POPULATION PROGRAMS IN THE ORGANIZED SECTOR IN AFRICA
A COLLECTION OF COUNTRY CASE STUDIES

edited by

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ISBN 92-2-106367-4

First published 1988

These studies have been compiled by the ILO Population/Family Welfare Education Progamme to illustrate examples of work done in different countries of Africa in the field of population/family welfare/family planning activities in the industrial setting.

Responsibility for the data and opinions expressed in the studies rests solely with the respective authors.

The volume has been produced by the ILO in collaboration with John Short and Associates Inc. of Maryland USA with financial support of the United States Agency for International Development.

Copies of the volume may be obtained from the following:

1. ILO Population Education Programme
   Employment Planning and Population Branch
   Employment and Development Department
   International Labour Office
   4, route des Morillons
   1211 Geneva 22, Switzerland

2. The TIPPS Project
   Contract No. DPE 3035-C-00-5047-80
   John Short and Associates, Inc.
   Columbia
   Maryland 21044
   USA

3. ILO Regional Labour and Population Programme
   P.O. Box 30218
   Nairobi
   Kenya

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PREFACE

This is a small volume of case studies on "Family Welfare and Planning" activities in the organized sector of six African countries. The words used in well-written texts often embellish reality, causing deception. For this reason, I have modified the original language or context only when necessary to clarify a point.

The value of these studies lies partly in their diversity which stems from the nature of the sectors involved, the different approaches used, and in the varied results obtained. This diversity enhances the "flavour" of each case study with its strengths and weakness.

My main contribution is the introduction. I hope that it will be useful to the readers of this book who are interested in the very important problem of population as it relates to development.

S. Hetata

INTRODUCTION

by

Sherif Hetata

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INTRODUCTION

This is not a manual. To write a general manual on Family Welfare Planning Programs for the organized sector of Africa is an unlikely undertaking. There are too many countries in the continent and the differences between countries are too great. There are also too many "organized sectors" and the differences between these sectors are even greater. Despite fifteen years of ILO activities in this field, writing such a manual, even if we wanted to, would still be too difficult for us to attempt.

However, our intention has not been to write a manual. Situations are so different, so diverse that to "systematize" would be cramping, and hardly feasible. A great deal of flexibility, of African subtlety or even sophistication is required. This is something that is perhaps most striking in the case study prepared by our friends from Sierra Leone. How can one put the wealth of daily human experience, the many shades of reality reflected in this study, into a manual? How can you "systematize" in a continent which has not been "systematized" by industry and technology?

But if you were to ask us what we have attempted to do, our answer would be three main things.

1) To clarify the rationale for establishing Family Welfare and Planning Programs in the Organized Sector.

2) To identify guidelines, based on case studies, which may help in setting up such programs.

3) To present a certain number of edited case studies of Family Welfare and Planning programs in the Organized Sector. The six studies prepared have come from Kenya, Sierra Leone, the Sudan, Tanzania, Tunisia and Zambia. We felt that these case studies could serve as illustrations rather than models: what works in one situation need not work in the same way in others, but what emerges from the studies is something that can be found to work in each of the various situations examined.

Our hope is that this volume will help people in different areas and at different levels of responsibility, who are involved, or may later become involved in the establishment of such programs, to see more clearly what can be done.

I. Africa and its Population

Population Characteristics

To start, let us say something relevant about the population of Africa. The area of the continent is 30,312,999 square kilometres; which represents 20

percent of the world area. In 1985, its population was 548,000,000; which is only 11 percent of the world total. Its highest point is Mount Kilimanjaro in Tanzania which reaches 5,985 metres. Its lowest point is the Qattara Depression in Egypt, which is 133 metres below sea level. Its coastline is 36,160 kilometres long including Madagascar and the Comoros. Therefore, although it is the second largest continent with one fifth of the worlds' surface, it has only slightly more than one tenth of the world population. Population density is consequently low, and large areas are either sparsely inhabited or not inhabited at all.

There are however, some densely settled sections in which population pressure on land resources has created serious problems. Some examples are: Zanzibar, Rwanda, Burundi, parts of the West Coast, and the Nile Valley of Egypt. In contrast there are extensive areas with very small populations and less than 30 percent of the arable land under cultivation. Where mining or other new enterprises have developed on a large scale in areas of low population density, the demand for labour has been met by immigrants. An example is the copper mines in Zambia which is discussed in our case study number six.

Without vital and migration statistics, and at least two or three reasonably accurate population censuses, it is not possible to draw a really accurate picture of population trends in Africa. Nonetheless, whatever the past history of growth and contraction in numbers may have been, the population of Africa is now increasing very rapidly; about 2.9 percent a year. The rate of increase of population in Equatorial Africa in the later 1970's was about 2.6 percent a year, and that of other regions of Africa between 2.8 and 3.1 percent.

Fertility is at a high level amongst most peoples of Africa. It is unlikely that the annual birth rate will drop below 40 to 50 live births per thousand population. There is very little reliable information about levels of mortality. Censuses and demographic surveys on a sample basis conducted in various parts of Africa since the end of World War II, have produced estimates of death rates for particular areas ranging from 14 to 45 deaths per thousand population. Mortality rates in most African countries are gradually decreasing. For the continent as a whole, the rate fell from 27 per thousand a year in the mid 1950's to 18 per thousand in the late 1970's. However, there are wide variations from country to country, and within any one country from one locality to another.

There has been very little intercontinental migration of Africans since the slave trade was suppressed. There are, however, important migrations within Africa towards the towns, mining areas, and some of the more prosperous farming areas such as the cotton growing regions of the Republic of the Sudan (see Case Study on Sudan); the cocoa growing areas of Ghana and Western Nigeria, and the coffee growing areas of Buganda in Uganda and the Kenya highlands. Many of these migrants seek work as unskilled labourers and stay in the towns, mining areas, and farms for relatively short periods of time (Gezira Province in Sudan). In some regions, such as the copper belt in Zambia and the urban areas in Zaire, many of the migrants have been followed by their families and have set up permanent homes. The movement of agricultural labourers for harvesting is seasonal, but the migration of the jobless to towns and mines is permanent.

There are two major forces currently affecting the growth and movement of the African population. First, the development of social services including better medical attention, improved sanitation and public health work, and expanded education opportunities tends to reduce the death rate and so increase the rate of population growth. This is particularly noticeable in urban areas and likewise in the "organized sector". Secondly, the often distorted growth of the economy has the effect of attracting migrants to the urban areas which results in depopulating some of the poorer rural areas.

Urban Centres

Despite the rapid growth of cities and towns in many parts of Africa during the 20th century, urban communities still only form a rather small proportion of the total population. It has been estimated that in 1960 the percentage of people living in cities of 20,000 inhabitants or more was but thirteen percent in Africa as compared to 58 percent in North America, 44 percent in Europe (excluding the USSR) and 16 percent in Asia. Moreover, the proportion of the urban population living in cities of 100,000 and more in Africa was smaller than in any other continent. In other words, urban life in Africa is, in general, small town life rather than metropolitan living to a greater extent than elsewhere. North Africa has been urbanized to a considerable extent since ancient times, and between 20 and 30 percent of the population lives in urban areas of 20,000 and over. South of the Sahara, only about 19 percent of Africans live in urban centres of a similar size. Most urban centres in tropical Africa are of rather recent origin and were created as trading centres, ports, and communication centres, or as government stations.

Nevertheless, tropical Africa like most developing areas, is experiencing an accelerating rate of urban growth. There is a tendency for the urban population to be concentrated in one or two cities. In most cases this urban population contains an unusually high proportion of young adults with a numerical preponderance of males.

Economically Active Population

Only a small proportion of the African labour force is in permanent wage employment. Occasional wage labour is more widespread; the majority of wage earners south of the Sahara are rural migrants. Most of them return to their native villages once the possibility of finding work has ended.

In most African countries the biggest employers of wage labour are the government and government-owned public utilities (power, railroads, port facilities and sometimes mines).

II. Some Problems Related to Family Welfare and Family Planning in Africa

Peoples' beliefs and values are strongly influenced by the concrete situation in which they live, by their collective experience which we call history and culture, and by their own individual life experiences. Where the African continent is concerned there are a number of political, economic, and cultural

factors which have to be taken into consideration when attempting to set up a Family Planning or Family Welfare Program.

Politically, Africa is a continent which went through an experience unique to the annals of human history. During the period of slave trade, the continent was depleted of a large proportion of its most vigorous and youthful population. Countless millions of slaves were shipped across the ocean under terrible conditions, most went to the American continent to labour on plantations and farms while some went to mines. This has left a deep impression on the historical memory of African peoples. Mention of population or birth control therefore, tends to elicit a negative reaction even if it does not show on the surface.

Many people believe that population control or birth control is another attempt to deplete the continent of its vital human resources, so that it remains subjugated to the "white man". When this is linked to the history of colonization or to the fact that many African countries are still dependent and subjugated to the world multinational economic system and the continued existence of a racist regime in South Africa, resistance to the idea of population planning or control may build up.

Added to these clearly political factors are certain demographic characteristics which must also be taken into consideration. As mentioned previously, Africa represents 20 percent of the world's total area. The general feeling in most African countries is that the continent is underpopulated, and arguments about overpopulation or potential overpopulation are often unconvincing. They can be looked upon as genocidal tendencies, or a continuation of the desire by the "white minority" to maintain control of a "black majority". But irrespective of such rather prejudiced reactions that exist in many parts of Africa, it is obvious that people are needed if any form of development is to become feasible. This is, for example, the rationale behind the UJAAMA policies of Tanzania which depended on a redistribution of people. The policies grouped people in villages to make a concerted development effort. It could also be made the rationale for an "organized sector" approach to population and family planning education which aims at giving priority to areas with a high population concentration, rather than to an even-handed spread of resources over a country regardless of the spread of population. The need for family welfare education and family planning in the interests of MCH, improved family well-being and the like might be just as relevant in a depopulated corner of the land. Unless the message is appreciated by the recipients, the effort is worthless. Far better to concentrate on areas where the audience can see and appreciate for themselves what is being said.

These aspects of the population problem in Africa are important in defining population policies and approaches. Population or birth control will not be acceptable at least for some time. What is more likely to succeed is a "sectoral" approach based on the welfare of the individual and his family; on spacing, and smaller family size as one of the elements of welfare. Hence, the term "Family Welfare Planning". But even this approach is likely to succeed only where changing conditions help to make people see and experience the validity of the arguments used.

III. Rationale for Concentration on Family Welfare Planning in the Organized Sector

At this stage, it is perhaps necessary to define the concept of the "organized sector". The term is used to cover those sections of the population, whether urban or rural, which have been submitted to some form of organization in the modern sense of the term. All populations are organized in one way or another. Some examples are villages, tribes or ethnic groups, or religious sects. These are the more or less traditional forms of organization which continue to be particularly prevalent in Africa. But in the context of the ILO's population program the "organized sector" is meant to cover those people in the labour force who are organized in the framework of industrial establishments of different sizes and with differing types of production. On the one hand, they can be modern and highly mechanized, while being largely dependent on manual labour on the other. The concept extends to extractive industries and mines as well as factories; governmental departments and services, public utilities; companies and corporations; cooperatives whether artisan or peasant; professional and women's associations, youth and peasant organizations, and trade unions for both industrial and agricultural workers.

Since the term covers such a wide range of seemingly disparate categories and groups, it might appear to be arbitrary. In a sense this is true. But what all these groups and categories have in common is some form of modern organization, and this produces a certain number of shared characteristics which are at the basis of the rationale for the organized sector approach in Family Welfare Planning.

- They are groups or categories which have undergone some degree of modernization in their economic activities, in education, social services, culture, degree of exposure to mass media, and are usually located in urban areas, or in the more developed rural areas.

- They tend to live and work in concentrations of higher population density whether in the urban or rural areas.

- They are better provided with health services than other categories of the population.

- They are easier to reach and to work with because they belong to some form of organization; government service, trade union, cooperative, or other institution.

- They are pace-setters in relation to other sectors of the population living in the less developed urban informal sector, or less developed rural areas.

The rationale for setting up organized sector Family Welfare Planning programs is therefore based on these characteristics which in general militate for a more rapid and widespread adoption of family planning practices. This is due to several factors.

- People who are undergoing a degree of modernization tend, after a certain period of time, to change their behavior towards child-

bearing. Or at least they can be influenced to adopt family planning more easily. The costs as well as the effort and time required in child rearing and education, the costs of housing, clothing and nutrition combine together to increase the socio-economic burden imposed by children on their parents. At the same time, children gradually cease to be a source of labour, or to undertake the manifold jobs they traditionally shoulder in a typical rural situation. As a result, the value system gradually changes. This process can be accelerated by education. On the other hand, new consumption needs arise like better food, clothing, housing, and entertainment, reading a newspaper, seeing a film or buying a radio or television set. Parents have to make a choice, and their priorities change.

- Informational and educational activities are made easier by a greater access to mass media and the relatively higher levels of understanding and education among organized sector groups.

- The presence of organizational frameworks is of great help in the designing and execution of Family Welfare Planning programs, and helps in the dissemination of family planning practices.

- The relatively higher concentration of these groups in specific areas permits a more rapid and effective diffusion of ideas, education and practices related to family welfare planning.

- Organized sector groups are usually provided with better medical facilities. One of the essential factors in the success of family welfare education programs is easy access to family planning services and contraceptives. These are provided more easily, effectively and safely if grafted on to existing medical facilities.

- Organized sector groups are often pace setters where new social practices are to be adopted. They are relatively more modern, more educated, and more receptive to new ideas. They live and work in bigger concentrations and so have an impact on the surrounding population. They maintain links with their home villages even if permanently settled in urban areas, going back for the holidays, or on different occasions such as marriages or deaths. Some workers live in surrounding villages and commute by bus, train or taxi to their work. Migrant labourers move between mining areas and farms on the one hand, and their home villages on the other. Therefore, new social practices tend to spread from the urban pace setting areas to villages or small towns. It is therefore important to study the channels which can be utilized in diffusing the practices of family welfare planning.

- It is easier to find trained personnel, or to train personnel for the various functions required in family welfare planning when dealing with the organized sector.

- In general the presence of social services such as transport, health, and education as well as of socio-economic infrastructures on which

to build, all help to overcome many of the difficulties inherent in social programs and especially in family welfare planning programs.

The existence of the many favorable factors mentioned above makes the planning and execution of family welfare planning programs in the organized sector much more economical when costs, time and effort expended are compared with results. A cost-benefit analysis would show that organized sector programs are less expensive and more rewarding. Hence, they should be given priority where resources are limited. In planning terms, phasing a program could mean starting with the organized sector.

Organized sector groups, especially in areas to which immigrants are being attracted, often show higher population growth rates. This is due to a drop in mortality rates as a result of improved socio-economic conditions and especially health coupled with an initial increase in birth rates for the same reasons. They should therefore be priority target groups for at least an initial period of time until the wave of increased growth is broken.

In Africa, where large areas are either sparsely populated or not populated at all, it seems more logical to start a population program in areas of high population density. This is where people feel the pressure and can see for themselves that a population problem does exist.

IV. Some Guidelines For Setting Up Family Welfare Planning Programs For the "Organized Sector"

General Considerations

The International Labour Office has quite a long experience in the designing and operation of family welfare planning programs for the Organized Sector. During the fifteen years which have elapsed since the program was first launched, many of the original ideas which seemed feasible have proved not to function in practice, whereas other ideas which appear simplistic and even primitive have tended to make their way, and to transform themselves into effective operational steps.

Before dealing with the practical aspects of such programs, it may be appropriate to mention a few general ideas which have proved to be important to the success of such programs.

Family Welfare Planning is above all a behavioral change, and behavioral changes cannot be forced upon people. The reality of their lives and their socio-economic conditions must change in a direction which helps them realize that repeated childbirth and many children are not an asset, or a fatality of life, or an essential replacement for children lost as a result of bad health conditions and high infant mortality rates. Appropriate information and education can accelerate behavioral changes by making people conscious of what is happening and showing them how to adapt. But they can never replace the premise of a change in the reality of peoples lives.

From this arises the need to maintain an appropriate level of intensity of activity where these programs are concerned. A sustained effort which is continued over a long period of time without too much noise, fanfare and use

of slogans is much more effective than crash programs characterized by one or another degree of over emphasis, which is most often counterproductive, and in any case cannot be maintained. Crash programs and high key campaigns often lead to a backlash by raising resistance. New behavioral practices like Family Welfare Planning are spread best through people and actual practice rather than elaborate educational and mass media efforts. In all cases, good services remain an essential component of success.

An integrated approach has usually been more successful than a one prong family welfare planning program, but there are no general rules. Flexibility and adaptation to local conditions and situations are essential. Integration means a multi-benefit program where family welfare is combined with other services and benefits for people. The Sierra Leone approach of grafting family welfare planning onto income generating activities, or the combination of spacing with Maternal and Child Health Services, are examples of such programs. The integrated approach to family welfare planning obviously necessitates multi-disciplinary planning and execution of programs, whether at national, regional, local or plant levels. In rural areas, working relations need to be built up between a wide range of people such as members of cooperatives, agricultural workers unions, agricultural extension departments, social and health services, developmental agencies and other institutions or bodies. In industrial situations, representatives of management and trade unions, social service workers, and health personnel will need to cooperate. But even in single approach family welfare planning programs, this form of multi-disciplinary cooperation will still be required.

Where an organized sector family welfare planning program is being set up for industrial or mining areas, the focal point can often be situated in the Ministry of Labour and Social Welfare. This is probably more competent in dealing with activities concerning workers than the Ministry of Health. The same applies to programs in which the cooperatives are involved, where in this case the focal point can best be placed in the Department of Cooperatives.

The "Zambia" and "Sierra Leone" cases are good examples of this way of operating organized sector family welfare planning programs when there is a national commitment. In the case of Tunisia, a compromise solution was worked out by which the program was integrated into the occupational health services.

The underlying objective of all family welfare programs is to introduce the idea of a smaller family norm, which, if achieved, will involve the practice of contraceptive techniques. Hence, in all cases it is not advisable to set up programs unless adequate health and family planning facilities are available. Creating a demand for family planning without being able to respond to it is counterproductive and delays the diffusion of such practices. In addition, health problems arising from contraception in the absence of appropriate medical advice and care have caused programs to break down.

Specific Matters Related to Plant Level Family Welfare Planning Activities

In every individual unit within the organized sector, different departments and people have to be involved if a family welfare planning program is to be successful. The most important of these are:

1. Management
2. Trade Unions
3. Personnel services
4. Health services (whether regular, maternal and child health, or occupational).

V. The Role of Management

The case study from Tanzania describes a plant level family welfare planning program in the "Kiltex" textile factory in Arusha. The conclusion is that the program was a failure and the study ends with a number of explanations as to why the program did not succeed. Prominent amongst these is management commitment:

- Despite the management being initially sensitized, there continued to be a lack of enthusiasm on its part.

- Management is often fearful of disrupting production.

- The existence of management commitment also proved to be crucial, and in its absence the program broke down from the beginning.

- The Kenya Case Study states that the majority of projects supported by the Family Planning Private Sector Program have proved to be successful. Failures can often be put down to lack of management interest and support.

- In contrast to Case Study 2, [This is a comment relating to Case Study 3 which was considered a relative failure] management showed little interest in the project. The FPPS staff at no time met with the general manager. All negotiations are being conducted at lower levels. Family planning activities were centred in the clinic with almost no information, education, or communication activities. The end result is that close to the end of the two year project, only 27 percent of the target has been achieved. This case clearly shows that adding extra family planning staff, training existing staff in service delivery, and supplying equipment and funds will not in itself ensure that clients come. The lack of commitment of management and senior clinic staff meant that there was little education and motivation work done in the plantation and community.

Why is the role of management crucial?

There are many reasons why success in the implementation of organized sector programs is unlikely without the involvement of management at all levels. These include:

1. The active participation of management, whether governmental, public, or private, bestows legitimacy on a program which is dealing with a sensitive area outside the general run of habitual practices. It allays the fears of the staff and the workers required to run the program. It bestows "authority" on what they do and without authority there is always a lack of seriousness, and inadequate follow up.

2. After the initial inputs of the project come to an end, the government, public, or private authorities are supposed to take over from the external agencies which have been involved. At plant level this implies that management will take over.

3. Management has to place facilities, staff, and some funds at the disposal of the program. Some examples of the inputs required are:

    - premises for training and meetings
    - time off for training and meetings without deduction of pay
    - clinical facilities
    - training of clinical, social, educational staff
    - participation in joint management worker committees set up specially for these programs, or grafted onto already existing committees.

The role of management is to give the green light and provide moral and material support. It is not appropriate for management to intervene directly in educating or convincing the workers of the importance of the family welfare program. If it tries to do too much, the program may appear to reflect a vested interest of the establishment in which case an antagonistic union attitude may prevent any impact. Management therefore has to play an active facilitating role, remaining in the background but at the same time letting those responsible for project implementation know that they have the complete support of those in authority. Not only is top management support necessary, but line managers much also be fully cooperative.

Management can be more easily convinced of the need to play a role in Family Welfare Programs if a cost benefit approach can be used. The Kenya case study mentions that the major part of the research work undertaken by the project shows that, in the long run, private sector institutions which include family planning in their health care are likely to spend less on health related problems of the employees and their dependents, particularly women and children. The companies are also likely to increase the level of productivity as a result of the reduced incidence of maternity leave. The findings of this study provide information relevant for convincing management in the private sector and policy makers, and planners of the need to incorporate family planning into private sector operations. The Kenya study states that operational research projects are providing evidence of

reduced benefit costs to employers through the provision of family planning services. Fewer prolonged absences due to maternity leave, less absenteeism for pre- and post-natal care and sickness of children, less time off from work to seek contraceptive services all add up to savings for both the company and the employee. The need for such supportive documentation cannot be over emphasized. The Kenyan, Tanzanian and Zambian case studies indicate this need even if they do not say so in such precise terms as those quoted above. It is therefore clear that management involvement is a "key" factor in the effective functioning and success of all plant level family welfare planning programs. In all the mentioned case studies, wherever top management has shown little or no interest in the initiation and running of such programs, they have either failed to achieve satisfactory results, or have broken down completely.

VI. The Role of Union Leaders

Plant level family welfare programs depend very much on the attitude of local trade union leaders. The attitude of the branch chairperson or the shop steward can make or break a program. Although the inter-relationship between family economics and welfare, with its implication regarding family size, may not be seen as an obvious trade union responsibility, it is nevertheless a message that should be put forward by trade union leaders at national and local levels. Local trade union leaders will follow the example of their national leaders. But what is more important is that they themselves are the real opinion leaders of the workers. These are the people whom the workers are going to listen to. If they are for the program who dare be against!

Both the Sudan study and the Zambian study bring out this point. In the traditional, conservative atmosphere of Gezira, it is the support of local union leaders that has enabled the population education activities to take place. Without that support it is more than likely that the meeting places would have been empty; the classes unattended and the potential for future progress unchanged.

VII. The Role of Personnel Managers

Personnel managers should not be regarded solely as part of the plant management function. By the very nature of their vocation, they are more concerned with the welfare aspects of the employee than anyone else in the factory. In most plant level programs they are seen as the representatives of management within the programs but they have the potential to be much more. Not only can they have a considerable impact on program implementation by undertaking responsibility for all manner of implementation activities ranging from program planning to day to day record-keeping, but also, when necessary they can function in the opposite direction too. They can influence not only middle but also top management. In order to optimize such impact it is necessary to have direct contact with personnel management rather than have them enter a program as "substitute employers". In which case, their role is likely to be confined to implementation. Until now, little direct contact has been made between organized sector population programs and personnel management associations in Africa. This may well account for

some of the general management problems documented in the Kenyan and Tanzanian studies in particular. However, attempts are currently being made by ILO to rectify this situation.

VIII. The Role of Health Service Staff

When it is suggested that a company should establish a family welfare and family planning program, the first reaction is to send for the clinic staff. Very often it may be the last reaction. "We'll have a program. The nurse will look after it". And that is the end of the discussion. It can also be the end of the program!

Family welfare and family planning are not health matters. As we have said in the preceding sections, a successful program requires the support of top management; the complete involvement of union leaders and the professional guidance of the personnel staff. The health centre workers can provide both advice and contraceptives, but it is not appropriate that they should be given the task of running the plant program. If this happens, and it often does, the plant program is no different than any other program. In this case its chances of success are also no higher. It is seen as being health oriented; the traditional attitudes towards family planning are likely to remain and the whole purpose of presenting a new approach based on the relevance of family welfare and decision making gets lost in the antiseptic environs of the plant clinic. The involvement, if any, of management and unions is minimized and consequently potential impact and growth is lost. The Kiltex experience in Tanzania indicates what can happen when a program is left in the hands of a nurse; no doubt a good, efficient and dedicated professional, but with no access to top management or strong links with union leaders. A program located in a clinic is better than no program at all, but if the role of the clinic were to be limited to a supply function with other parts of the program being run by a works committee centred on the personnel office, the supply needs would likely be very much greater.

Having said that, it is necessary to ensure that family planning services are available in the health facilities of the plant or the area in which the program is to function. The availability of these services depends on the existence of a minimum health structure, a steady supply of contraceptives, and training of the health personnel including the plant doctor or the doctor who may be serving a group of industries, auxiliary staff like the nurse and also the social worker. Wherever possible family welfare planning services should be grafted onto the maternal and child health facilities or into occupational health. Medical personnel should be represented wherever committees are formed to deal with family welfare planning activities, or wherever committees created for other purposes have included family welfare planning in their activities.

The health centre staff has a very important role to play in all plant level programs. But it must never be forgotten that because of the relationship structure within the organization, this is a technical supportive role rather than a leadership role.

Other Key Elements in Implementing Organized Sector Programs

In addition to the roles of the four specific groups mentioned in the preceding paragraphs, namely; management, unions, personnel and health services, there are a number of other unique characteristics essential to the optimal implementation of family welfare and planning programs at plant level. These are:

- the need for a representative leadership epitomized in a committee structure
- the role of worker motivators
- the importance of record keeping
- the establishment and maintenance of effective links with "like-minded" outside bodies.

All these features are mentioned in one or more of the individual case studies.

Planning Committees

There has to be a body responsible for planning and running a plant based program. The committee has to be responsible for the education and motivation of the work force as well as assuming that adequate provision is made for the supply of services. The committee has to include representatives of management and unions as well as technical inputs from the clinic staff. Experience in all parts of the world has indicated that programs located with personnel departments have the most impact. An important requirement in all cases is that plant level committee members have to undergo specific training so that they understand exactly the objectives and proposed activities of the program. As can be seen from the case study material, most of these training programs have three distinct components; the content of family welfare and planning issues; communication techniques, and finally, the importance and nature of simple record keeping techniques. One of the most important tasks of the trained committee member is to provide the necessary leadership, guidance and inspiration to the "worker motivators" who are the key element in the implementation of the plant program. Hence it is vitally important that they are able to easily relate to the motivators.

The committee structure for rural projects will require a broader base bringing in village representatives of local administrative structures and government services such as health, social services and agricultural extension workers. In addition, the local village council should be involved. Such an appropriate structure is brought out in the Sierra Leone study where the importance of the local religious leader is also clearly emphasized.

The Role of Worker Motivators

All organized sector projects are based on worker motivators. These are the people who talk their colleagues into the idea of improving family welfare by accepting the small family norm. In order to do this they must first be accepted by their colleagues. Second, they must know how to talk about such personal matters in a acceptable way. Third, they must know what they are talking about, but above all, they themselves must be convinced of the relevance of what they are doing. Clearly, selection is of vital importance. So too is commitment and dedication on the part of the potential motivator. Appropriate training is also necessary.

Motivators should be chosen from both sexes so that couples are reached effectively since contraception is necessarily a joint decision. They should preferably be about 30 years old, with a slightly higher educational level than their colleagues, but nevertheless working within the heart of the production process and therefore close to the rank and file. They should be practicing family planning themselves and be capable of answering the kinds of questions that are commonly raised in this area. They should also be trained in simple communication approaches and in leading group discussions. Some formal system of supervision will always be necessary.

The Importance of Record Keeping

Record keeping has always been a problem in family welfare planning programs since it involves a certain amount of tedious work, to which people are often averse. It also implies a form of control and evaluation of results. But as the Zambian case study indicates, it is not something that cannot be overcome. Record keeping is essential if there is to be any evaluation of results, comparison of experiences, and some rudimentary research, not to mention efficient program implementation. The forms used for record keeping will vary from one project to the other depending on the degree of sophistication in the running of the plant, and availability of trained service staff. In any case people who are to keep the records should be trained before hand (which is not difficult) and appreciate the importance and significance of this aspect of the work they are doing. In addition, accuracy of records can be linked to some form of incentives.

There are two possible locations for introducing population related records. They are either in the Personnel Department or in the Health Clinic. If family planning data is the primary requirement, then the latter may be the appropriate location. Conversely, if the demographic profile of the plant is required, the Personnel Department would be the place. In fact, a logical arrangement would be to prepare a demographic profile as part of every worker's personnel records. Then if or when that worker becomes a family planning practitioner, the document could be permanently moved to become part of the Health Centre records.

Cooperation With Outside Bodies

Although the organized sector provides an excellent opportunity for the introduction of innovative population related programs, it would be wrong to regard this sector as providing an acceptable environment in which something new can be developed in isolation from the rest of the country. A successful organized sector program needs to draw on the institutional experience that already exists within the country, because simply by doing so it will increase its own impact.

Institutions involved in adult education, such as trade unions or cooperative education programs, illiteracy campaigns, professional associations, not to mention national and voluntary family planning bodies, can often be of great help in promoting and expanding plant level family welfare programs. Their main thrust will most likely be in the educational field. Not only can they contribute to plant programs, but population related issues can be included in their own regular training activities. Such is the case in some African countries like Zambia, Sierra Leone and several others. It has the distinct advantage of providing a regular flow of opinion leaders and trainers in activities related to family welfare.

Wherever feasible, the integrated approach to family welfare and family planning should be followed. The very nature of family welfare which relates population issues to a whole range of economic, social, cultural, health, and educational factors seems to make it naturally a part of some total program. Apart from this consideration, one-prong family planning programs will always tend to appear as birth control activities which are still looked upon with a good measure of suspicion and aversion throughout the African continent.

In order to maximize the impact of existing institutional facilities, any country wishing to set up population programs in the organized sector should establish a National Advisory or Coordinating Committee. The primary task of this will be to facilitate cooperation and mutual support. The composition of such a Committee will vary from country to country, but clearly it must include all interested government departments and non-governmental organizations including trade union and employer associations. This particular requirement has been met in each of the six case studies presented in this volume.

This Introduction has attempted to point to a few guidelines which have emerged from the individual case studies that can help in the setting up of family welfare planning programs for the organized sector. Nevertheless, it is necessary to remember that each situation will require its own solutions, and that local initiatives both at the planning and implementing stages are one of the primary keys to success.

The Case Studies

The six case studies in this publication are from Kenya, Sierra Leone, the Sudan, Tanzania, Tunisia and Zambia. Each one is unique in that it deals with a specific area different from the others. The case of Kenya deals with

a project on family welfare planning implemented by the private sector corporations in a number of industrial and plantation establishments. That of Sierra Leone is located within the cooperative movement with its ramifications in rural areas. The Sudan Case Study deals with a program implemented in the cotton growing area of Gezira Province but which also covers one of the industrial establishments in the province. Tanzania is an example of a straight industrial plant program launched along classical lines but which seems to have met with reverses which are attributed mainly to the lack of support from management. Tunisia is an attempt to use a new approach mainly integrating family planning into the occupational health services. And finally Zambia is an example of a government program implemented from the national level by a unit in the Ministry of Labour and Social Welfare.

Of the six projects included in this collection of case studies, the Kenyan one is the most sophisticated. Before implementation, criteria were defined for the choice of the plants where the sub-projects would be situated. So far the chosen establishments have been those which are well provided with services, and function on a relatively modern pattern of management and production. Records have been kept, and some research is completed. Intensive information, education and communication activities are an integral part of the program and include the use of different forms of folk art. The strengths of this comprehensive approach are also one of its weaknesses because repetition will remain a problem, at least on a large scale, as new companies entering the program are smaller, less sophisticated and perhaps more traditional in outlook.

In contrast with the Kenyan study, the program outlined in the contribution from Sierra Leone deals with rural areas, and is based on the introduction of family welfare planning activities through the Cooperative movement. The study is particularly interesting for its local colour and original experiences in dealing with rural populations still in the early stages of development. It is also interesting in its attempt to utilize an existing structure with around 1,000 cooperatives with a membership of 50,000 of whom 16,000 are women. Some of them are grouped in exclusively women's cooperatives. The fact that the impact of this program has been felt not only in the rural areas but also in the country, is worthy of note.

Finally, the mixed nature of the target group of the Sudan study deserves special mention. The Gezira province development scheme is at the heart of Sudanese economic life. It is the cotton growing area of the Sudan, but now also includes a number of industrial establishments. The family welfare project consequently has to encompass the various different categories of the population covered by the development scheme. Hence, it has a very heterogenous target audience which includes agricultural and industrial labourers, migrant agricultural workers, peasants owning land, and agricultural tenants. Of the two and a quarter million people living in Gezira Province, the very modest family welfare planning activities can only cover a limited percentage of this total. The value of this case study is perhaps that it shows, in all its starkness, the problem which faces population programs even in the relatively more developed areas of the developing countries.

The three studies highlighted in the above paragraphs are completely different in terms of audience. One is entirely industrial, the second entirely rural,

while the third is a mixture of both. Such diversity is the essence of this volume. As stated in the opening sentence of the introduction: "This is not a manual"; it is merely an attempt to show what has been done; what can be done and what remains to be done. Along the way an attempt is made to suggest how pitfalls may be avoided! The variety contained in the volume may enhance the utility and interest of these studies and show how original approaches and thinking are a requisite in dealing with the complex area of Family Welfare Planning for the organized sector in Africa.

THE PRIVATE ORGANIZED SECTOR APPROACH TO FAMILY PLANNING IN KENYA

by

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Family Planning Private Sector Program, Kenya

I. INTRODUCTION

In 1983 the Government of Kenya, in discussions with the United States Agency for International Development (USAID), requested funding for a program that would encourage non-government organizations to add family planning services to already existing health facilities. Though the program was to be available to all non-government organizations, emphasis was to be placed on the private sector, particularly the large employer.

The program, which emerged after competitive bidding, was contracted to the John Snow Research and Training Institute, a non-profit arm of JSI, a Boston based Health Management consulting firm. The JSI team that was to implement the Family Planning Private Sector Program (FPPS) began operations in Kenya in January 1984. This paper will describe the establishment and growth of the program concentrating on several of the larger employers who have established family planning projects.

II. ESTABLISHING THE FPPS PROGRAM

The FPPS team developed a brochure outlining the program. This was sent to all approved non-government health facilities. The response was rapid. Within the first few months site visits were made to projects, and proposals were developed and submitted to the National Council for Population and Development (NCPD) for approval. The government asked the NCPD to set up a Technical Advisory Committee headed by its Chairman to monitor FPPS and approve all projects. By July 1984, the first two projects were established. In the meantime, the FPPS team had made contact with the Congress of Trade Unions (COTU) and received support from its leadership and from individual trade unions. Similar support was received from the Federation of Kenyan employers.

The major objectives of the FPPS program are:

1. To establish 30 sub-projects offering a full range of family planning services on a daily basis to the population served by the health facilities of the organization. These were employees, usually with their families, and sometimes members of the wider community, especially in remote areas.

2. To recruit 30,000 new acceptors in the four year program period.

3. To train 200 clinical officers, registered nurse/midwives and enrolled nurse/midwives in all aspects of family planning service delivery including maternal and child health. This is done through a contract with the African Medical and Research Foundation (AMREF). The nine week course uses an updated and revised curriculum based on that offered by the Ministry of Health. The two curricula are now consolidated. The actual physical facilities are provided by the organizations. The organizations agree to continue the family planning program as well as ensure the provision of services after the expiration of the two year FPPS grant. The FPPS program offers organizations the following assistance:

1. If there are sufficient staff members qualified for training in family planning service delivery, FPPS provides the training at AMREF, and funds for replacement staff during the nine weeks of training. If additional staff is required, FPPS can provide full-salary and benefits for two years for the hiring of enough staff to ensure that family planning services are offered on a full-time basis.

2. If supplementary staff such as field educators and record clerks are needed, funds can be provided for up to two years to pay for them. In all cases where FPPS provides funds for staff, the organization commits itself to keeping them on the payroll when the assistance ends.

3. When space is made available, all equipment necessary to provide a full range of family planning methods (except surgical contraception) is provided.

4. Technical assistance is provided for project design, clinic management and administration.

5. Funds are available for information and education activities.

6. A records system is provided to continue monitoring all projects. In selected projects, baseline information will be collected.

7. A full range of contraceptives from the Ministry of Health when the clinic is registered as an SDP. These are provided free to the clinic, and by the clinic to the clients.

III. ESTABLISHING FPPS SUB-PROJECTS

The request for projects came in from a wide variety of organizations. Criteria were soon established such as size of work force; proximity of other family planning facilities; potential numbers of new acceptors and continuing users; and commitment of management to the welfare of workers as expressed by the provision of other benefits.

The FPPS team visited projects and worked with management. Where possible, they worked with unions to determine the right mix of funds, services and technical assistance to ensure the establishment of viable family planning services. Encouraged by the government and USAID to be innovative, the resulting projects range from large scale multinationals such as Brooke Bond with its tea, coffee, flour, and sisal estates and Kenya Canners with its pineapple plantations and factory; medium sized companies and plantations such as Kenya Cashewnuts, Kenya Flourspar and Panafrican Paper Mills; to small private doctors, firms and clinics such as Canaan Medical Services in Nairobi and Kangaru Clinic in Embu. These doctors and

clinics have contracts to provide health services to firms and organizations who are too small to operate viable health facilities.

By mid 1986, after two years operation, contracts had been signed with eight organizations and over 70 new family planning service delivery points had been opened. In many firms the addition of family planning services has led to a demand for maternal and child health services. These firms have been assisted by the Kenya Expanded Programme for Immunization (KEPI). Many also operate ante and post natal clinics. Requests for FPPS assistance are increasing. Following the recommendation of the mid-term evaluation in February 1986, twenty additional projects are to be developed and 20,000 additional new acceptors are to be recruited

Some of the sub-projects have been exceptionally successful, far exceeding their targets of new acceptors and showing high rates of current users. The majority have managed to reach their targets. Several firms, though initially requesting a project, have not followed through for a variety of reasons. A major factor in the successful operation of a project has been the enthusiasm of management. Where management has been clearly committed, new facilities have been built and existing facilities expanded and refurnished. Medical staff have been hired, trained and encouraged to spread the family planning message. Without the commitment of management, clinic staff have often been blocked in their efforts to expand the program and to reach the workers and their families. Promised facilities have not been provided, and the bare minimum of acceptors have been recruited. Fortunately, this has happened in only three of the on-going projects and in three projects which did not materialize.

Table 1 summarizes the results in terms of use of services by populations associated with the various projects through the end of October 1986. The table gives the months the project has been in operation; the name of the organization; the users by contraceptive methods; the numbers of new acceptors recruited; the target date and percentage achieved.

TABLE 1: FFPS PROJECTS BY CONTRACEPTIVE METHODS USED IN OPERATION, NEW ACCEPTORS RECRUITED AND PERCENT OR TARGET ACHIEVED

MONTHS IN OPERATION	COMPANY	PILLS (1)	CONDOMS (2)	VASECTOMIES (3)	FOAMING TABLETS (4)	INJECTABLES (5)	IUD'S (6)	TOTAL USERS	NEW ACCEPTORS REPORTED	TARGET OCT. 1986	% ACHIEVE
28	Miwani Sugar	5	14	10	--	23	48	357	737	700	105
28	Panpaper	14	33	--	2	13	36	289	453	400	113
27	Kenya Canners	19	17	2	1	17	44	1111	1043	1200	87
27	Nzoia Sugar Co.	7	66	--	1	15	11	845	1771	900	197
26	Kenya Flourspar	21	25	6	--	13	35	146	238	250	95
25	Kenya Cashewnuts	48	9	2	--	32	9	266	219	250	88
22	Brooke Bond Naivasha	20	45	2	1	11	21	880	886	1100	81
21	Chemelil Sugar	18	19	--	--	6	57	187	189	710	27
21	Brooke Bond Mabroukie	29	34	1	--	8	28	349	318	415	67
21	Brooke Bond Kericho	5	75	3	7	6	4	1149	314	1540	20
20	African Highlands	11	70	3	1	11	4	761	529	1000	53
16	Brooke Bond Sulmac (SISAL)	15	13	--	1	23	48	162	147	230	64
15	Kenya Breweries	20	14	3	1	37	25	365	361	610	591
15	Oserian	16	56	--	--	17	11	219	87	130	67
10	B.A.T. Kenya	31	37	6	2	12	12	49	81	65	125

Note: Current users of family planning are calculated from monthly records of contraceptive distribution by clinics as follows:

(1) Number of cycles of pills distributed in 12 months divided by 13
(2) Number of condoms distributed in 12 months divided by 100
(3) All surgical methods
(4) Number of tubes of foaming tablets divided by 100
(5) Injectables dispersed over previous 3 months
(6) All IUD's inserted

It should be noted that there is considerable variation in the mix of contraceptive methods in the various projects. Usually when a doctor is employed in the clinic and is trained in family planning, there is a much heavier emphasis on clinic methods such as the IUD. Where there is an active and ongoing information program and community based distribution of contraceptive methods, the oral contraceptive and condoms are favored.

The table also shows that the majority of organizations which have completed their two year grant period were close to achieving their targets or exceeded them. The targets were somewhat arbitrary and were decided on the basis of an assessment by the clinic staff of patient demand, and what seemed reasonable to expect, given the size of population served and the number of the staff providing family planning. Seven establishments exceeded 80 percent or more of the target. Two of the firms achieved less than 30 percent of the target. The first, Chemelil Sugar Company, was reviewed as a case study and the causes of failure were identified as lack of management support and an emphasis on clinic based services. The other, Brooke Bond Tea Company initially based its program at the hospital in Kericho. After FPPS had trained 19 dressers at outlying dispensaries in a community based distribution (CBD) program the number of male acceptors shot up dramatically. Thus Brooke Bond is shown as having more than three users of contraceptive methods for each acceptor. This highlighted a major problem in recording new acceptors who, because of clinic based methods such as the IUD, injectable, orals and tubal ligations, are mainly female, whereas the population being served is mainly male.

IV. PROJECT BASED INFORMATION, EDUCATION (IEC) AND MOTIVATION ACTIVITIES

Though FPPS was funded as a family planning service delivery project and was expected to rely on IEC activities provided by the Ministry of Health and the Family Planning Association of Kenya, it was soon clear that these services were neither adequate nor appropriate. Additional funds were therefore sought to prepare materials and organize local activities.

One of the problems of many IEC activities is that they are generally centrally organized on a nation-wide basis. FPPS IEC activities are project specific and are based on conditions found in each organization. This takes into account local development needs and adjusts the level of the program accordingly. It fits the education and economic level of the community, and capitalizes on local technical expertise.

a) IEC Committees

At each project site, a local IEC committee is formed. The IEC committee consists of management representatives, usually from the personnel or welfare department; clinic management and a doctor or nurse coordinator; worker representatives, shop stewards, cell and village leaders; local leaders, the District Officer, Chief or Assistant Chief, and village leaders; leaders of local women's youth and church groups; and local agencies including community development workers and representatives of the Ministry of Health and the Family Planning Association of Kenya (FPAK). Each committee is asked to appoint a coordinator and to explore the information needs of the community; to plan and budget IEC activities; and to recruit locally-based motivators. The committee also acts as spokesmen for the program and to lend it respectability and credibility. FPPS staff and consultants held working sessions for the committees and trained the coordinators in IEC methods and techniques.

b) Educators and Motivators

An essential element in the IEC program has been the use of committed educators and motivators. These have included volunteers who are respected women, teachers, church members, and worker representatives. They also often act as community based distributors of non-prescription methods. Other motivators are drama and music teachers, and leaders of performing groups who use dance, drama, songs and poetry to entertain audiences and disseminate family health messages. Finally there are the full-time health educators employed by the company who visit homes, talk to groups, and counsel individuals on the need to plan families and improve understanding of the available methods.

c) Training

Training of various levels of workers is both situation specific and general. Situation specific training is done on-site, on a project by project basis. General training brings together a number of participants who perform identical functions in several projects.

Specific training consists of project visits to evaluate and discuss strategies with implementing personnel. The orientation of the committee members is done for one day to discuss program objectives, policies, activities and plans. The training of volunteer motivators and media producers on benefits and methods of family planning, communication methods and media production techniques, takes place at project sites for three days, and it involves practical exercises.

Resource persons and facilitators come from local health agencies, site project implementors, and Nairobi based organizations and universities. In most of the training events, analysis of local beliefs and practices and learning needs is emphasized. The discussions of roles of various cadres as well as planning of implementation strategies is given emphasis while theoretical issues are kept to a minimum. Skills in how to reach

and communicate with clients in interpersonal situations seem to be needed most by participants with requests centering on how to counter rumors, and fears of side effects caused by contraceptives. Traditional, religious and pro-natalist reservations about adoption of family planning rank next as the category of problems or obstacles facing project implementors and volunteers who now seek to overcome them.

4. IEC METHODS AND MATERIALS

The following methods are used:

a) Addresses to group meetings such as those organized by local leaders, e.g. church congregations, youth clubs, women's groups and local community meetings - There are often occasions when only general information can be disseminated since these groups are mixed and not suitable for detailed teaching on contraceptives. Some people in the audience become sensitive to the mention of body parts and sex. The objectives of family planning, policies and education on methods, side effects and procedures for method choice are discussed.

b) Small group education - This is often done at the clinic while patients wait to be attended. Fairly detailed discussion of methods and side effects is done.

c) Individual counselling - In depth discussion of how methods work and their suitability to clients is done in consultation rooms or at their homes to enable them to choose or change methods. This is particularly suitable for new acceptors, the undecided and dropouts. Where volunteers, community based distribution (CBD) workers, and field educators are not able to deal with difficult issues they refer clients to medical personnel or satisfied acceptors.

d) Use of folk entertainment media - Church choirs, traditional dance groups, school choirs, youth performers and singers, story tellers and poets are trained to select relevant health messages and compose acts using drama, songs, dance, poetry and stories to be performed in public.

e) Film shows, open air shows and presentations for small groups - The films are followed by questions and answers and then discussion. These are very popular due to the general lack of entertainment in most communities. Such activities are not confined to family planning related films but also include general interest and feature films.

f) Public shows and displays of works of art (posters, paintings, and cultural artifacts) on health and family planning are effectively used.

The following materials have been prepared, distributed and used as visual aids:

a) Posters for public viewing - A series of posters on small families, education, land, food, breast feeding. The Ford Foundation provided funds to organize a project involving 15 leading African artists in the design of family planning posters. Family planning messages for specific target groups relating to development themes were first formulated at a workshop involving representatives of all organizations conducting health and family planning activities. These were discussed by the artists who then, over a two-week period, prepared over 80 paintings and posters. These were pretested at project sites around the country and changes were suggested. An exhibition of the paintings was presented in Nairobi and then, with funds provided by Family Planning International Assistance, selected paintings travelled to projects all over Kenya further stimulating interest in family planning. Six of the paintings have been produced as posters with messages in English and Swahili.

b) Family planning calendars - Calendars featuring paintings by some of the African artists illustrating themes relating to teenage pregnancy, hunger and poverty, fatherless families, and unemployment were produced for 1986 and distributed not only to FPPS projects but also to hospitals and clinics throughout Kenya. Several of the FPPS companies sponsored the calendars. The 1987 calendar will feature themes relating to family planning and spacing, breast feeding, the burdens of a large family, hunger, poverty, sex education, and the joy of a small family.

c) A series of brochures - Titles including: "Family planning for men", "Family planning for women", "What boys should know about family planning", and "What girls should know about family planning" have been produced in English and Swahili. Brochures on sexually transmitted diseases, AIDS, advantages and disadvantages of various contraceptive methods and a directory of the locations of family planning services are planned.

d) A poster listing the rights and responsibilities of clinic and client has been produced for display in clinics.

Special mention must be made of folk media which has become a major feature of the FPPS IEC program. The leading television comedy group, the Vitimbi Players, were asked to prepare two plays relating to family planning. They toured project sites and performed to extremely large and enthusiastic audiences. Soon requests came to FPPS from the projects for assistance in developing their own folk media groups. A consultant was engaged to train local teachers and others interested in play writing, acting and productions. The result has been a veritable outpouring of poetry, song and drama. FPPS staff are continually asked to attend field days where women's groups, youth groups, secondary and primary school pupils and sometimes men's groups sing, dance, recite and perform family planning related materials. The exercise now involves many thousands of adults and youth, all performing, watching and listening to family planning messages and the problems of large families.

FPPS is now seeking funds to harness these activities by organizing a folk media festival. Local groups will be selected to perform in regional festivals. The outstanding regional groups and individuals will be brought to Nairobi to perform in a three-day national folk media festival titled "Dramatic Visions of Family Planning". In this way, national attention will be focused on the interest and enthusiasm for family planning being shown in the non-government sector. Some of the groups will be recognized for the long hours of preparation they have volunteered.

A folk-media manual is being prepared and a video training tape will be produced. The entire exercise will be evaluated for its impact at the local and national levels in terms of changing knowledge and attitudes of family planning and motivating couples to use family planning services.

Operational Research

The FPPS program has also funded a number of operational research activities. These increase knowledge and understanding of key family planning issues. They also involve the sub-project staff in research and disseminating results to the management and IEC committees. This gives motivators a better understanding of the issues and problems and consequently, a basis for dealing with them in their educational activities.

1. Baseline Survey on Fertility Related Factors of Family Planning Practices

The Survey sampled 15 of the demonstration projects selected from all provinces of Kenya in order to adequately represent the social and cultural diversity of the country. The study emphasizes male perception of family planning on the premise that it is males rather than females who make important household decisions, including decisions on the number and spacing of children. It also provides information on the characteristics and aspirations of project employees with respect to health services in general, as well as the pattern of contraceptive use prior to implementation of FPPS activities. The report therefore will be used for providing a benchmark against which to measure progress of the FPPS, and has also provided a basis for developing and implementing an effective IEC program.

2. The Impact on Income on Family Size and Family Planning Practice

This study was based on an assumption that success of FPPS demonstration projects depends both on the cooperation and support of management and on the attitudes of the target population itself. Acceptability of family planning depends on the employee's attitude towards family planning and family size. These attitudes are thought to be influenced by wages, salaries, and non-pecuniary benefits. The report provides data which would be useful in encouraging employees to view their benefits in a manner likely to facilitate improvement in their standards of living. This is particularly important given the fact that the findings of the study show that regular wages, salaries and benefits provided to the employee by the employer tend to encourage couples to have more children because they provide the means of feeding additional mouths.

3. The Cost Impact on Family Planning Programs in Private and Non-Governmental Organizations

The objectives of the research were as follows:

- identify whether there are sound economic reasons for companies in Kenya to add family planning to their services, and

- demonstrate the cost impact of reducing the number of children born to employees.

The major finding in this study is that, in the long run, private sector institutions which include family planning in their health care are likely to spend less on health related problems of the employees and their dependents, particularly women and children. The companies are also likely to increase the level of productivity as a result of the reduced incidence of maternity leave. The findings of this study provide relevant information for convincing management in the private sector as well as policy makers and planners, of the need to incorporate family planning into private sector operations.

4. Operations Research on Alternative Approaches to Family Planning Service Delivery

The broad objective of this study is to assess four main family planning service delivery systems in Kenya in terms of relative cost per acceptor, cost per year of protection provided for the couple, relative advantages and disadvantages as perceived by clients and potential clients, and actual prospective change agents. Listed are the four service delivery systems:

- Static Clinic
- Mobile/Outreach Units
- Community Based Distribution (CBD)
- Commercial Outlets.

The project is being implemented as a joint venture with the Family Planning Association of Kenya (FPAK) and Maendeleo Ya Wanawake (MYW). FPPS is funding the project.

5. Follow-up Baseline Survey

The main purpose of the follow-up Baseline Survey is to assess the progress made by sub-projects over time, and to determine the difference between contraceptive prevalence at the time FPPS activities were initiated and at the time of the survey. Continuation rates will also be calculated to provide information on drop-outs.

Assessment of the impact on various IEC activities will be made during the follow-up of the Baseline Survey. The information obtained as a follow-up to the Baseline is expected to provide a solid basis for making important management decisions on FPPS sub-projects and on identifying and implementing appropriate intervention activities likely to enhance project performance.

Future Plans

Dissemination of operation research findings will be prominently featured in FPPS activities in 1987 and 1988.

V. CONCLUSION

The FPPS program is now entering its fourth year. During that period it has established 30 projects in the private and non-governmental sector specified in the program objectives. These projects provide over 90 new family planning service delivery points and have recruited almost 20,000 new acceptors of family planning. The mid-term evaluation endorsed the approach and recommended that since the demonstration had proved effective, the program, as requested by the government of Kenya, should be extended and expanded. Twenty more projects are to be added and a total of 50,000 acceptors recruited.

FPPS has stressed that the projects are the responsibility of the individual organizations, and not FPPS. Unsolicited requests for FPPS support are still being frequently received. Avenues of funding are now being explored to assist successful projects in expanding the reach of their MCH/FP services to the surrounding communities. A number have completed the two years of FPPS assistance. In all cases the firms or organizations have taken over the responsibility for funding and services, and motivation activities are continuing.

Throughout, the program has been under the coordination and supervision of the National Council for Population and Development (NCPD). The Technical Advisory Committee (TAC) has representatives from the Ministry of Health, the Family Planning Association of Kenya, the Ministry of Finance, private interests, the University of Nairobi and USAID. It initially met bi-monthly to approve projects but now meets less frequently and has delegated authority for approval between meetings to the chairman who is also chairman of the NCPD. This mechanism has proven to be effective at ensuring government support with a minimum of actual involvement in the projects. The TAC is also a vehicle for dissemination of information about FPPS activities.

As the program developed, the scope of FPPS activities expanded. Originally mandated only to help establish expanded family planning delivery services and ensure the provision of trained service providers, repeated requests from projects for information and education activities led to TAC endorsement and USAID (and other donors) provision of funds for IEC activities. Posters, brochures and calendars have been produced, folk media activities initiated, and IEC coordinators committees and field educators trained in all projects. Similarly, project demand for maternal and child health services to be coupled with family planning has led FPPS to provide links for projects to the Kenyan Expanded Program of Immunization (KEPI) and provide basic information and equipment for such services.

Operational research projects are providing evidence of reduced benefit costs to employers through the provision of family planning services. Fewer prolonged absences due to maternity leave, less absenteeism for pre and post natal care and sickness of children, and less time off work to seek contraceptive services all add up to savings for both the company and the employee.

The majority of projects supported by FPPS have proven to be successful. Failures can often be attributed to lack of management interest and support. The provision of funds for private sector initiatives in establishing efficient family planning services at work sites has often shown that reasons for Kenyan resistance to family planning lies less in cultural and social barriers than in the lack of access to information and services for family planning. The FPPS approach in creating an alternate family planning delivery network throughout the country in factories, plantations, private clinics, and mission hospitals has improved availability of services and relieved pressure on overcrowded and understaffed government clinics. There certainly is a case for expanding this private sector approach.

CASE STUDY 1: KENYA CANNERS

This enterprise is one of the larger multinational related employers in Kenya employing over 6,000 workers, 4,000 of whom work in the plantations while 2,000 (three quarters of whom are young single women) work in the canning factory. The plantation workers live in four villages in staff quarters. Some seven hundred casual workers are sometimes housed. The majority of the cannery workers use their housing allowance to seek accommodation in a nearby town. Transportation is provided by the factory.

Each plantation village has an elected village committee. A social welfare worker handles the welfare needs of the workers and their spouses. She organizes women's groups which conduct income generating and cultural activities. Housing supervisors are also employed to oversee housing conditions. The company provides eight nursery schools and employs 12 teachers to run them. Free medical services are provided, as is two months of maternity leave. At any one time 25 to 30 employees are on maternity leave. High population growth is making it more and more difficult for the company to upgrade, let alone maintain this high level of service.

The company has five clinic dispensaries for providing health services, one at the factory and one at each of the plantations. They operate on a shift basis to provide full-time outpatient services. The clinics are staffed by a clinical officer, 10 enrolled nurses and two ungraded nurses. On the average over 8,000 patients are seen each month. At the outset, when FPPS was asked to develop a family planning project, a minimal MCH/FP program operated. Oral contraceptives were distributed but less than sixty employees or their spouses were registered as users. No immunization and pre or post-natal services were offered. Clients requiring MCH/FP were usually referred to the district hospital or private doctors in the town which is 10 km from the factory and 30 km from the farthest plantation dispensary. Workers were faced with long walks or transportation costs, forfeiture of pay for lost work time, and in some cases medical fees.

FPPS was requested to review the situation and assist the management and clinical staff to develop a family planning project. The management was fully committed to the project and expressed the wish to establish "a model family planning program which would be an example to other firms". This was, in fact, one of the first projects that FPPS funded.

FPPS inputs into the project were as follows:

1. Full salary and benefits for one registered nurse/midwife coordinator and one clerk for two years

2. Training in the delivery of family planning services for the clinical officer and 10 nurses for nine weeks each and the payment of replacement staff while they are away

3. Technical assistance in administration, management record keeping, information, education and communication, monitoring and evaluation

4. Five complete sets of family planning equipment to provide complete range of contraceptive services in the plantation and the factory (except surgical sterilization).

Listed are the company inputs:

1. Expansion of dispensary facilities where necessary to provide space for family planning services

2. Staff time for supervision; the release of nurses for training; social worker and housing supervisors for IEC activities; the part-time services of a doctor to consult on family planning and MCH problems

3. Transportation of employers or wives to the nearest medical facility for surgical contraception for those who request such services

Over the two-year grant period a target of 1,400 new acceptors of family planning services were to be recruited. An IEC campaign was to be planned by a committee composed of representatives of management, unions, clinic staff, workers and their families and community leaders. Activities were to include: workshops for village committees; use of posters, flip-charts, films, etc. to provide information; lectures and discussions to dispel rumors; follow-up visits to clients who miss appointments; and coordination with local Ministry of Health and Family Planning Association personnel to provide information and education.

The total cost of the project is KShs. 562,544 or about $35,000. After six months it became clear that two field educators, one clinical officer and additional equipment would be needed. These were provided at an additional cost of KShs. 300,000 ($18,750).

In addition to the above, the company was one of 16 where a baseline survey was conducted. Two hundred female and 100 male employees together with 33 opinion leaders were interviewed. The study was supervised by the welfare officer, whereas the social worker assisted in the data collection.

The company certainly succeeded in establishing a model family planning program, and in creating one of the most successful of the FPPS projects. The clinic recruited well over 1,000 acceptors. Through its community based program, the clinic distributed over 30,000 condoms to its male workers. The continuation rate is well over the 60 per cent target that they agreed to maintain. They appointed a representative committee who planned an extensive IEC program of seminars for opinion leaders, shop stewards, nursery school teachers and workers. Meetings were scheduled with many groups of employees, shop-stewards, security men, and women's groups where lectures and discussions on family planning were conducted.

The popular Voice of Kenya theatrical group, the Vitimbi Players, performed two family planning plays in each of the five plantations and drew huge crowds, total attendance being over 7000. This was followed up by the training of troupe leaders in drama, song, and poetry production, which resulted in field days of songs, stories, plays, and poems on family planning

presented by primary and secondary school children, women groups, and employee groups.

The programme is continuing vigorously after the completion of the FPPS financial assistance, though the FPPS team continues to give technical advice when called on.

CASE STUDY 2: NZOIA SUGAR COMPANY

This company is a parastatal organization employing 2,300 permanent employees and 3,000 to 5,000 casual labourers for weeding and cutting. The area owned by the company and the outgrowers has a 20 km radius and comprises some 14,000 hectares. The 6,400 outgrowers are closely linked to the company. Thus, over 12,000 people and their families are dependent on the company, the rest of the permanent staff being paid a housing allowance. Two nursery schools are staffed and four teachers are provided. Free medical services are provided to permanent employees. Families pay a nominal fee. Polygamous wives and their offspring pay slightly higher fees. The clinic is staffed by a full-time doctor, 2 clinical officers, 1 laboratory technician, 1 registered nurse/midwife, 2 community nurses, and support staff and attends to about 250 patients a day on an outpatient basis. Minor surgery and laboratory tests are available. Serious cases are sent to the District Hospital by company ambulance.

MCH services such as ante and post natal care and immunizations are provided by a mobile Ministry of Health team twice a week. Prior to the start of the FPPS project minimal family planning services were offered-mainly oral and injectable contraceptives. Only about 10 family planning clients a week were seen, though demand for services was said to be high. Motivation was confined to lectures.

The management of the company was keen to add family planning services and applied to FPPS for a project. After a thorough review of the existing services the FPPS team and management agreed on the following inputs:

1. FPPS would provide full salary and benefits for a nurse and social worker for two years.

2. Training would be provided in family planning service delivery by the African Medical Research Foundation (AMREF) for two nurses and two clinical officers. Nine weeks of replacement salary would be paid for each while they are away on training. Also to be provided is technical assistance in clinic management administration and record-keeping; a record system; a complete set of all equipment to provide a complete range of family planning services; IEC materials and audio-visual aids, assistance in planning a locally based IEC program plus training in IEC methods for selected staff; assistance in monitoring and evaluation along with the implementation of a base line survey.

3. Nzoia Sugar was to provide space for a family planning clinic, i.e. construction of a new facility; the services of a doctor to supervise the program; clinical officers and nurses for implementing training courses as well as providing family planning services; a welfare officer and nursery school teachers for IEC activities; space for IEC motivational activities; and the ambulance for transporting clients to the nearest facility for surgical contraception. The project was to recruit 1,500 new family planning acceptors in a two year period. The total cost of the project was KShs. 342,800 or $21,450.

Throughout the two years of the project the initial enthusiasm for motivating families and providing family planning services has remained. Everyone involved including the managing director, personnel manager, doctor and clinic staff have shown a strong commitment to the program.

A new clinic was built, new staff were hired, and existing staff have been trained. An IEC committee was appointed, and the social worker was trained in communication methods.

The committee met quarterly and planned an ambitious program of workshops, lectures and media activities aimed mainly at men. Included were these activities:

1. A seminar for 39 opinion leaders included briefing on the program, and family planning methods with planning support of activities.

2. A seminar for female employees and employee's wives included briefing and appointing women representatives to the IEC committee.

3. Seminars for Kenya African National Union (KANU) youth officials, women's group leaders, teachers, etc.

4. Lectures given at chiefs and sub-chiefs barazas (public meetings); for youth groups and village polytechnics; primary and secondary schools; and to employees and employee's spouses.

5. Individual counselling to men in polygamous families.

6. Home visits conducted for motivation and follow up on clients who missed appointments.

7. Training of drama and choir teachers with the help of an FPPS consultant. Scripts were written and actors were identified among employees, women's groups and in schools. Plays, poems, songs and stories with family planning themes were rehearsed and presented to large audiences including local officials.

8. Distributors were trained, and a community based distribution program was launched, over 50,000 condoms have been distributed.

9. Family planning films were shown and posters were distributed.

10. The baseline survey was conducted. A random sample of 345 employees and spouses were selected and interviewed on a wide range of topics. The results were reported back and incorporated in the IEC lectures and counselling.

As a result of these activities, the initial target figure of new acceptors was exceeded and continuation rates were very high. Interest in family planning in the community is high. FPPS organized a tour of IEC coordinators to attend a field-day of folk media at Nzoia so that they could witness the high standard of IEC activities.

CASE STUDY 3: CHEMELIL SUGAR COMPANY

This company is a parastatal sugar company situated in Nyanza Province. The total area under cane in the nuclear estate is 3,110 hectares. Cane is also bought from outgrowers. The company provides free housing and water to its employees. Transportation is provided to the workers. A primary school with eight teachers is provided, as is a nursery school with several teachers. Plots are provided for vegetable gardens.

There are 1,500 men and 28 women employees. Approximately 2,000 wives live on the estate. The total population is over 8,000. In addition, there are about 500 casual workers not housed, and about 1,000 families in the community. The community pays the costs for drugs but gets other services free.

The clinic has a manor theatre, a 12 bed maternity ward, consulting rooms and transportation for serious cases to the district or provincial hospital. The staff includes a doctor, three clinical officers and four nurses. Over 4,000 patients are seen per month. MCH services are available, but at the time the company approached FPPS, no family planning services were offered and no contraceptives were supplied.

The company and FPPS developed a project which would contribute the salary and benefits for a nurse/midwife and field educator for two years each. It would train five clinical officers and nurses already employed in family planning service delivery and provide funds for replacement staff while the staff were being trained. Also provided is technical assistance in management and record keeping, education and motivation, monitoring and evaluation; supplies and equipment to fully equip a family planning service delivery clinic; information and educational materials, and visual aids and funds for IEC activities.

POPULATION/FAMILY WELFARE EDUCATION THROUGH COOPERATIVES

by

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I. INTRODUCTION

Sierra Leone is situated on the West Coast of Africa between 7° latitude, 10° North and 10° longitude, 13° West. Sierra Leone is bordered by the Republic of Guinea in the North-West and North-East, and by the Republic of Liberia in the South-East, and by the Atlantic Ocean on the South-West. Sierra Leone is a tropical country, similar to Ceylon and Panama. Because of its location, it has tropical characteristics including climate, vegetation and soil. The soil is the laterite type and extends from the mountainous and hilly regions of the North-East to the lowland regions of the South-East.

Sierra Leone has a total land area of some 27,935 square miles (73.326 Km), with a total population of nearly 3.7 million people. The country is relatively small; smaller than Ghana, Nigeria, and Guinea, but bigger than Gambia and Togo. It is almost circular in shape, and from the extreme West to East and North to South, there is no straight line distance that is more than 200 miles.

The country is divided up into four major administrative regions, the Western Area, and the Northern, Southern and Eastern provinces. The three provinces are subdivided into twelve districts. Each district is subdivided into chiefdoms.

It has a heterogeneous population in terms of race, national, and ethnic groups. Today, a mixture of various ethnic groups is found in every part of the country, though certain areas may be occupied by a greater number of one ethnic group than the others.

Sierra Leone's population is largely indigenous. In 1963, the people of Sierra Leone comprised 97.3% of the total population of 2,180,355 (1963 census). They are grouped into 18 ethnic groups. Since Independence, the non-national population has grown modestly from 2.7% (1968) to 2.9% (1974) of the total population.

Sierra Leone's population is predominantly rural at 75.5% (1984), (UN 1985), although the urban population is growing increasing fast. Urban growth may be attributed to both natural increase (fertility) and migration.

The 1974 census revealed a population of 2,738,159 while the 1985 preliminary census results revealed an unadjusted population of 3,517,530. This reflects a growth between census of 28.60% or an average annual growth rate of 2.31%.

The population is very youthful; about 40% is under 15 years of age. In 1982 the crude birth rate was estimated at 49 per 1000 population and the crude death rate at 27 per 1000 population. The life expectancy is exceptionally low, being only 37 years for males and 39 years for females. Thirty-four percent of all deaths in the country occur among infants. Infant mortality is very high; for the whole country the rate is between 225 and 250 per 1000 live births (Okoye 1980). However, recent estimates put it at around 190 per 1000 live births. The total fertility rate is 6.5 per woman.

Historically, the mining sector played a dominant role in the nation's economy. But over the years, agriculture has emerged as the mainstay of the country's economy. It provides jobs for about 80% of its manpower, and

accounts for one-sixth of the country's export earnings while contributing about 40% of the country's export income.

II. GOVERNMENT ATTITUDE TOWARDS FAMILY PLANNING

Although the Government has not yet formulated a clearly defined policy on population and family planning, the interest and commitment of government to promoting family planning and related activities in the country is manifested in the 1974-1979 development plan as well as in the documents dealing with the relationship between population and development. The 1974-1979 Development Plan, states that:

> It is generally recognized that a population growing too rapidly aggravates many economic and social problems. The increase in demand for food, clothing, housing, sanitation and drinking water as well as education, medical care and other social services is largely determined by the growth rate of the population. As the population grows rapidly, the increase in income and consumption per person slows down, among other things. Moreover, the increase in national consumption caused by rapid population growth tends to reduce the share of national product available for investment in physical and human capital for the development of the country.

The Government's commitment to family planning was also manifest in the Sierra Leone country statement at the second African Population Conference in Arusha Tanzania (1984). Among other things, it states that:

> The Ministry of Health, through its experience in cooperation with the Planned Parenthood Association of Sierra Leone (PPASL), and the Fertility Advisory Services Project, seeks to extend the provision of family planning services to 120 locations containing maternal child health centres in Sierra Leone, serving roughly about two thirds of the population of the country.

The terms of reference of the National Population Commission set up in 1982 include the formulation of a population policy, the promotion and fostering of an integrated approach to family planning development, and the general coordination, promotion and integration of population activities into planning in Sierra Leone, including family planning programs.

The government has translated words into action through the establishment in 1980 of the Fertility Advisory Services clinic at the Lumley Health Centre near Freetown, which provides family planning services to surrounding settlements, as well as training in maternal child health (MCH), and family planning (FP) for all categories of health personnel.

The Ministry of Health has also set up a Family Health Initiative Program, which provides MCH/FP services in government hospitals and health centres.

III. POPULATION AND FAMILY PLANNING PROGRAMS IN THE ORGANIZED SECTOR

Although Sierra Leone has not yet approached population and family planning issues directly at the plant level, various methods have been successfully applied to reach the workers, at the plant level, as well as other members of the community.

A recent project document on the non-formal sector entitled "Population and Family Welfare Information Education and Communication", examines the family welfare education and family planning services. It introduces medical services as a part of plant-level activities in ten selected commercial enterprises. Five centres are to be located in the Provincial Regions and five in Freetown, the administrative headquarters. However, over the years several projects and activities have been sponsored by international organizations, the Sierra Leone Government, non-governmental and self-help institutions. The projects, financed by UNFPA, UNDP, IPPF, ILO, FPIA, UNICEF, WHO, USAID, and Path-finder Fund, have contributed to the population and family planning activities in various organizations. Notable among them is the Planned Parenthood Association of Sierra Leone.

Another project, which in the past four years has contributed to awareness and motivation of the public at the grass roots level in the rural areas of Sierra Leone is a UNFPA funded project executed by ILO. It was implemented by the Department of Cooperatives in the Ministry of Trade and Industry, and is entitled "Population and Family Welfare Education for Cooperatives".

IV. RATIONALE FOR INVOLVING THE COOPERATIVE MOVEMENT IN POPULATION, FAMILY WELFARE AND FAMILY PLANNING ACTIVITIES

The are over 1,000 cooperative societies spread over Sierra Leone, with a membership of well over 50,000 men and women.

In the rural areas, there are Agricultural Marketing and Producer Cooperative Societies. The man, as head of the family, registers as a member. On an average, over 85% of cooperative members are in the rural areas. Although most of the membership is mixed (men and women), there are cooperative societies with women members only. The total women membership numbers well over 16,000.

The government of Sierra Leone knows that the cooperatives are an important part of the organized sector which can be an effective channel for reaching people. Therefore, the Cooperative Movement has been encouraged to be actively involved in population and family welfare education activities.

Sierra Leone's development problems are greatly felt in the rural areas, where about 85% of the total population live as subsistence farmers. The Government's development priority is to increase the level of agricultural production and to raise the general standard of living in the rural areas.

The Cooperative Movement aims at improving living conditions in the rural areas and at assisting people to participate more effectively in the social, cultural and economic development of the nation. It aims at improving the rural people's standard of living by boosting their income through increasing production, adopting better health standards, and coordinating functional literacy with other associated rural extension services which are all designed to achieve the cooperative slogan "Better Farming, Better Business, Better Living." The Movement continues to place emphasis on the integrated approach to social and economic development, thereby involving the rural population together with other development agencies in a total approach towards the improvement of life.

V. POPULATION AND FAMILY WELFARE EDUCATION FOR COOPERATIVES 1981-1985

The aims of the program include:

(a) Exchanging ideas on the importance of population and family welfare education within the Cooperative Movement

(b) Integrating the subject of population and family welfare education into all sectors of the national cooperative education system and other institutions dealing with the education of young people

(c) Training women cooperative leaders and members of cooperative societies in order to promote better family living, paying special attention to the role of rural women in the promotion of better family life and economic development

(d) Designing curricula and training materials covering population issues such as family welfare and income, population and social development, and family health and nutrition. These materials will be used in training cooperative committee members at the local level

(e) Training a core of personnel at all levels within the cooperative system, including one representative from each society. They will be able to serve as resource persons capable of integrating population and family welfare concepts first into the normal activities of their cooperative societies and then the community at large

(f) Providing assistance to trained cooperative members in their efforts to integrate population and family welfare education into the on-going activities of their respective societies

(g) Creating an awareness and understanding in the cooperatives of the nature and implications of population and family welfare issues by incorporating population and family welfare education into their ongoing education programs

VI. ORIGINAL TARGET AUDIENCE

The specified target audience for the project covered a number of different categories. These included: policy makers in large cooperative societies and

the government cooperative department, cooperative leaders, cooperative officials, members and prospective members, and men and women in towns and villages.

VII. THE COVERAGE AND LEVEL OF OPERATION

Cooperative societies all over Sierra Leone served as the base. Nevertheless, in practice it went beyond the cooperators and involved non-cooperators particularly from the rural areas.

The program was basically a training project for future trainers. Every effort was made to increase the knowledge and understanding of the target audience about population and family planning issues with emphasis on total family welfare.

VIII. CHANNELS OF COMMUNICATION

The principal channels of communication were through seminars, workshops, group meetings, group discussions, home visits and counselling by cooperative field workers who had undergone basic training on population and family welfare issues.

Given the relatively high literacy rates prevailing even in rural areas, it was possible to use the print media extensively. Booklets, brochures, pamphlets and stickers were all used. Some were designed specifically for the project, while others already in use by other organizations, were also utilized when considered appropriate. During training and orientation meetings, appropriate films, slides, local songs, jingles and village drums were all used appropriately.

Below is a description of two major training activities, which proved particularly effective in introducing population and family welfare education to the most remote villages. These were villages which had not previously been exposed to this teaching.

IX. DESCRIPTION OF PROGRAM

One Day Orientation Meeting Approach - Community Participation

Host Organizers The Cooperative Society in the village plays a leading role in the conduct of the meetings. The cooperative society together with other facilitators and resource persons spread the news about the day and timing of the meeting in the village or town and surrounding hamlets within a three to five mile radius.

Participants: All active men, women, young and old, in and around the village participated in the project. Non-cooperators as well as cooperators participated.

Resource Persons and Facilitators: Project officials, cooperative officers, school teachers, health sisters and health educators, agricultural workers, social and community development officers, native administration officials,

local chiefs and elders including the Member of Parliament of the area formed the group of resource persons and facilitators. Activists in the area who had been exposed to population and family welfare education or practiced family planning also functioned in similar capacities, as well as political party activists, religious leaders, and other opinion leaders. These are all drawn from the area, as well as professionals outside the locality who share the same developmental aspirations.

Method: Night Program: On the night preceding the "Day Meeting," films on population and family welfare, cooperatives, agriculture and recreation (e.g. football, a commonly played game) are shown. The purpose of the following day's meeting is announced at the beginning of the film show, as well as during intervals. A summary of the important and relevant films was always prepared so that a commentary could be given in the local language of the area.

Effect: In most of these villages, electric light and film shows do not normally exist; thus, when a special show is arranged, it attracts the whole village to the meeting area. This initial event drew the attention and sustained the interest of the villagers, who looked forward anxiously to the following day's program.

The One Day Orientation Meeting: Slight variations were generally made in the scheduled program content in order to match the particular environment and cultural background.

X. DEVELOPMENT OF PROGRAM

a) **The Cooperative Society:** This is the most effective organized sector in the locality. The committee members and other active members assist in the organization of facilities for the meeting. They identify and encourage opinion leaders and youths to be involved. Sometimes the Cooperative Society donates small funds to meet incidental expenses not originally envisioned, but essential for the successful conduct and administration of the program. This introduces and encourages self-help to enable the people to conduct similar meetings in the future by themselves.

b) **The Villagers:** They assisted the Cooperators in the organization of the meeting, particularly some of the elders who were not cooperative members. They allowed the free use of the community centre, the village band and other village facilities as well as the village school facilities. In villages where they was a "Hunting" society, they organized a special hunt to provide meat for lunch as well as collect fresh fruits in season for refreshment during the day meeting.

The "Hunting Society" is a village club in which the village men join youths with hunting nets and traps to hunt bush animals and game. It also serves as a training ground for youth in bush hunting. Their contribution to the feeding creates a sense of community participation and involvement in the planning of the program. The village women have a similar society for fishing in areas where there are rivers, streams or lakes. They also make similar contributions.

Moral support and a warm welcome to the visitors and resource persons by the villagers created a feeling of acceptance and belonging. The very cordial atmosphere on this very sensitive occasion neutralized the tension and suspicion sometimes present in such gatherings when they are held for the first time.

c) **The Cooperative Department:** The cooperative department provided staff in the area of technical arrangements and other organizational matters before, during and after the meeting. This ensured smooth conduct of the program. The department initiated and assisted in the background to facilitate the success of (b) above. It was at this stage that the cooperative department field officers and motivators did their work as "change agents", soliciting the support of people for the meeting. In areas where the people were very difficult to deal with, the cooperative department staff, with the aid of other local government staff members, made up to three preparatory visits. They tactfully talked with the elders to ensure that they were interested in population and family welfare issues, and prepared to actively support the one day meeting in the village. Once the elders agreed, they were given a positive role to play in the planning of the one day meeting.

d) **Other Departments:** All collaborated with other sectors in the program. This was an integrated effort for the successful conduct of the meeting. Together, they provided multi-sectoral and interdisciplinary technical and professional input. They addressed meetings as well as became involved in interpersonal communications. Departments remained available for follow-up discussion and action, private discussion with individuals, particularly on family planning and service delivery issues. The PPA staff and health sisters attending the meeting offered their respective services after the meeting by dealing with questions and consultations, and by setting up "mini-clinics."

XI. RESOLUTIONS, RECOMMENDATIONS AND FOLLOW-UP ACTION AT THE END OF THE ONE DAY MEETING

Participants in the one-day meetings were encouraged to come up with specific resolutions and recommendations with respect to follow-up action. In this way, their long-term involvement was ensured. The various recommendations generally made during meetings can be divided into:

(a) What the villagers could do for themselves without outside help;

(b) What they could do with the assistance of the professionals and technical inputs; and

(c) Continued discussions and other activities on family planning in private homes, and the arrangement of appointments for further action particularly on family planning issues.

XII. EVALUATION OF THE ONE DAY ORIENTATION MEETING

The address by the Project Director on "What is Population and Family Welfare Education" gave the lead and set the tone for the meeting. In addition, the effect of the various addresses and demonstrations on environmental sanitation provided material for resolutions and actions concerning environmental sanitation to be reinforced. These were:

(a) Properly use the village stream and water wells;

(b) Build a compost fence, and fit drying ropes and plate racks;

(c) Improve and erect private and public toilets;

(d) Make arrangements for mobile clinics, and declare a "Health Day" in the village to ensure follow-up action that the village is clean and tidy; and

(e) Have various professionals who addressed the first meeting make periodic follow up visits to the village to assist and ensure follow-up actions. The Cooperative Society agreed to meet some of the initial expenses of these tasks, while villagers made some voluntary contributions.

Two reactions became very evident after a few follow-up visits were made:

(1) Villagers became more responsive to other development agencies. They discussed and made practical requests for technical support from these agencies e.g. request for support to erect a health centre. There was acceptance of an immunization program, particularly for the children under five years old; and

(2) More acceptors were reported by the PPA officer of family planning services. Agricultural officers reported that master farmers began to use new high yielding seeds and appropriate fertilizers.

The following is a specific example quoted from a report.

> "The President of the Cooperative Society Alhaji Humaru Sesay in his Vote of Thanks requested the Project to arrange for periodic visits by doctors and other related extension workers to their village, particularly the Civil Registration Team to set up a registration centre [for births and deaths]. He requested assistance to sink clean water wells and toilets in the village and the neighbouring villages.

The District Chairman and the Rural Area Council members who attended the meeting expressed their appreciation for participation in the meeting and congratulated the society for initiating the program. They looked forward to such programs taking place in other towns in the District. The Project Director joined the Muslim worshippers in their friday prayers. The sermon was focused on population and family welfare and how a good cooperator should behave in the community and his cooperative society. Similar reports and testimonies are recorded for other villages and other times.

XIII. ADVANTAGES OF A ONE DAY ORIENTATION MEETING INVOLVING EVERYONE AT VILLAGE LEVEL

(1) Very economical considering the average of 100 adults reached at every meeting.

(2) Suitable for us to introduce several extension workers and their related disciplines to the villagers.

(3) A cordial atmosphere combining a sensitive business meeting in a social setting at village level.

(4) Easy follow-up opportunity for the extension workers.

(5) Once the villagers at various levels have agreed to participate and support the "New Approach" to development in the village, the few unconvinced could feel left out. Thus to avoid such a feeling of social disapproval in their village, those who were not fully convinced were prepared to accept what the others accepted, as most village members tried to lend support to the village project. This is a phenomenon which is tactfully and professionally utilized and fully exploited by the extension agent. The integrated approach helped considerably in follow-up visits.

Village members inquired about other members of the party when a motivator or extension worker made a follow-up visit to the village. This also enabled follow-up officers to find out the special interests of individuals, where community matters are concerned. This information is passed on to the appropriate extension agent for further action. In almost all cases, family planning is a very sensitive subject to discuss with the villagers for the first time. But when it is first presented in a relationship with other economic, social and cultural practices, the understanding of the sensitive subject is enhanced. It even creates a comfortable base, and point of access for the extension worker or motivator.

XIV. STUMBLING BLOCKS IN THE ONE DAY MEETING

(a) Special effort must be made to bring the various resource persons to villages which are difficult to traverse and have no regular public transportation. Projecting the need for a means of self-transport is not only desirable but essential.

(b) There must be some attraction to villagers to attend a meeting for the first time, to compensate for leaving their farms for a day. A main meal must be provided.

(c) The absence of a core group to help in the arrangements for the meeting could be difficult and time consuming.

(d) After a one day meeting is successfully accomplished, frustration can occur if the follow-up visits by the various disciplines were not made. The lack of follow-up could lead to a big set back to other development efforts in the village. The villagers would always mention that they had once been promised but the promise was never fulfilled.

(e) The success of the first meeting would depend upon the arrangements involving the villagers, e.g. the presence of the village orchestra or band to reduce boredom is very necessary. Otherwise they would leave the meeting hall one by one before the end of the program. It is so important that the new message is accompanied by what is best described as entertainment. The packaging is most important.

(f) The opinion leaders in the village, particularly the non-cooperative society members, should be personally involved in the planning of the meeting. It is at this stage that a lot of convincing had to be done, otherwise the meeting without the support of the elders could not be successful. If necessary, several visits should be made to convince any conservative village leaders before a one day meeting is held. This requires funds for travelling to the village. Without such funds, the one day meeting could not be possible or successfully accomplished.

XV. FIVE DAY TRAINING COURSES AND SEMINARS

Other important aspects of the project are the training courses and seminars, (training the trainers program).

During the first two years of the project, training programs were of one week duration. However, due to rapid inflationary trends, commodity prices increased dramatically. Particularly the cost of stationery, transportation, fuel and oils soared in Sierra Leone. At that time the "five day" training programs were condensed to a "three day" residential period. In areas where support from the host cooperative society was substantial, a five day non-residential course was arranged.

This section will focus its attention on the five day programs which were originally conducted. However, one should mention that notwithstanding the reduced period from a five day to a three day duration, the essential core subjects and messages continued to be discussed. Evening discussions after

films had been shown to assisted greatly in compensating for the reduced days.

Target Trainees

The need for a multi-sectoral and multi-disciplinary approach in development issues is now generally acknowledged. To ensure that an effective integrated approach is pursued in the population and family welfare education program, particularly in the rural areas, trainees were selected from among the extension workers of various disciplines. Extension workers at lateral levels, currently working in the same area were chosen. These included participants from the Ministries of Social Welfare, Education, Health, Agriculture, Cooperative, Community Development, Local Native Administration as well as representatives from non-governmental organizations, especially those closely interested and connected with family planning and service delivery programs.

Core messages were aimed at better living conditions with a strong family planning component. The cumulative experiences of the participants working with villagers in their respective disciplines greatly enhanced the impact of the presentations on the method of approach to people at village level.

Methodology

The sharing of experiences at group discussions to analyze a problem, taking into consideration the various economic, social, cultural and religious backgrounds, together with an up to date knowledge and experience of current political and government statements on various issues, makes the training courses an experience tapping, brainstorming and sharing symposium.

The analysis and comments at the beginning of the program by participants on the statement below by "Mr. Wiseman", which is usually written and posed at prominent places in the classroom, helps to develop a common outlook and frame of mind for the participants during the period of the course.

"MR. WISEMAN SAYS"

Go To The People,
Live Among Them
Live With Them,
Learn From Them;
Start With What They Know,
Build On What They Have,
But O'. The Best Leaders,
When Their Task Is Accomplished;
Their Work Done,
The People All Remark;
We Have Done It Ourselves.

We tried as best we could, particularly at residential training courses, to create conditions such as the one described above that could assist the participants as well as resource persons to reflect and share experiences and problems of communicating family planning techniques to villagers and urban workers. We also endeavoured to develop constructive proposals for action which would assist in solving some of the problems in the field.

The non-residential programs were also designed to create opportunities for interaction between participants and resource persons so that they could learn from each other's experiences, particularly during group discussions. We solicited well structured inputs from high standing professionals as facilitators, who were invited to participate informally during group discussion periods.

All these techniques and methods of approach on the subject contribute, in a very practical manner, to better understanding among our resource persons, participants and facilitators in discussing the subject.

Another big advantage of learning by participation is that it allowed for a built-in action committed program, developed by the participants for implementation within a specific time of their return home.

The problem solving methods, as well as role playing techniques adopted in the study groups, encouraged participants to introduce their case studies based on real-life experiences in their respective places of work. The knowledge and expertise of the group helped considerably to reach an acceptable solution of the presented problems. Trainees were further encouraged to report at a later time to the project or cooperative officer in the area, about their experience in using the solutions or answers that were developed during the training course.

Contribution By Past Participants

Some of the "graduates" from the training courses and seminars, who were typically hand picked, later became additional contacts and motivators for the implementation of the program in the field, in villages and cooperatives other than their own. In this way a "multiplier effect" was generated.

They serve as one of the most active change agents in the field to promote family welfare activities. They act as facilitators whenever a one day orientation meeting is held in and around the various regions or districts were they work. Some of them have been reported as active catalysts in meetings or training programs organized by other allied development agencies in their respective areas.

Using the Cooperative Societies as a base, all committee members and Secretary/Managers who participated in the training program contribute through:

(a) Addressing Cooperative Societies' general meetings, as well as arranging for guest lecturers to address people on the various facets of population and family welfare and planning at Cooperative Society gatherings.

(b) Explaining how the knowledge gained at the sessions assisted the trainee personally, as well as his organization and the effect on the community in which he or she is working.

(c) During the training courses, trainees are encouraged to develop a program they will conduct on their return home. They are required to submit a report to the Project Director or Cooperative Officer within 6 to 9 months after the end of the training.

The Project Director maintains a register of past participants and potential resource persons who allowed themselves to be called upon to give voluntary services whenever the opportunity arises.

In some of their testimonies, former "graduates" have reported initiating family welfare programs and requested assistance for technical advice and support from allied institutions.

Past participants within the area have been invited during refresher courses, or regular training programs to give their testimonies on what they had accomplished since their return from their original training course. In virtually all instances this was an inspiration to the new participants.

XVI. ACTION PLANS BY PARTICIPANTS

The villagers were given practical training in simple local intermediate technology to serve as models during the training sessions. This was to ensure that the trainees are better equipped to make practical contributions to the improvement of the lives and general welfare of the masses.

Cleanliness, balanced diet, and income generating activities to help improve family income levels were emphasized by most course lecturers. To translate some of these ideas into action, practical lessons on soap making and food preservation were given. The participants were interested by the preparation of a high protein diet for the aged and especially the children under five years old, as well as the preparation of various fruit juices. Field reports and testimonies from past participants showed that cooperative societies, small groups and some previous participants benefitted from this type of knowledge.

Collaboration with other disciplines and agencies to enable us to concentrate on the improvement of the total life of the man and woman in the rural area has produced the desired result. Our effort to create an integrated approach, involving multi-disciplinary and inter-sectoral collaboration has shown that the way for success is now open. But it has to be seen as a continuous process. Repeating and following up the teachings to ensure that the knowledge is put into practice is a vital stage in the process of development.

Participants were encouraged to save money and time by passing this vital message on to others. It was stressed to be proud, to rely upon their resources and have the satisfaction of using their local materials to the best advantage.

In most villages, particularly those away from the main motor roads or market centres, various types of fruits in season were left to waste and rot. Yet children suffer from the lack of sufficient fruits in their diet for most parts of the year. Guidance and simple instruction can not only prevent waste but also improve health. The programs have been concerned with these simple things. Included were practical lessons and recipes for making soap, fruit juice, and various types of fruit jam in addition to home made polish for furniture and shoes. Techniques for homemade cider, various fruit wines, tomato sauce and various food preservation methods, as well as preparation of high protein food from local cheap food items were taught to our participants. They were not only encouraged to make use of the information themselves but also to transfer both the knowledge and their positive experience to others.

Participants with the knowledge and experience of various simple income generating methods, were chosen as group leaders. They would not only teach others, but serve as a practical demonstration of what is expected from all participants when they return to their villages. The art of sharing useful knowledge for total development was the primary emphasis of the training course.

Practical Implementation of Family Planning Methods

The experience gathered from the implementation of the information education and communication project on population and family welfare and family planning is that as soon as people become convinced they find themselves wanting. They want pills and other contraceptives on a regular basis, but cannot afford to pay the small token fees in addition to maintaining a balanced diet. It is therefore considered absolutely necessary particularly in poor and backward communities where the problems of maternal and child morbidity and mortality are very acute, that projects aimed at increasing awareness in population and family welfare issues and family planning practices should include income generating components, or active liaison with projects that have income generating activities with a view to giving practical effects to the knowledge gained.

Teaching and emphasizing to the people how to eat a balanced diet, and to

use the pill and other contraceptives regularly, should go side by side with improvement of their income.

The development of market gardens and cottage industries in order to create an ability to pay for the pill and other prophylactic methods should be given high consideration. When one has the ability to purchase cheap soap, then one can afford to wash the hands with soap and water before and after every meal. One can afford to wash the children with soap before they go to school in the morning and before they go to bed. It is only when a man increases his production can he begin to think of saving for the future. It is only when he begins to think of the future that he realizes that with many children he cannot hope to save some of what he has produced for the future. It is only at this point that the concept of family planning starts to effect the village dwellers. Therefore, the starting point has to be income generation. This need not be expensive or complicated, but without it little can be done.

Lessons Learned from the Project Implementation Process

(a) There should be sufficient resources in the work plan to allow for continuous follow-up action.

(b) In our training programs participants are from varied disciplines. Therefore, we collect the various ideas about their concept of family planning as well as those of the different people with whom they are working. This enables us to appreciate the numerous ideas and views people have in our country about family planning. We became better able to help our hand-picked participants to become effective motivators; after having discussed all the various views and problems related to our cultural and religious taboos, as well as the economic and social situation of our traditional extended family patterns.

(c) Every opportunity to follow-up the good work that past participants were doing in the field should be encouraged:

    (1) by inviting them to refresher courses in order to update their knowledge, and

    (2) by involving them in any survey or other work related to population and family welfare programs.

Changing a habit, particularly on an issue like family planning, is very difficult. Experience shows that the effort must be continuous. Whenever success is obtained, the process should be repeated. Convinced people should begin first, and then continue by convincing others. People should see the positive advantage of changing from one way of life to another. Thus the work of the "motivators" and "change agents" has to be a continuous process.

Payment for services is a must. Thus the emphasis on the development of self-help and self-reliance. But people must be assisted one way or another to improve their earning capacity. They need further assistance to utilize the increased income for useful, desirable and beneficial purposes.

Projects which have these vital components increase knowledge, help to improve attitudes, and provide opportunities to practice what is learned. They are therefore more likely to succeed and have a lasting effect than projects with a single purpose. Thus the need for collaboration continues to be a factor which should not be overlooked by project executors or extension workers.

POPULATION EDUCATION IN THE ORGANIZED SECTOR

OF SUDAN

by

Khalil Khalil

Director, Public Corporation for Workers Education, Sudan

59'

Population Education in the Organized Sector of the Sudan

The Sudan is the largest country in Africa with an area of 2.6 million square kilometres. Because of its vast size, it has considerable variations in climate, geography, and ethnic makeup. The Sudan, located between latitudes 3^0 and 22^0 North and longitudes 21^0 and 38^0 East, also shares borders with eight other African countries.

Settlement patterns, population dynamics, population growth and other demographic aspects are influenced by the physical features of each area in the Sudan.

The most economically developed area of the Sudan follows a central band beginning with acacia shrubs and becoming Savanna woodlands. Farther south is the tropical region of bush, savanna and forest.

The Sudan gained its national independence in 1956. The instability of the parliamentary system adopted after independence led to a military coup in 1958. The popular October Revolution of 1964 restored civilian rule and the parliamentary system. The relative political stability that prevailed following the 1969 May regime has set the stage for a more effective utilization of the country's resources and a faster rate of economic and social development.

Agriculture is the dominant sector in the Sudanese economy. It contributes nearly 40% of the Gross Domestic Product. Eighty percent of the population depends on subsistence agriculture and related activities. Extra-long staple cotton is the major export crop, making up to 60% of the country's total exports. Other products are oil seeds, vegetable oil, gum, oil cakes, livestock, hides, skins and sorghum.

Industrial development, which began after World War I, accelerated after Sudan gained independence. Industrial production has been confined mainly to the processing of agricultural products and the production of import-substituting consumer goods and building materials. An ILO comprehensive Employment Strategy Mission, fielded in 1976, noted that the share of the manufacturing sector amounted to 8% of the Sudanese Gross Domestic Product. According to the 1973 census, the industrial sector only absorbed 4 percent of the Sudanese economically active population. Most of the industrial activities are concentrated in the Khartoum and the Red Sea provinces (ILO 1976).

Transportation is a very important factor in the economic development of the Sudan. The need for a rapid expansion of transport and communication facilities has been stressed in the various documents produced since the planning process was started in the country.

The educational system is characterized by a national uniform structure, but access to the education system varies greatly. Enrollment rates decline, of course, as we move up the educational ladder. The Sudanese system of education is an "upward push" system, each level preparing students for the next levels. The educational system encounters many problems such as crowded classes, shortage of educational facilities and a lack of teachers. It is also characterized by its urban and male bias.

Information on health in the Sudan is sparse, apart from occasional sample surveys in certain regions based on in- and out-patient service figures at health units. Health units include hospitals, health centres, dispensaries and dressing stations. In the Sudan, the number of general practitioners is one per 8,159 people while the number of hospital beds is one per 1,023 people. These 1983 census figures vary widely across different geographic regions of the country.

Population

According to the preliminary results of the 1983 census, almost 80% of the population lives in the rural areas with 11% of the population being classified as "rural nomadic." Various estimates suggest that up to 98% of Sudan's population may be on the move at least part of the year. Of the 20% of the national population classified as "urban," most live in 38 centres each exceeding 20,000 inhabitants. The country as a whole has a ratio of 103 males per 100 females in 1983. The ratio in urban areas is 113 males while in rural areas the figure stands at 99 per 100 females.

The available figures on age structure show a very high and increasing proportion of the population under the age of 15. The 1955-56 census estimates this sub-population to compose 45.2% of the total population, while in 1973 it had increased to 46.6%. Totals in the age category 65 years and older remain small, with little more than 3% of the population. These figures translate into a dependency ratio of 95 dependents per 100 working age people.

Fertility figures for the country as a whole rely on the 1973 census. Corrected figures gave a crude birth rate of 48 per 1000 population, a gross reproduction rate of 3.2 and a total fertility rate of 6.8. In 1979, the Sudan Fertility Survey (SFS) measured the total fertility rate at 6.9. The survey presented the following major conclusions:

- Marriage is universal, but the age at first marriage is rising.
- Fertility is high, and a rise in early marital fertility is evident.
- The level of fertility during the recent past has changed very little.
- Sudanese women prefer large families.
- Knowledge of family planning is limited, and the use of contraceptive methods is very low.
- Breast-feeding is almost universal and prolonged, acting as a constraint on fertility.

The official statistics for mortality estimate the Crude Death Rate for the period 1980-1985 at approximately 18 per 1000 population. Based on the analysis of the 1973 census data, the estimated life expectancy was 46.5 years. Today this figure is probably nearer to 49 years. There are no reliable estimates for the level of infant mortality. The 1979 Fertility Survey

suggested that more than 100 out of every 1,000 live births die within the first year of life.

With respect to internal migration, various estimates suggest that between 10 and 40% of the population may be on the move at anytime in a given year. Rural migration, particularly among males from the subsistence farms in the west to towns in the centre and east is substantial. There is considerable seasonal migration of agricultural workers. The Gezira and related schemes offer a striking example. Based on provincial data, the main targets of migrants in Sudan appear to be Khartoum and the irrigated agricultural schemes of the Gezira area. In 1973 these areas had 200,000 and 300,000 immigrants respectively. At the other extreme, to the North, Kordofan and Darfour provinces showed significant outflow of 200,000 to 250,000 people.

International immigration is also a significant characteristic of the Sudan. Over a long period of time there has been a significant movement of immigrants into the country from the west, mainly from Nigeria and Chad. More serious is the substantial and increasing influx of refugees into the country. The Sudan has hosted refugee populations for the last 20 years, when the first officially defined refugees arrived from Zaire. Since then, there have been influxes from Uganda, Chad and Ethiopia.

These trends imply certain important consequences for the economic and social development in the Sudan. The population growth rate of 2.8% puts Sudan at the top of all less developed countries in the world. The implications of population growth on the economic and social development of the Sudan convinced the Government and the United Nations, as early as 1960, to formulate a population policy. The studies emphasized that "the Sudan faces a number of problems connected with growth, distribution and composition of the population which are of a great importance... and which need to be taken into account as national plans and policies for economic and social development are worked out"... (Population Growth and Manpower in the Sudan, 1964).

Workers Population Education Programs

Since 1978, the Ministry of Social Services and Administration Reform, through its subsidiary body, the Public Corporation for Workers Education (PCWE), has been implementing a workers population education program in the Sudan. During the UNFPA project formulation mission to the Sudan in 1979, the desire was expressed to extend the existing workers' population education program to new areas of the country where industry was expanding at a fairly rapid rate. It was also felt that with relatively modest external funding for 1984-86, the program could reach a substantive proportion of the total working labor force in the Gezira province. The aim was to introduce an understanding and awareness of population issues to organized workers, effectively involve the workers trade union movement in population issues, and promote acceptance of revised family norms by workers in the organized sector.

The Gezira Province Program

The Gezira province population program is located at the PCWE centre at Wad Medani. The project coordinating council holds a meeting in the province every four months to follow up the implementation and development of the program.

The main objectives of the program are as follows:

a) To reinforce the understanding and awareness of population issues among organized workers;

b) To involve the trade unions in population issues;

c) To create an awareness of the implications of population change in relation to socio-economic development among social personnel and trade union leaders in Gezira province;

d) To help workers understand the relationship between population size and the quality of life;

e) To enable workers and trade union members to undertake population education activities at the province, plant and farm levels;

f) To increase the number of women workers and workers' wives who benefit from mother and child health and family planning services provided by the Ministry of Health;

g) To develop a cadre of worker motivators drawn from the workers' leaders; and

h) To produce population and family welfare information and educational material specially designed to meet the needs of the work force in the province.

Activities of the Program

The 1984 Working Plan organized ten 3-7 day seminars, twenty-four symposiums, three meetings for the Coordinating Council, and eighteen motivational meetings. There were also two seminars for female leaders in the province. Tables 1 and 2 indicate the numbers and participants attending in the province during 1984 and 1985.

Table 1: Population Education and Family Welfare Seminars, 1985

Target Groups	Seminars	Participants
Kindergarten teachers	1	22
Workers Trade Unions Leaders	1	19
Friendship Textile Workers	1	27
Genied Sugar Factory	1	29
Trade Union Workers	1	29
Gezira Scheme Personnel Workers	1	25
Population Education Motivators	1	25
El Qurashi Trade Union Workers	1	15
Social Welfare	1	25
Voluntary Workers	1	33
Total	10	235

Source: PCWE, Wad Medani, Annual Report; (1985)

Table 2: Motivational Meetings in Population Education and Family Welfare For Workers and Their Families (1984-1985)

Target Groups	Number of Meetings		Participants	
	1984	1985	1984	1985
House wives	9	6	1070	3000
Health Visitors and Midwives	6	4	213	100
Agricultural Workers	3	6	965	4000
Industrial Workers and their Families	0	2	0	400
TOTAL	18	18	2252	7500

Source: PCWE, Wad Medani, Annual Report, 1985

The interest shown by the participants in the seminars and symposia reflect the effectiveness of the program. The target groups which made use of the program in the province are extensive. The main target groups were identified in the base-line survey conducted in 1985, and are shown in Table 3.

Table 3: Target Groups for the Population Education and Family Welfare Program in Gezira Province (1984-1986)

Target Groups	Numbers
Health personnel	3830
Educational personnel	14,366
Socio-economic Services Trade	
Union Committees	375
Social Welfare Workers	453
Tenants in the Gezira Scheme	101,124
Agricultural workers in the Gezira Scheme	
Ministry of Irrigation	136
Cotton Pickers in the Gezira Scheme	470,420
Water and Electricity Workers	995
Rahad Scheme Tenants and Workers	26,182
Trade Union Committees in the Industries	429
Agricultural Research Corporation	684
Blue Nile Textile Company	2,506
Wad Medani Textile Company	1,174
Haj Abdalla Spinning Factory	1,495
Food Industries	7,268
Gezira Tenancy Company	392
El Bagair Ginning Factory	450
Maringan Ginning Factory	2,252
El Hasahiesa Ginning Factory	2,219
TOTAL	621,190

Source: A. Hafize Gaafar, Workers Force in Gezira Province (1985)

Attendants can be classified as follows:

1. Agricultural workers (mainly tenants) and their families in the different agricultural schemes of the province such as:

   a) The Gezira scheme

   b) The Managil extension

   c) The Rahad scheme

   d) The Eastern Gezira rain-fed tenants and river bank tenants scheme.

2. Industrial Workers and their families in different private or government factories including:

   a) The Haj Abdalla spinning factory

   b) The Friendship Textile Company.

3. Welfare service workers and their families.

This target population differs greatly in terms of age, social status, educational level, vocation, degree of literacy and so on. It is a vast audience, composed of individuals mainly involved in agriculture including housewives, youth, old people, etc. There are also artisans, workers, agricultural extension workers, educators in home economy and nutrition, personnel in kindergartens, social workers, trade union leaders, as well as general health, maternal and child health, and family planning workers.

As a result of this great variety, the beliefs, interests and needs of the various groups are not uniform. This must be taken into consideration in the execution of the population education program. A particularly important factor is the very high proportion of illiterates, or poorly educated people engaged in agricultural activities.

The Gezira Province is a heavily populated area. According to the preliminary results of the 1983 population census, the number of inhabitants in the province was 2,025,215 with a population density of 28.3 persons per square kilometer. A large number of important economic schemes and projects are operational, and constitute the mainstay of the Sudanese economy in both the agricultural and industrial domains. As a result there exists a relatively heavy concentration of labor engaged mainly in agricultural activities but also in light or medium industry. This has an important bearing on the nature of the population education programs developed.

I. Agricultural Tenants and Workers

According to the statistics issued by the Office for Economic and Social Research in Gezira Province the number of agricultural tenants is 95,197. This includes adult males and females as well as youth and children. Agricultural laborers and professionals engaged in agricultural activity together compose a much smaller figure of 7,696. Seasonal labor is very important in the Gezira scheme and has been estimated as follows:

- Seasonal labor from agricultural tenants and their families (141,940 of whom 90,850 are recruited locally and 52,004 come from gathering centres)

- Seasonal labor recruited from outside the area 179,929

- Migrant or moving workers equal 5,697. The Rahd scheme accounts for only 11,596 agricultural tenants with their families (including 183 technicians). To this number should be added 2,473 local workers (cotton pickers) and 2,844 migrant or moving workers, and 9,075 seasonal workers.

Agricultural labor in Gezira Province is estimated at 615,084. These workers belong to 28 different Trade Unions which cover the various agricultural and professional departments in the three schemes of Gezira Manakil, and Rahd. The number of executive officers in these Trade Unions is 271.

However, only 1 percent of workers are reached by the population education program. The Trade Union Leadership involved in educational meetings represent 4.1% of the total number of the Trade Union Councils.

II. Workers in Industry

Industrial labor is concentrated in spinning, weaving, and ginning factories, as well as in a number of plants that produce consumer goods. Examples of these are:

1. The Hassassia Gumming factory- 2,219 Workers
2. The Blue Nile Weaving factory - 1,847 Workers (668 women workers)
3. The Friendship and Hassassia Textile factory - 2,114 workers (1,093 women workers)
4. The Wadi Textile Factory - 1,184 workers (714 women workers)
5. The Hag Abdalla Spinning Factory - 1,495 workers (602 women workers)
6. The Maringan Gumming Factory - 2,060 workers
7. The Abbaker Gumming Factory - 450 workers
8. The Gezira Dyeing Factory - 433 workers.

In Gezira Province there is a total of 32 industrial plants which are linked to predominantly cotton crops that are cultivated in the area. Industrial labor has grown quite rapidly in this province and is mainly concentrated in four areas. Wadi Madani has 12 establishments, Hassassia has 4, Al Bakir has 9, and Al Manakil has 6 establishments.

The total number of industrial workers is 19,273. Of those, 1,030 (approximately 5%) have attended population education meetings. The number of industrial trade unions is 39; these cover over 40 industries. A total 105 (24.6% of total) executive officers have attended population education meetings.

Services in Gezira Province

The Gezira Province is relatively well provided with services including health, education, water and electricity. The total number of employees in these services is 33,069 of whom 6,102 are in the health sector and, therefore, are included in the population education program. Services extend to other sectors such as agriculture, veterinary care, forestry, public works, finances, and security have another 41,133 employees. From this group, 219 have attended population education meetings. In addition special training and educational sessions have been set up for supervisors in kindergartens, nutrition guides, health visitors, and health visitor trainees as well as at different levels of trade union leadership. The total number of employees involved in these activities is 766.

Developmental and Service Departments are covered by 111 Trade Union Organizations. The number of Trade Union leaders at different levels is 1,422 of whom 412 (29%) participated in population education meetings.

Programs for Cotton Pickers

As mentioned previously, cotton pickers may be divided into different categories. Some of them are settled in the areas of cotton cultivation whereas others migrate to the area during the cotton picking season. The different groups may be categorized as follows:

1) Agricultural tenants and their families living near their cultivation areas

2) Agricultural workers living in villages around the cotton fields and who move in to work during the season

3) Agricultural workers who are recruited from various gathering centres in the country and then transported to the cotton cultivation areas

4) Local agricultural workers hired by the agricultural tenants themselves

5) Mobile agricultural workers who are on the move looking for a job.

The vast majority of agricultural workers are illiterate. Seminars and other forms of systematic training would not be appropriate. So the project has turned to motivational group meetings as a means of addressing this group. Such a method is also necessitated by the fact that the target groups are not organized and tend to shift from one place to the other. Such motivational meetings concentrate on issues of family welfare and are held in the evenings close to the workers living quarters. The topics discussed concentrate on the relationships between family size and income, nutrition, health, and education. In carrying out this educational program, it was important to work with existing institutions in the area and particularly the health department, social services and the Family Planning Association. Population Education Caravans are set up to cover the different areas. These caravans consist of a team of three people, provided with audio-visual facilities. The teams draw on the expertise of medical doctors, specialists in child care and nutrition, men of religion, demographers, social workers, and members of the Family Planning Association.

A large number of these motivational meetings have been organized and were received with great enthusiasm and interest by the agricultural workers since they raised important issues concerning their lives.

Some examples of these meetings can serve as an illustration.

Location	Subject Discussed	Speakers
Club 114 Gezira Scheme	Problems of motherhood and child care	Medical doctor, social worker, MCH worker
Shakaba Village Gezira Scheme	Repeated pregnancy and its effect on the health of the mother, the children and nutrition	Specialist on nutrition and cultivation, Family Planning Worker, Man of religion
Shakaba Jaak Village Gezira Scheme	Population Problems and Development	Demographer, Social Worker, Family Planning Worker
Village 12 Al Koraishi Extension 24 Gezira Scheme	Family Planning and Child Health	Medical Doctor, Health visitor, Man of Religion

The Program Implemented in the Sadkaka (Friendship) Textile Factory

The workers in this factory typically belong to different educational, social and age groups. Out of the 2,114 workers, almost 50% (1,039) are women. The recruitment policy of the company has been to select young workers with a middle level education; hence, in this particular factory, illiteracy is confined to a small minority of the unskilled labor force. Other characteristics of the working force are the prevalence of youth of both sexes, a high proportion of females, and a limited number of those who are married. In addition, worker education programs have been a feature right from the start and have included some social and cultural activities. The aim of the population education program was to integrate its activities into the social component of workers education.

However, in order to cover the whole working force it was necessary to follow a two phase approach. The first phase consisted of training a certain number of Trade Union leaders and workers in population education. The second phase was to utilize these trained workers in organizing motivational meetings for the work force either on the factory premises, or in the housing areas.

As a preliminary step to organizing these population education activities, the opinion of numerous institutions and organizations was elicited to ensure that the subject matter of the training sessions and motivational meetings would correspond to the needs of the workers in this factory and in the other factories included in the program. Institutions and organizations consulted included the Population Studies Centre, Social Services Department, Agricultural Extension Department, College of Abou Hiraz, Ministry of Education, Nutrition and Cultivation, Health Visitors Scheme, Gezira Scheme, Gezira Trade Union Organizations, Federation of Agricultural Tenants, Ministry of Health the Family Planning Association, and several factory Administrations.

Population Education Program Design and Execution: Training Workshops

The first phase in implementing the organized sector program was the training a sufficient number of Trade Union Leaders and workers who would then act in turn as worker motivators. The function of these worker motivators was to organize meetings and discussions which would cover the bulk of the working force in the factory. The trainees were organized into 6-day workshops (one week including the day of rest) and were relieved of all their duties. Three sessions were held every day. The 35 participants were chosen by the administration of the factory and the trade union by joint agreement. Conference and secretarial rooms on the premises of the factory were placed at the disposal of the program.

Details of Training Program in Population Education (Friendship Textile Factory)

Day	First Session	Second Session	Third Session
First	Inauguration. Aims and details of the program.	Population education and workers education.	Population problems and development in the Sudan.
Second	The World Population. The role of ILO in population issues.	Population, information and communication.	Discussion.
Third	Socio-economic factors in population growth in the Sudan.	Population problems and family planning.	Group discussion.
Fourth	Methods for convincing and discussing with mass audiences.	Health, nutrition and family planning.	Case Study.
Fifth	How to organize a panel population discussion.	Panel discussion on role of workers in population education.	Discussion circle.
Sixth	Practical skill training.	Evaluation of program.	Distribution of certificates.

Population Education Program Design: Motivational Meetings

After training the worker population educators the second phase was to organize motivational meetings.

In these meetings, the main thrust was directed towards issues of family welfare and the free choice to practice or not practice family planning. Any suggestion of population control whether direct or indirect was avoided. A certain number of elements were taken into consideration when arranging these meetings:

- They are and will probably remain the most important way of reaching the masses of workers.
- The characteristics of each specific group must be taken into consideration by the speakers during the discussions. These groups include factory workers, agricultural workers, cotton pickers, service workers, women, youth and families.
- The choice of area should be made where bigger concentrations of workers and their families can be reached.
- Coverage must include both the work place and at home.
- The subject matter, language and methods of communication should be adapted to specific audience groups.
- Each speaker should deal briefly with his area. Most of the time is concentrated on questions and exchanges.

The number of motivational meetings held during the period 1984-86 was as follows:

Year	Number of meetings
1984	18
1985	18
1986	33

Specific Subjects Included in the Meetings

. Family planning and child health

. Population and Environmental Health

. Repeated pregnancies, nutrition, and child development

. Family Planning

. Development of the child and nutrition

. Motherhood, child care, and role of parents in socialization

. Maternal and Child Health

- Dangers of repeated pregnancy
- Unplanned housing and its dangers
- Family planning: economic, socia and religious aspects
- Family planning: medical and religious aspects
- Family planning and social relations
- Population education as related to social development of the citizen
- Spacing and its effect on maternal and child health
- Social and economic effects of family planning
- Child health and nutrition; breast and artificial feeding
- Gynecological disorders related to pregnancy and labor
- Early childhood health problems and diseases.
- Nutritional problems in middle Sudan.
- The need for planned parenthood; medical and social methods of family planning.

This program, as its name implies, is very much an educational one. It can be described as a "pre-family planning program". Consequently, "acceptor statistics," even if they were available, are not applicable as indicators of impact. The program is interested in [illegible]cing on a voluntary basis a taboo subject in a relatively conservati[illegible]nvironment. Low percentage participation rates should therefore be viewed in the broader context and seen as indicators of impact and change. People are prepared to attend meetings and then listen to motivational messages on a one to one basis. Clearly, such group meetings are the beginning; small and insignificant in a global context but dramatic and encouraging in its own right. UNFPA has been sufficiently impressed with the impact that they have approved additional funds for a subsequent phase of the Gezira program. During that phase it is hoped that not only the incidence of listening will increase, but family planning practice will also become evident.

POPULATION/FAMILY WELFARE EDUCATION ACTIVITIES IN TANZANIA

(1973 - 1985)

by

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Labour, Population and Family Welfare

I. Introduction

The United Republic of Tanzania is an Independent Republic composed of mainland Tanganyika and the Islands of Zanzibar and Pemba in the Indian Ocean. The country's total land area is 945,000 square kilometres including 59,050 square kilometres of inland water. The country is surrounded by Lake Tanganyika (to the West), Lake Victoria (to the North), Lake Nyasa (to the South) and the Indian Ocean to the east. Zanzibar is located about 32 kilometres off the Indian Ocean coast and has an area of 1,656 square kilometres. Pemba lies 40 kilometres North-East of Zanzibar and has an area of 983 square kilometres.

The United Republic of Tanzania is basically an agricultural country. Its economy is based on subsistence agriculture. Cash crops like coffee, tea, tobacco, cotton, are the major foreign exchange earners apart from minerals.

The country's population currently estimated at 21.7 million shows a rising annual growth rate from 3.0 percent per annum between 1957 and 1967[1] to 3.52 percent between 1980 and 1985.

Table 1. Population projections 1948-1978 Mid-Year Estimates

Year	Mainland	Zanzibar	Total
1948	7,716,395	264,725	7,981,120
1957	9,303,495	297,357	9,600,852
1967	11,909,265	353,687	12,262,952
1968	16,105,000	454,300	16,558,300
1978	17,048,329	479,235	17,527,564

Source: Central Bureau of Statistics (1973)

Current estimates put the population of Tanzania at 21.7 million (1984 estimates)[2].

Despite an increasing population with obvious implications on development, Tanzania does not have an official population policy. However, over the years, the country has instituted measures and has taken actions which could be viewed as having long term demographic implications. For example, the

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[1] Henin, Roushdi: The recorded growth rate from 1957-1967 is well over 3 per cent per annum and this increasingly higher figure was not compatible with the recorded growth of 1.8 per cent per annum between 1948 and 1957. However, it appears probable that the 1957 census underestimated the size of the population. Population Growth: The Population of Tanzania: 1967 Analysis: Vol.16 BRALAVAP/CBS (1983).

[2] World Population Wall Chart, UNFPA, (New York) (1982)

Maternity Leave with Benefit Act of 1972 restricts maternity leave with benefits to 12 weeks[3] for working women once every three years.

However, the major step has been the recognition by the Government of a Voluntary Family Planning Association (UMATI) in the area of information education and communication. Family planning activities were started on a voluntary basis in 1959 by UMATI with the financial support of the International Planned Parenthood Federation (IPPF). This Non-Governmental Organization has carried out information, education and communication activities, and training as well as the delivery of family planning services. Recently the Government, through the Ministry of Health, assumed responsibility for family planning delivery services as part of maternal and child health. UMATI has continued to provide training facilities and information, education and communication activities.

In 1979, the Government of Tanzania, with financial support from the United Nations Fund for Population Activities (UNFPA), launched a Population and Family Life Education Program under the auspices of the Office of the Prime Minister. This program was supported technically by the Food and Agriculture Organization (FAO) and the International Labour Organization (ILO), under the project known as "Population/Family Life Education, Communication and Applied Research." This project had two major components, namely: (i) Integrated Rural Development/Population Family Life; (ii) Population/Family Welfare Education - Organized Sector.

In 1973 the ILO began work in the field of population/family welfare education for the organized sector when the ILO with UNFPA financial support organized the first national seminar on "Workers Education, Population and Family Planning" in Mwanza. The objectives of the seminar were:

(i) to stimulate interest among the leaders of the National Trade Union of Tanzania in population and family planning questions;

(ii) to promote awareness of the population problem in the major political, economic, social and other non-governmental organizations.

Eighty-one participants from the top leadership of the party (then TANU), the Trade Union Congress, the National Youth League, and the Women's Organization attended this seminar. Some of the major issues discussed during this seminar were related to:

(1) Absence of any commitment by trade union leaders to population and family welfare objectives due to lack of information;

(2) Absence of a concrete Government policy on population.

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[3] Maternity Benefits in the Eighties: An ILO Global Survey (1964/84) ILO, Geneve (1985)

The participants accepted that trade unions have a major role to play in population/family planning. The 1976 workshop dealt with two major questions:

(1) The need to intensify and expand the activities of the Ministry of Labour and Social Welfare to include programs related to population and family welfare;

(2) The need to involve the organized sector in family welfare programs.

Early ILO interventions were considered to be the basis for the population/family welfare education activities carried out between 1979 and 1985.

2. Population and Family Welfare Education in the Organized Sector

Population and Family Welfare Education activities started in 1979 when the FAO/ILO executed project(s) was first launched. However prior to this, UMATI, the country's only major NGO involved in population/family planning had been doing some IEC work in the organized sector.

A more systematic effort to reach the organized sector by the UMATI IEC program began in 1980. A workers' education project was started with the objective of increasing workers (especially males) awareness of family planning and the role that family planning practice can play in promoting the socio-economic welfare of the workers and their families.

The approach was for the association's staff (field workers and headquarters) to conduct short seminars, give talks backed up by film shows and distribute information materials. A seminar was organized for about 40 workers education officers from the public and private sector industrial concerns in Dar-es-Salaam, the capital, to study how to include population and family planning information in workers education programs.

Between 1981 and 1982 UMATI reached 58,000 workers through 350 activities undertaken by the staff. UMATI believes that these activities have generated interest in family planning education among workers of various categories and have led to the establishment of MCH/FP clinics in four major industrial concerns[4].

However, despite this success in reaching workers it is believed that the IEC content does not meet the specific needs of the different audiences in the target groups. What is required is the re-direction of strategies towards promotion of behavioral changes in order that men accept and practice family planning.

Although no data are available to show the number of workers educated and motivated by UMATI who actually practice family planning, it can reasonably

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[4] UMATI - 1985 Annual Report - Dar es Salaam, Tanzania (March 1986).

be assumed that a good proportion of the workers (females particularly) are among the present acceptors of family planning (Table 2).

Table 2. Family Planning Acceptors in UMATI Clinics by Method Per Year (1978-1983)

YEAR	Oral		IUD		IMPA		Condom		Spermicide		Total Other
	Na(1)	Ca(2)	Na	Ca	Na	Ca	Na	Ca	Na	Ca	
1978	2,894	15,062	766	2,202	83	787	-	-	1,179	304	23,277
1979	2,424	13,700	697	2,290	136	794	-	-	503	505	21,049
1980	1,854	9,750	630	2,065	100	971	-	-	1,277	503	17,140
1981	1,223	5,351	404	939	93	336	179	159	505	140	9,319
1982	847	3,707	489	911	76	306	193	141	369	41	7,080
1983	401	2,943	201	666	35	302	52	71	121	57	4,855
Total	9,643	50,513	3,177	9,073	523	3,496	424	363	3,954	1,550	82,720

(1) Na = New Acceptors
(2) Ca = Continuing Acceptors

Source: UMATI Annual Report, 1985; Dar es Salaam (1986).

A general and broad based UNFPA/ILO awareness creation program was the starting point in 1979. A series of activities were organized by the project under the International Project Adviser (FAO) and with technical support from the ILO regional Adviser on Labour, Population and Family Welfare from the Addis Ababa ILO Labour and Population Team. Training and awareness activities carried out involved a total of 224 worker education officers, management representatives and trade union leaders from four regions: Arusha, Dar es Salaam, Kilimanjaro and Tanga.

The main objectives of these activities were:

(1) to bring together management personnel, trade union officials and workers education officers for an exchange of views on the importance of population and family welfare education for workers;

(2) to provide trainees an opportunity to learn about and understand various population/demographic issues and their relationship to socio-economic development and employment;

(3) to understand the roles of management, workers (unions) and the Government in population/family welfare education;

(4) to suggest, discuss and evolve plant-level family welfare education activities (plan of action).

By the end of 1979, the above objectives were almost achieved and follow-up activities were started. The organized sector population education officer on the project, with the assistance of the Project Adviser (FAO) and technical

support from the ILO, carried out follow-up activities in selected industries where officials and workers had participated in the training activities.

3. Population/Family Welfare Activities in Selected Industries

The implementation of organized sector activities as part of the Population and Family Life Education Program under the Office of the Prime Minister between 1979-1985 aimed at:

- Institutionalization of population and family welfare education and services at the plant level as a part of workers' education and medical services

- Training of workers' education teachers at the plant level as a preliminary step to the incorporation of population and family welfare education concepts in plant-level workers education activities

- Introduction of plant level population family welfare education activities and services.

The organized sector officer with technical support from the ILO selected five enterprises from one of the four regions with the largest concentration of organized sector groups, namely Dar-es-Salaam, Tanga, Arusha and Kilimanjaro.

Table 3 shows the distribution of enterprises and the number of workers involved per region in population/family welfare education activities. A total of 18,660 workers were involved in these activities in 20 enterprises (5 from each of the four operational regions). The 20 enterprises were selected by the following criteria:

1. size of labour force per plant

2. sex composition of the workers

3. attitude of management towards population/family welfare activities

4. effectiveness of plant level workers education activities

5. existence of plant level medical/health facilities/services.

Table 3. Industries Involved in PFW and Workers per Region

Regions	Number of Enterprises	Number of Workers
Ashura	5	2,919
Dar-es-Salaam	5	6,000
Kilimanjaro	5	7,619
Tanga	5	2,122
TOTAL	20	18,660

Source: Country Project Report URT/83/PO2 (1983).

Consideration was also given to the type of enterprise, to ensure representation of different categories and groups of workers as illustrated in Table 4.

Table 4. Number of Establishments and Workers Per Sector

	REGIONS									
	Arusha		D'Salaam		Kilimanjaro		Tanga			% of
SECTOR	(E)	(W)	(E)	(W)	(E)	(W)	(E)	(W)	Total	Total
Textile	1	1200	2	3900	-	-	-	-	5100	27.3
Agriculture Forestry	2	987	-	-	4	7263	1	215	8465	45.4
Mining	1	152	-	-	-	-	2	1423	1575	8.5
Manufacturing	1	580	2	1400	1	356	1	170	2506	13.4
Commercial	-	-	1	700	-	-	1	314	1014	5.4
Total	5	2919	5	6000	5	7619	5	2122	18660	100.0%

E = Establishments
W = Workers

Source: Country Project Progress Report URT/83/PO2 (1984).

Workers in the agriculture/forestry sector represented 45 percent of the total workers involved in population/family welfare activities followed by workers in the textile industry at 28 percent, manufacturing at 13 percent, and mining at 9 percent. The lowest proportion was in the commercial sector with 5.4 percent.

The size of the labour force was notable in agricultural plantations (particularly in Kilimanjaro region which alone accounted for 7,263 workers). Almost 86 percent of the total workers in the four operational regions were in this sector. Project activities in the 20 establishments were not without their problems and constraints. In 1984, the organized sector population education officer found that at many work places, workers education programs

were not being implemented, that there was no proper communication between management personnel who had earlier participated in project activities and those responsible for worker education activities, and that union leaders involved in the project activities were not directly concerned or involved with worker education.

Establishments which successfully initiated plant level activities were those that had a well established worker education program and a relatively stronger plant level medical/health service. Table 5 shows the distribution of plant level clinics in the 20 participating establishments. Although the data here shows 100 percent presence of plant level clinic facilities only one establishment has an 85 bed hospital with a comprehensive MCH/FP service. This is the Tanganyika Planting Company (TPC) in Kilimanjaro Region, one of the agricultural establishments referred to in Table 4.

Table 5. Distribution of Plant Level Medical Facilities Per Establishment/Region

REGION	NO.(E)	Hospital	Dispensary	Clinic	Other/None
Arusha	5	-	3	1	1
D'Salaam	5	-	3	-	2
Kilimanjaro	5	1	4	-	-
Tanga	5	-	5	-	-
TOTAL	20	1(5%)	5(75%)	1(5%)	3(15%)

NO.(E) = Number of Establishments

Source: Country Project Report - Project URT/83/PO2, Arusha, Tanzania (1984)

This table also shows that of the 20 establishments involved in population activities, 15 (75 percent) had a dispensary, one (5 percent) had a general hospital, one (5 percent) a clinic and three (15 percent) had either no medical facilities or received help from group occupational health services where the workers receive medical services under a group health service scheme to which the employer contributes financial inputs. In all these group arrangements family planning services are provided either as part of MCH or on an ad hoc basis. Information available, but not documented, indicates that almost all plant level dispensaries provide basic information about family planning services and make referrals to Government MCH/FP clinics. This is particularly important to establishments that employed a large female work force like the textile manufacturing and agricultural/forestry industries. Table 6 shows the sex distribution per sector of the workers involved in population and family welfare activities. Data here shows the relationship

between availability of plant level medical services, MCH/FP services and the number of female workers.

Table 6. Distribution of Workers by Sex and Sector

Sector	No. of Establish-ments	Total Worker	No. of Clinics	Male No.	Male %	Female No.	Female %	Total
Textile	3	5100	3	4100	80.4	1000	19.6	100
Agriculture Forestry	7	8465	6	7154	85	1311	15	100
Mining	3	1575	3	1430	30.8	145	59.2	100
Manufacturing	5	250	4	1901	75.9	605	24.1	100
Commercial	2	1014	1	910	89.7	104	10.3	100
TOTAL	20	18660	17	15495	83	3165	17	100

Source: Reports on Project URT/83/PO3 prepared by the Organized Sector. Population Education Officer, Arusha, Tanzania (1984).

The agricultural/forestry, textile and manufacturing establishments employed a large female labour force (1,311, 1,000, and 605 respectively) and these are the establishments with the largest percentage of plant level medical facilities, one of the criteria for selecting potential participating enterprises. Information, education and communication activities are introduced with these services in order to sensitize, educate and motivate workers and management to use the family planning services provided as part of these plant level medical services. Table 7 shows the number and type of IEC activities carried out, and the total number of workers involved between 1979-1985, in the 20 enterprises.

Table 7. IEC Activities and Workers Involved Between 1979 and 1985

POPULATION/FAMILY WELFARE	YEAR	No. of Activities	No. of Workers	% Of TOTAL
Trade Unions Leaders/Officials Awareness Creation Seminars	1979	2	48	2.0
Seminars for Management Personnel	1979	2	45	1.9
Workers Education Training	1979	2	20	.9
Plant-level Educators Training	1980/1984	24	2065	88.7
Plant-level Self Evaluation	1985	20	150	6.5
TOTAL		50	2328	100.0 %

Source: Country Report Project URT/82/PO1, UNFPA/ILO, Arusha, Tanzania (1984).

Training of a plant level educators and motivators was the major activity and involved the biggest proportion of workers (88.7%). A total of 2,328 workers participated in population/family welfare activities during the period 1979/1985. This activity was followed by a self-evaluation exercise at the plant level where workers, with the guidance of the Organized Sector Population Officer, reviewed various activities, problems, and successes.

4. Conclusions

It can be seen from the above that of all the types of activities carried out between 1979/1985, plant level training activities were the major pre-occupation of the project involving (88.7 %) of the total coverage. In these six years of operation, population/family welfare education activities were carried out in pilot establishments. Awareness creation and sensitization of the management and labour unions were given priority. The training of plant level educators came later in this step-by-step approach to organized sector population/family welfare education activities. All the establishments covered have plant level medical services/facilities as shown in Table 5. However, data which shows how many of the total workers in the 20 enterprises have actually become acceptors of family planning and how many have actually utilized plant level services are not available (see Table 2.). It is reasonable, however, to assume that there is now a potential group of educated and probably highly motivated people who can be used as educator/motivators for other organized sector groups.

Plant-Level Program

An example: Kiltex, Arusha Kilimanjaro Textile Corporation (KILTEX) based in Arusha was considered a good choice because of it's involvement with family welfare programs since 1979. KILTEX was also selected on the basis of the results of an evaluation organized for management staff, trade union and workers education officials which assessed the progress in the integration of population/family welfare education activities into plant-level workers education. This was done to obtain the reactions of the three institutions involved in the program to the question: Why was it difficult to introduce plant-level family welfare ecucation?

(1) As Expressed by Management

1. Unawareness of the family welfare education project.
2. It is not of high priority.
3. Workers education committees do not function.
4. Effect of activities on production.
5. Negative attitude towards family welfare education.
6. Limited or no time at all allocated for workers education.
7. No (effective) workers education officers at plant-level.
8. Ambiguous definition of workers education.
9. Functions of workers education committee not clearly defined.
10. No funds for such activities.

(2) As Expressed by Workers Educatlon Officers

1. No expertise in carrying out family welfare education.
2. Lack of interest among management/workers educators.
3. Continuous staff transfers and changes.
4. No time allocated for such activities.
5. No plan of action.
6. No workers education officer in some industries.
7. Unclear definition of workers education.
8. Ineffective/defunct workers' education committees.
9. Lack of financial resources.

(3) As Expressed by Workers

1. Lack of interest by workers.
2. Negative attitude by workers.
3. Non-endorsement of the activities by management.

Plant Profile (KILTEX)

KILTEX is situated in the eastern industrial area of the town of Arusha, in Northern Tanzania. The corporation manufactures certain types of textile materials and operates on a 24-hour shift basis. It employs about 1,300 workers of whom 100 are females.

DEPARTMENT	NO. OF STAFF
Management	44
Administration	114
Weaving	463
Spinning	370
Finishing	99
Quality Control	38
Engineering	101
TOTAL	1,289

Workers Profile

The ages of the employees range from 18 to 65 with 1200 males and 100 females. There are no data to show the workers marital status or family size. The country's income tax laws provide for tax relief to a maximum of only four children per worker. Therefore, even if a worker has more than four children, the additional children are not normally registered.

This industry has comprehensive workers welfare facilities which include a plant clinic, cooperative shop, canteen and employee transport services and a workers education program for all members of the staff, hence its suitability for pilot activities. The Organized Sector Population Officer worked out the necessary plans to introduce plant-level education activities as part of the on-going workers education program and to introduce family planning delivery services within the plant-clinic services. The following were the steps taken:

(1) **Discussions with Management and the Workers Education Committee.**

The purpose and objectives of the pilot activities at KILTEX and the rationale for a plant-level family welfare education program were explained.

(2) **Appointment of a Planning Committee.**

When management and members of the workers education committee of the plant were sufficiently convinced and sensitized, they agreed to the formation of a Planning Committee of eight people representing all the departments in the industry. The function of this committee was to plan and implement a plant-level family welfare education program.

(3) Orientation of Planning Committee Members.

A four-day orientation workshop was organized for all the eight members of the committee. The management gave its consent for the workshop to be held at the factory. The workshop objectives were:

(1) Defining the content of the Family Welfare Education Program

(2) Training of the Planning Committee members in IEC activities

(3) Providing skills in organizing and carrying out the program.

The workshop was conducted in English and largely depended on group discussion. The results of a pre-evaluation exercise revealed the following:

Desire to increase their knowledge on family welfare (65 %)

Need to increase/add new knowledge in population/family welfare and responsible parenthood (25 %)

Ability to organize/conduct family welfare education activities at the plant level (10 %).

The training exercise was well attended. The next step was the designing and launching of a plant-level program. This was not easy for the following reasons:

(1) Despite management being initially sensitive, there continued to be a lack of enthusiasm on its part.

(2) The workers education committee at the plant was ineffective. This is an important institution for the integration of family welfare education activities in workers' education.

(3) Management's fear of disrupting production.

(4) There were no funds for such plant-level activities.

(5) Declining interest of the members of the Planning Committee after their orientation training.

Despite a relatively smooth start in the establishment of a plant-level program in the KILTEX (pilot industry), problems followed and made it impossible to start the program.

The ineffectiveness of the worker's education committee largely contributed to this failure. The existence of management commitment to the plant-level program also proved to be crucial and in its absence the program broke down from the beginning.

It would appear that the initial motivational meetings for top management did not create sufficient interest and this may be attributed to the fact that management, while being made aware of the importance of family planning in the context of workers' welfare, were not persuaded with respect to the benefits they would reap from the successful introduction of such a program within their enterprise. Persuasive literature directed to industrialists which emphasis economic advantages to the firm should be made available. If management were to be convinced of their possible gains, workers' education committees would quickly become more effective.

LIST OF ENTERPRISES COVERED IN THIS STUDY

1. Kilimanjaro Textile Mill (KILTEX), Arusha - (textile)
2. General Tyre East AFrica Ltd., Arusha - (agri/forest)
3. Tanzania Breweries Ltd., Arusha - (manufacturing)
4. Tanganyika Meerschaum Corporation Ltd. - (mining)
5. Fibreboards East Africa Ltd. - (agri/forest)
6. Tanzania Breweries Ltd., Dar es Salaam - (manufacturing)
7. Kilimanjaro Textile Mill Ltd., Dar es Salaam - (textile)
8. Tegry Plastics Ltd. - (manufacturing)
9. Workers Development Corporation - (commercial)
10. Sungura Textile Mill Ltd. - (textile)
11. Tanga Cement Factory - (mining)
12. Tanzania Sissal Authority - (agricultural)
13. Sabuni (Soap) Industries Ltd. - (manufacturing)
14. Tanzania Fertilizer Company Ltd. - (mining)
15. Tanganyika Industrial Corporation Ltd. - (manufacturing)
16. Tanganyika Planting Co. Ltd. - (agricultural)
17. Kilimanjaro Timber Utilization Co. Ltd. - (forestry)
18. Tanzania Tanneries Ltd. - (agri/processing)
19. Tanganyika Coffee Curing Co. Ltd. - (agri/processing)
20. Tanzania Bag Corporation - (manufacturing)

FOR AN INTEGRATION OF FAMILY PLANNING EDUCATION IN THE ORGANIZED SECTOR: THE TUNISIAN EXPERIENCE

by

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INTRODUCTION

Since 1966, fertility has been dropping in Tunisia. Today there are 220,000 births per year compared to 185,000 in the sixties. Birth rates dropped from 45 to 32 per 1000. The Tunisian "Office National du Planning Familial et de la Population" states that this is directly related to important social changes in the age at marriage. Today, two thirds of the recorded births occur among women less than 30 years old. Whereas in 1966, the same age group only covered 1/5 of the births. The 1978 Tunisian Fertility Survey established that factors which particularly affect fertility are: area of residence, female literacy and use of contraception.

OCCUPATIONAL HEALTH/FAMILY PLANNING

In 1975, the population office initiated a program in collaboration with the Occupational Health Department of the Ministry of Health to enhance the physical, mental and social well being of the worker.

The objective was to identify and revise the orientation of the occupational health and family planning strategy in terms of messages directed to a specific target population, namely the workers at home and at the work place. Emphasis was shifted to questions of protection and safety. Workers face difficult social conditions which not only affect their mental and physical health but also their productivity. These conditions can be a cause of occupational injuries. It has been established that in seven out of ten cases, labour injury is caused by "human factors" and difficulties in the workers' personal life. This led the occupational health and family planning specialists to study the effect of fertility on a certain number of problems related to work, health and employment.

1. **Absenteeism and Fertility:** Problems related to the occupational environment cause only 5 to 10 percent of total female absenteeism. However, 20 to 25 percent of absenteeism is directly related to pregnancy, delivery and maternity leave. Minimizing problems in these areas considerably reduces female absenteeism. These figures were shown to be particularly noted in studies carried out in textile and electronics plants.

2. **Employment and Fertility:** The rapid increase of the Tunisian population has had negative socio-economic repercussions on the economy. The demand for new jobs was 31,000 per year in 1958-1966 and 51,000 per year in 1967-1976. It has now reached 88,000 per year (1977-1986). In order to remedy this situation it is necessary to create labour opportunities and to alter demographic trends. A reduction in population growth rates can lead to a decrease in the costs of education, housing, health and other elements of the infrastructure. The money saved can then be made available for job creation programs directed towards the unemployed population.

3. **Health and Fertility:** Family planning can contribute to a decrease in mother and child mortality rates. It can reduce malnutrition among children through birth spacing and better nutrition.

4. **Occupational Health and Fertility:** Family planning can have beneficial effects on the worker's socio-economic development. In addition, it creates a better rapport between the company and employee, who will feel more valued by the company.

The core of the Tunisian population office's message was identified as follows:

Know: The worker should be informed about how family planning can improve his living conditions as well as those of his family.

Want: Human behavior is usually aimed at fulfilling a need or wish. The worker cannot change his attitude if he is not convinced of the benefits of proposed changes. Therefore, messages should respond as precisely as possible to his needs and expectations. They should be built on the considerations mentioned above.

Can: Required health and social services should be organized parallel to workers' motivation. This will ensure that the worker and his spouse can chose an appropriate form of family planning.

The relationship between fertility and absenteeism, employment, health and occupational health led the Tunisian Government to adopt a policy based on the principle that:

> The worker is human capital, the most important national resource, possessing the intelligence and alertness which ensures development and progress, and that this resource should be preserved, developed, and enriched as an aim in itself and for the good of the whole nation. The major aspiration of every worker is to be fit physically and mentally. Then, everything can be achieved through will, work, perseverance and ambition.

This policy has been the basis for action implemented by the medical services of the Occupational Health Department for the last eleven years. Strategies used to provide educational and medical services are also based on this policy. Services are aimed at promoting the health and well being of the workers both at their work place and at home.

Below is a chronological listing of activities undertaken during the period 1973-1986.

1. Motivation of higher management in the enterprises.

2. Periodic training and/or recycling of occupational practitioners in the field of family planning.

3. Training of paramedical, social, hygiene, and safety workers.

4. Decentralization of health education activities to different regions of the country, and the joint management of the Population Office and the Occupational Health Department.

5. The creation of family planning units at the plant level. Their role is to undertake motivational activities, to follow up with women using contraception, to provide health examinations, to detect any diseases, to provide contraceptives, and to refer some clients to more specialized health units.

The Family Planning/Occupational Health joint program has embarked on a series of activities aimed at developing and improving what has been done during the period 1973-1986. These activities are to be implemented in three main areas: target group surveys, studies on content of the messages, and establishment of a medical file system.

Program Activities 1973-1986

A. The Survey

A number of the characteristics of the 200,000 workers who are now covered by the services of the Occupational Health Department posses an undetermined number of characteristics which have not yet been studied. The knowledge of these should allow for a better strategy in the message. A worker's behavior and performance in his family and professional life is the result of his preoccupations, wishes, resistances, and hopes. This can also help to explain the cause of injuries and the relationship between fertility and absenteeism. To this effect, a survey was jointly taken by the Family Planning Office and the Occupational Health Department. The stages of the survey were as follows:

- pretest
- selection of a representative sample of 1/50 of the salaried group
- selection and training of those chosen from the medical and paramedical staff of the enterprises to carry out the survey
- utilization of the results of the survey to improve educational and medical services.

B. The Strategy of the Message

In 1986 the Family Planning/Occupational Health Department defined the available target population in the inter-plant centres as well as the autonomous plant centres. There, the education of the worker and his family was to be carried out. Problems would be identified, together with reasons for resistance to existing services and facilities. Although the best way to arrive at convincing results is to set up operational surveys, it was decided to define a series of themes. The workers would discuss and utilize these

themes and thereby reinforce their own education. The 23 themes defined came from actual field situations and were suggested by a special commission. Some of them are:

- Labour injury and family size
- Preparation for a happy delivery
- Fertility and sexuality
- Absenteeism and parental responsibility
- Family planning and communication training for the occupational health services staff.

C. The Medical File of the Enterprise

Traditional medical files contain data on an individual worker's health, sickness, injuries, etc. To provide a better understanding of the workers' general and psychological health, it was decided to include additional social indicators. This new type of medical file could eventually be converted into a data bank which could help evaluate the impact of family planning motivation on the worker's health in the home and at the work place. The file would also include information concerning the worker's family health, including the number of births, vaccinations, hereditary and consanguinity history, and contraceptive methods used.

The revised joint Family Planning/Occupational Health Program was implemented during 1986 on an experimental basis. It will be finalized during the years 1987-1991.

A concrete example

The preliminary stages of the program included extensive meetings. It was here that occupational health was defined not only as the prevention and treatment of labour injuries and professional diseases, but as a more global health protection of the workers. In this context, it was noted that although the worker spends a good deal of the day at work, he spends the rest of the day at home with his family. Therefore a number of factors inherent to the family influence him. Industrial management should therefore keep in mind that a preventive health measure cannot be efficient if priority is not given to the total health of the workers. This in turn will improve productivity. In addition, productivity itself substantially affects the worker's total health. Studies show that seven out of ten labour injuries are directly or indirectly linked to difficulties in the private life of the workers. This is why security at work starts at home.

Birth spacing and limitation were recognized as preventive health measures which must be fully integrated in preventive medicine and especially in occupational health.

In conformity with these guidelines, family planning education and services were integrated with the medico/social department activities of the Tunisian Power and Gas Department (Societe Tunisienne de l'Electricite et du Gaz, STEG). STEG, had a 1985 revenue of 193 million dinars (approx 230 million U.S. dollars). It was nationalized in 1962, only six years after independence. Its official activities are the production, transport, distribution, importation and exploration of household electricity and gas. Although STEG is a nationalized industrial enterprise, it enjoys important privileges and great autonomy in business operations such as recruitment, finances and representation. Nevertheless, development policies are based on high level decisions. The policies fit into the general framework of the National Development Plans. As a public institution STEG ensures continuity of services with its production. STEG adapts its policies to the needs and fair treatment for all its customers. It employs a total of 7,853 permanent workers. During the last six years it offered 1,707 job opportunities. In the seventh, they plan to create 1,460 new posts. All of STEG's personnel enjoy appreciable social benefits, to upgrade the quality of their lives. Several of these benefits are: medical care, social security, cultural and leisure opportunities and loans for purchases of houses, and cars. These privileges create a situation where it is easy to experiment with the integration of family planning education and services into general social benefits. The experiment will be implemented in six phases:

1st Phase: Raise awareness of the top management to the relationship between the workers' life at home and at the work site.

2nd Phase: Offer training courses for the medical, paramedical, and social personnel of STEG, in addition to representatives from STEG's Workers' Union.

3rd Phase: Plan information, education and communication sessions by the Family Planning Office. The sessions will be at national then regional levels. They consist of debates, movie projection presentations, and case studies for STEG's workers and their spouses. These aim at providing knowledge to the workers concerning contraceptive methods, to encourage acceptance and eventual use of one of them.

4th Phase: During this phase, training continues for STEG's paramedical and social workers, as well as labour unions' delegates. The goal is to ensure that STEG trainees take over from the Office's specialists and become trainers and motivators themselves.

5th Phase: A Family Planning Unit was created in STEG where Family Planning Medical Services will be made available. Services include: gynecology, pill prescription and distribution, insertion and withdrawal of IUD's and referral to other medical units for abortion and sterilization. The unit consists of a waiting room, two examination tables and four beds. Instruments, contraceptives and other drugs are provided free of charge by the Family Planning Office, whereas STEG pays for doctors and other medical and paramedical personnel. The office's countrywide reports and statistical data include monthly office

statistical reports on the unit's performance, and provides data on contraceptive prevalence.

6th Phase: This phase consists of continuing the operation of the unit, following up its activities, and improving them.

The Office's assistance continues as follows:

- Training of paramedic/social staff and the union's representatives in family planning communication and education.

- Defining daily work schedules for STEG's gynecologists.

- Provision of contraceptives, drugs and equipment.

- Provision of education teams available upon request.

The case of STEG is one example of the participation of the population office in reinforcing health activities within plants and industrial areas. The population office makes available the following concrete assistance:

- Participation in the execution of health education programs, with a family planning component.

- Conducting regular countrywide regional and interregional training courses for social, paramedical, and administrative staff from industry and trade unions.

- Provision of a family planning mobile unit which regularly visits industrial areas which are not yet sufficiently equipped with family planning services.

It will be interesting to see what impact such an integrated and structured program can have both in the short and long run. The availability of the new Enterprise Medical File will ensure that the basic inputs into such an analysis will be forthcoming. Consequently, by the end of the decade, this "data bank" will be able to evaluate the impact of family planning programs on the workers health not only in STEG but in all other enterprises participating in the Family Planning/Occupational Health Program.

THE POPULATION AND FAMILY WELFARE PROGRAM IN THE ORGANIZED SECTOR OF ZAMBIA

by

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I. INTRODUCTION

One of the major objectives of the third National Development Plan in the field of social welfare is to "strengthen the family unit in light of the knowledge that it is only a strong and healthy family that produces useful individuals necessary for the building of a strong nation".

In setting this objective, the Government of Zambia is aware of the demographic trends of a growing young population and it's strain on the resources available for social and economic development.

A large portion of the labour force population is engaged in the production of goods and services. Mining, the largest single organized sector, contributes 97.8 percent of the country's foreign exchange. It represents about 30 percent of total paid employment and contributes roughly 30 percent of government revenue.

These figures help you to realize the importance of the organized sector in the social and economic development of the country and its potential role in population and family welfare issues. The Government, with the technical assistance of the ILO and funding from the UNFPA, launched a project in 1978 on Labour and Family Welfare Education for the Organized Sector. One of the major objectives of the project was to help the organized sector to better understand the wider aspects of population and family welfare, their effect on national development, as well as on the individual worker and his family. This understanding will facilitate positive decisions in the area of parental responsibility and family size. The project has generated considerable interest in population and welfare issues beyond the limits of the main target groups in the organized sector.

The present program is now carrying the education process to the workers, at both the union and plant levels.

An intensive program is being implemented at the plant level, together with the provision for family planning services within the context of occupational health and other medical/welfare services in the industrial setting. The first phase combines 100 enterprises employing more than 100 workers each with ten local administration clinics in towns with a concentration of industrial and plantation workers.

II. IMMEDIATE OBJECTIVES OF THE PROGRAM

- Integrate population and family welfare education in the educational programs of the Trade Unions, the Zambia Congress of Trade Unions and its affiliates.

- Integrate population and family welfare education in some of the courses at the President's Citizenship College and the Community Development Training Centres.

- Establish family planning service outlets in medical facilities and clinics in selected enterprises.

Strengthen the family planning services in community clinics in the urban areas inhabited predominantly by industrial workers and their families.

III. ACTIVITIES OF THE PROGRAM

The program is a logical development arising from the activities of the ILO/UNFPA project, and decisions of the Zambian government. The decisions were:

(a) to institutionalize population and family welfare activities within the Ministry of Labour and Social Services by establishing a permanent unit in the Ministry, and

(b) to spread the activities to the grassroots level by involving enterprise level facilities and services.

The activities of this first phase were directed at increasing population and family welfare awareness among trade union leaders, employers' representatives, and concerned government officials. They also strove to involve national trade unions and workers in the population, labour and family welfare education program. Another goal was to create a general awareness among trade union leaders, workers and supervisors about population dynamics affecting employment opportunities; wages and family incomes; productivity; migration and the general economic and social well-being of workers and their families. To achieve these ends, orientation programs on matters related to labour and family welfare were organized for labour and government officials. This helped the Ministry of Labour and Social services by giving guidance to the various organized sector groups in how to produce relevant training, educational and motivational materials to support the program.

A survey of major industrial, mining, agricultural and parastatal enterprises was conducted in June, 1980. The survey collected information on the type and range of welfare, community, medical and health facilities into which family welfare education and services could be integrated. The program was formulated based on the findings of this survey, coupled with information from the Employers Federation of Zambia about the size, labour force, and location of various kinds of enterprises. Almost all major enterprises have a wide range of welfare and community development programs which lend themselves to the integration of family welfare with proper staff training. At the same time, many smaller enterprises exist where facilities and services can be improved with a minimum of effort. They can be used effectively for family welfare education and other labour welfare services.

The second phase of the program concentrates on education and motivation of workers and their families, together with providing family planning services, as part of the occupational health, medical and welfare provisions available in the industrial sector. The educational activities include intensive education of trade union officials, the introduction of population and family welfare education to the curriculum of the President's Citizenship College and the Community Development Training Centres in the Copperbelt, and factory level educational programs.

The Zambia Congress of Trade Unions and its affiliates as well as the President's Citizenship College and the Community Development Training Centre were involved in the first phase. Their personnel participated in training activities.

IV. DIFFICULTIES ENCOUNTERED

Initially, the program was resisted by the Party and the Government of Zambia. The employees, church and Labour Movement people in responsible positions did not appreciate the effect a growing population can have on economic and social development of the country. Nor did they grasp the effect of frequent pregnancies on the health of the mother and the high infant mortality rate resulting therefrom. Zambia, like most African countries, is a traditionalist society which believes in large families, since children are a "gift" from God, and an investment. It was therefore, considered taboo to talk about family welfare and family size. These views are particularly prevalent among the illiterate and the Christian faithful.

However, things are changing and so are people's beliefs. This is particularly true of those living in urban areas and working in the organized sector. This is partly the result of economic problems, a high cost of living, shortages of essential commodities, plus the lack of employment opportunities. Standards of living are going down as a result of population pressure on goods and services. Hence, an appreciation of population pressure is emerging. This in turn stimulates an interest in family planning education. The preceding paragraphs clearly show that it took the program almost three years before it began to influence traditional beliefs of leaders in the country so that they would accept the concept of family planning and give their support and co-operation.

V. PROGRAM IMPLEMENTATION

As a result of the initial success achieved under phase one, (awareness creation), the program has now been taken to the workers at enterprise levels. Enterprises participating in the program were invited to become involved if they possessed one or more of the following criteria:

(a) one hundred or more employees

(b) a works council

(c) clinic facilities

Twenty-three Labour Department Officials and 34 secretaries of national unions received training under the program and are thus the spearhead for taking the program to the plants. These key individuals are assisted at the factory level by local trade union leaders who have benefited from the fact that a number of trade unions have introduced family welfare education into their regular trade union training programs. The importance of local trade union-trained leaders participating in the setting up of factory-based programs cannot be over emphasized. This situation has also been helped

because the President's Citizenship College has included family welfare education in its regular courses. A total of 733 government civil servants at managerial levels have participated in these family welfare education courses. This has helped to get things going at the plant level.

VI. TRAINING AND CREATION OF AWARENESS

So far, the program has trained 218 motivated workers from selected enterprises. These trained "motivators" spread the message of family welfare and population education to their fellow workers at the plant level. A total of 201 establishments have participated so far in the training program. The "worker-motivators" are trained over a period of five days and receive an introduction to a certain number of subjects, namely:

(a) Family welfare and family size

(b) Facts about family welfare

(c) Conception and contraception

(d) Natural methods of family planning

(e) The role of trade unions in family planning

(f) The role of employers in family planning

(g) Population trends and problems of development

(h) Traditional arguments people use against family planning

(i) Nutritional needs of a worker in relation to family size

(j) Communication and motivation

(k) The use of simple visual aids in educational activities.

At the end of each of the five-day workshops, the management of plants represented at the workshop are advised to set up a Labour Management Committee (LMC) at the place of work. The LMC is comprised of trained worker-motivators, trained representatives of the management including medical welfare and personnel staff, and trade union representatives. It must be mentioned that a Works Council or Committee, when established in an enterprise, can play a major role in influencing management's decision in favor of future development in the family planning field. It is suggested that the LMC should be composed of one third management representatives and two thirds worker representatives.

Information regarding family planning is mainly to be obtained from the Ministry of Health through the Maternal Child Health, Ante-Natal/Pre-Natal clinics frequented by mothers. In the organized sector, the family welfare program provides information and education on family welfare. The main theme around which information and education activities are centred is

meant to create awareness among couples of reproductive age. Subjects centre on the dangers to the health of the mother and child when pregnancies are not spaced, and infant mortality and malnutrition.

The first phase of the program creates awareness with opinion leaders in the country. As a priority, a number of seminars and meetings involving employers, as well as the leaders of the trade union movement were conducted. The goal was to solicit their cooperation and support in accepting and including family planning components in their on-going training programs. Then, workers may have a wider understanding of family welfare planning so that they in turn would make positive decisions about family size. It is pleasing to note that despite the financial constraints the unions have, a number of them incorporate family welfare planning in their educational programs with a view to promoting the quality of life of the Zambian people. Apart from the Labour Movement, the President's Citizenship College has accepted the inclusion of family welfare and planning lessons in its programs. Specific family welfare lectures are delivered at this leading institution each month.

VII. ROLE OF MANAGEMENT

Implementation of any national organized sector family welfare program needs the participation of management at enterprise level if it is to gain the support and acceptance of the working force.

Management personnel can ensure that information regarding family welfare and family planning required by workers is made available to them. Management should be encouraged to use their relations in contacting the health and labour administrations, national family planning associations and other relevant authorities engaged in, or associated with, family welfare and family planning to obtain materials and assistance for the workers at plant level. Management can support programs by arranging family welfare meetings for workers without change of shift or loss of pay.

They can encourage group meetings for workers and where possible, can allow and even encourage families to attend such meetings. Management should also seek the assistance and co-operation of trade unions in obtaining and disseminating information and in organizing and conducting group meetings at their own expense. Management can integrate family welfare/planning education in the educational activities arranged by them for the benefit of workers and their families, particularly in the mining and agricultural industries. Employers should be encouraged to provide family planning, welfare, and motivational services through the staff of the company clinics at plant level after they have been trained for this purpose. Social workers, employed at enterprise level should be encouraged to devote more time to educating workers and their families on the need to accept and practice family planning. In an attempt to achieve these very necessary objectives, the Labour Family Welfare Unit in the Ministry of Labour and Social Welfare has so far held 16 one-day orientation seminars for top management personnel.

It is important that the senior management be motivated and well informed if the program is to succeed at the enterprise level. Top and middle managers

should regard the promotion of family welfare as an important element in occupational health and welfare services in the enterprise. A senior officer should be given the responsibility of supervising the promotion of family welfare at the plant. Management should reward efforts which are being made in promoting family welfare among workers. Joint consultation between management and workers in formulating and implementing the program within the plant is necessary to facilitate and dispel suspicion. Whenever Labour and Management family welfare committees are established, senior members of staff should be appointed to serve on these committees.

VIII. DAY-TO-DAY SUPERVISION AND ADMINISTRATION

The day-to-day administration of Labour/Management Committees at plant level should be handled by the Chairman of each committee assisted by the senior officer of the management team of the plant. At the district level, all committees should come under the supervision of the local Labour Officer who has been trained in family welfare education. He can provide the necessary assistance, guidance, and motivation to the various committees. The local Labour Officer will analyze and act upon the reports received from individual enterprises before submitting them to the Ministry Headquarters.

It is a considered view that Management, Trade Unions and the Government should meet the financial and material requirements. At the present time, however, most companies are not in a good financial position because of the current economic crisis. For this reason, an appeal should be made to the Labour Movement to set aside part of their members' contributions to meet the specific primary needs of the workers. This in turn will contribute highly to improved productivity and promote the quality of life of the members and their families.

IX. ROLE OF TRADE UNIONS

The role of the trade unions in family welfare education is very important. Workers in this country tend to listen to their elected leaders in the Labour Movement rather than to a Government official. Trade unions are concerned with workers living conditions and the quality of life of their members. The Zambia Congress of Trade Unions and its affiliates have included family welfare education in their educational programs to assist their members in making positive decisions about family size. Trade unions in Zambia are playing an important role in the provision of information and education about family welfare by inviting experienced persons from associations dealing with family welfare and maternal and child health programs to participate in their activities. With a population of 6.7 million and only about 1 million people in paid employment, trade unions have taken it upon themselves to educate their members. They teach the need to practice family planning. They realize that there will be a surplus labour force for the next twelve years in the age groups 15-49 years. This requires an acceleration of the campaign to educate members on the need to reduce family size in order to relieve pressures on job creation, housing, etc. With a rising population, unions are aware of the implications a surplus of labour will have on their bargaining power.

Trade unions can convince their members of the importance of family welfare education. Smaller families can realize increasing opportunities for school education, saving and investment, better health for working mothers, and higher standards of living for workers and their families. The unions can conduct regular seminars and meetings designed to promote family welfare education.

X. TRAINING AND EDUCATIONAL ACTIVITIES

Materials for training and educational activities are not sufficient to cover the needs of the program in this country. This is due to the high production costs of these materials, together with the lack of manpower possessing the necessary skills in the production of IEC materials.

If the impact of the program is to be optimized, visual aids must be produced in large numbers in order to compensate for the high illiteracy rate in the country. This requirement assumes even larger significance when one considers that there are as many as 73 different languages spoken in the country; a feature which makes mass communication a less suitable channel of information dissemination than would be the case in a more homogenous society.

XI. CONTRACEPTIVES

The price of contraceptives in Zambia is beyond the reach of most likely users, especially those in lower income groups. Most contraceptives are distributed through hospitals and clinics. In the rural areas, the Zambia Flying Doctor Service has done a commendable job by providing contraceptives where adequate surface means of transportation do not exist. The present distribution of contraceptives is particularly inadequate since working people cannot afford the time to join endless queues at the hospitals.

Now that workers have been introduced to methods of family planning, the majority feels that the distribution of contraceptives should be carried out in the company clinics so that they and their families can have easy access to them. Most companies in Zambia have employed qualified nurses and have engaged visiting doctors who can prescribe a method to a couple. Where there is no visiting doctor or qualified nurse, non-prescription methods should be distributed. Most of the enterprises selected in the program have expressed interest in distributing them to their workers, but the problem is an inadequate supply. In the future it will be important to ensure that educational programs do not create a demand for contraceptives which cannot be met due to a persisting inadequacy of supplies.

XII. INCENTIVES

Management and trade unions should consider offering financial as well as material incentives to workers who wish to limit family size or those motivators who recruit more acceptors monthly. Incentives could be given to those who promote the program, especially to members of the Labour Management Committee (including clinic staff) who have exceptionally good

motivational records. Numerous types of incentives have been considered. These include providing:

(a) Free contraceptive and medical services to acceptors

(b) Scholarships for study

(c) Privileges or facilities for credit and housing

(d) Leave with pay

(e) Allowances for attending meetings.

XIII. AN EXAMPLE

The Zambia Sugar Company is one of the largest state owned companies. The company was established in the 1960's to help the country meet its demand for sugar and to improve the much needed foreign exchange. This company is located in the Copperbelt Province. It produces enough sugar to meet the needs of the country, and exports its surplus to neighboring countries within the region.

Their labour force of 4,945 workers is divided as follows.

Males: 4,799
Females: 146

Educational standards of the workers are as follows.

Employees with education below Primary level	=	2,055
Employees with Primary level education	=	2,017
Employees with University education	=	7

MARITAL STATUS

Married workers = 3,945
Unmarried workers = 1,000

AGE DISTRIBUTION

Workers under 20 years	=	582
Workers between 20 to 35 years	=	1,994
Workers 35 years and above	=	2,369
Average number of dependents	=	10

The Zambia Sugar Company was selected for participation in the training program at its commencement in 1984. This particular plant program started with an orientation meeting for employers held in Ndola during 1984. The meeting was held for employers within the Ndola district. Afterwards, a five day workshop for middle management, works counsellors, trade union leaders, and medical personnel was held at the National Import and Export Training Centre. Participants were introduced to the following subjects:

Family welfare and family size

Population - problems of population and development

Facts about family welfare and family size

Conception and Contraceptive methods

Communication

Traditional arguments people use against family planning

Natural Methods of family planning

Services provided by the Planned Parenthood Association of Zambia

The ILO program and its relevance to Zambia.

The workshop was attended by 24 participants drawn from 14 establishments. Management participants were requested to form family welfare and labour management committees to spread the message of family welfare and population education to workers employed at the factory level. The Zambia Sugar Company responded to this request. However, one thing which management refused to do was to establish a committee at the factory level. The management's argument against the establishment of such a committee was based on the premise that there were already too many committees operating within the plant. The management felt that the family welfare program should be run by the senior nursing officer who had participated in the program. It was felt that she had the capacity to motivate the workers and their families.

Although the provision of medical services is the responsibility of the state, the Zambia Sugar Company has supplemented the state's efforts with an industrial clinic located on the company premises. In addition, the company rents a building from the City Council which has been converted into an infant and child health clinic which serves workers' families and the surrounding community. These "under-five" clinics are held twice weekly. In addition, a family planning clinic is held twice weekly. The Senior Nursing Officer provides family counselling to wives of the workers and the community. The factory clinic is serviced by a private medical practitioner who visits twice weekly. At this plant clinic, minor diseases and injuries are attended to by the doctor and supporting medical personnel.

In order to limit family size, workers at the sugar plant regularly visit the plant clinic for counselling by the nurse on methods of family planning. Discussions cover the advantages of a small family, education for the worker's children, how good food is required for a decline in infant mortality, and the resulting better health of the child and the mother if pregnancies are spaced at least two years apart.

At the township clinic where "under-five" clinics are held, mothers are encouraged to use some form of family planning. Special encouragement is given to those found with children suffering from malnutrition and other related diseases as well as those who fail to space their pregnancies. At this clinic, the most popular method of family planning is the pill. However, before the pill is dispensed, the husband is asked through the plant Personnel Office to visit the under-five clinic. His approval is sought before the wife is put on the pill. On the 30th of November 1986, there were more than sixty women on the pill and more than sixty males using the condom. Hence about 4 percent of married workers are now participating. If this figure is considered in terms of most fertile age groups, the percentage more or less doubles to 8 per cent.

Although the workers at the Zambia Sugar factory have accepted the use of modern methods of family planning, particularly the condom and the pill, the company clinic continues to suffer from the lack of a constant supply of contraceptives, like many other clinics in the country. Most contraceptives in the country are supplied by the Planned Parenthood Association of Zambia (PPAZ) which is an affiliate of the International Planned Parenthood Federation. In an attempt to overcome the constant shortage of supplies, the Zambia Sugar Company has come to an agreement with the Zambia Flying Doctor Services, a non-governmental agency, to provide the bulk of the contraceptives required by its workers. This positive initiative on the part of the management should not be overlooked. At the present time the contraceptive acceptance rate for the Zambia Sugar Company may appear to be rather low, but in the light of the problems encountered at the beginning of the program, it is rather encouraging. In addition to the usual fear of side effects, the project workers had to overcome strong political and cultural opposition. Most workers believed that family planning was another of the many alien Western ideas floating around in Africa. In addition, most supporters of the program, and users of contraceptive methods, were regarded as morally weak by their work colleagues as well as by the moral majority in the communities in which they lived. By now however, these negative attitudes have been eliminated through the successful campaigns undertaken by the project staff.

Although an encouraging proportion of the workers in the reproductive age groups are now prepared to practice family planning through the use of condoms and pills, it is felt that the impact of the program could be greater. If the management of the Zambia Sugar Company had established a LMC, it would increase the level of program activities and at the same time share the responsibility for program implementation over a wider range of the work force.