IMPACT
- o Objectives - EFFECTS AND OUTPUTS
- o Strategy - PROCESS/ACTIVITIES
- o Resources - INPUTS

This analysis can be done for "intervention" systems, such as family planning (FP) or oral rehydration therapy (ORT), or for "support" systems such as training, logistics, or supervision which cut across several or all intervention systems.

In Phase II solutions are developed to the design problems or to the operational problem, and in Phase III a test or trial implementation is conducted of the solution or newly designed system. Such a process could be used by health project managers to systematically plan and design the addition of FP services to their PHC programs.

Case Studies

1. Danfa Comprehensive Rural Health and Family Planning Project

The Danfa Comprehensive Rural Health and Family Planning Project in Ghana illustrates an example of integrated services. That project's FP program began with a mobile family planning team which integrated its services as to time and place with the project's other PHC services. This highly trained team provided its services at the same time and at the same locations as the under-fives and maternal care clinics. Later all health service personnel were trained to deliver FP services so that men and women would receive education and services at all health centers and satellite clinics. A third level of integration occurred when community health workers were trained to provide a broad range of PHC services, including family planning. Each FP program component boosted FP in the area to a new level. After four years 38 percent of couples in this rural area of Ghana had accepted family planning.

Health staff in the Danfa Project frequently witnessed the following encounter at the under-fives clinics: A community health nurse asks the mother of a nine-months-old infant, "I see that your

child is now nine months old. When do you plan to have your next child?" Usually the mother will answer, "Oh no! I don't want the next one for another three or four years!" If the woman indicates that she has resumed sex with her husband, the nurse asks her if she or her husband are taking any measures to prevent a pregnancy. The woman usually says that she didn't realize there were any reliable measures to be taken. The nurse informs her of the modern methods available and how they work. In most cases the mother accepts a method. In the Danfa District at least 10 percent of women become pregnant in the first 12 postpartum months despite lactation and 35 percent of the acceptors reported such an experience in the previous five years. It was the impression of the staff that if the opportunity were used to introduce family planning to women in under-fives clinics in Africa, family planning would become widespread in a short period of time.

2. Eye Care Project, Haiti

Another example is provided by the Eye Care Project directed by Dr. Antoine Augustin in Haiti. In each of three rural areas of Haiti, Eye Care provides primary health care services to 50,000 persons. The most important PHC activity is daily rally posts. Each of the three areas are divided into approximately 25 zones. Each zone is served by a rally post once every 6 weeks. At the rally post PHC services are delivered which include growth monitoring, immunization, ORT, food supplementation for malnourished children, first aid and family planning.

Paid Community Health Workers, called Collaborateurs, are located in each zone. They visit homes regularly, provide health education and encourage mothers to come to the rally post. Like the Danfa Project, the Eye Care Program is a "population based" one involving the registration of every family and the monitoring of service coverage to each family member.

There are several advantages to incorporating family planning (FP) into primary health care (PHC) services. PHC already covers sizeable portions of the population and those women in need would get improved access to FP services, especially at critical times when FP could result in lowering the risk of infant or maternal death. Very often women have more familiarity and confidence in the PHC system.

There can be disadvantages, however. Competing demands on health personnel or other resources may result in compromise in the amount or quality of FP services delivered or of the other PHC interventions. Program managers must carefully plan and monitor the necessary resources.

It is important to realize that there are three dimensions to integration. FP can be integrated with PHC services as to the time at which services are offered, the place (location at which services are offered) and the personnel (the same staff might deliver both FP and other PHC services). Integration might occur along one or all of these dimensions depending on resources available and other considerations.

There are two critical service factors related to acceptance of family planning: education and accessibility. Men and women must be informed of the methods available and the benefits of family planning and these services must be made readily accessible. PHC programs have special opportunities to provide women with education and make service accessible.

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CONTRACEPTIVE METHODS AND THEIR EFFECTIVENESS

by Patti J. Benson, Assistant Program Officer, and Gordon W. Perkin, M.D., President, Program for Appropriate Technology in Health and Program for the Introduction and Adaptation of Contraceptive Technology (PATH/PIACT)

It has been estimated that approximately 5.6 million infant deaths and 200,000 maternal deaths could be prevented in developing countries in a single year if births were optimally timed and spaced and did not exceed a total of three per woman (Rinehart, Kols and Moore, 1984). Family planning is one way to effectively reduce maternal and infant mortality because contraceptive use can help couples avoid high-risk pregnancies, such as those occurring in very young women who have not yet attained their own full growth, older women, women who have borne large numbers of children, and pregnancies spaced less than two years apart.

Birth spacing significantly reduces infant mortality (Rinehart, Kols and Moore, 1984), and child spacing is the primary intervention in preventing high-risk pregnancies that are likely to result in maternal death (Weston, 1986). Births among high-risk groups can leave women anemic, undernourished, and unable to recover from successive pregnancies. Malnourished mothers are likely to experience premature births, to give birth to low birthweight infants, and to be less successful at breastfeeding. Moreover, spaced siblings tend to be less prone to malnutrition and infectious diseases. Thus, maternal and child health can be improved by preventing high-risk pregnancies, and the health of those women who become pregnant can best be improved by preparing traditional birth attendants, health workers, health centers and hospitals to provide appropriate prenatal and natal care.

While contraception is not without risks, a recently reported study of reproductive mortality in two developing countries showed that deaths related to contraceptive use were rare (Fortney et al., 1986). In Bali, Indonesia, a pregnancy and delivery carried 120 times the risk of death as a year of contraceptive use, and in Menoufia, Egypt, the risk of pregnancy and delivery was 48 times more likely to result in death than a year of contraceptive use.

According to data obtained from the World Fertility Survey, conducted between 1975 and 1982, use of modern contraceptive methods can vary widely within and between regions (Lightbourne, Singh and Green, 1982). As an example, data available in 1982 from 29 of 42 developing countries participating in the survey indicate that within Africa, contraceptive use tends to be low (under 10%) and varies little between countries. Among Latin American and Caribbean countries, however, usage rates are higher and more diverse, ranging from 20 percent in Haiti to 71 percent in Costa Rica. These figures are for currently married, fecund women aged 15-44 (except for Costa Rica, where women were age 20-49), using contraception at the time of the survey. While specific preferences vary among couples, the limited research available suggests

that prospective users believe effectiveness, absence of side effects, and convenience are the most important attributes of a contraceptive method.

 Table V-1. Distribution of Contraceptive Use Among Methods by Region

| Method (Number of Countries: | Percent of Use by Region | | | |
|--------------------------------------|--------------------------|---------------------------|-------------------------------|----------------------|
| | Africa 4 | Asia and Pacific 10 | Lat. Amer. Caribbean 12 | Middle East 3) |
| Oral Contraceptive (OC) | 32 | 28 | 29 | 30 |
| Injectable Contraceptive | 4 | 1 | 6 | 4 |
| IUD | 5 | 12 | 11 | 10 |
| Condom | 3 | 10 | 9 | 8 |
| Other Barrier | 1 | 1 | 4 | 2 |
| Prolonged and Periodic Abstinence | 31 | 17 | 13 | 17 |
| Female Sterilization | 9 | 14 | 14 | 13 |
| Male Sterilization | 1 | 10 | 1 | 4 |
| Other Methods ¹ | 15 | 8 | 14 | 14 |
| TOTAL USE ² | 101 | 101 | 101 | 102 |

Based on regional averages obtained from weighting each country equally. African countries include Senegal, Sudan (North), Lesotho and Kenya. Middle East countries include Syria, Jordan and Turkey.

1 Includes douche, withdrawal and folk methods.

2 Does not total to 100 due to rounding.

Source: Adapted from Lightbourne, Singh, and Green, 1982: Table 12, pp. 34-35.

This paper will discuss contraceptive method effectiveness, describe the major contraceptive methods available internationally, summarize factors affecting the selection of contraceptives in developing countries, and briefly review selected areas of contraceptive research.

Method Effectiveness

A number of factors contribute to the effectiveness of a given contraceptive method: the characteristics of the method; the health status of the user; and the skill, knowledge, and consistency with which a method is used. A method's theoretical-effectiveness refers to its ability to prevent pregnancy in ideal circumstances when the method functions perfectly and is used properly. Use-effectiveness refers to the ability of a method to prevent pregnancy in circumstances of actual use. For methods that require action on the part of the user (for example, barrier methods), the difference between theoretical- and use-effectiveness may be considerable. Cultural beliefs and practices, combined with educational programs, can cause variation in use-effectiveness rates among countries and programs.

Types of Contraceptive Methods

Hormonal Methods:

Widely available hormonal contraceptive methods include: oral contraceptives (OCs); the three- and two-month injectable contraceptives, depot-medroxyprogesterone acetate (DMPA) and norethindrone enanthate (NET-EN), respectively; and subdermal implants (NORPLANT^R). All hormonal methods act systemically, which means they affect the whole body rather than intervening at a single point in the reproductive cycle. Hormonal methods have the highest use-effectiveness of all currently available reversible contraceptives; one exception may be oral contraceptives which require daily action on the part of the user and therefore can have a lower use-effectiveness than might otherwise be expected.

 Table V-2. Use-effectiveness of Various Contraceptive Methods

| Type of Contraceptive Method | Contraceptive Method | Use-effectiveness Range (%) |
|------------------------------|--|-----------------------------|
| Hormonal | Oral contraceptive | 81.6 - 99.5 |
| | Injectable | 96.4 - 99.9 |
| | Implant ¹ | 99.0 - 99.7 |
| Device | IUD (inert and copper-releasing) | 92.2 - 99.6 |
| Barrier | Condom | 62.0 - 96.9 |
| | Vaginal spermicide | 80.0 - 93.5 |
| | Diaphragm/cervical cap | 80.3 - 97.6 |
| Periodic Abstinence | Rhythm/cervical mucus/basal body temperature | 62.5 - 89.1 |
| Surgical | Female sterilization | 99.4 - 100 |
| | Male sterilization | 99.85 |

¹ Although other implant contraceptive delivery systems are in various stages of research, all implant data and discussion in this paper refer to the NORPLANT^R implant system.

Source: Adapted from Hutchings and Saunders, 1985: Table 1, p. 10.

Combination OCs contain two synthetic steroids similar to the naturally occurring hormones estrogen and progesterone. They act by inhibiting ovulation, causing cervical mucus to become thick and impenetrable to sperm, and by inducing endometrial changes that inhibit implantation of fertilized ova. The progestin-only pill, or mini-pill, contains the same synthetic progestin as combined OCs but in a considerably lower dose and does not contain estrogen. In some areas of the world the mini-pill is used by breastfeeding women because, unlike estrogen-containing formulations which slightly suppress lactation,

promote production of breast milk. Because the mini-pill does not always suppress ovulation, it is less effective than combined OCs.

Injectable contraceptives are made of synthetic progestins and prevent pregnancy by inhibiting ovulation, inducing changes in the endometrium and causing cervical mucus to become impenetrable to sperm. NORPLANT[®], a subdermal implant system, is also based on the slow, continuous release of a synthetic progestin for its effect. The NORPLANT[®] system, which consists of six three-centimeter Silastic-TM capsules placed under the skin of the upper arm, provides contraceptive protection for five years. Insertion and removal are performed using a local anesthetic.

Complications associated with OC use (heart attack, stroke, and blood clot) are rare, especially for nonsmoking women under age 35, and can be controlled in part by identifying high-risk women and assisting them in choosing another method. The two largest studies to date to investigate the possible relationship between OC use and breast cancer recently reported that women who use OCs are not at increased risk for breast cancer (Stadel et al., 1986; Sattin et al., 1986). Other studies have shown that OC use reduces the risk of ovarian and uterine cancer, although there is some evidence that OCs may slightly increase the risk of cervical cancer. Animal studies have raised concern about increased risk of uterine and breast cancer with use of injectable contraceptives, but human studies to date have found no increase in cancer. The major side effect of injectable contraceptives is disturbances in menstrual bleeding. The reported disturbances include diminished or absent bleeding, irregular bleeding or spotting, or heavy or prolonged bleeding.

Device:

The intrauterine device (IUD) has a high use-effectiveness rate because its theoretical-effectiveness is high and its contraceptive effect is not dependent upon consistent user motivation and action. Use-effectiveness may vary from 92.2 to 99.6 percent and is influenced by such factors as clinician experience, likelihood of expulsion, and the ability of women to detect an expulsion. After an IUD insertion by a well-trained clinician, the user needs only to check periodically for the IUD tail to verify that the device remains in place.

The IUD is a small device placed high in the uterus, inserted through the vagina and cervical os. While the full range and combination of mechanisms by which an IUD works are not fully understood, the IUD appears to stimulate a natural immune response in the uterus causing cellular and microbiological changes in the endometrium and uterine fluids, thus making the uterus inhospitable to both ova and sperm. IUDs in wide use internationally are: plastic, or inert devices; plastic devices bound with copper wire or copper collars; a progesterone-releasing device; and tailless stainless steel rings (used in the People's Republic of China). With the exception of the progesterone-releasing device which must be replaced annually, IUDs can

remain in place a minimum of three years, and many are effective for longer periods of time.

The most common side effects associated with IUD use are bleeding, cramping pain, and partial or complete expulsion of the device. Excessive bleeding and pain are frequently recorded as a single category and account for the greatest percentage of IUD removals. Pelvic inflammatory disease (PID) is the major complication associated with IUD use. While all other contraceptive methods appear to provide protection against most PID, IUD users face a greater risk of developing PID than non-IUD users. Studies have shown that there is an increased risk of primary tubal infertility among women who have not borne children and who have used an IUD. However, research does not show an increased risk of infertility among women who have had at least one birth and have used copper IUDs, which suggests that IUDs are not appropriate for nulliparous women. Also, due to the increased risk of PID and the possibility of subsequent infertility, IUDs are not recommended for women who have multiple sexual partners and may be at increased risk of sexually transmitted diseases (STDs).

Barrier Methods:

Since the most commonly used barrier methods (condoms, vaginal spermicides, diaphragms and cervical caps) are used specifically during or in anticipation of intercourse, they are dependent upon user motivation. Condoms are the most widely used barrier method and their use-effectiveness among well-motivated couples is high, even though the range is wide -- 62.0 to 96.9 percent.

The most widely used variety of condom is a sheath of thin, vulcanized rubber worn on the penis to collect sperm-containing ejaculate. Vaginal spermicides include foams, creams, jellies, suppositories, and foaming tablets that contain a sperm-killing chemical substance and must be inserted in the vagina before intercourse. The diaphragm and cervical cap are made of rubber and must be used with a spermicide. Placed in the vagina prior to intercourse to cover the cervix, the diaphragm and cervical cap mechanically prevent sperm from entering the uterus, and the spermicide provides a chemical barrier. The vaginal sponge, which contains spermicide, is placed in the vagina prior to intercourse and, unlike the diaphragm and cervical cap, can be used only once. Properly placed, it covers the cervix but functions primarily as a vehicle for spermicide.

Protection against certain sexually transmitted infections is an important noncontraceptive benefit of both physical and chemical barrier methods. Recent studies have confirmed that condoms can prevent the transmission of the acquired immune deficiency syndrome (AIDS) virus contained in semen. There are no known significant safety risks associated with use of barrier methods.

Periodic Abstinence:

Except when used by highly motivated couples, periodic abstinence methods are generally the least effective of all methods.

Periodic abstinence methods require that the fertile period surrounding ovulation be identified and that couples abstain from intercourse during this time, often about half the length of each menstrual cycle. Sometimes referred to as natural family planning (NFP), periodic abstinence may include a combination of the following methods for determining the fertile period: calendar charting (rhythm); cervical mucus examination (Billings method); and charting basal body temperature (BBT). Couples using these methods must be highly motivated and willing to learn skills needed to determine fertile periods and keep extensive records for several cycles before using the method. Frequently, two or more of these methods are combined for more effective protection.

Women who have irregular intervals between menses, a history of anovulatory cycles, or irregular temperature records will have difficulty using these methods. The only major safety issue associated with the use of periodic abstinence relates to the method's high failure rate and the possibility of pregnancy resulting from method failure.

Surgical Methods:

Voluntary sterilization for both men and women is the most effective and most prevalent of all modern methods of contraception. It should be used only by men and women who are certain that they want no more children, and who consider the method permanent. The effectiveness of voluntary sterilization is directly dependent upon surgical expertise and the technical properties of the occlusion method used.

Vasectomy is a permanent method of contraception whereby the vas deferens, the tube that carries sperm from each testes, is identified, severed and sealed so that sperm can no longer be expelled. Sterilization for females involves surgically closing the fallopian tubes with bands, clips, electrocautery or by cutting and tying. Male sterilization and some types of female sterilization can be performed under local anesthesia on an outpatient basis. Reversal of sterilization is possible, but it is not reliable and requires specialized training and equipment.

Serious and life-threatening complications following sterilization procedures are rare.

Common Variables Affecting the Selection of Contraceptives in Developing Countries

In the absence of physiological contraindications, oral contraceptive (OC) use may be appropriate for women who want to delay a first birth or space births. However, age and smoking are two critical variables. Among nonsmokers, oral contraceptives may be used by women up to 40 years of age; among smokers, OCs should not be used at age 35 or beyond. In addition to being able to follow a daily pill-taking regimen, women who use OCs must be free of circulatory disorders, cancer of the breast, uterus or liver, or impaired liver function. OCs can reduce the risk of certain pelvic infections, ovarian and uterine

cancer, anemia and rheumatoid arthritis. The mini-pill may be an appropriate contraceptive method for women who can successfully use OCs but who are breastfeeding, as long as there is no history of ectopic pregnancy.

Characteristics of use (including frequency, ease or convenience, duration of effect, resupply requirements) of hormonal methods vary. OCs require motivation and regular action on the part of the user. However, the daily regimen offers the advantage of relatively rapid reversal of the contraceptive effect. If the source of supply is not easily accessible, the need for periodic resupply presents a difficulty for OC users.

Injectable contraceptive or implant use may be appropriate for women who want to space births, who have completed their families but are not ready for voluntary sterilization, or who want to delay a first birth for several years. These methods are useful to women who do not want to bother, or have difficulty using systems that require daily or regular action. Women who want the convenience and privacy that long-acting systems offer, and have access to a health care provider at intervals required for continued use may be good candidates for these methods, as might women who have developed estrogen-related symptoms while using OCs.

Injectable contraceptives may be appropriate for women who are not concerned about the timing of their return to regular menstruation and fertility, which may be four to eight months following the last injection (Population Crisis Committee, 1985). Injectables and implants should not be used by women who cannot tolerate menstrual disturbances that can include changes in volume of flow, intermenstrual bleeding, bleeding irregularity or amenorrhea (absence of menses). Injectables and implants are appropriate for breastfeeding women and women who do not have undiagnosed genital bleeding, or a history of malignancy or cardiovascular disease (although there is no evidence that injectable or implant use will adversely affect these conditions).

Contraceptive injections are generally easy to use from the perspective of the user, bearing in mind the need to obtain an injection every two or three months. While the return to regular menstruation and fertility may be delayed, investigations have not shown permanent impairment to fertility as a result of injectable use. Implants can provide up to five years of continuous contraceptive protection and eliminate the need for resupply. Women who have used NORPLANT R implants to space births have returned to normal fecundity after removal (Hutchings and Saunders, 1985).

Women for whom IUDs may be most appropriate are those who have at least one child, have no history of pelvic disease, are in a monogamous relationship and have access to continuing medical care for treatment if problems develop. IUDs can be used by women who are breastfeeding, but they should not be used by women who are anemic or who have a history of tubal pregnancy.

The IUD is a long-lasting device and, with the exception of the Progestasert^R which requires annual replacement, eliminates the need for frequent resupply. Once it is inserted, there is little required of the IUD user except to periodically check the IUD tail to ensure that the device is in place.

The use of all barrier methods requires high motivation because they are coitus-related. The need for frequent resupply may present a difficulty if a source of supply is not accessible or if it is difficult to obtain supplies discreetly. Where access is difficult, users may be given a supply that will last for several months. However, a large supply in the home requires an adequate and appropriate storage space, and most barrier methods are susceptible to deterioration in extreme climatic conditions.

Condoms are advisable for men and women who may be exposed to sexually transmitted diseases (STDs). Barrier methods may also be appropriate for women who cannot or should not use OCs or IUDs, or who have infrequent intercourse and therefore do not need ongoing protection from pregnancy.

Barrier methods can be safely and effectively used by breastfeeding women. Among women who are not candidates for barrier use are those who are uncomfortable touching their genitals, have a history of toxic shock syndrome (which contraindicates diaphragm, sponge and cervical cap use), are six to 12 weeks postpartum, have certain vaginal abnormalities, or have little privacy to obtain, insert, remove, clean and/or dispose of barrier products.

Periodic abstinence may be appropriate for men and women who are willing to abstain from intercourse for about half of each cycle (10 to 14 days) and for couples who are highly motivated and are willing to learn the skills needed to determine fertile periods -- skills that are neither quickly nor easily acquired. Couples for whom periodic abstinence is not likely to be successful are those who are unwilling to abstain from intercourse for long periods, are unable to keep extensive records for several cycles before using the method, or those in which the woman has irregular intervals between menses or a history of anovulatory cycles.

Surgical sterilization is an appropriate method for men and women who are certain that they want no more children and consider sterilization to be permanent.

Contraceptive Research

Contributions to contraceptive research have come from three major areas: private pharmaceutical companies, governments, and philanthropic organizations. Support for contraceptive research has declined in recent years from each of these sources and is not expected to increase substantially through the end of this century. Noteworthy is the fact that funding of research by United States pharmaceutical companies,

before 1970 the major contributors to contraceptive research, fell by about 90 percent between 1970 and 1985 (Holden, 1985).

Methods Available within Five Years:

It is likely that the only contraceptives to be introduced in the next five years will be modifications of existing systems, with the possible exception of the vaginal ring. Silicone vaginal rings releasing the natural hormone, progesterone (intended for breastfeeding women), progestin/estrogen, or progestin are in various stages of testing. A ring is inserted into the vagina by the user, and with the exception of one ring designed for longer continuous use, can be worn for three weeks each month, removed for menstruation, and reinserted. Other methods likely to appear in the near future include NORPLANT-2, a two-rod system that, like NORPLANT^R with six capsules, is effective for five years; a reformulated injectable depot-medroxyprogesterone acetate (Depo-Provera); and a monthly injection of combined estrogen and progestin expected to allow more regular menstrual patterns.

Methods Available in 5-10 Years:

On the basis of encouraging results from clinical trials to date, some researchers think that other new contraceptive methods may be available in five to ten years. These include systems that will provide the continuous release of long-acting steroids from injectable microcapsules and from implanted biodegradable capsules and pellets. Also expected are new and more potent spermicides. Under study and showing promise are several agents that both kill sperm and reduce the ability of sperm to penetrate the cervical mucus.

Nonsurgical sterilization techniques intended to be safer than surgical sterilization and to be performed by trained nonphysicians may be in use within the next decade. These techniques include formed-in-place silicone plugs that are non-adhesive and designed to be removable and chemicals that are vaginally delivered to the fallopian tubes and form scar tissue and block the tubes at the point of contact.

A very active area of reproductive health research is the investigation of once-a-month pills that block the effects of progesterone. Scientists have produced anti-progesterones which, when taken, are followed promptly by a menstrual period. As "menses assurers," anti-progesterones are taken for several days each month just before the expected time of menstruation.

Methods Available After Ten Years:

New methods not expected to be available to users for at least ten years include luteinizing hormone-releasing hormone (LHRH) analogs, devices for reversible vasectomy, oral contraceptives for males, and a contraceptive vaccine. LHRH analogs are nonsteroidal, long-acting compounds that inhibit spermatogenesis in men and ovulation in women and are administered by nasal spray, injection, suppository or biodegradable capsule. Devices being developed for reversible vasectomy include removable SilasticTM and plastic plugs inserted or formed-in-place in

the vas deferens. Gossypol, a compound derived from cottonseed oil that inhibits sperm maturation and production, has been tested as an oral contraceptive for males in the People's Republic of China and elsewhere. Due to serious complications found in systemic use, however, interest in gossypol is shifting from its use as a male oral contraceptive to its application as a vaginal spermicide. The World Health Organization (WHO) is currently conducting safety tests on a contraceptive vaccine for women among already sterilized females. If found safe, the vaccine will be evaluated for safety and efficacy in fertile women. This vaccine stimulates production of antibodies against human chorionic gonadotropin (hCG), a hormone produced during pregnancy and needed to maintain gestation. The major problems with antifertility vaccines relate to antigen specificity and the need to maintain adequate levels of antibody to disrupt gestation. A vaccine for males is thought to be many years away.

No single contraceptive available today is suitable for all women, nor is it likely that a universally ideal contraceptive will be developed. Nevertheless, contraceptives used properly are safe and effective. On a small scale they can improve the health and well-being of a single family and on a larger scale they can reduce infant and maternal mortality, especially among high-risk groups.

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FAMILY PLANNING METHODS: SAFETY, CHOICE AND DELIVERY IN THE PRIMARY HEALTH CARE CONTEXT

by Miriam H. Labbok, M.D., M.P.H., Assistant Professor, Department of
Population Dynamics, The Johns Hopkins University

Every primary health care program must deal with issues unique to contraceptive dissemination when incorporating family planning services. In the past 25 years a great deal has been learned about the management, logistics and record keeping of family planning programs. A comprehensive family planning program provides a cafeteria of methods so that each couple is confronted with a proactive choice not usually operative in other types of public health programs. And because the perfect contraceptive has not yet been developed, informed choice includes an assessment of the comparative benefits and risks for each method. The question of choice is further complicated by the fact that mortality and morbidity rates in developing countries are comparatively much higher than in "western" nations so that computations applicable to countries where contraceptives are developed are often misleading for LDC users.

Safety

Primary health care and child care survival programs actually increase the need for contraceptive services. The promotion of weaning foods as early as four to six months unfortunately decreases the contraceptive efficacy of lactation, resulting in a shortened pregnancy interval with the concomitant risks. Therefore, it is mandatory that any program that teaches weaning behaviors also provides family planning services.

Contraceptive safety is a much publicized issue. The perfect contraceptive (i.e., one which is 100% effective, has 0% side effects, can be used by a man or woman, and is unrelated to the coital act) is unlikely to become available in our lifetimes. Safety has probably become more of an issue because of the preventive nature of family planning; unlike ORT or immunization, family planning responds to no readily identifiable acute disease syndrome. Yet, the adoption of healthful family planning practice could reduce mortality among mothers and children. One study shows that a child born after a short interval, whose next sibling is also born after a short interval, has twice the risk of death in early childhood as a child born in a family with well-spaced births (Hobcraft et al., 1983). Maternal mortality could be reduced by 30 percent in some areas if women had no more than three children (Chen et al., 1979). In sum, it is clear that use of contraceptives saves lives.

However, we must also consider the risks and benefits involved in contraceptive use. Oral contraceptives carry an increased risk of thromboembolism due to their steroid content. This negative side effect is seen primarily in older women who are smokers (Bruce and Shearer, 1977). It should be noted that the steroids produced during a pregnancy

are much higher than those found in oral contraceptives and, as might be expected, thromboembolism risk is increased by pregnancy. IUDs and voluntary sterilization carry surgical risks while barrier and periodic abstinence methods are relatively free of mortality risks, except for those associated with the unwanted pregnancy or abortion that may occur following a method or user failure.

When the balance of risk of contraceptives is weighed against the risk of an unwanted pregnancy, any contraceptive carries less mortality risk than no protection, with its risk of unwanted pregnancy (with the exception of oral contraceptives in older smokers). Figure V-1 clearly illustrates this point. It should be noted that in developing countries, where maternal mortality related to pregnancy is many times greater, this effect becomes even stronger. (Further information on specific risks and benefits of contraceptive methods can be found in Hatcher et al., 1986.)

Choice

The choice of which contraceptives should be introduced should follow two basic principles:

1. Appropriateness: The selection of contraceptive methods should include considerations of health, cultural and resource parameters. Matrices have been developed for assessment of appropriateness (see Gray and Labbok, 1985 and Perkin and Saunders, 1979). These matrices are not meant to serve as definitive guidelines. The decisions made for an individual program should be based on health, cultural and resource variables pertinent to that program area and, generally, would include variables in addition to those listed in Tables V-3 and V-4.
2. Cafeteria Approach: Research has shown that an increase in number of methods available is associated with increased acceptance of family planning. Therefore, all programs should strive to deliver as many methods as possible (the cafeteria approach), with one major caveat: the number of methods should not exceed the capacity of the logistics system or the workers.

Delivery

The delivery of family planning services is a specialized skill. When adding family planning to existing social or health systems, or when establishing family planning services de novo, there are a number of program elements that must be examined. For this discussion, four of these elements will be highlighted.

1. Worker Selection: Where possible, workers should be selected who have personal experience or a high level of interest in family planning. The worker should also be a respected, accepted member of the

community. This is especially important since family planning and preventive health activities in general are a very new concept in many areas.

2. Task-Oriented Training: Workers should be given skill or task-oriented training, rather than the traditional anatomy and physiologically based comprehensive training given to medical practitioners. Workers could be trained using algorithms such as the one attached as Figure V-2, as a basis for training, so that the worker would have a specific response to a specific situation. Algorithms could be developed as well for other educational and supervisory tasks (Labbok and Chassell, 1986).

3. Service Data Forms: Family planning is a multi-decade activity for practicing couples. This long-term, ongoing service necessitates a different kind of data collection than would be necessary for clinical or "once in a lifetime" preventive services. In general, "tickler" systems have been developed to allow ongoing client follow-up. These systems either file client cards by the month when follow-up is necessary or present a picture to the care provider of whom she/he must visit in a given month. Figure V-3 illustrates a simplified format that when properly used, allows timely follow-up. The worker enters the appropriate letter in each month for which supplies have been delivered. For example, if a woman is given two pill cycles in March plus one reserve, a "P" is entered in March and April and under Reserve. The worker then knows she must see the woman in April to assure continuity (Labbok and Chassell, 1986).

4. Logistics: A sound logistics and warehousing system is vital to the success of any family planning program. Other primary health care interventions are not generally destroyed by a one-month delay, while one month's lack of family planning services can lead to a complete breakdown of the system.

Family planning services are a mandatory aspect of primary health care and an appropriate adjunct to other social development programming. These services necessitate special planning in terms of contraceptive mix and program development. Contraceptive methods are safe, in fact much safer than an unwanted pregnancy. Therefore, the primary consideration should be in assuring ongoing high-quality service delivery of an appropriate mix of methods.

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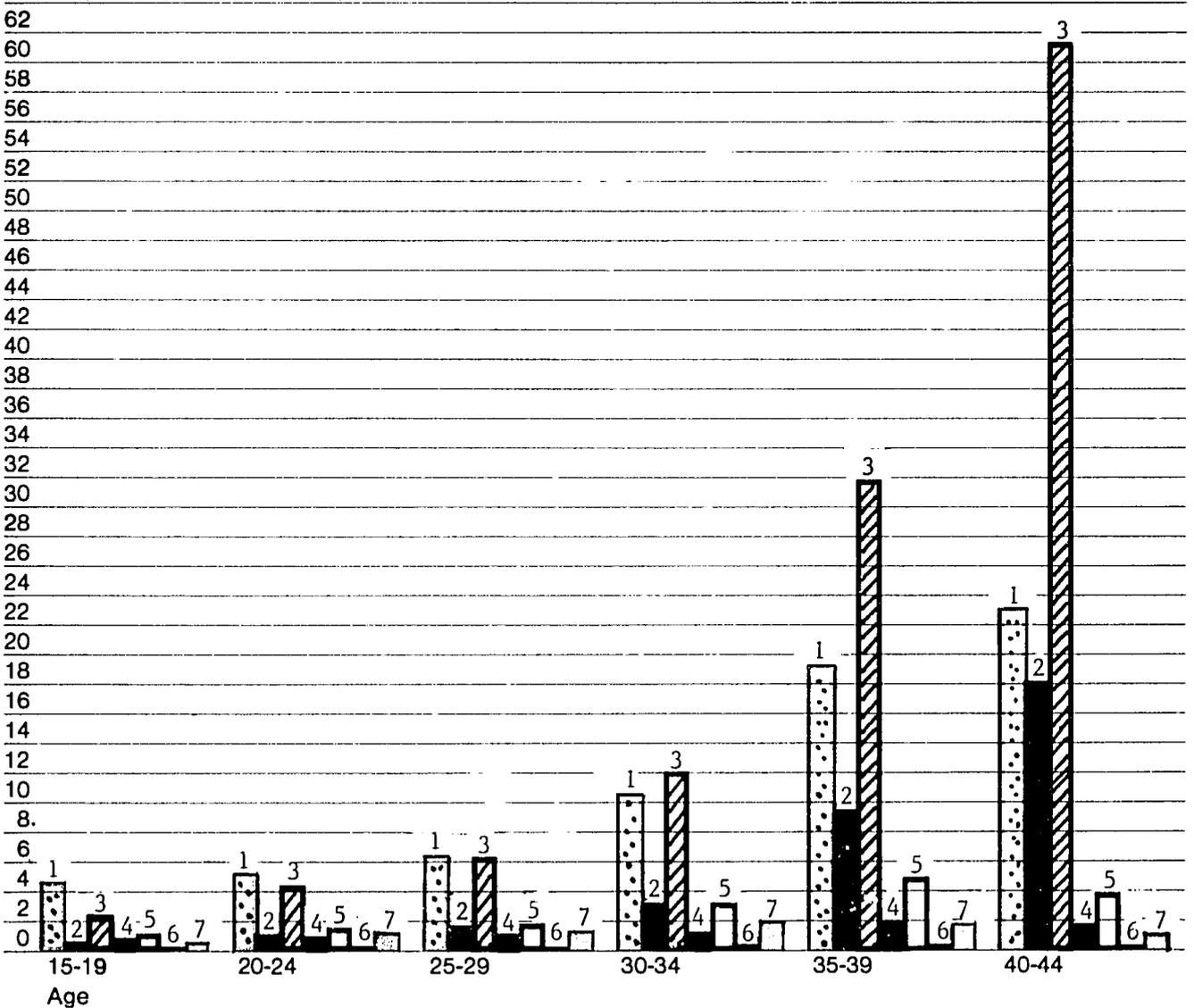
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Figure V-1

Estimated death rates associated with use of different methods of fertility control, by age of woman, United States, 1972-1978

- 1  No method
- 2  Pill/nonsmokers
- 3  Pill/smokers
- 4  IUD
- 5  Diaphragm and condom
- 6  Diaphragm, condom, and legal abortion
- 7  Legal abortion

Deaths per 100,000 women per year



Source: Tietze, C. Induced Abortion: A World Review, 1981. 4th ed. New York: The Population Council, 1981.

Artwork from: Maine, D. Family Planning: Its Impact on the Health of Women and Children. New York: Center for Population and Family Health, Columbia University, 1981, p. 47.

Figure V-2

C.B.D. CHECKLIST FOR CHW'S TO USE WHEN (RE)SUPPLYING PILLS

Instructions to the CHW:

Discuss condoms, foam, IUD, pills and sterilization with client. Then administer this checklist.

If the answer to any of the following questions is "YES", take the action pointed to by the horizontal arrow (→).

If the answer is "NO", follow the downward arrow (↓) and ask the next question.

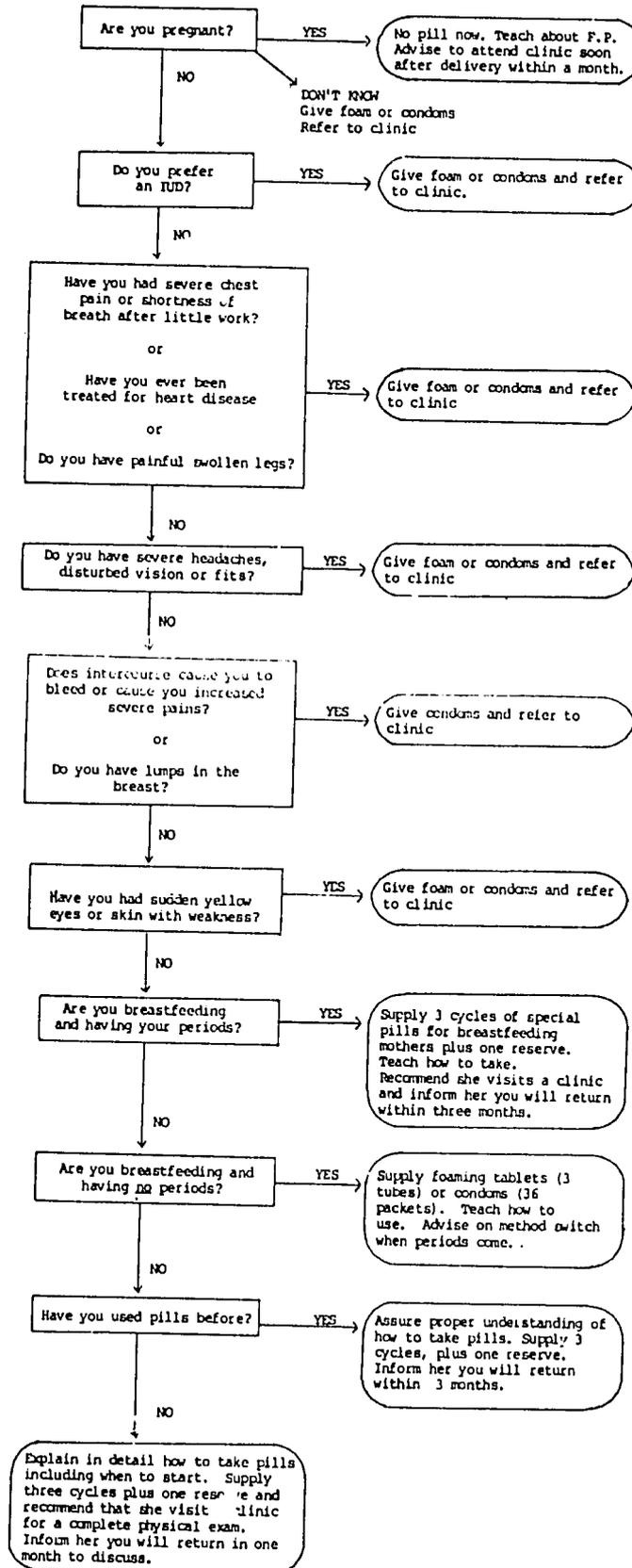


Figure V-3

CHW CONTRACEPTIVE DISTRIBUTION RECORD

CHW NAME _____

| NAME & VILLAGE | FIRST TIME USER OF CONTRA-CEPTION? | MONTHS (Fill in P, L, C, F or R) | | | | | | | | | | | | | DROPOUTS | | |
|----------------|------------------------------------|----------------------------------|---|---|---|---|---|---|---|---|---|---|---|---|----------|------|--|
| | | J | F | M | A | M | J | J | A | S | O | N | D | R | CODE | DATE | |
| | | A | E | A | P | A | U | U | U | E | C | O | E | S | | | |
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- DROP OUT CODE:
- | | | |
|---------------------------------------|-------------------------------------|----------------------------|
| 1. Husband or relative disagrees | 7. Rumors about method | P = 1 cycle pill |
| 2. Method side effect | 8. Menopause | L = 1 cycle lactating pill |
| 3. Moved away | 9. Unrelated disease | C = 12 condoms |
| 4. Death, unrelated to method | 10. Religion | F = 1 tube |
| 5. Pregnant or desires to be pregnant | 11. Transferred to another provider | R = Referral slip |
| 6. Tubal sterilization | 12. Other | |

Table V-3 Health and Cultural Factors Influencing Choice of Methods to be Considered in Program Planning

| | STERILI- ZATION | ORAL CONTRA- CEPTIVES | INJECT- ABLES | IUD | DIAPHRAGM | CONDOM | SPERMI- CIDE | RHYTHM/ WITHDRAWAL |
|--|--------------------|-----------------------------|------------------|-----|-----------|--------|-----------------|-----------------------|
| <u>HEALTH</u> | | | | | | | | |
| High Levels of STD or PID | NI | I | I | C | I | I | I | NI |
| High Levels of Smoking | NI | C | C | NI | NI | NI | NI | NI |
| High Prevalence of Vascular Disease | NI | C | C | NI | NI | NI | NI | NI |
| Lactation | I | NI/C | NI | NI | NI | NI | NI | NI |
| High Prevalence of Iron Deficiency and Inadequate Dietary Iron | NI | I | I | C | NI | NI | NI | NI |
| Frequent Use of Rifampicin for TB Therapy | NI | C | C | NI | NI | NI | NI | NI |
| Severe Forms of Female Circumcision | NI | NI | NI | C | C | NI | NI | NI |
| <u>CULTURAL</u> | | | | | | | | |
| Regular Menses of High Importance | NI | I | C | NI | NI | NI | NI | I |
| Injections Preferred | NI | NI | I | NI | NI | NI | NI | NI |
| Restrictions on Genital Contact | I | I | I | C | C | C | C | C |
| No Storage Place | I | C | I | I | C | C | C | I |

Chart may be read as follows: If factor exists, stated method is indicated, has no impact, or is contradicted (e.g., if there are high levels of STD or PID, sterilization has no impact on it; if there are high levels of smoking OCs are contraindicated).

KEY: I = Indicated
 NI = No Impact
 C = Contraindicated

Table V-4 Resource Factors Influencing Choice of Methods to be Considered for Inclusion in a Specific Program

| | STERILI- ZATION | ORAL CONIRA- CEPTIVES | INJECTABLE | IUD | DIAPHRAGM/ SPERMICIDE | CONDOM | SPERMI- CIDE | RHYTHM/ WITH- DRAWAL |
|--|--------------------|-----------------------------|------------|-----|--------------------------|--------|-----------------|----------------------------|
| CBD Worker Sophistication | ++ | + | ++ | ++ | ++ | + | + | +++ |
| Length of Training: Clinic Worker | +++ | + | + | ++ | ++ | + | + | ++ |
| CBD Worker | + | + | ++ | ++ | ++ | + | + | +++ |
| Clinics for Referral and Backup | +++ | + | ++ | +++ | ++ | - | - | - |
| Total Time per Visit to Household | ++ | + | + | + | ++ | + | + | +++ |
| Ongoing Worker Avail- ability to Client | + | + | + | ++ | ++ | + | + | +++ |
| Logistics/ Resupply | - | ++ | ++ | + | +++ | +++ | +++ | - |
| Commodity Cost | +++ | + | + | + | ++ | + | ++ | - |

The +'s indicate the level of the resource necessary to consider including the method. This chart does not include any output considerations, but is simply a tool to aid in the decision as to which methods may be considered for inclusion in a program.

KEY

- +++ = high level of the resource is necessary to consider including the method
- ++ = medium level of the resource is necessary to consider including the method
- + = lower level of the resource is necessary to consider including the method
- = resource is not a necessary element in considering including the method

CHAPTER VI

COMMUNICATING FAMILY PLANNING

THE SELLING OF HEALTH AND FAMILY PLANNING

by Richard K. Manoff, President, Manoff International, Inc., and author of Social Marketing: New Imperative for Public Health

Inducing the public to accept new health interventions has always been a challenge. The first successful demonstration of smallpox inoculation was in the 18th century, but the practice did not become prevalent until well into the 19th century, and this disease was not eradicated until the second half of the 20th century. Wearing auto seat belts clearly reduces morbidity and mortality resulting from accidents, but many otherwise sophisticated people still refuse to use them. Examples of resistance to health benefits are legion.

Attempts to implement health interventions -- health education, advertising and legislation -- have met with varying degrees of success. Generally, passive interventions which require no behavior modification (e.g. adding niacin to bread) have met with more success than those that do.

It has long been believed by many health professionals (and some family planning specialists) that family planning is one of the more difficult health interventions to "sell" in traditional societies. Constraints noted include:

- o traditional supports to high parity
- o lack of knowledge of the physiology of reproduction
- o lack of open communication about sexuality and reproduction, even between married couples
- o religious resistance/fatalism; "it's God's will"
- o high infant mortality
- o economic role of young children
- o lack of understanding of causal relationship between family planning and improved infant and maternal health.

To confront this resistance, family planning pioneers began to explore innovative marketing approaches for social programs, frequently borrowing from private-sector marketing techniques of the Western world. These have led to remarkable success in greatly expanding contraceptive usage and lowering age-specific fertility rates, maternal mortality and infant morbidity and mortality. These techniques can also be utilized to promote other health and development programs.

The adoption of marketing techniques has given rise to a new discipline, perhaps, if not a new field -- "social marketing." The strategic difference between commercial and social marketing is

two-fold: (a) social marketing is concerned with social programs; and (b) social marketing is complementary. Commercial marketing is competitive, concerned primarily with the battle for share-of-market and market expansion. Social marketing's task is the more difficult. Among health interventions, the social marketing of family planning is the most complex. Yet the fruits of effectively designed and executed social marketing efforts are demonstrably worthwhile.

Numerous examples exist of successfully "selling" family planning in traditional societies. Travelers to India who see for the first time the exquisite erotic temple sculptures of Khujaro and Bubaneswar are stunned by their uninhibited and diverse depictions of the sex act. Some historians suggest that they were the inspiration of ambitious rulers in need of bigger armies and work forces, who saw in these sculptures a clever device for promoting fertility. If so, then they were among the earliest of social marketers and extraordinarily ingenious.

Using the temple as a mass medium insured maximum target audience in those days. It also lent authority to the message and sanction to its instruction: make love freely. And the messages, each with a beautifully graphic demonstration of the joys of sex, not only employed the most motivating appeal, but also executed it brilliantly. Engraving the messages on temple walls insured continuity of exposure. All in all, this is a good example of social marketing -- so good, in fact, as to be more than slightly responsible, perhaps, for India's population plight today.

Preempting temple walls then was the equivalent of using radio and TV today. No place in those ancient communities was more heavily trafficked -- proof that our ancestors had a fair grip on the task of getting the message out. True, they did not have anywhere near the mass communications capacity nor the penetrating research techniques we have today, but they made the most of what they had to an extent we have yet to attain.

Family planning is a health intervention, a key element of PHC, and like PHC needs intense, exhaustive communications/public education intervention. For example, Primary Health Care as enunciated at the 1978 Alma-Ata Conference promised to deliver health for all by the year 2000. But it appears unlikely that the goal will be met because of fiscal constraints, misplaced priorities and failure to integrate all PHC components, including family planning, into the health scheme. But even where resolution is strong, funding adequate, and integration complete, PHC could still miss its target in almost every way:

- o in health centers which are underutilized because people who need them most use them least;
- o in the private sector where stores stocking oral rehydration salts (ORS) and contraceptives will de-list the items if there is so little demand so that even people who want to buy them will be unable to do so;

- o with ORS because availability does not guarantee utilization;
- o with family planning because service availability does not guarantee practice;
- o with Expanded Programs for Immunization (EPI) because accessibility does not insure immunization;
- o with breast-feeding because if supply were the answer then breast-feeding would not be in crisis;
- o with timely, nutritious weaning because of too much of the wrong foods too soon, or too little of the right ones too late;
- o with weighing even if the scales are there but the children are not in them, and
- o with growth charts for every child if every child's mother does not want one.

The creation of demand is necessary. If people do not want, do not demand them, then even limited supplies and services can prove to be superfluous. "Oh you thirsty, go to water" (Isaiah).

The biggest waste in health programs may be the cost expended for infrastructures without providing for effective health education and promotion. For example, the EPI infrastructure is not cost-effective if only 25 percent of the target audience is immunized. Effective health education and promotion could raise that percentage and make the whole program cost-effective. Thus, additional investment and better quality of health education makes possible better cost-effectiveness of health programs.

Past programs have been "hardware" oriented, concentrating on the supply factor, on the assumption that demand is automatically appeased by supply. But demand is not inherent in health and family planning programs. Creating it must be factored in from the start. Program managers did not always have the wisdom to know this or to know how to do it. Wisdom is the product of inquisitive minds and adventurous spirits.

The apple may have been the source of worldly wisdom for Adam and Eve. In communications, however, it may very well have been the orange. Until the recent era an orange was an orange was an orange. But almost a century ago one unconventional California orange grower was moved to question this perceived wisdom. What was an orange really? Was its place properly in the family fruit bowl? Who buys it? How do they consume it? Why? He went to the community to find out. He knew about orange supply. He needed to discover the magic of its demand. This reaching into the community helped him discover that the orange was not so much a fruit to be peeled and eaten but a fruit to be cut open, squeezed and drunk. Heavy orange consumers were consuming it that way, so "Drink an Orange for Breakfast!" he proclaimed to a vast untapped market.

By adopting a demand strategy he shifted his communications focus from the product to the consumer. He no longer sold a fruit, but marketed a consumer want or need for which the orange could ideally be positioned. He had a new objective: not to sell supply, but to satisfy demand.

Thus, if among the people were to be discovered the insights to new market opportunities, then innovative techniques were needed to penetrate the hard crust of consumer resistance to the rich subsoil of consumer desire and motivation. Messages could no longer present only the facts about a product, a service or a new behavior and expect that the consumer demand would logically follow. Now the message had to be "positioned" with a new sensitivity toward the consumer. That meant that communications planning would have to begin at the beginning of the project -- in the community and among the people.

The historic U.N. conference at Alma-Ata in 1978 ordained the same new responsibility for communications in primary health care. For communicators the rule became no more hand-me-down programs. Communications development had become a two-way process: to communicate with the people in order to ascertain how to communicate to them. It established the preeminence of "feed-forward" over "feedback" -- to listen and learn from the people in advance so that program design might benefit from that input. It was not to replace feedback but simply to minimize "feedback-shock" -- the belated discovery of preventable error.

This kinship between commercial marketing and primary health care inevitably led to a sharing of methodology. The focus group interview is a case in point. This technique of commercial marketing is designed to overcome the limitations of traditional quantitative research in which prestructured questionnaires treat people as respondents. The focus group empowers them to be participants in the search, volunteers of unsolicited information, initiators of questions of which the program planners are unaware. This innovation of the commercial marketer has since been seized on by social planners, but there was even more they were to share -- disciplines of message design, ingenious uses of modern media techniques and in-process uses of evaluation.

This explains the emergence of the new discipline we have come to call social marketing. The social marketing approach makes it possible to: 1) maximize awareness of health problems and the causes of infant disease and death; 2) educate target populations on how to deal with them; 3) promote use of MOH facilities and services and motivate wider use of them; 4) motivate health system personnel; and 5) enlist the private sector to broaden distribution of PHC products and to assist with other aspects of PHC programs. Two important aspects of the social marketing approach should be noted: 1) the qualitative research described as "feed-forward," exemplified by the Indonesian Nutrition Improvement Program; and 2) the creative use of this research in defining communications strategies and in designing messages as illustrated by the Bangladesh family planning program. The aim in deliberately drawing these examples from two normally separate sectors

-- the health and family planning sectors -- is to demonstrate the validity of social marketing for both.

Indonesian Nutrition Improvement Program

The Indonesian nutrition program illustrates "feed-forward" research. In operation since 1974, the Indonesian Government's Nutrition Improvement Program (UPGK) was targeted primarily at children under five and at pregnant and lactating women on the premise that the home and community are the most effective points of entry for improving nutritional status of infants and children. In 1977, a special Nutrition Education and Behavior Change Pilot Project, funded by the World Bank, was introduced in Central Java and South Sumatra to determine whether a new and different approach to nutrition education could positively affect the behavior change goals of the underlying UPGK program.

The different approach was the observance of social marketing disciplines in going to the community for essential inputs: for target audience perceptions of the problems (if, in fact, they perceived them as problems); for the implications of these perceptions for target audience differentiation and segmentation; for the proposed solutions and concepts; and for message design, media strategy and media materials. This meant household investigations, and it also meant that traditional quantitative research would not suffice for what needed to be uncovered. The "feed-forward" research was designed to embrace a community-based qualitative process of preparatory actions.

A community-conducted "self-survey" was carried out in which all children were weighed and their weights charted on a single community graph. Then followed a community meeting at which the results of the "self-survey" were announced and discussed. It was also the forum for winning village leaders' endorsement of the plan for the household investigations. A household investigations guide -- a set of key questions for discussion with mothers -- was designed to stimulate discussion and exchange, unlike a quantitative research questionnaire. In exploring the formulation of an enriched weaning food, it provided for examining local food preparation patterns and mother's preferences from among the suitable ingredients mentioned at the community meeting.

Recruitment of the investigation team was carried out from among women with children of their own. They were trained in simple qualitative research and participant observation techniques. They were required to live in each village to which they were assigned for the investigation. Selection of the target-audience sample was done with the assistance of village volunteers. During the interviews investigators used an innovative dietary recall analysis worksheet (DRAW) to calculate instantly the nutritional quality of the infant's food intake the day before. The worksheet also provided the basis for making selections from the recommended foods to make up for nutritional deficiency. But the choice was left with the mother.

The weaning food recipe was worked out together from ingredients on hand and in accord with the mother's food preparation pattern. The new

food was served to the child immediately so that the mother and investigator could witness it together and discuss it. Having agreed on the regimen to be followed, the investigator promised a return visit in 3-4 days.

The return investigation was an opportunity to review the mother's experience since the first visit. This opportunity for participation in "product development" is one of the critical elements of this phase of social marketing research. It is another adaptation of the commercial marketer's method of involving the consumer in product testing for acceptability, modification and intent-to-buy (retrial).

The investigations produced insights into the mothers' enlarged views of the weighing session as an educational opportunity. This changed the planners' concept of the weighing session as more than a growth monitoring strategy; it was also a strategy for education.

Also, the insights had profound implications for target audience segmentation. The focussed investigations had brought into sharper light differences among an ostensibly homogeneous target audience of mothers. Investigators learned that they were segmented by differing concerns that shifted with each change in their own status -- pregnancy, childbirth, etc. After childbirth, their concerns changed with each advance in the age-related dietary needs of their infants. This, in turn, had critical implications for message design and media for delivery.

The weighing session became the prime educational opportunity for the precise delivery of the precise message to the precise mother at the precise time of her precise need for the instruction. This is social marketing's primary tactic: focus on priority need when, where and for whom it is essential and minimize all extraneous factors.

Differing food preparation customs from area to area were found to be significant, particularly for the addition of a fat source to the Bubur Campur, the enriched weaning food: 1) frying the tahu or tempe before mashing in the porridge; 2) in another area, the addition of a few drops of coconut oil; or 3) in yet another, cooking all the ingredients in coconut milk. The Bubur Campur messages were adapted by area to accommodate these differences.

These qualitative investigations also yielded important information about village mothers' media habits, sources of information, the impact of the mass media and certain critical "resistance points," one of which was the heretofore overlooked practice of feeding infants from only one breast. To change this behavior required a separate strategy and message design.

The social marketing discipline insists that painstaking "feed-forward" inquiry is indispensable to the development of effective communications. Its absence is a major reason for the failure of many communications programs, resulting in inadequate and, often-times, irrelevant message designs.

The social marketing discipline also prevents barren strategies and sterile messages. The key is creativity. Many message designers at work on health and family planning programs are unskilled in the creative interpretation of research into ingenious message design even when the research is rich in revelation. This need not happen as illustrated in the Bangladesh family planning program.

Bangladesh Family Planning Program

"Feed-forward" research conducted by a Bangladesh research organization identified several target audience attitudinal constraints to the social marketing program in that country. The charge was to develop a new motivational campaign to narrow the gap between awareness, which was high, and relatively low practice. Of these, at least four stood out as major resistance points to be dealt with:

- o a view that family planning is against religion;
- o concern that family planning methods are unsafe;
- o widespread ignorance about contraceptive options; and
- o reluctance to discuss family planning with others, particularly wives.

The first was a taboo subject in this traditional Muslim society. Careful examination of the "feed-forward" findings gradually sharpened the focus on the last. The major problem was the men. It was they, not the women, who were the most resistive, saddled with mistaken beliefs about contraceptive safety, ignorant of options and unwilling to consider or discuss them with their wives. This led to a definitive target audience strategy:

- o primary target audience -- rural males
- o secondary target audience -- urban males and urban females
- o tertiary target audience -- local officials

Unless the men's attitudes were turned, unless they could be persuaded to consider family planning, to discuss it with their wives and to seek out wise advice, there was little hope of adding significant numbers of acceptors to family planning practice. Women were not only positively aware, but willing to accept. Thus, they represented the most effective change agent if only husbands could be persuaded to discuss the subject with them. Our product strategy was pre-determined by the ongoing contraceptive social marketing program. Emphasis was on secondary, non-clinical methods -- the pill, the condom and foaming tablet -- because they were the most widely distributed, the easiest to obtain and the least likely to be resisted.

The media strategy was immediately clear: radio to reach the rural male (and the rural female, secondarily), mobile vans for filmed

messages to the same audience, and TV for the urban audiences and officials. The short message was to be repeated frequently day in and day out to reach the maximum percentage of the primary target audience. But content of messages was another matter and this is where creative strategy formulation and, subsequently, creative message design would make the difference.

This leads us to an examination of "message strategy vs. message objective." Too often, family planning messages are sterile restatements of barren strategy formulations: ("A small family is a happy family." "Two or three children, that's enough!") or nothing more than mere restatements of the campaign objectives. Objective is one thing but strategy is the means of getting there, and message strategy may often need to have its own objective -- the overcoming of a major resistance point -- that is only indirectly related to the campaign objective. In Bangladesh, the message strategy had to be to get husbands to talk about family planning with their wives. This called for an ingenious, powerful appeal to their perceived masculine prerogatives which, in effect, would be modified by their positive response.

Thus, the "message strategy" had to be based on these strategic elements:

- o husbands should discuss family planning with wives and make a joint decision;
- o the adoption of family planning is "a wise man's decision";
- o modern contraceptives, particularly the condom and the pill, are safe to use; men should not believe "ignorant tales from ignorant people"; and
- o the primary benefits of family planning are better economic conditions for the family and improved health of mothers and children.

Furthermore, the "feed-forward" research was rich in its provision of key words and expressions right from the lips of the people, such as "a wise man's decision," the perception of contraceptive danger as "ignorant tales from ignorant people," "the right thing," etc. They then became "key phrases" to be used to reinforce the positive attitude values they represented.

The results of these interventions in Indonesia and Bangladesh demonstrate that family planning, and health and development programs in general, can be marketed in this manner. The World Bank evaluation of the Indonesian experience states:

The low-cost nutrition education as practiced in Indonesia looks particularly attractive . . . The evidence has shown that nutrition education alone can make a difference in improving nutritional status. Nutritionists

have long held out the promise of this possibility; the Indonesian experience is the first time it has been demonstrated in an operational setting.

Social marketing works. It has been developing for 20 years and we are past the point of an idea whose time has come. The examples cited, admittedly, represent large-budget programs with access to mass media. But also illustrated are techniques for obtaining relevant information and converting this into culturally sensitive, effective health education campaigns. The use of the techniques can be as simple or as complex as the budget and desired behavior change warrants. The smallest voluntary agency or multifunded national program can successfully "sell" health and family planning with this approach.

THE EDUCATIONAL AND SERVICE NEEDS OF SPECIAL GROUPS

by Julia J. Henderson, Ph.D., Consultant in international family planning programs and Former Secretary-General, International Planned Parenthood Federation

Thus far in our discussions of program aims, we have concentrated on program decisions that need to be made by program managers in the provision of family planning service options with respect to clinical services, degree and type of integration with other health services, community-based distribution systems, social marketing systems, etc. But attention must also be given to the educational and service needs of special groups in the population. There are many such groups to choose from. In one sense every group is special -- young married couples, mothers-in-law, grandfathers, adolescents (both married and unmarried), males, tribal populations living in some isolation in developing countries, refugees and migrant workers who exist in the millions in Africa, Middle East, and Asia, the handicapped who are so often treated as if they were made of stone and have no right to families of their own, and many other groupings. Obviously, constraints of space do not allow me to deal with all of these groups so I have chosen to address only the special issues in dealing with adolescents and with males and to give some references which may be useful in dealing with others in this list.

Special Problems of Teenagers

We are all aware that bearing children at too early an age is dangerous for the health of the young mother as well as her baby. We are also well aware that providing family planning services to her if she is unmarried is highly controversial in most societies, including in the United States and among many families and communities in Third World countries. In spite of this, the number of teenage pregnancies outside marriage continues to increase in developing countries, partly due to the increase in numbers of children surviving into the reproductive age groups and partly due to urbanization and breakdown of traditional social contracts of sexual behavior.

In most African countries, for example, health officers, family planning associations (FPAs), and school masters are all deploring this trend and asking what can be done. It has been the practice in many countries to deny the girl any further schooling once she is pregnant, although this is now changing in some countries.

There are vastly greater numbers of married adolescents giving birth, particularly in Asia, where girls are married before the age of 16 and are still expected to provide a child in the first year of marriage. The health consequences for the adolescent mother and her child are largely the same, although she is more apt to have the support of the extended family unless they too are on the move.

There is a great deal of evidence that family life education, including sex education as well as provision of appropriate contraceptive services, can make a dent in this worldwide problem. However, one must expect opposition in the community, including the school system in most countries. A growing number of national governments in the Third World accept some form of population and family life education. However, most children, especially girls, are not in school long enough to benefit from the formal system at the ages when it matters most.

This puts a special obligation on the non-governmental voluntary organizations which serve out-of-school youth. The International Planned Parenthood Federation (IPPF) has given special attention to this problem over the past ten years. The FPAs in most developing countries not only have working papers and booklets on ways of reaching, educating, counselling and serving the needs of young people, but also many FPAs have experience with pilot projects adapted to the special social and cultural situation in areas where they have clinics. For example, the 1985 IPPF Report documents the experience of FPAs in Panama, Hong Kong, Indonesia, and Jamaica. Other IPPF publications review broader educational issues or selected research studies. FPAs welcome collaboration with other organizations in reaching additional young people.

How Do You Reach Males?

The second group needing attention is the sexually active male population. This is definitely an area where attitudes need to be changed; and men need to have a greater sense of responsibility about the spacing and care of their children. Time and again women tell us "You don't need to convince me about family planning. I don't want to be pregnant every year." or "I don't want more children, but you must convince my husband." If you are talking to a Bangladeshi peasant, he will tell you that he needs at least four sons -- one to keep the cow, another the goat, another to help him on the land, and perhaps the fourth son may be sent to school and then migrate to the city to help the parents in old age. The danger of too many children to his wife or to the health of the children is not very high on his priority list.

Responsibility on the part of the young male who has migrated to the city but has no steady job is also astonishingly low, whether he lives in New York or Nairobi. In South Africa it is common practice for migrant workers to father a second family and return to Botswana or Lesotho every year or so only long enough to get their first wife pregnant again.

These attitudes do not grow only out of "machismo" or the attitude that women exist only to serve male needs, but also out of ignorance and the scarcity of appropriate services. Only a small fraction of the male population is given any formal sex education or any counselling about the responsibility of parenthood. Male methods of contraception are basically limited to condoms, withdrawal, periodic abstinence, or vasectomy, none of which are widely popular in most developing

countries. They can be made more popular if communications skills to reach males in several different age groups are developed in training courses, if choices are made more attractive to men and boys, and if social marketing and community-based distribution schemes are developed with males in mind.

There is growing interest in including men in family planning programs, and IPPF has developed several good papers which are available through the national FPAs. A lively presentation may be found in IPPF's People magazine, Vol. 13, No. 1, 1986 devoted to the theme, "A Changing Role for Men." Johns Hopkins University/Population Communication Services has recently developed some excellent communication materials on male responsibility, especially for boys in Latin America including two hit songs for adolescents. Suffice it to say that no program is complete if it does not have a specific initiative to involve males.

CHAPTER VII

CASE STUDIES OF PVO PROJECTS

ILLUSTRATIONS OF PVO INTEGRATED FAMILY PLANNING/HEALTH PROJECTS

by Christine Burbach, Ph.D., Director, Washington Office, Interaction

A. The Pathfinder Fund's Busoga Multi-Sectoral Rural Development Program (MSRDP) in Uganda

This project makes family planning services available to the rural communities of Busoga through the infrastructure established by the Busoga MSRDP (Involves a total of 1577 paid staff, volunteers, community leaders, and others throughout the province). One enrolled nurse/midwife trained in all aspects of family planning, information education and service delivery will be deployed to each of the 45 project areas. The AID Post in each project area will be equipped to provide family planning services and strengthened as back-up clinics. Approximately six volunteers selected by the Village Development Committee of each project area will be trained to provide community based family planning education and resupply of contraceptives under the supervision of the enrolled nurse/midwives. By the end of the 2 years (Oct. 1985 - Sept. 1987), at least 5,000 new and continuing users will be provided with effective family planning services.

For more information, contact Elliott Putnam, The Pathfinder Fund, (617) 731-1700.

B. The Salvation Army World Service Office's Comprehensive Primary Health Care (CPHC) Project in Pakistan

The CPHC strategy is to offer voluntary family spacing information and services as an integral part of antenatal or post-natal care. While the Salvation Army has no formal policy on family spacing, it considers voluntary spacing and limiting pregnancies to be an important part of maternal and child health care.

The targeted areas had varying results. For example, in Khanewal, the base for the outreach areas reporting the most acceptors, all acceptors chose voluntary sterilization. This is because the Nurse-in-Charge there believes strongly in sterilization for women who have completed child bearing, and apparently supports tubal ligation exclusively. She opposes contraception for both cultural and health reasons. In one outreach area (Shantinagar), a village of 7,000, where she had worked for 13 years before taking charge of the Khanewal dispensary, she has recruited 125 women over the years for tubal ligation; she takes five women at a time in her car to the nearest hospital (Multan) for the surgery and brings them back. This level of acceptance, unusually high for a single village, undoubtedly results not only from this highly qualified expatriate nurse's singular personal commitment to recruiting and assisting women desiring an end to child bearing, but also from her respected position in the village where she has lived for so long, from the proximity of good surgical care, from free transport, and from the government stipend of Rs 20 to each woman sterilized.

The level of commitment of the Nurses-in-Charge and the outreach teams to family spacing only partly explains usage levels. The supply of contraceptives is also important. All Nurses-in-Charge complained that chronic shortages of supplies occur; no dispensaries had adequate supplies of contraceptives. In particular the evaluators found an acute scarcity of condoms and oral contraceptives. None of the base dispensaries provide intrauterine devices. Several dispensaries rely on the Family Planning Association of Pakistan for contraceptive supplies, but they claim that the FPAP often runs short. None of the dispensaries use the local government family planning agency (District Family Welfare

Offices) for supplies. The FPAP headquarters in Lahore say that they do have adequate supplies; all they require from the SA is a record of distribution which is given when supplies are from the FPAP, which often require a member of the clinic team to undergo a week's training before they give supplies.

For more information, contact Doug Hill, SAWSO, (202) 833-5646.

C. World Neighbors Grace Children's Hospital Family Planning Clinic in Haiti

The strategy was to link this family planning clinic with the Outpatient Clinic for tuberculosis treatment. For the period July 1, 1984 - June 30, 1985, group education sessions were held every working day, which have included virtually every adult attending the tuberculosis outpatient clinic, either as a patient or accompanying a child who is a patient. Of the 235 patients who came to the family planning clinic after a group session to receive more specific information in order to choose a method, only 23 declined to choose one after individual counselling. This means that 90% of those who came to the clinic for counselling became acceptors.

There were a total of 1416 new cases of TB diagnosed in the outpatient clinic during the year, 222 of whom were also new acceptors in the family planning clinic. This represents a rate of 16% acceptance among adults frequenting the outpatient clinic.

World Neighbors has begun to emphasize nutrition, the preparation of oral rehydration serum and the importance of vaccinations in the education sessions in family planning clinics. Vaccinations and oral serum packets are made available from the family planning nurse. It is difficult to give statistics for this activity, as it is performed in conjunction with the same activity in the outpatient clinic.

For more information, contact Bob Curtis, Overseas Director, World Neighbors, (405) 946-3333.

D. World Neighbors Community Based Family Planning And Primary Health Care Program In North Sulawesi, Indonesia

The project's initial activities were limited to family planning. As the project evolved, other activities in the primary health care field were included:

o The Tuberculosis Program

Started in 1983, case finding is done by home visiting in the village. Patients with positive results are treated with the so-called "short course" of six months with rifampicine, isoniazide and ethambutol, the same as is advised by the Government Health Service. These medicines are handed out to the patients in their home, by the village worker. The patients are also seen at regular intervals in these hospitals by a medical officer.

Presently 58 villages are involved in this Program and over 200 patients have been treated or are still under treatment.

o Malaria Treatment

Instruction has been given on malaria and its treatment. The village workers were taught to recognize malaria and were enabled to buy at low cost packages with 10 tablets of chloroquine, sufficient to treat a patient with a malaria attack.

Four months after this instruction, a questionnaire answered by 52 V.W.s showed that they had treated 420 cases of malaria, some even over 20 cases in their village.

o Oral Rehydration Treatment for Diarrhea

V.W.s have been given a supply of oralyt packages, to prepare 200 ml of the fluid. These are prepared at low cost to the V.W.s. Two months later the 52 V.W.s who filled out the questionnaire reported to have treated some 455 cases of diarrhea. Most are now using the sugar-salt mixture, prepared by themselves.

o Home Visiting

The tuberculosis program required a systematic home-visiting for case finding. Also the new village workers have to visit all the houses in their village to find out about family planning and to motivate the non-users. In 1984 there were 30,046 home visits reported.

o Lectures

It appears that only part of the V.W.s are able to give a lecture. Family planning is not often the subject of these lectures any more. In 1984, 393 lectures were given in the villages, usually on subjects like diarrhea, nutrition and hygiene.

For more information, contact Bob Curtis, Overseas Director, World Neighbors, (405) 946-3333.

E. World Neighbors Dahunipati-Helambu Integrated Development Project In Nepal

The long-term objectives of the project included:

- 1) To reduce birth rate and improve the health of children and mothers by providing effective family planning and basic health services.
- 2) To assist increasing agricultural productivity and family income of small farmers by:
 - a. Demonstration of improved fodder trees, grass and horticulture.
 - b. Demonstration of soil conservation, green manure and compost fertilizer.
 - c. Providing appropriate farmer training.
- 3) To provide and continue basic curative and preventive health services in the project area and in each block design and implement a comprehensive community health program at least in one ward.
- 4) To integrate activities with government and non-government organizations for effective utilization of available resources.
- 5) To try to discourage permanent migration out from the project area by providing income generation opportunities and better health care.
- 6) To encourage local committees in fund raising activities in order to make them self-supporting.
- 7) To demonstrate the cost-effectiveness of the project approach to development and develop it into a resource project.
- 8) To increase community participation in program planning and implementation by block level program planning and increasing volunteers over salaried personnel.

Some achievements of 1985 as set objectives:

Family Planning

- Project organized two vasectomy camps.
- Forty-five women have been provided sterilization service who wanted a permanent family planning device.
- Altogether 227 new clients have been administered depo injection in 1985 from centers and depo points.

Agriculture Development

- 22,432 Ipil Ipil seedlings were produced and distributed from Bahunipati Nursery. The objective for the year was 23,000 seedlings. Priority was given to Majhi, one of the poorest income groups. Sixty-seven Majhi families have received and planted 17,868 seedlings. Twenty-five percent of Majhi families have at least 400 Ipil Ipil plants per large animal to feed per year.
- Two farmers of Ichok Panchayat who were trained the previous year are trying to motivate other farmers on the value of compost fertilizer and method for preparation.
- The project has motivated and trained local farmers to produce and sell coffee plants to other farmers. This activity is being carried out farmer to farmer.
- In 1985 the following farmers trainings were organized:
 - I. 29 farmers on Ipil Ipil transplantation
 - II. 22 farmers on Ipil Ipil management
 - III. 18 farmers on home nursery and 19 on plantation and management
 - IV. 6 farmers on swine management

Community Health Services

- 19,932 people from Centers and Posts were provided curative services.

Community Development

- In 1985 the project assisted two different communities to construct new irrigation canals at Dhakalthol and at Timbu and has helped Majhi community to repair one 4 km long irrigation canal. The project contribution is less than 50% of the total cost.
- The project constructed a nursery in Hinguwapati with cooperation of a local nursery management committee. The home will be used as meeting hall, training center, depo point, etc.

Training

- A two-day refresher training of community development workers focused on planning, implementation, and evaluation of small projects. The emphasis was on community participation.
- Once a month local volunteers were provided training on hygiene, family planning, kitchen gardening, nutrition from both centers.

Fundraising

- The project has raised Rs. 30,620.50 from clinic registration, donation and selling of Ipil Ipil seeds. The project is mobilizing local funds in the form of cash also.

Foster Parents Plan

Family Planning Policies and Guidelines

I. Introduction

From time to time, Foster Parents Plan receives inquiries concerning family planning. These inquiries concern Foster Parents Plan policy as well as practices in specific program locations. In order to adequately respond to these inquiries and at the same time protect the privacy of Foster Families on such a personal matter, standardized procedures have been established for use by all Foster Parents Plan personnel in responding to these inquiries.

II. Procedures for Responding to Inquiries

A. Questions regarding Family Planning Policy

A copy of the Board Statement (Section III.A.) should be sent to those who inquire about Foster Parents Plan's policy on family planning. That is, "What is Foster Parents Plan's position on family planning?"

B. Questions regarding Family Planning Practice

Inquiries as to the practice of Foster Parents Plan in regard to family planning in specific countries (i.e. "Is there a family planning program in?") or circumstances should be responded to in the following ways:

1. Individual families. All inquiries into the family planning practices or participation of any individual or family will be responded to with the "privacy" statement in Section IV.A. This statement explains the personal nature of the decision and Foster Parents Plan's opposition to any kind of coercion.
2. Country Specific Requests
 - a. Foster Parents Plan's participation in family planning programs by country is explained in Section IV.B. Use the appropriate language provided in this section.
 - b. For countries in which Foster Parents Plan has family planning programs, more details about the nature of the program can be found in the SAGE report. In addition, the specific activities of Foster Parents Plan in any given fiscal year are to be found in the World Wide Program Activity Report. These details should be provided as necessary to adequately explain the extent of Foster Parents Plan's involvement.
3. Foster Parents Threatening Cancellation Foster Parents threatening cancellation over dissatisfaction with an individual family's practice of family planning (either because they are not

using family planning or because they are) will be told that Foster Parents Plan supports family planning as an important component of a primary health care system but opposes coercion of any kind.

These Foster Parents will be offered a Foster Child in a country with family planning practices in accordance with the Foster Parent's beliefs.

A label should be placed in the Foster Parent's folder to alert staff to replace any cancelled FC with an FC from a country whose family planning practice coincides with FP preference.

Language found in Section IV.C. should be used in these instances.

C. Abortion The inquirer will be informed that Foster Parents Plan is not involved in abortions in any way.

D. Field Inquiries

1. No inquiries will be made at any time in regard to an individual family's participation or practice of family planning.
2. Any other inquiry to the field on family planning must be approved by the Director of Foster Parent Services.

III. Foster Parents Plan policy on Family Planning

A. This is the policy statement on family planning approved by the Board of Directors of the U.S. National Organization on January 19, 1985:

"A primary health care system includes, at least, the following major categories of service: health education concerning major health problems; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal/child health services, including family planning.

Foster Parents Plan's approach to family planning respects the cultural norms of the societies in which it works and the individual values of the people it serves.

This approach depends on the local situation, level of interest, local technical capacity, as well as the technical and administrative talents of the Foster Parents Plan staff.

Foster Parents Plan supports family planning. It will become involved as far as it legally, psychologically, and culturally possible in each society, always being sensitive to government as well as individual views.

Although family planning programs evoke a variety of political and emotional reactions, and sensitivity is needed, family planning should be, whenever possible, an important component of a good Maternal/Child and Primary Health Care Program. Family Planning, as part of the Maternal/Child Health Program, is more acceptable than a family planning program executed alone. Child spacing helps improve the nutrition status of the mother as well as the other children in the family. Where interest is high, Foster Parents Plan need only provide a consistent supply of family planning medication and supplies through community health workers, clinics, health posts, and mini-pharmacies. Foster Parents Plan is opposed to coercion in any aspect of family planning.

Where orientation/education aspects are also needed, training/retraining of Community Health Workers, volunteer workers, midwives, clinic and health post personnel, as well as orientation of social workers may be appropriate.

- B. The policy statement from Foster Parents Plan International can be found in Section 10-E of the Program Manual. Also consult NOCL #307 for an explanation by country of our family planning practices.

IV. Paragraphs and Letters to be Used in Responding to Family Planning Inquiries

A. Privacy Statement

"Family planning is an important component of Foster Parents Plan primary health care programs. We are involved in family planning as far as is legally, psychologically, and culturally possible in each society, always being sensitive to government as well as individual views.

Though we understand your concern, the decision of individual families to participate in family planning programs or to practice family planning is a personal and private matter based on social, religious and personal convictions. Foster Parents Plan respects those decisions.

Our assistance to a family is never contingent on their participation in a family planning program. We offer families information and services as appropriate but respect their privacy. We never inquire about the decisions they make. Any inquiries would violate their right to privacy and have the potential to be taken as coercion. We are opposed to coercion in any aspect of family planning."

B. Family Planning Practices by Country

1. AFRICA

Burkina Faso Foster Parents Plan informally encourages family spacing through the promotion of longer periods of breastfeeding which often acts as a natural contraceptive. Foster Parents

Plan works within the guidelines established by the host government. Because the government of Burkina Faso has not indicated its support for family planning, Foster Parents Plan does not have a formal program at this time.

Egypt Foster Parents Plan works within the guidelines established by the host government regarding family planning. Although Foster Parents Plan does have an agreement with the Cairo Family Planning Association, we are unable to proceed because we have not received formal permission from the Ministry of Social Affairs. We are unable to participate in family planning programs at this time, but will begin a program upon approval by the government.

Kenya Foster Parents Plan's primary health care program in Kenya has three components: to improve health facilities so they can offer maternal and child health services including family planning, to vaccinate children under five and their mothers and to train local midwives.

Foster Parents Plan also supports the family planning services of the Kenyan government. Families are referred to community facilities in their area.

Liberia The government of Liberia supports family planning. Foster Parents Plan works within the guidelines established by the host government. Foster Parents Plan wishes to support the family planning policy of the government but cannot do so until our Primary Health Care Program (of which family planning is a part) has been approved by the government.

Mali Foster Parents Plan is not involved in family planning in Mali. Foster Parents Plan works within the guidelines established by the host government which has not indicated an interest in family planning at this time.

Senegal Foster Parents Plan is not involved in family planning in Senegal. Foster Parents Plan works within the guidelines established by the host government which shows no interest in family planning at this time.

Sierra Leone Foster Parents Plan's primary and secondary health care program in Sierra Leone is concentrating on immunization, renovation of clean water supplies, latrine construction and restoration of health facilities. Because Foster Parents Plan is concerned with these priorities, and also respects the Muslim religious beliefs of many Foster Families, we are not engaged in family planning programs in Sierra Leone at this time.

Sudan Foster Parents Plan programs operate within guidelines established by the host government. We have not received permission at this time from the Sudanese government to offer family planning services.

2. ASIA

India Foster Parents Plan is involved in family planning as part of its primary health care program.

Indonesia Foster Parents Plan provides information on family planning during health related meetings with local health promoters. Our staff refers individual families to local Puskesmas Health Centers.

In addition, Foster Parents Plan provides funds to help the Indonesian government implement its successful family planning services. Family planning is a high priority for the Indonesian government.

Nepal Foster Parents Plan works cooperatively with the government of Nepal in providing family planning services. In addition to helping the government distribute contraceptives, Foster Parents Plan provides funds to families for supplies and medical services and maintains an active relationship with area hospitals and clinics.

Philippines

- a. Baguio, Bicol (formerly Naga), Mindoro Foster Parents Plan staff provide information on family planning as part of health education. In addition, staff refer families to the nearest government health care facility that offers family planning services. The Philippine government supports family planning by making available both education and contraceptive devices.
- b. Cebu, Iloilo Foster Parents Plan's primary health care program in Cebu (Iloilo) is concentrated on the prevention and control of malnutrition, diarrhea, tuberculosis and childhood diseases. Family planning will gradually be phased in as one component of this program.

Sri Lanka Foster Parents Plan does not have a formal family planning program in Sri Lanka. However, health promoters do include family planning information as an informal component of the health care program.

Thailand Foster Parents Plan works within the guidelines established by the host government. The government of Thailand has limited Foster Parents Plan's participation in family planning to motivation only.

3. CENTRAL AMERICAN/CARIBBEAN

El Salvador Foster Parents Plan social and health workers provide information and referrals on family planning. The government of El Salvador supports family planning by providing both education and contraceptives.

Guatemala Foster Parents Plan social and health workers provide information and referrals on family planning. The government of Guatemala supports family planning by providing both education and contraceptives.

Haiti

- a. Port-au-Prince, Jacmel Foster Parents Plan actively supports family planning as part of its primary health care program. Contraceptives are distributed free of charge. Foster Parents Plan also supports the family planning efforts of the government.
- b. Croix-des-Bouquets Foster Parents Plan social workers discuss family planning with Foster Families as part of our health education program. Families are referred to local public medical facilities for more information.

Honduras Foster Parents Plan social and health workers provide information and referrals on family planning. The government of Honduras supports family planning by providing both education and contraceptives.

4. SOUTH AMERICA

Bolivia Foster Parents Plan is not involved in family planning in Bolivia. The policy of the government of Bolivia is to increase the population.

Colombia Family planning is a sensitive issue in Colombia, a strongly Roman Catholic country. The government of Colombia is in favor of family planning. The Catholic Church is not. Foster Parents Plan supports the efforts of the government while remaining sensitive to the religious beliefs of the people.

- a. Cali Foster Parents Plan social and health workers provide information and referrals on family planning. The government of Cali supports family planning by providing both education and contraceptives.
- b. Buenaventura Foster Parents Plan social and health workers provide information and referrals on family planning. The government of Buenaventura supports family planning by providing both education and contraceptives.
- c. Tulua Foster Parents Plan social and health workers provide information and referrals on family planning. The government of Tulua supports family planning by providing both education and contraceptives.
- d. Tumaco Foster Parents Plan provides family planning information, services and contraceptives to families through the Foster Parents Plan clinic as part of the primary health care program. All services are provided under the supervision of health professionals (M.D.'s and nurses).

Ecuador

- a. Bolivar Family planning is a component of our primary health care program. Our health care workers discuss family planning in ways appropriate to the rural setting and local government programs.
- b. Guayaquil There is strong opposition to family planning from the Roman Catholic Church. Family planning is discussed in our Road to Health, primary health care program. Interested families are referred to local public and private family planning centers.

CHAPTER VIII

DONOR PERSPECTIVES

AID'S COMMITMENT TO FAMILY PLANNING AND CHILD SURVIVAL PROGRAMS

by Nyle C. Brady, Ph.D., Senior Assistant Administrator, Bureau of Science and Technology, U.S. Agency for International Development

The U.S. Agency for International Development (AID) considers population assistance an important part of its overall development program, and AID has had a long-standing commitment to working with private voluntary organizations (PVOs) in the field of child survival.

Population assistance is a high priority for AID, especially because of the impact of family planning on maternal and child health. Speaking at the American Enterprise Institute, AID Administrator M. Peter McPherson emphasized three main reasons for AID's continued support for family planning:

- o Family planning is a major contributing factor in improved maternal and child health;
- o Too many births at short intervals result in increased maternal and child mortality; and
- o Where there is an effective system of family planning services available in a country, the demand for abortion services is reduced.

From AID's perspective, working with health care PVOs under the child survival program and in other areas has a number of advantages. PVOs have been successful in operating development programs overseas for a number of reasons, including:

- o Commitment : Historically, PVOs are known for their idealism. They promote programs with a dedication and zeal beyond what is expected and normally found in government-run programs.
- o Growing Professionalism : While maintaining their commitment, PVOs are becoming more "professional," in the best sense of the word -- committed to good planning, achievement of objectives, quality control and accountability.
- o Flexibility : Their relatively small size and extensive experience in community-level programs enable PVOs to adapt programs to existing conditions. PVOs have been able to meet this challenge without compromising organizational integrity.
- o Independence : A certain amount of both financial and philosophical independence has allowed PVOs to explore new ways of operating. The very important concept of

community-based family planning service delivery was pioneered by private voluntary agencies.

- o Strong Host-country Government Support : Successful PVOs have managed to retain the respect and support of host-country governments because of their integrity and good work. Many governments seek out PVOs to carry out new ideas, particularly in culturally sensitive areas such as family planning.
- o Close Contact with Local Communities : Close ties with local communities cannot be overrated in implementing health programs, especially those including family planning. We all rely on health care professionals we know and trust. PVOs operate well in this community context.

Today, couples in the developing world are seeking -- even demanding -- the ability to choose when they will have children and to limit their family size. The organizations present at this workshop are uniquely suited to assist couples in the Third World to achieve their childbearing desires because the improvement of maternal and child health is an important objective for them and they have existing networks to deliver community health care services effectively. We at AID wish you success in this important endeavor.

FOUNDATION FUNDING FOR INTERNATIONAL PROGRAMS

by Thomas H. Fox, Vice President, International and Public Affairs,
Council on Foundations

Grantmaking International, a group of foundation and corporate representatives who banded together in 1982 to encourage grantmaking for international programs among their peers, conducted a survey which revealed that many foundation and corporate executives do not understand global interdependence and find the logistics of international grantmaking difficult. Furthermore, the executives stated that domestic needs take precedence over international matters for most corporations and foundations. Moreover, many grantmakers, especially in small foundations, feel that support for international programs is the responsibility of the U.S. government and/or large foundations such as Ford and Rockefeller.

Although hard data related to the level of funding for international programs are not available, some educated estimates can be made. Total U.S. philanthropic giving is well over \$70 billion annually; 2-3 percent goes to international programs. Individuals give about 2 percent of their gifts for international programs, often in response to a disaster situation or other programs that have some personal or emotional appeal. Corporations give between 2 and 3 percent of their grants for international purposes. Foundations are proportionately the largest contributors, allocating 7 percent of their grant monies to international programs.

Foundation Funding

The Foundation Center in New York has a publication on international giving which analyzes foundation trends and priorities. Health and medicine are recurrent international priorities. Small foundations, which often reflect in their grantmaking the founding family's personal interests are more likely to vary their funding priorities from year to year than large foundations. The current international funding priorities of major foundations (Ford, Carnegie, Rockefeller, Kellogg, Mellon) include: research, health and medicine, international security, population and family planning, and international education. Some foundations which have recently become involved in funding international programs are: MacArthur Foundation (international security), Hewlett Foundation (family planning), W. Alton Jones Foundation (international security, environmental issues), Pew Memorial Trust (health, Africa), and William Penn Foundation (Africa).

Corporate Giving

U.S. corporate giving in the international field seems fairly stable. One noteworthy trend is the new interest among corporations in partnership relationships with PVOs, where both parties' interests are served.

International funding sources outside the U.S. are also worthy of note. Japanese corporations are funding charitable institutions in the U.S., run by Americans, to conduct international programs; the largest of these is the Hitachi Foundation. This model may well be replicated by European and other international corporations in the next five to ten years.

A second noteworthy trend in international corporate giving is the creation of foundations by U.S. corporations in foreign countries. Coca-Cola Corporation recently established two foundations in South Africa, run by South Africans (six out of seven Board Members are non-white), to support South African programs. The foundations have been started with a gift of \$10 million from Coca-Cola.

Funding for Family Planning

When talking about foundation support for family planning, one is talking about a very limited universe. Few private foundations are involved in development projects in the Third World. Some of those few, typically the bigger ones, might prefer not to work through U.S. organizations, since they have the capacity and contacts to work directly with groups in developing countries. Smaller foundations, however, frequently look to private voluntary organizations to make these contacts and to facilitate the handling of U.S. tax-related questions.

Few foundations are really involved in international programs, but the universe gets even more limited for family planning. The heavy involvement of the U.S. government, with the accompanying feeling by foundations that perhaps family planning is a governmental responsibility, is probably the biggest single factor. The controversy about family planning and the breadth of the problem may also be deterrents.

A few suggestions or observations might be helpful.

1. The non-governmental organizations involved in development assistance, environment, and population seem to be coming closer together in a common statement about sustainable development. This kind of sharing of perspective and resources is very promising.
2. There are other foundations interested in development assistance programs or health programs or refugee-related programs. It might be possible to encourage those foundations to add family planning to their existing program interests, as a complement.
3. It is important to demystify the field of family planning. It seems as though the problem is perceived to be so big that it scares away people and organizations which could make an important

contribution by adding family planning to their ongoing overseas activities. In other words, there may be a confidence problem that inhibits organizations' thinking about family planning.

4. The idea of forming a consortium of sorts to approach donors might be attractive to some donors. If the consortium or intermediary were respected, it might encourage donors to go forward with confidence -- and also avoid several smaller grants.
5. As in all fundraising, the key is to keep asking. All of the current studies say that there is more charitable giving potential than is now being tapped by non-governmental organizations of all sorts. People and institutions simply have to be asked in a way that touches their particular priorities.

MULTILATERAL SUPPORT FOR FAMILY PLANNING

by John North, Director of the Population, Health and Nutrition Department, World Bank

How can non-governmental organizations (NGOs) have access to World Bank support for their work in the field of family planning in developing countries? First, we should confirm that the Bank continues to give very high priority to tackling the world's population problems and is building an increasing lending program aimed at doing so. Second, the Bank endorses strongly the linkages between good health and family size and timing; most of the Bank's operations in population and health aim to use and build on these linkages.

The World Bank's appreciation of the unique role of NGOs in working beyond the effective reach of government systems and reaching underserved populations and communities has come with its increasing involvement in social sector development. It has come, for example, with its involvement in rural water supplies, population programs, urban development, and since 1980, in health.

NGO understanding of the needs of communities, under-served populations and special sub-groups constitutes a strong basis for designing and implementing actions to promote social and behavioral change. NGOs can complement the skills available within governments to put their people-oriented policies into meaningful effect. This NGO support may be a sine qua non for the success of such policies, and of the programs and projects the Bank supports in the social sectors. The importance of the NGO role in the social sectors has been realized, and the Bank is still developing ways to encourage NGO participation in such programs and projects. Staff in the Population, Health and Nutrition Department of the Bank are directing much more effort now to working with NGOs in family health and population work, particularly in sub-Saharan Africa where the greatest current challenge exists. My remarks will focus mainly on sub-Saharan Africa, although the Bank by no means intends to neglect opportunities in other parts of the world.

At the international level, in order to promote policy dialogue with an operational perspective between the Bank and the NGO community, a Bank/NGO committee has been established. Composed of NGO representatives from both donor and recipient countries and Bank staff, it meets regularly and has proven helpful in identifying mutual interests and common objectives in a number of important areas, for example in food security. The committee does not and, of course, cannot replace collaborative mechanisms at the country level, but it has been successful in inspiring both the Bank and NGOs to pursue collaboration more assiduously at the country and sectoral levels.

The Bank's mode of operation in development work does not make direct support of NGOs easy, although some small direct Bank financial support has been possible recently for specific collaborative activities; we hope that this can continue.

The Bank's general mandate is to support the economic and social development efforts of its member countries. The main channels of that support are Bank loans and, for the poorest countries, IDA credits made to the government concerned. The Bank's financial link is, therefore, inevitably with governments. Bank funding can only be made available to NGOs through and at the request of a government as a part of Bank or IDA financial support for specific government projects or programs. What this means in practical terms is that there must have been developed an effective partnership between government and NGOs in which the government looks to one NGO or another to undertake a specific role in relation to the design or implementation of the project or program for which funding has been made available.

What it also means in practical terms is that both governments and NGOs must be prepared to adapt the ways they go about their respective businesses so as to be able to mesh effectively with one another. But the special advantages of NGOs lie in their administrative flexibility and their willingness to innovate, to take risks, and to try new approaches. Obviously, then, adapting their ways to fit in with government must not mean sacrificing these advantages. On their part, governments must be prepared to create practical mechanisms for channelling their own or Bank funding to NGOs; they must incorporate such mechanisms into their regular planning and budgeting processes.

Many NGOs may need to strengthen their management and internal administrative and accounting procedures to enable them to meet the financial accountability and auditing requirements of governments. NGOs must plan their pilot projects and innovative work with scaling up in mind; this means they must be prepared to introduce monitoring procedures which permit evaluation of such work in order that there may be a dependable basis to make decisions for wider follow-up. Both governments and NGOs must be ready to share information on their plans and programs regularly and freely if they are to collaborate effectively. One key to collaboration will be to identify a division of labor which accommodates differences in policy direction while facilitating complementarity rather than competition. One might also suggest to staff and NGOs based in the U.S. and other "donor" countries that they examine whether they can help the groups with which they are associated in Africa or elsewhere to make the sort of adjustments noted above.

It is apparent that much is still to be done in sub-Saharan Africa to reach the point where effective joint NGO-government action can occur. Professional staff in the Bank have been pleased to assist in two recent very encouraging experiences in which NGOs and government staff have sat down together and discussed each other's problems. They sought to create ways to enable them to work better together, such as the creation of standing working committees, the drafting of guidelines for transfer of funds to NGOs, or the establishment of national apex institutions to focus joint NGO actions. Workshops took place in Botswana in 1985 and Kenya in 1986, and the Bank is -- with the assistance of IPPF -- making plans for more such workshops, both regional and national, elsewhere in Africa.

In addition to these workshops, the Bank is providing some seed money for training NGO staff in management, planning and budgeting; the training will be carried out by another NGO with particular skills in these fields. This sort of institutional support ought to be followed up. We should like to acknowledge that in this process we have been pleased to have the active collaboration of other donor agencies such as the Hewlett Foundation and the Carnegie Corporation. We hope that they will look sympathetically at future such initiatives. Indeed we hope that funding from other private sources might be attracted to support such cooperative efforts to strengthen NGO capabilities.

There are a number of countries in Africa and elsewhere -- Kenya, Nigeria, Bangladesh and Indonesia to name but a few -- where NGOs are already actively involved in the implementation of Bank health and population projects. The Bank is fully committed to substantially increasing the level of its population and related health lending, and we would hope that a substantial number of the projects we will fund involve NGOs in increasingly meaningful ways. We do not wish to give the impression that we believe NGO involvement is the answer to all health and population problems in sub-Saharan Africa or elsewhere. But quite clearly there is much more room for NGOs in official projects and programs in these fields than has been acknowledged so far. And we would like to state our firm intention that the Population, Health and Nutrition Department of the Bank will encourage governments to create opportunities for such involvement in their plans for the future.

APPENDICES

APPENDIX A

National Council for International Health
"Family Planning within Primary Health Care:
A Workshop for PVOs"

Ramada Renaissance Hotel
Washington, DC

Wednesday March 12, 1986

6:00 P.M. -- 8:00 P.M.

RECEPTION AND KEYNOTE ADDRESS

Reception

Welcome: Russell Morgan, Dr.P.H.
Executive Director
National Council for International Health

Renaissance I
Ballroom

Workshop Overview: Julia Henderson, Ph.D.
Chair, Workshop Planning Committee

Keynote Speaker: Maxine Garrett, Chairperson Emeritus
Centre for Development and Population Activities
(Vice President for International Banking Services
Riggs National Bank)

Thursday, March 13, 1986

8:30 A.M. -- 9:00 A.M.

PRIVATE VOLUNTARY DEVELOPMENT ORGANIZATIONS AND
FAMILY PLANNING

Plenary
New Hampshire
Ballroom III

Speaker: Nyle Brady, Ph.D
Assistant Administrator
Bureau for Science and Technology
Agency for International Development

Q/A

9:00 A.M. -- 10:00 A.M.

HEALTH ASPECTS OF FAMILY PLANNING

Plenary
New Hampshire
Ballroom III

- spacing and infant mortality
- maternal mortality and child limitation
- the "M" in MCH

Speaker: Allan Rosenfield, M.D.
Dean, School of Public Health
Columbia University

10:00 A.M. -- 10:30 A.M.

BREAK

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10:30 A.M. -- 11:30 A.M.

ETHICAL ISSUES IN FAMILY PLANNING

Plenary

- family planning as a human right
- ethical issues of service delivery raised by new technology

Q/A

Speaker: Fred Sai, M.D., M.P.H.
Senior Population Advisor
The World Bank

11:30 A.M. -- 12:30 P.M.

SMALL GROUP DISCUSSIONS: Health outcomes of family planning and ethical issues in providing and not providing family planning services

Small Groups

Small Group Leaders: PVO representatives at workshop

- A. New Hampshire III
- B. Conference Room B
- C. Conference Room C
- D. Conference Room D
- E. La Martine

12:30 P.M. -- 2:00 P.M.

New Hampshire Ballroom II

LUNCH

2:00 P.M. -- 3:30 P.M.

POLICY AND POLITICAL ISSUES IN IMPLEMENTING FAMILY PLANNING PROGRAMS IN LDCs

Panel
New Hampshire Ballroom III

Panel Convener: Sharon Camp, Ph.D.
Vice President
Population Crisis Committee

Q/A

Panelists: Nancy Harris
Deputy Director
John Snow, Inc.
Enterprise Project

David Syme, M.P.H.
Director of Program Support
Adventist Development and Relief Agency International

Stephen Isaacs, J.D.
Director
Development Law and Policy Program
Columbia University

3:30 P.M. -- 4:00 P.M.

4:00 - 5:30

PROGRAM ISSUES IN PROVISION OF FAMILY PLANNING
SERVICES

Panel
New Hampshire
Ballroom III

Panel Convener: Peggy McEvoy, Dr.P.H.
Associate - International Programs
The Population Council

- Panelists: Hernan Sanhueza, M.D.
Regional Director
International Planned Parenthood Federation,
Western Hemisphere Region
- : David Nicholas, M.D., M.P.H.
Director
Primary Health Care Operations Research
- : Miriam Labbok, M.D., M.P.H.
Assistant Professor
Dept. of Population Dynamics
Johns Hopkins University
- : Julia Henderson, Ph.D.
Consultant on Population Questions
(former Secretary-General, International
Planned Parenthood Federation)

Friday, March 14, 1986

8:30 A.M. -- 9:00 A.M.

REPORTS OF SMALL GROUPS

Plenary
New Hampshire
Ballroom III

9:00 A.M. -- 10:00 A.M.

COMMUNICATION FOR PROMOTING HEALTH AND FAMILY PLANNING

Speaker: Richard Manoff
President
Manoff International, Inc.

Plenary
New Hampshire
Ballroom III

Q/A

10:00 A.M. -- 10:30 A.M.

BREAK

10:30 A.M. -- 12:00 Noon

SMALL GROUP DISCUSSIONS: Dealing with organizational constraints within PVOs on policy change

Small Groups

Small Group Leaders: PVO representatives at workshop

A. New Hampshire I
B. Conference Room A
C. New Hampshire III
D. Renaissance II
E. Renaissance II

12:30 -- 1:30 P.M.

LUNCH

Renaissance Ballroom II

1:30 P.M. -- 2:00 P.M.

REPORTS OF SMALL GROUPS

Plenary
New Hampshire Ballroom III

2:00 P.M. -- 3:30 P.M.

MECHANISMS FOR OBTAINING SUPPORT FOR FP SERVICES

Panel
New Hampshire Ballroom III

Panel Convener: John Dumm
Assistant Director
Office of Population
Agency for International Development

Panelists: Tom Fox
Vice President for
International & Public Affairs
Council on Foundations

John North
Director
Population, Health & Nutrition Dept.
The World Bank

Christine Burback, Ph.D.
Director
Washington Office
InterAction

Pamela Johnson
Coordinator for Child Survival
Agency for International Development

3:30 P.M. -- 4:00 P.M.

New Hampshire Ballroom III

SUMMARY/REVIEW/OPPORTUNITIES

Panelist : Julia Henderson

NATIONAL COUNCIL FOR INTERNATIONAL HEALTH
"Family Planning Within Primary Health Care:
A Workshop for PVOs"
March 12-14, 1986
Ramada Renaissance Hotel
Washington, D.C.

Participant List

Academy for Educational
Development
1255 23rd Street, N.W.
Washington, D.C.

- Michele Lloy
Program Officer
Health and Population Programs

Adventist Development and
Relief Agency
6840 Eastern Avenue, N.W.
Washington, D.C. 20012

- David Syme, Director, Program Support
- John Wilkins
Board Member
- Richard Wilmot
Assistant Program Officer

Africare
1601 Connecticut Avenue, N.W.
Suite 600
Washington, D.C. 20009

- Alemada Harper
Public Health Specialist

Agency for International Development

- Nyle Brady
Assistant Administrator
Science and Technology
- John Dumm
Associate Director
Office of Population
- Pamela Johnson
Coordinator for Child Survival
Office of Health
- Connie Carrino
Project Manager
Office of Population

American Public
Health Association
1015 15th Street N.W.
Washington D.C. 20005

- Michael Favin
Staff Associate

CARE
660 First Avenue
New York, NY 10016

- Sue Toole
Assistant Director of
Primary Health Care
- Robert Frelick
Board Member

Center for Development and Population
Activities
1717 Massachusetts Avenue, N.W.
Suite 202
Washington, D.C. 20036

- Susan S. Richiedei
Human Resource Development
Evaluation Coordinator

Center for Population and Family Health
Columbia University
School of Public Health
60 Haven Avenue, B-3
New York, NY 10032

- Allan Rosenfield
Director, Center for
Population and Family Health
- Stephen Isaacs
Director, Center for Development
Law and Policy

Council on Foundations
1828 L Street, N.W.
Washington, D.C. 20036

- Thomas Fox, Vice President
International and Public Affairs

Coverdale, Inc.
2054 N. 14th Street
Arlington, VA 22201

- Norman Bramble
Vice President

Dooley Foundation/Intermed
420 Lexington Avenue, Room 2428
New York, NY 10170

- Verne Chaney, President
- Julia Neidecker
Director of Development

Direct Relief International
P.O. Box 30820
Santa Barbara, CA 93130

- Robert McGill, President

Episcopal Church Center of the U.S.A.
Overseas Development Office
815 2nd Avenue
New York, NY 10017

- Jane Watkin
Director
- Rebecca Stiles
Health Specialist

The Foundation for the Peoples
of the South Pacific
Pacific House
P.O. Box 727
2-12 West Park Avenue
Long Beach, Ca 11561

- Rae Gallaway
Director - Nutrition and
Health Programs

Helen Keller International
1101 Connective Avenue
Suite 605
Washington, D.C. 20036

- John Costello, Executive Director

InterAction
2121 L Street, N.W.
Suite 916
Washington, D.C. 20037

- Christine Burbach
Director - Washington Office

International Child Care
P.O. Box 6687
Lakeland, FL 33807

- Harley Snyder, Executive Director
- Norbert Anderson
Board Member
- Marie Lubin, Chief Doctor
Grace Children's Hospital

International Human Assistance
Programs
360 Park Avenue South
New York, NY 10010

- Myles K. Ren
Executive Vice President
- Midge Tyner
Board Member

International Nursing
Services Association
P.O. Box 15086
Atlanta, GA 30333

- Robin C. Davis
Executive Director
- Sylvia Sultenfus
Board Member

International Planned Parenthood
Federation
Western Hemisphere Region
105 Madison Avenue
New York, NY 10016

- Hernan Sanhuenza
Regional Director
- Park Swan Low
Program Officer

International Planned Parenthood
Federation
London
18-20 Lower Regent Street
London SW1Y 4PW
England

- Julia Henderson
Executive Secretary (retired)

INTRAH
University of North Carolina
Program for International Training
in Health
School of Medicine
Chapel Hill, NC 27514

- James Lea
Director - INTRAH

John Snow, Inc.
Enterprise Project
1100 Wilson Boulevard
9th Floor
Arlington, VA 22209

- Nancy Harris
Deputy Director

Johns Hopkins University
School of Hygiene and Public
Health
615 N. Wolfe Street
Baltimore, MD 21205

- Miriam Labbok, Professor

Lutheran World Relief
360 Park Avenue South
New York, NY 10010

- Neil Brenden
Associate Executive Director
- Marie Sump
Board Member

Management Sciences for Health
1655 N. Ft. Meyer Drive
Suite 700
Arlington, Va 22209

- Anthony Schwarzwald
Director

Manoff International, Inc.
950 3rd Avenue, 23rd Floor
New York, NY 10022

- Richard Manoff
President

Meals for Millions/Freedom
from Hunger Foundation
1644 Da Vinci Court, P.O. Box 2000
Davis, CA 95617

- Harlan Hobgood
President
- Charlotte G. Neumann
Board Member

Medical Care Development
11 Parkwood Drive
Augusta, ME 04330

- John La Casse
President
- Beverly Tirrell
Board Member

Minnesota International Health
Volunteers
122 West Franklin Avenue, Room 5
Minneapolis, MN 55404

- Hakon Torjesen
Board Member
- Elizabeth Jerome
Board Member

Overseas Education Fund
International
2101 L Street, N.W., Suite 916
Washington, D.C. 20037

- Emily Diccio
Director of Program Coordination

Oxfam, America
115 Broadway
Boston, MA 02116

- Jacquie Kay
Board Member

The Population Council
1 Dag Hammarskjold Plaza
New York, NY 10017

- Peggy McEvoy
Associate - International
Programs

Population Crisis Committee
1120 19th Street, N.W.
Suite 550
1120 19th Street, N.W.
Washington, D.C. 20037

- Sharon Camp
Vice President
- Catherine Cameron
Special Projects Division

PRICOR
5530 Wisconsin Avenue
Suite 1600
Chevy Chase, MD 20815

- David Nicholas
Director

Project Concern International
3550 Afton Road
P.O. Box 85323
San Diego, Ca 92138

- Henry Sjaardema
Chief Executive Officer

Riggs National Bank
1909 Massachusetts Bank
Washington, D.C. 20036

- Maxine Garrett
Vice President for International
Banking Services

Salvation Army World Service
Office (SAWSO)
1025 Vermont Avenue, N.W., Suite 305
Washington, D.C. 20005

- Mona Moore
Health Educator

Save the Children Federation
54 Wilton Road
Westport, CT 06880

- Gretchen Berggren
Family Planning Coordinator
- Phyllis Dobyns
Executive Vice President

Unitarian Universalist Services
Committee
78 Beacon Street
Boston, MA 02108

- Richard Scobie
Executive Director
- Mary Ann Oakley
Board Member

The World Bank
801 19th Street, N.W.
Washington, D.C. 20037

- John North
Director, Population/Health/Nutrition Department
- Fred Sai
Senior Population Advisor

World Relief Corporation
450 Gunderson Drive
P.O. Box WRC
Wheaton, IL 60187

- Dale Harro
Board Member

World Vision Relief Organization
919 West Huntington Drive
Monrovia, CA 91016

- Doug Glaeser
Manager for Project Development

APPENDIX C

RESOURCES

I. PUBLICATIONS ON THE HEALTH IMPACT OF FAMILY PLANNING

Maine, Deborah. Family Planning: Its Impact on the Health of Women and Children. New York: Center for Population and Family Health, 1981. Available from: Center for Family Health, Columbia University, 60 Haven Avenue, New York, NY 10032.

Maine, Deborah, and McNamara, Regina. Birth Spacing and Child Survival. New York: Center for Population and Family Health, 1986. Available from: Center for Population and Family Health, Columbia University, 60 Haven Avenue, New York, NY 10032.

Reinhart, Ward, and Kols, Adrienne. "Healthier Mothers and Children Through Family Planning," Population Reports Series J. Number 27. Baltimore, MD: Population Information Program, Johns Hopkins University, 1984. Available from: Population Information Program, Johns Hopkins University, 624 North Broadway, Baltimore, MD 21205.

World Federation of Public Health Associations. Family Planning for Maternal and Child Health: An Annotated Bibliography and Resource Directory. Washington, D.C.: World Federation of Public Health Associations, February 1986. Available from: American Public Health Association, 1015 15th Street, N.W., Washington, D.C. 20005.

II. LISTS OF AGENCIES WORKING IN FAMILY PLANNING

Lewison, Dana. "Sources of Population and Family Planning Assistance," Population Reports Series J, Number 26. Baltimore, MD: Population Information Program, Johns Hopkins University, 1983. Available from: Population Information Program, Johns Hopkins University, 624 North Broadway, Baltimore, MD 21205.

Population Crisis Committee: "Private Organizations in the Population Field," Population Briefing Sheets. No. 16. Washington, D.C.: Population Crisis Committee, 1985. Available from: Population Crisis Committee, 1120 19th Street, N.W., Washington, D.C. 20036.

United Nations Fund for Population Activities. Guide to Sources of International Population Assistance, 1985 (Fourth Edition). New York: United Nations Fund for Population Activities, 1986. Available from: U.N. Fund for Population Activities, 220 East 42nd St., New York, NY 10017.

III. INFORMATION ON COUNTRY PROGRAMS

United Nations Fund for Population Activities. Inventory of Population Projects in Developing Countries Around the World 1984/85: Multilateral Assistance, Bilateral Assistance, Non-Governmental Assistance. New York: United Nations Fund for Population Activities, 1986. Available from: U.N. Fund for Population Activities, 220 East 42nd Street, New York, 10017.

IV. TRAINING SOURCES

Institute for Development Training. A Training Course in Women's Health. Chapel Hill, NC: IDT, 1982. Individual modules, designed for self-instruction, on a variety of topics related to women's health and reproductive concerns. Most modules are available in English, Arabic, French and Spanish. Available from: Institute for Development Training, P.O. Box 2522, Chapel Hill, NC 27514.

U.S. Agency for International Development. 1986 Calendar of Training Opportunities in Primary Health Care and Family Planning. Washington, D.C.: Office of Population, U.S. Agency for International Development, 1986. Available from: Information and Training Division, Office of Population, U.S. Agency for International Development, Washington, D.C. 20523.

Also available from the National Council for
International Health ...

Alternative Health Delivery Systems: Can They Serve
the Public Interest in Third World Settings?
(1984)

Directory of U.S.-Based Agencies Involved in
International Health Assistance (1980 with 1982
addendum)

Guide to U.S. Based Agencies Involved in Water and
Sanitation in Developing Countries (1983)

Health for Humanity: The Private Sector in Primary
Health Care (1979)

International Health & Family Planning: Controversy
and Consensus (1985)

Management Issues in Health Programs in the Developing
World (1986)

New Developments in Tropical Medicine I (1982)

New Developments in Tropical Medicine II (1983)

Oral Rehydration Therapy Supplement (1981)

Pharmaceuticals and Developing Countries: A Dialogue
for Constructive Action (1982)

The Role of the Private Sector: Immunization and the
Developing World (1986)

The Training and Support of Primary Health Care
Workers (1981)

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