JOHNS HOPKINS BLOOMBERG SCHOOL of PUBLIC HEALTH

PFHS 380.665 FAMILY PLANNING POLICIES AND PROGRAMS

Reading List

W. Henry Mosley

Reference Reading

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PFHS 380.665 FAMILY PLANNING POLICIES AND PROGRAMS

Introduction

W. Henry Mosley

A. Introduction

1. Course Introduction
    a. Course schedule
    b. Learning objectives
    c. Class introductions

2. Course materials
    All course materials (with the exception of a few handouts) are on Course Supplement Web Site. Go to the course "Family Planning Policies and Programs" in the Department of Population and Family Health Sciences listing.

3. Working Groups
    The class will be divided into small groups for most assignments. Each group will have a diverse group of students

based on information provided on the class registration forms. The working groups will be responsible for guiding class discussions from time to time as well as preparing and presenting the Final Assignment. Students are encouraged to work in small groups on all assignments, but all required papers are to be individually written.

4. Written Assignments

Students are encouraged to discuss the written assignments before submitting their papers, but each student must individually prepare his/her own paper for submission. All written assignments are to be in **MSWord format, 12 point type, single spaced. The required page** length will be given with each assignment. All assignments are to be submitted by e-mail to hmosley@jhsph.edu by the due date. Unexcused late assignments will lose one letter grade.

B. Session 1

Lecture Presentation: *Introduction to Population Policies*
(See Powerpoint Slides.)

Required Reading

***The Unfinished Agenda: Meeting the Need for Family Planning in Less Developed Countries. PRB Policy Brief, Population Reference Bureau,* 2004.**

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Recommended Readings

Chapter 2: Origins and evolution of family planning programs. In Judith R. Seltzer *The Origins and Evolution of Family Planning Programs in Developing Countries,* pub. Rand, Santa Monica, CA, 2002. http://www.rand.org/publications/MR/MR1276/ accessed January 15, 2005

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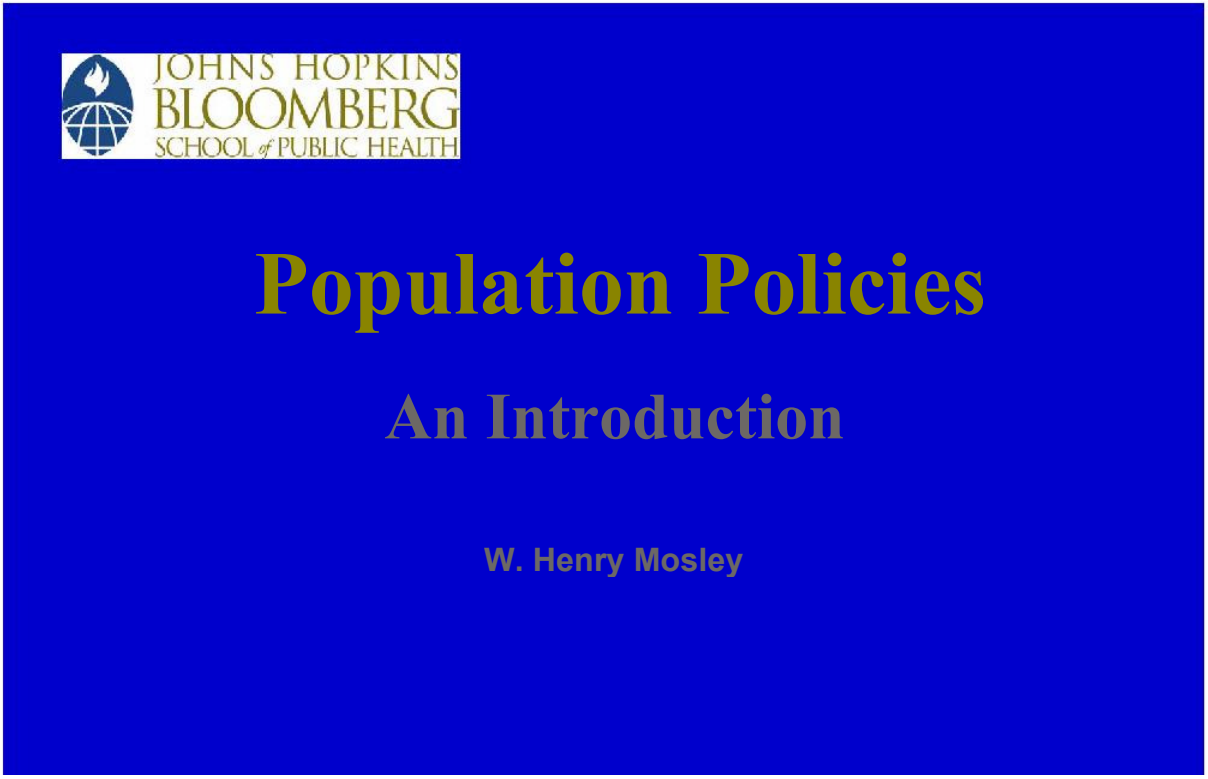
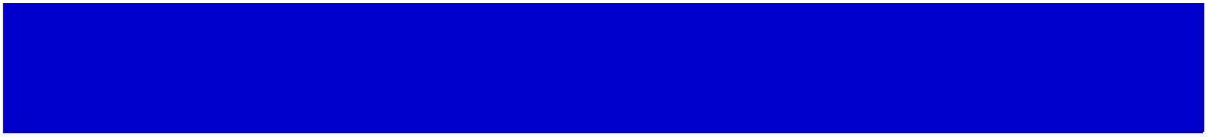




Lecture Outline

1. Introduction to Population Policies
2. Historical Overview of Population Policies Prior to the 20th Century
3. Population Policy Development in the Post-World War II Period, 1950-2000
4. Evolution of Population Policies in Sub-Saharan Africa

Learning Objectives

Upon completion of this lecture, the student will be able to:

- Describe the policy instruments of government
- Explain why and how population policies are formulated
- Distinguish between explicit and implicit population policies
- Give examples of population policies affecting fertility, mortality


and migration

Learning Objectives

Explain the Malthusian controversy relating to population and poverty

Trace the major trends and controversies in population policy since the 1950s

Describe the major shifts in population policies since the 1994 International Population Conference in Cairo

What Is a National Policy.

A policy is a set of government statements and actions that are designed to influence the behavior of the people in order to achieve a desired outcome

Government actions can be categorized into five broad policy instruments

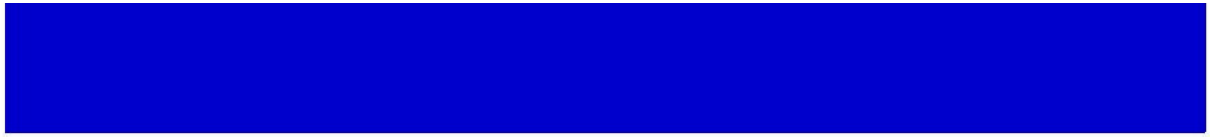
The Policy Instruments of Government

- Information
- Laws and regulations
- Taxes and price controls
- Direct spending/investments
- Research

Illustration of the Application of the Policy Instruments

Policy Objective: Reduce HIV/AIDS transmission

1. Mass communication programs about HIV/AIDS
2. Legalize and regulate commercial sex
3. Subsidize the distribution of condoms
4. Provide free diagnosis and treatment of HIV/AIDS
5. Develop an HIV/AIDS vaccine



Population Policies

Definition: Population policies to influence population growth and distribution involve a wide range of decisions and actions by governments, both direct and indirect, which influence individual and family decisions regarding marriage and childbearing, working arrangements, place of residence, etc.

Types of Population Policies

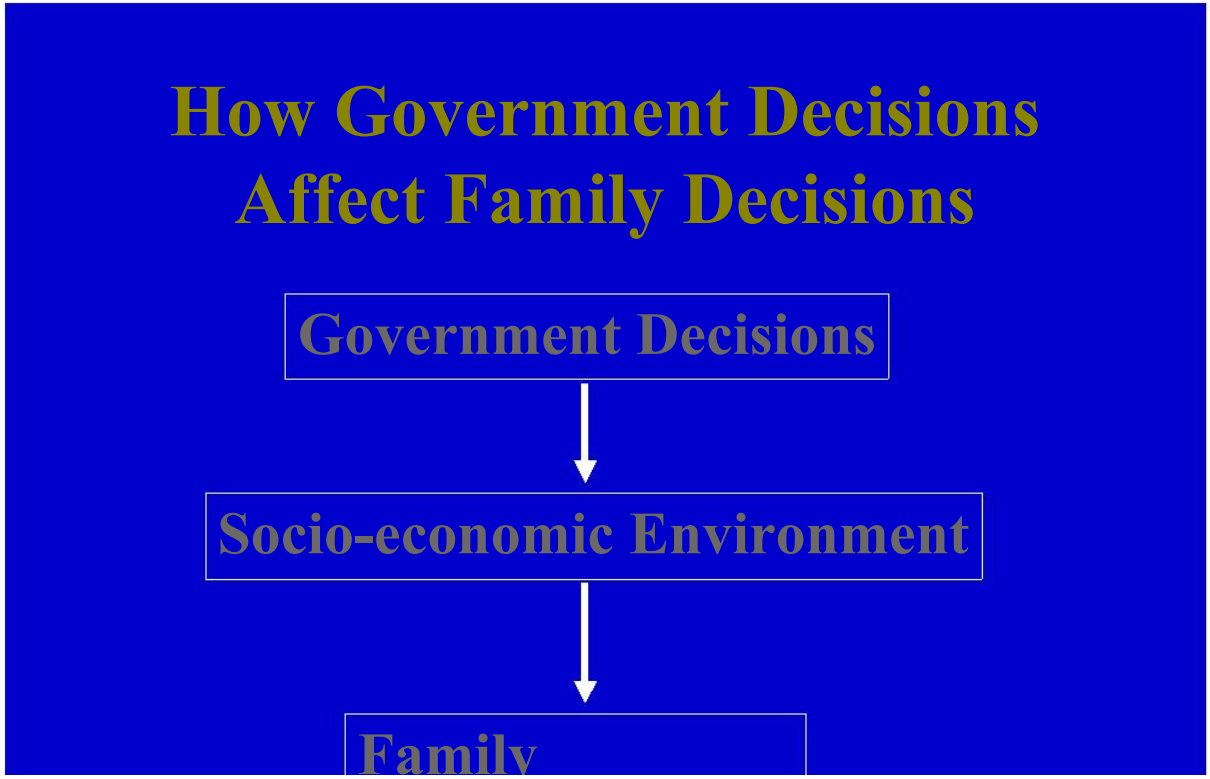
Direct or explicit government actions taken for the purpose of affecting a demographic outcome , e.g., migration laws

Indirect or implicit government actions that only indirectly have some demographic effects, e.g., promoting female education

Explicit *versus* Implicit Policies

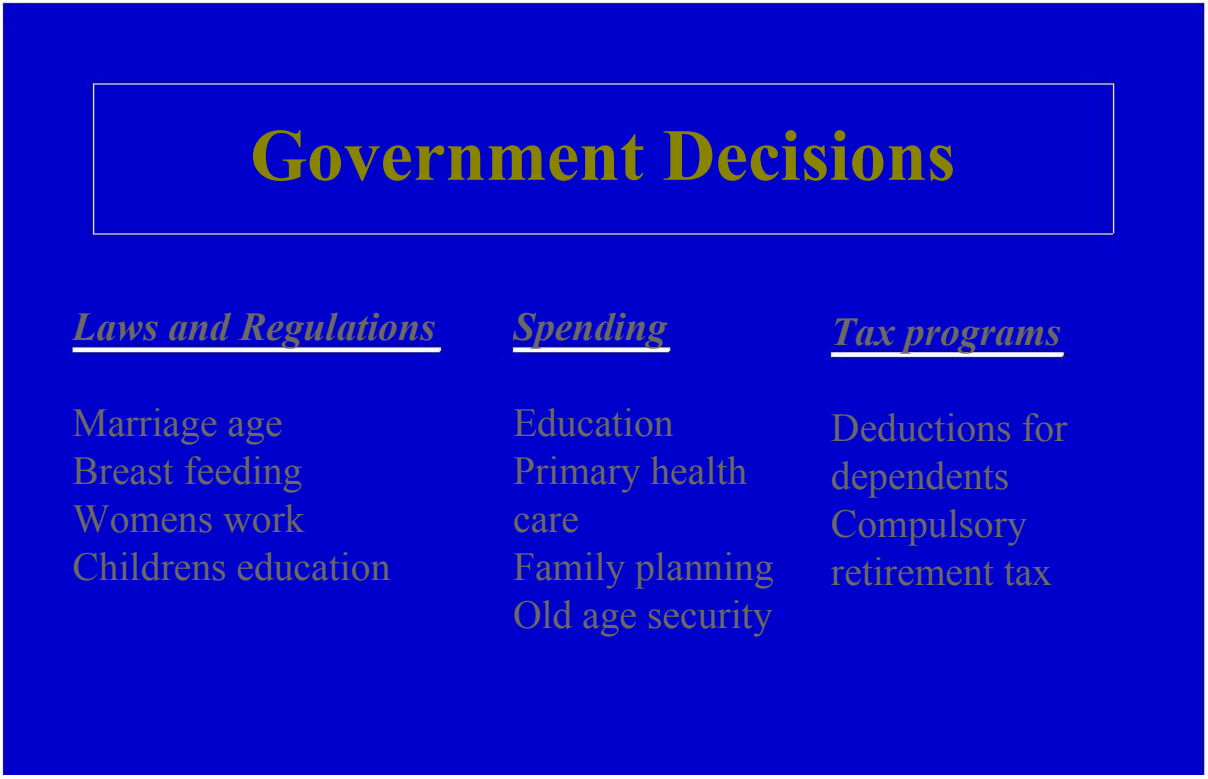
Example: Slowing Population Growth

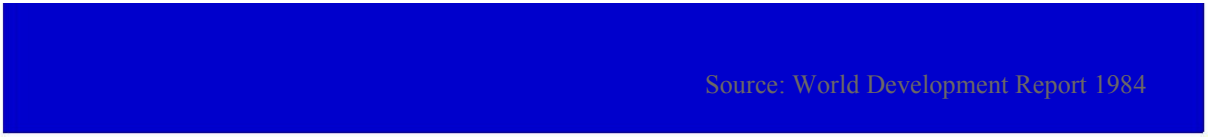
Explicit Policies	Implicit policies
Provide free family planning services	Compulsory secondary education
Increase taxes for each additional child	Restrict child labor
Restrict immigration	Limit size of houses
Raise the age of marriage	Raise status of women
	Provide old age security



Decisions

Source: World Development Report 1984




Source: World Development Report 1984

Socio-economic Environment

- Educational opportunities, especially females
- Availability of health and family planning services
- Status of women
- Financial and labor markets


Source: World Development Report 1984

Family Decisions

Timing of marriage

Number of children

Childrens education

Saving and consumption

Work time within and outside the home

Rationale for Adopting Population Policies

To change the future prospects of a country, specifically:

- To enhance economic development
- To improve social welfare
- To improve individual welfare

Steps in Formulating a Population Policy

- What is the likely social/economic future if current demographic trends continue unchanged.
- What is a more desirable alternative demographic picture of the future.
- What current behaviors must be changed to achieve the more desirable future.

Major Areas of Concern for Population Policies

- Historically
  - Fertility - pronatalist
  - Migration restrict emigration, encourage immigration
- Currently
  - Migration restrict immigration, encourage redistribution
  - Mortality prolong survival
  - Fertility primarily antinatalist

Population Policies

A Brief Historical Overview Prior to the 20th Century

Primitive Population Policies

God created male and female in His image, and He blessed them and said, Be fruitful and multiply, fill the earth and subdue it, rule over the fish in the sea, the birds in the heaven and every living thing that moves upon the face of the earth. The Bible,

Genesis.

Ancient Population Policies

Emperor Augustus, Rome, 9BC - 18AD

To encourage more births among Roman citizens there were laws that:

Removed any barriers to marriage of children

Made marriage a civic duty; unmarried men cannot hold public office or receive inheritance

Gave fathers preferential public positions

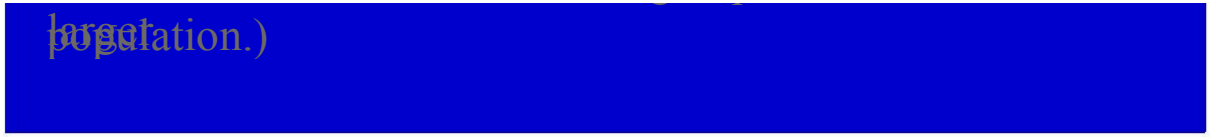
Awarded mothers distinctive ornaments

17th - 18th Century Europe

Rise of Mercantilism - manufacturing, commerce and colonialism

Economic, political and military advantages of a large and growing population were the primary consideration.

Premise - a large population would decrease wages, giving the workers an incentive to work longer hours, thereby increasing factory production and widening the gap between national income and personal wages. (Also, the division of labor in manufacturing required a


target
population.)

17th - 18th Century Europe

Pronatalist policies under Louis XIV, 1666

1. Penalties for celibacy
2. Partial tax exemption for early marriage
3. Lifetime tax exemption for father of 10 children, and, pension for father of 12 children (10 legitimate), provided none are celibate priests or nuns
4. Emigration forbidden under penalty of death*

*Note: Revocation of the Edict of Nantes led to persecution of Protestants in France, and

persecution of Protestants in France, and
500,000 persons fled to other countries.)

18th Century - Revolutionaries

Condorcet: French revolutionary wrote that poverty was due to mismanagement by clergy and royalty; when overthrown, men would be free, no more inequality, reason would prevail, poverty would be eliminated, and mankind would naturally limit population.

Godwin: British revolutionary also believed in perfectibility of man, and promoted destruction of social institutions which created inequality and poverty.

Thomas Malthus

An Essay on the Principles of Population as It Affects the Future Impoverishment of Society, with Remarks on the Speculations of M. Godwin and M. Condercet and Other Writers

(Published in 1798)

Thomas Malthus continued

Thesis: The absolute impossibility from the fixed laws of nature that the pressure of want can ever be completely removed from the lower classes of society.

Therefore: The schemes of Godwin and Condorcet would only increase the numbers of the poor by removing the existing

barriers to marriage and multiplication.

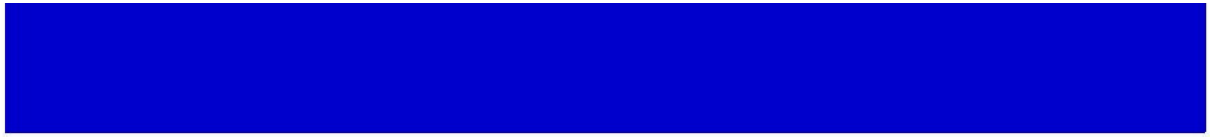
Thomas Malthus continued

Postulates:

1. Food is necessary to existence.
2. Sexual drive is necessary to survival.

Therefore:

- Population is limited by subsistence
- Population invariably increases where subsistence increases unless limited by checks



Thomas Malthus continued

The checks against population growth are:

Moral Restraint - restraint from marriage. (Malthus did not support fertility limitation in marriage as it would promote indolence among the poor leading to underpopulation.)

Vice and misery - famine, pestilence, war, and

immorality (including use of contraception)

Thomas Malthus continued

Malthus favored the abolition of the poor laws and other welfare arrangements which freed man from individual responsibility.

He believed that without the pressure of children in the family, the poor would not work; there would be idleness, vice, and even underpopulation.

Birth Control Movements and Womens Rights

1822, Britain - Francis Place - Illustrations *and Proofs of the Principle of Population - first* treatise in English to propose contraception as a substitute for Malthus moral restraint.

1832, US - Charles Knowlton - Fruits of *Philosophy - proposes that physicians should* prescribe contraception to protect

prescribe contraception to protect
women's health while permitting sexual gratification.

Birth Control Movements and Womens Rights

1869 - J. S. Mill - The Subjugation of Women - disagreed sharply with restricting women to childbearing, childrearing and housework, and promoted contraception.

Late 19th-early 20th Century Marie Stopes (UK) and Margaret Sanger (US) were pioneers in promoting the public provision of birth


promoting the public provision of birth control services

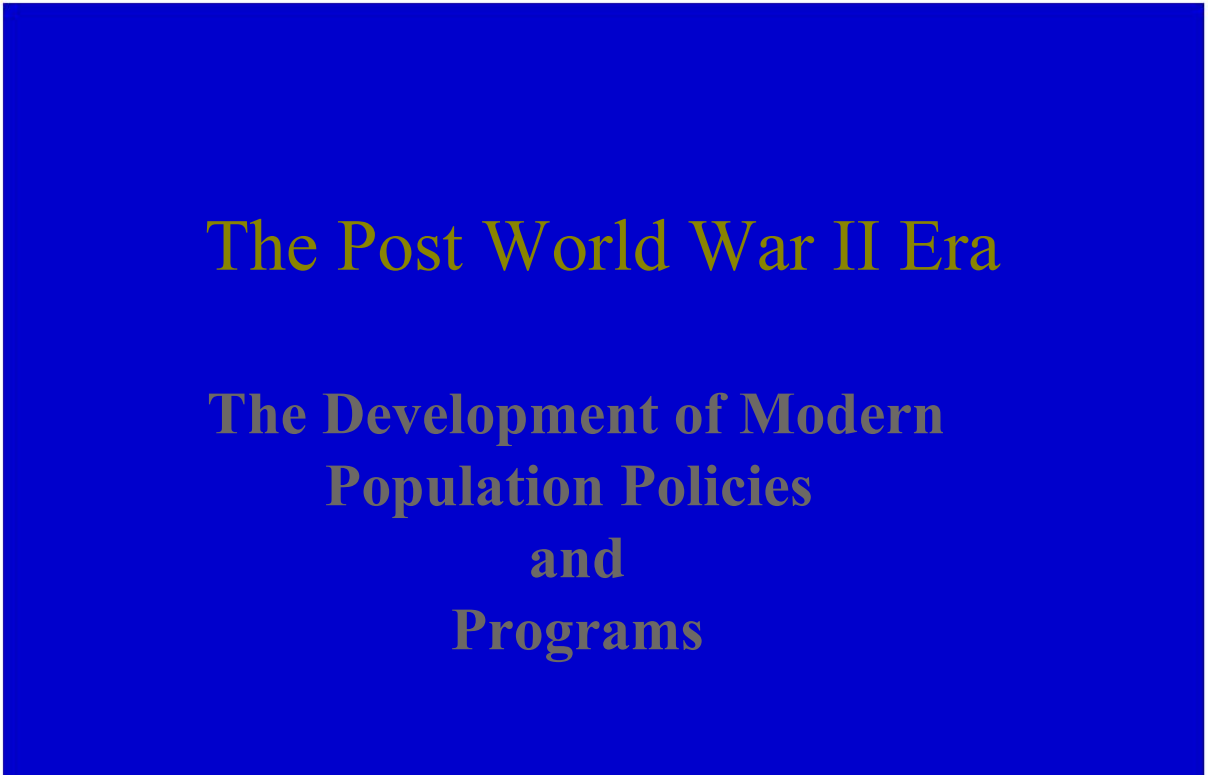
Marxismand Population

An Opposing Viewpoint

A surplus population is a creation of capitalism, and a necessary condition for its continuance.

Capitalism requires a surplus of readily exploitable manpower which it creates by expropriating land, and by displacing workers with


machines.


The Post World War II Era
The Development of Modern
Population Policies
and
Programs

Early International Policies and Programs

1948 - Japan (after defeat in WW II) - Eugenic Protection Law made abortion available for economic as well as medical reasons.

1952 - India - establishes the worlds first national family planning program.

Analysis of Population and Development Interrelations

1958 - Population Growth and Economic *Development in Low Income Countries* *(Coale and Hoover)*

Provided projections of economic development for India and Mexico under assumptions of constant fertility and of declining fertility

The analysis supported the importance of slowing population growth to accelerate economic

development

Theories of Population and Development Interrelations

Coale-Hoover Theory(1950-60)

Theory: High population growth causes poor socioeconomic development.

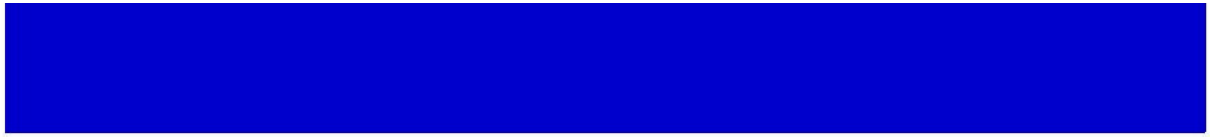
Policy: Government should


Policy: Government should
intervene
to control of reproduction.

U.S. International Population Policy

1959 - A Presidential Commission recommends the U.S. provide contraceptive assistance to nations that request it; this is emphatically rejected by president Eisenhower.

1960 - John Kennedy is elected as the first Catholic president. He reverses Eisenhowers policy. USAIDs international population assistance program begins in 1965.



International Policies and Programs

1966 - Statement on Population by World *Leaders - signed by 30 heads of state, it stresses the* adverse implications of unplanned population growth and supports the provision of family planning services by governments.

1969 - U.N. Fund for Population Activities (UNFPA) established.

Human Rights and Reproductive Rights

1968 - International Conference on Human Rights (Tehran)

Resolution 18: Parents have a basic human right to determine freely and responsibly the number and spacing of their children and a right to adequate education and information in this respect.

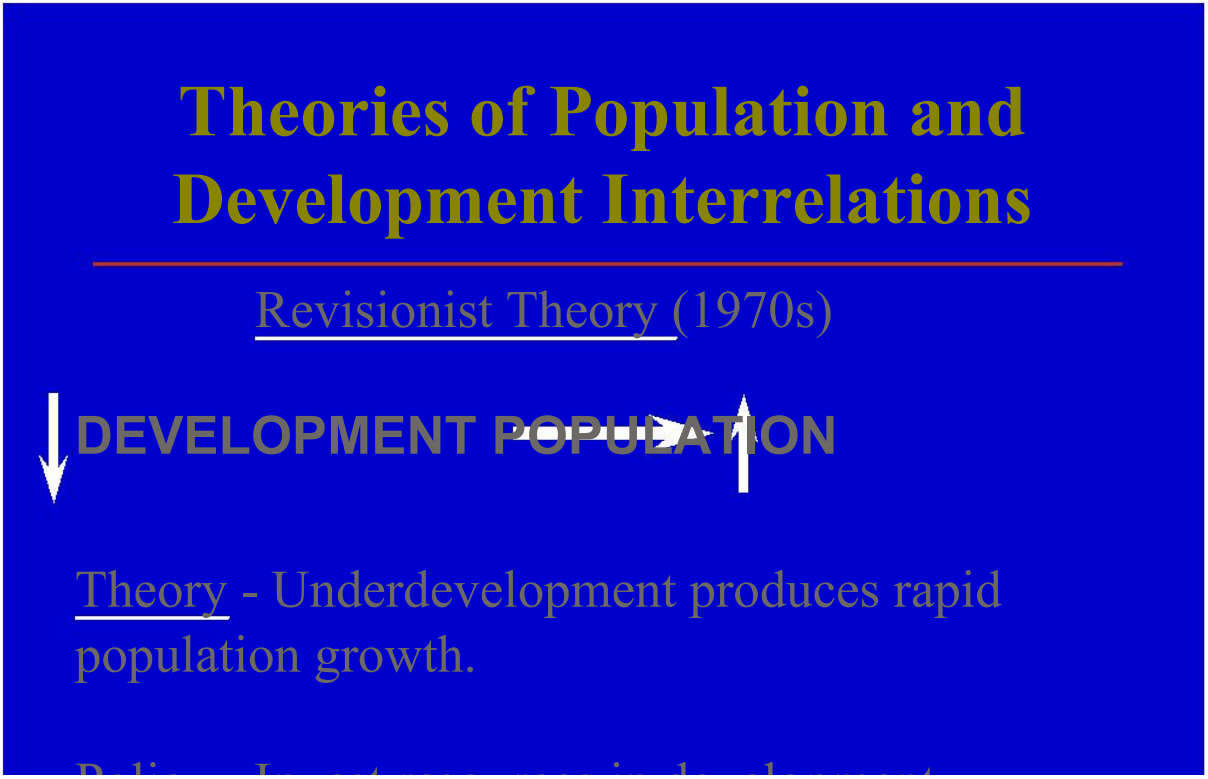
International Population Conferences

1974 - Bucharest

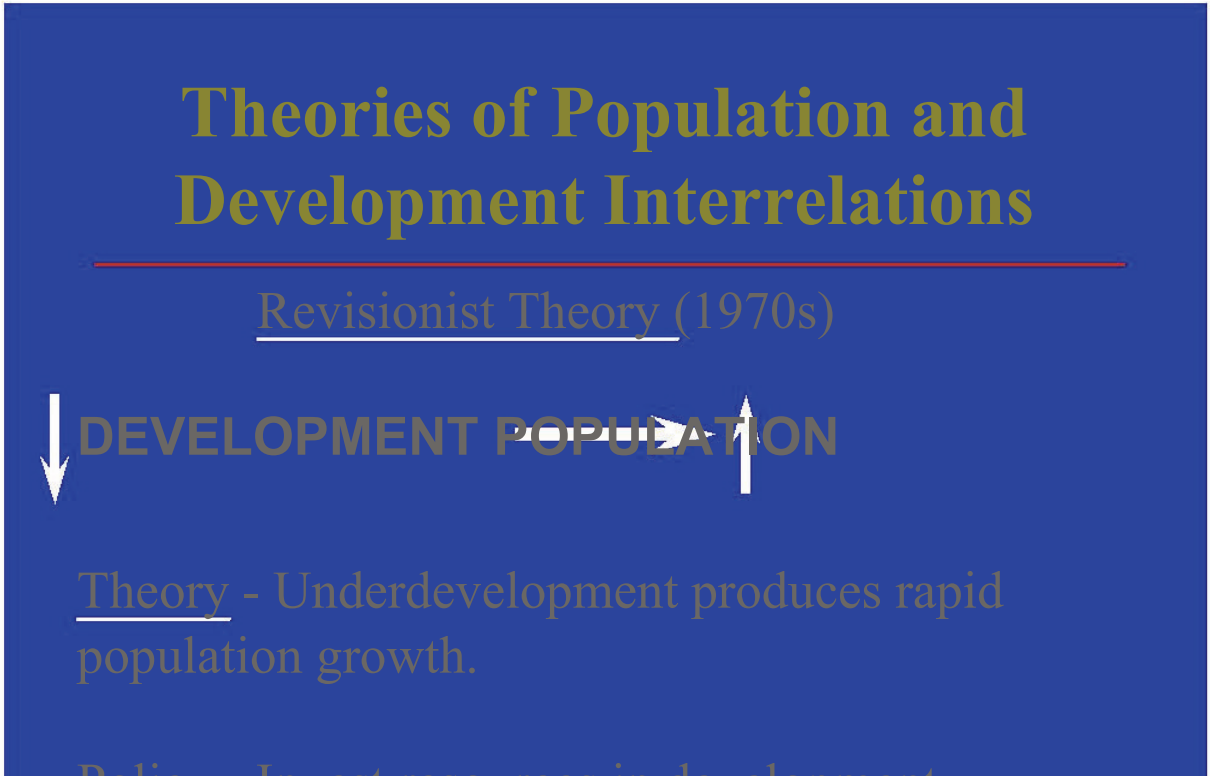
The USA and other developed countries held a strong position favoring family planning programs as essential to national development.

This view was strongly attacked by many developing countries including China and India, which argued that investments in development

would naturally lead to declines
in fertility.



Policy - Invest resources in development activities.



Policy - Invest resources in development activities.

International Population Policy

Changing National Policies

1976 - Indira Ghandi institutes emergency rule in India; introduces coercive sterilization to curb population growth; government collapses.

1979 - China introduces one-child policy.

1980 - Ronald Reagan elected US president; supports conservative policies including anti-

abortion
legislation.

International Population Conferences

1984 - Mexico City

The USA reverses its position and considers population growth a neutral phenomenon in development. The major problem was seen as governmental control of economies, and the solution proposed was economic reforms that put *a society on the road toward growth, and, as an after effect, slower population increase as well.*

This position disputed by most developing countries including


China.

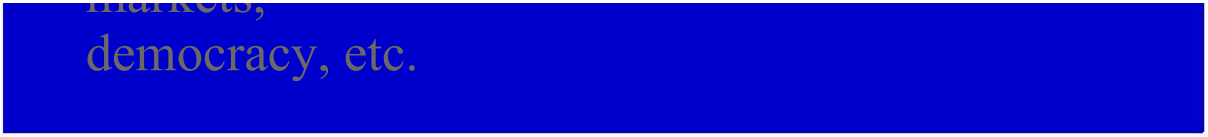
Theories of Population and Development Interrelations

Revisionist Theory (1980s)

POPULATION ≠ DEVELOPMENT

Theory - Population is a neutral phenomena in the process of economic development.

Policy - Other issues must take priority, e.g., free markets


markets,
democracy, etc.

Human Rights and Reproductive Rights

1974 and 1984 World Population Plans of Action (WPPA)

all couples and individuals have the basic right to decide freely and responsibly the the number and spacing of their children and to have the information, education, and means to

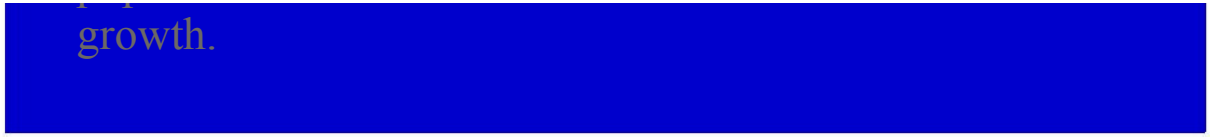
means to
do so.

Human Rights and Reproductive Rights

Weakness in the 1974 and 1984 WPPA:

Who decides if individual reproductive decisions are responsible.

Coercion may be justified if the State considers that present individual injustices due to coercive policies are less important than future collective injustices due to economic underdevelopment from too fast/slow population


growth.

Human Rights and Reproductive Rights

Weakness in the 1974 and 1984 WPPA:

Examples of coercive policies based on economic justifications:

- Chinas one-child policy
- Romanias pronatalist policy
- Indias mass sterilization camps
- Indonesias IUD safaris

International Population Conferences

1994 - Cairo - International Conference on Population and Development (ICPD)

Human rights, womens rights, and reproductive rights are given priority. Explicitly included are issues of gender equality, equity, empowerment of women and reproductive health care. The aims of population-related goals are to improve the quality of life of all


people.

Human Rights and Reproductive Rights

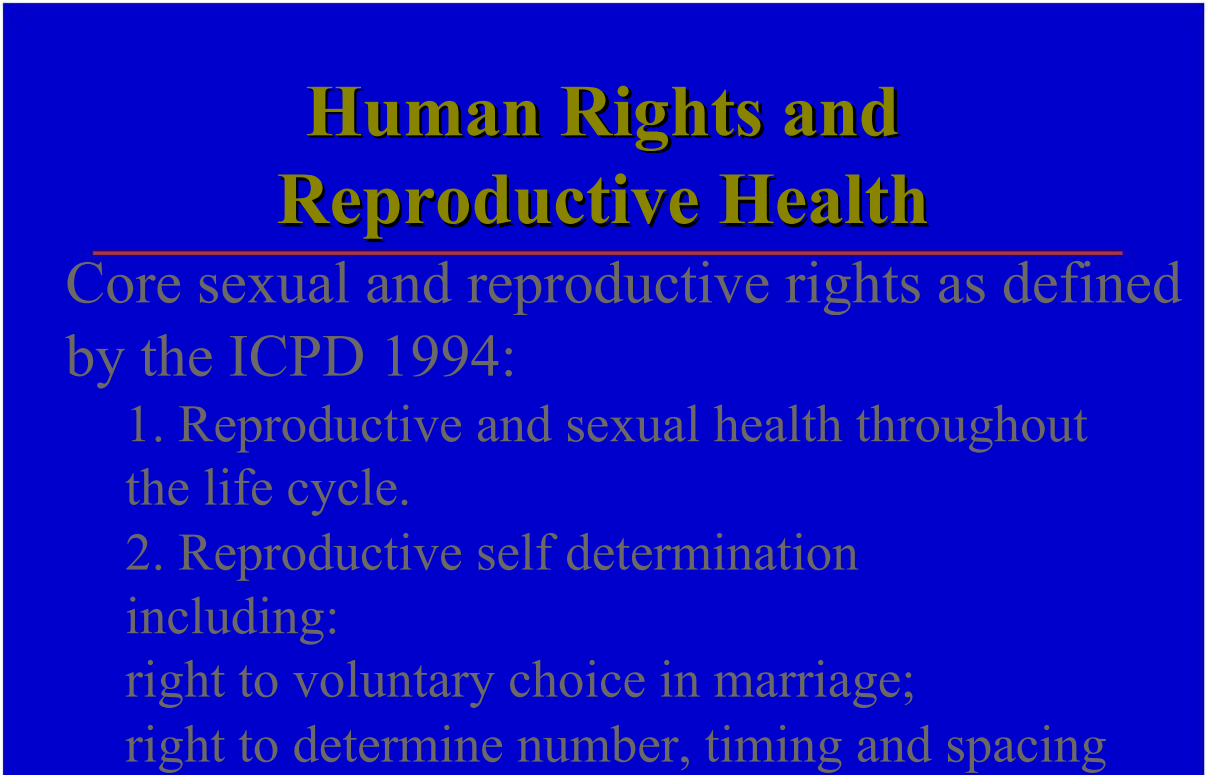
1994 (ICPD) Plan of Action

Principle 3: .While development facilitates the enjoyment of all human rights, the lack of development may not be invoked to justify the abridgement of internationally recognized human rights..

Human Rights and Reproductive Rights

1994 (ICPD) Plan of Action

Principle 4. Advancing gender equality and equity and the empowerment of women, and the elimination of all kinds of violence against women, and ensuring womens ability to control their own fertility, are cornerstones of population and development-related programs.



of ones children.

Human Rights and Reproductive Health

Core sexual and reproductive rights as defined by the ICPD 1994: (continued)

3. Equality and equity for men and women in all spheres of life.
4. Sexual and reproductive security including freedom from sexual violence and coercion.

Theories of Population and Development Interrelations

A Paradigm Shift (1990s)

HUMAN RIGHTS → POPULATION + DEVELOPMENT

Theory - Human beings and human rights are at the center of concerns for sustainable development.

Policy - Advancing human rights, especially gender equality, equity and empowerment of women are key to

population and development related programs.

Reproductive Health Policies

The Old Paradigm

1. Family Planning
   - Unmet need for contraception
2. Maternity Care
   - Antenatal care
   - Safe childbirth
   - Post-partum care
3. Child Health Care
   - Breast feeding promotion
   - Nutrition, growth monitoring

Immunizations
Sickness care (ORT, ARI, malaria, etc)

Reproductive Health Policies

Additions with the New Paradigm

1. Gender discrimination
   - Sex selective abortions
   - Son preference for food allocation, health care, education, etc.
2. Violence against women
   - Child pornography
   - Commercial sex
   - Female genital mutilation

Spouse
Rape, incest

Reproductive Health Policies

Additions with the New Paradigm

3. Adolescent sexuality
4. Reproductive rights regarding marriage and childbearing
5. Gender equity and equality
6. Unintended pregnancy
   - Emergency contraception
   - Safe abortions

Reproductive Health Policies

Additions with the New Paradigm

7. Chronic complications
   of pregnancy and childbirth
8. Sexually transmitted diseases
   Acute infections
   Chronic complications, e.g.,
   - infertility
   - cervical cancer

9


HIV/AIDs

Government Policies on Fertility and Access to Contraception, 1976-1996

	Percent of Countries		
	1976	1989	1996
Policy to lower fertility			
All countries*	26%	38%	45%
Sub-Saharan Africa	25%	47%	67%
Direct support for FP			
All countries*	55%	72%	79%
Sub-Saharan Africa	50%	78%	83%

**Includes developed countries*

countries

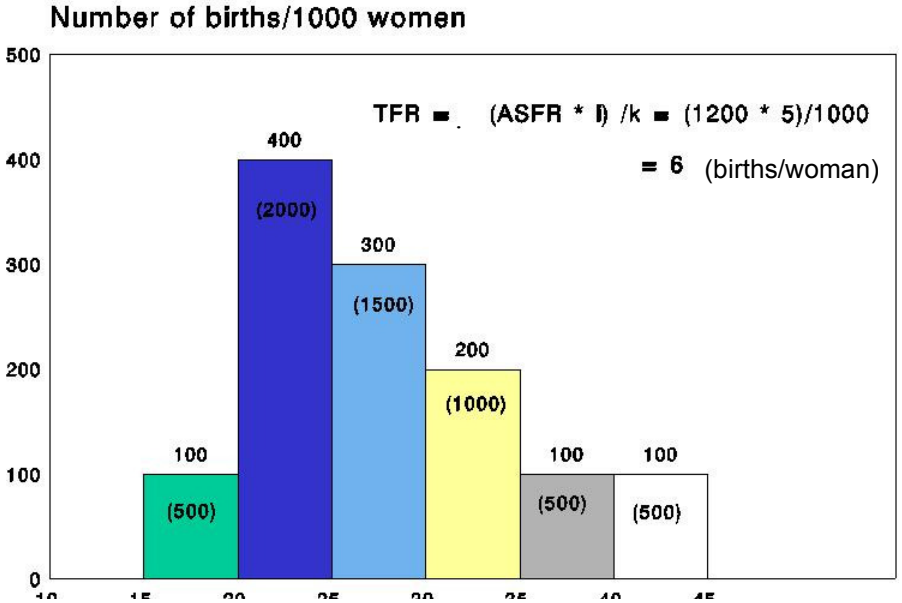
Family Planning Policies and Programs

Henry Mosley

Session 2 Slides

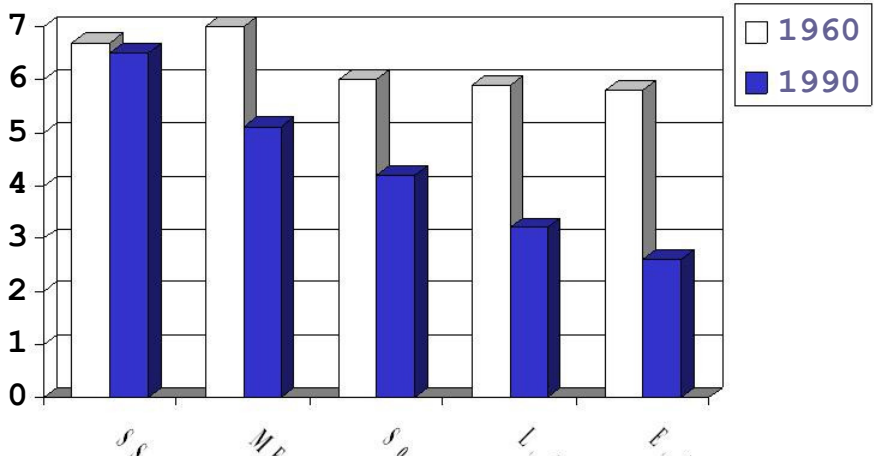
Fertility: Measurement, Trends, Proximate Determinants and Contraceptive Continuation and Failure

Measurement of Total Fertility Rate (TFR)



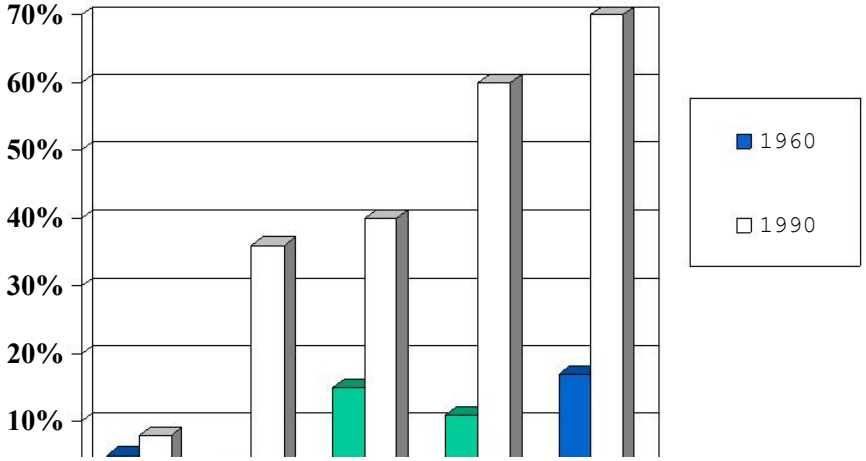
Where: i = age interval; k = multiplier (1000)

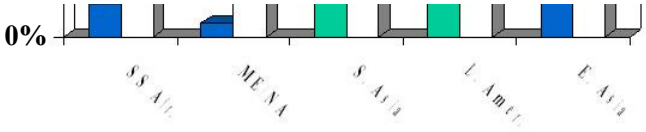
Trends in fertility in developing countries




Africa
NA
Asia
America
Asia

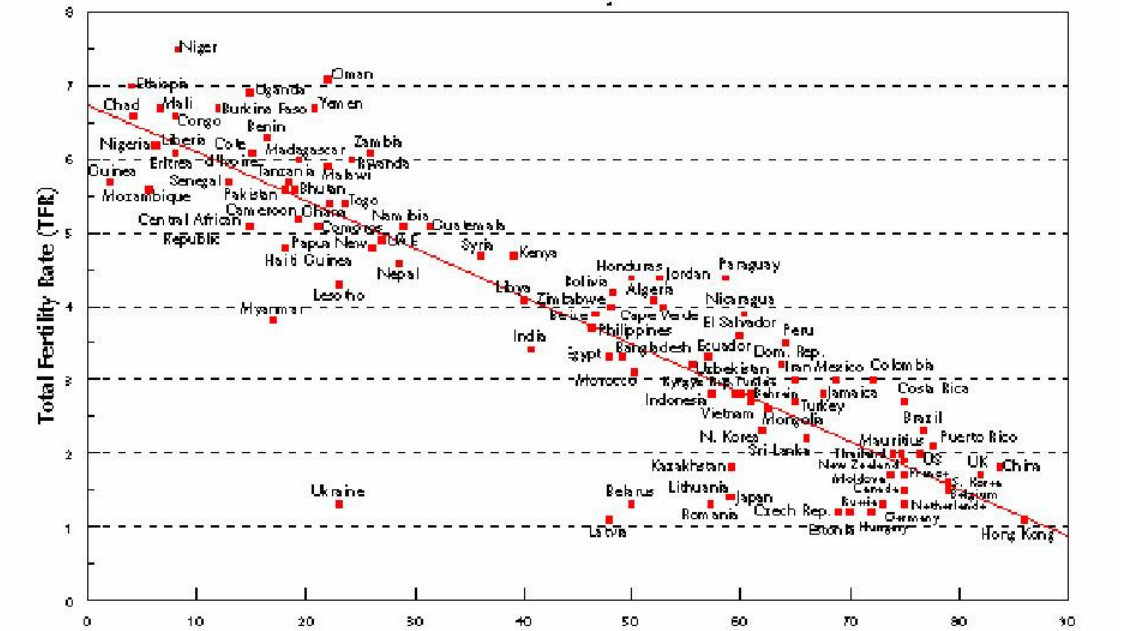
Trends in Contraceptive Use in Developing Countries




0%
SSA
MENA
SAsia
LAmer
EAsia

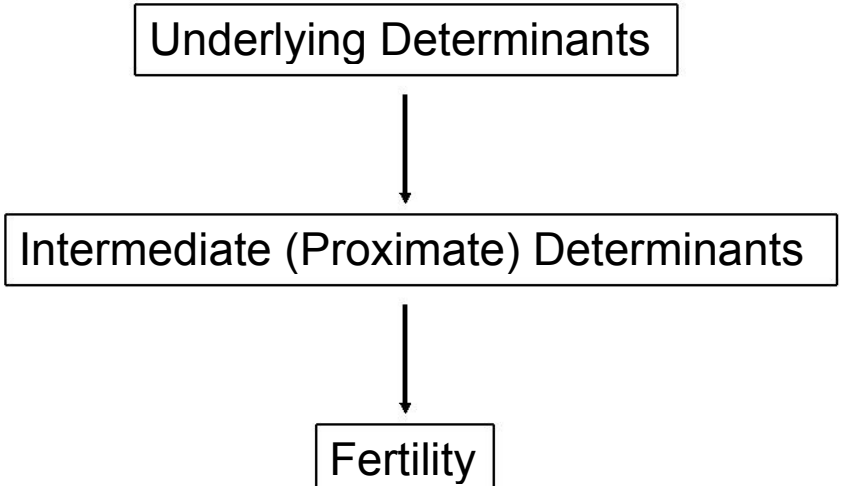
Relationship Between Fertility and Contraceptive Use

100 countries Surveyed in the 1990s



Population Reports

Fertility Determinants Model



Bongaarts Proximate Determinants of Fertility Model

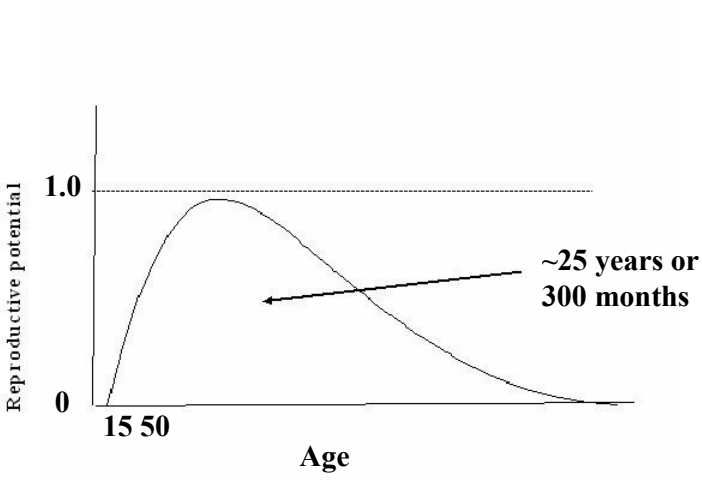
Rating of Intermediate Fertility Variables

Intermediate fertility variables	Sensitivity of fertility to intermediate Variables	Variability among Populations	Overall Rating
Proportions married	+++	+++	+++
Contraceptive use	+++	+++	+++
Prevelance of induced abortion	++	+++	+++
Postpartum infecundability	++	+++	+++
Fecundability	++	++	++
Spontaneous intrauterine mortality	+	+	+

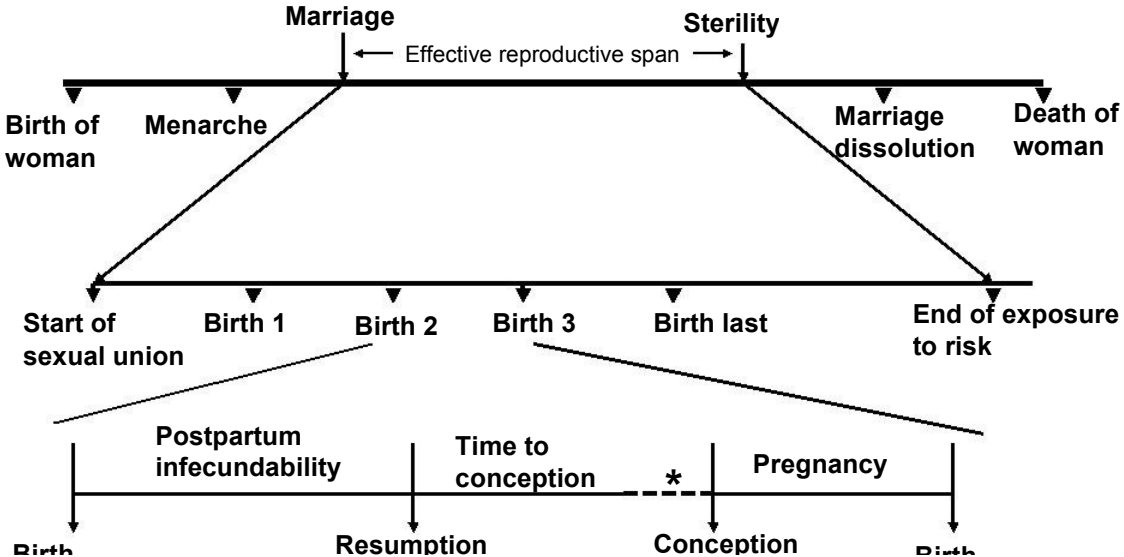
Mortality	.	.	.
Permanent sterility	++	+	+

+++ = **High** ++ = Medium + = Low or absent

Potential Reproductive Life Span



Model of Reproduction



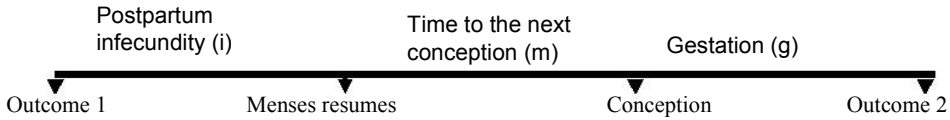
Birth 2

of menses

Birth 3

* Effective increase in the average time to the next conception due to spontaneous fetal losses.

A Model of Birth Interval Dynamics

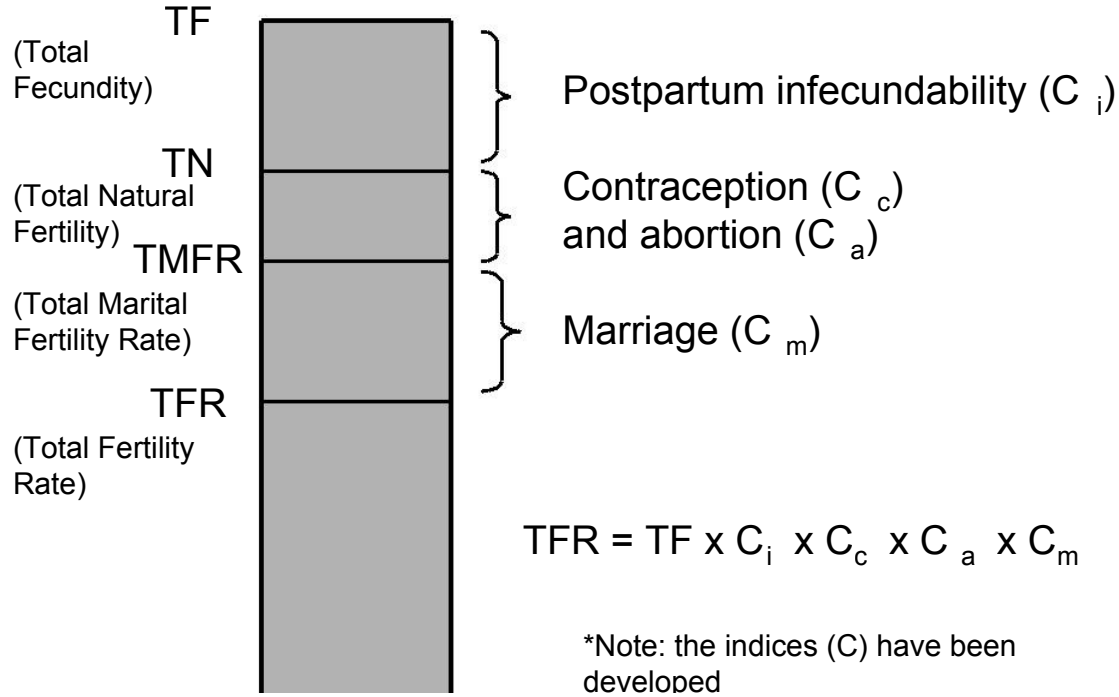


Birth Interval Model with:	Postpartum infecundity (months)	Time to next conception (months)	Gestation (months)	Total interval (months)	Total events in 300 months
Maximum	**1.5**	**9.5**	**9.0**	**20**	**15**
Breastfeeding	**17.5**	**9.5**	**9.0**	**36**	**8.3**
Contraception	**1.5**	**95**	**9.0**	**105.5**	**2.8**
Abortion	**1.5**	**7.5**	**1**	**10**	**30**

Birth Interval Dynamics Model
Key Points

1. Breast feeding with lactational amenorrhea is a major determinant of lower fertility in developing countries.
2. Contraception prolongs the waiting time to conception by reducing the probability of conception in each ovulatory cycle.
3. Abortion actually shortens the inter-pregnancy interval. Therefore two to three abortions may be required to prevent one live birth.
4. While abortion alone is a very inefficient method of fertility control, abortion with contraceptive backup can be highly efficient.

Bongaarts Indices*



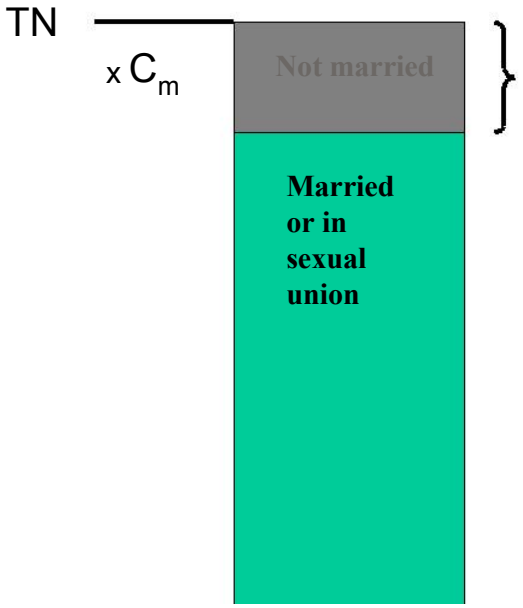
$$TFR = TF \times C_i \times C_c \times C_a \times C_m$$

*Note: the indices (C) have been developed

ranging from 1.0 signifying no effect of the factor, to 0.0 signifying 100% effect.

so that all will have a value

Index of Marriage



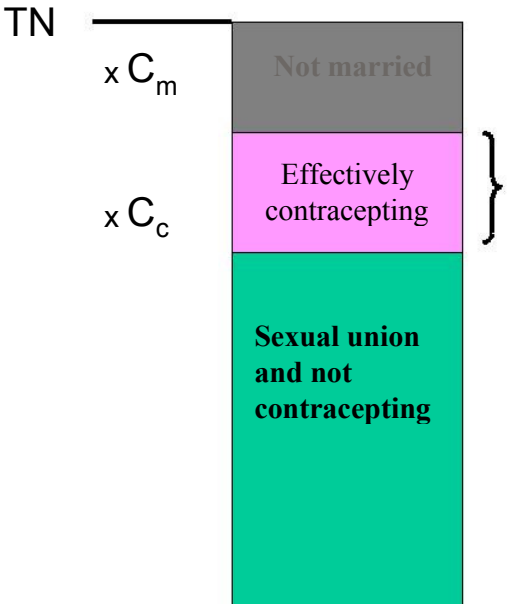
$$C_m = \frac{TFR}{TMFR}$$

$$= \sim \%\ \text{Married}$$

TFR

TFMFR = Total Marital Fertility Rate
Total
Fertility
Rate

Index of Contraception

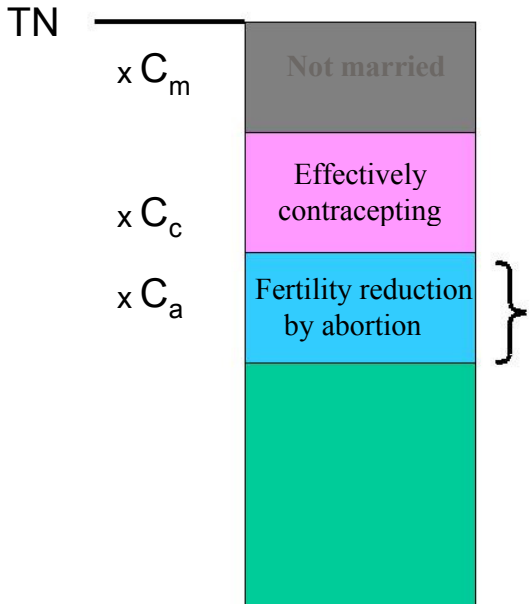


$C_c = 1 (1.08 \times u \times e)$

u = contraceptive prevalence
e

=
contraceptive
effectiveness

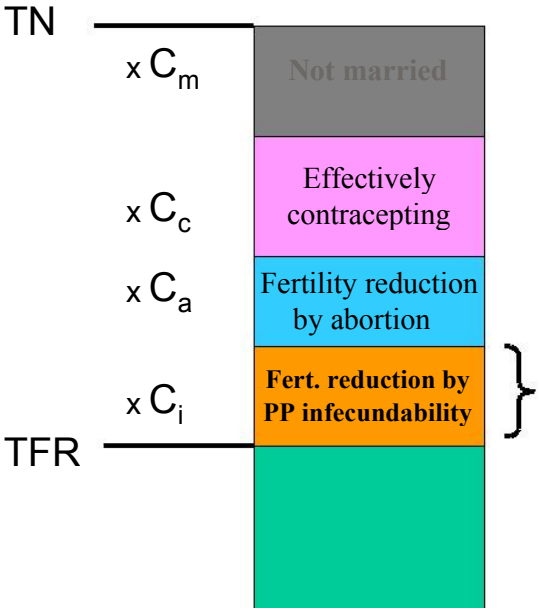
Index of Abortion



$$C_a = \frac{TFR}{TFR + 0.4 \times TA\,(1+u)}$$

TA = Total Abortion Rate

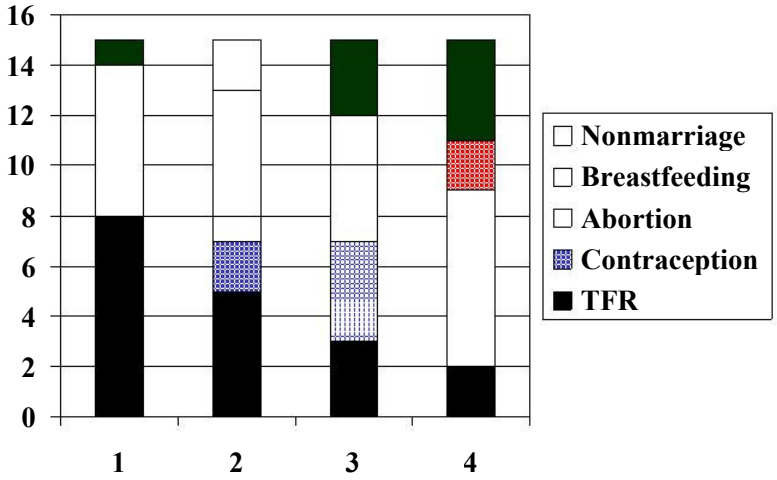
Index of Postpartum Infecundabilty



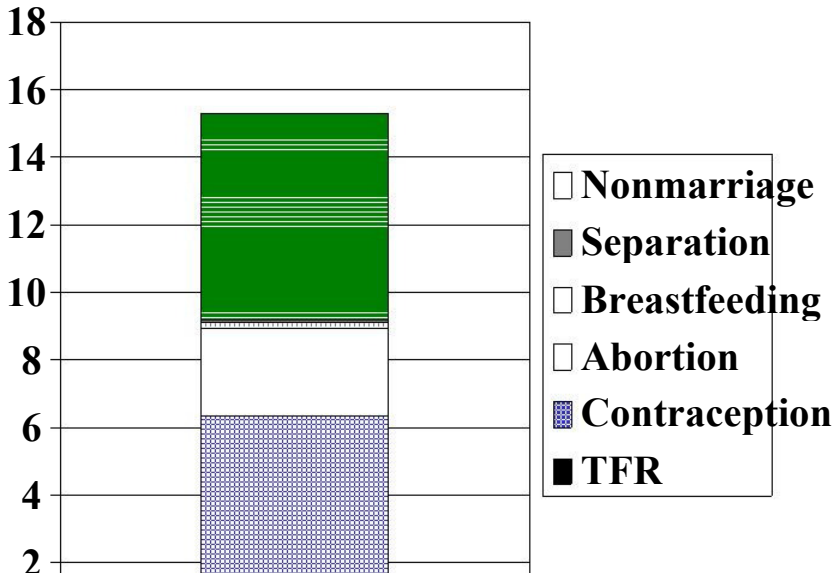
$$C_i = \frac{20}{18.5 + a}$$

a
amenorrhea in months (minimun is
duration
1.5 months)
of
postpartum

Hypothetical Model of Bongaarts Indices with the Fertility Transition



Proximate Determinants of Fertility
Beijing, 1982



(Data from: Wang, et al., 1987)

Examples of Applications of Bongaarts Indices

Bongaarts, J., The fertility inhibiting effects of the intermediate fertility variables. Studies in Family *Planning 13: 170-189, 1982.*

Wang, S-X., et al., Proximate determinants of fertility and policy implications in Beijing. *Studies in Family Planning 18: 222-228, 1987.*

Contraceptive Technologies

Continuation
And
Failure Rates

Relationship of Contraceptive Prevalence to Acceptance and Continuation

From epidemiology

Prevalence = Incidence x Duration

For contraceptives

Contraceptive prevalence = acceptance rate x duration of use

The critical issues in contraceptive programs are:

1. Recruiting acceptors
2. Dropouts by users of temporary methods (pills, IUDs, etc.)
3. Failures by all methods, especially user-dependent methods

Method Discontinuation Rates

METHOD	DISCONTINUATION (Range in percent/year)
IUD	10-30%
Orals	20-40%
Condoms	25-60%
Injectables	30-40%
Norplant	15-20%

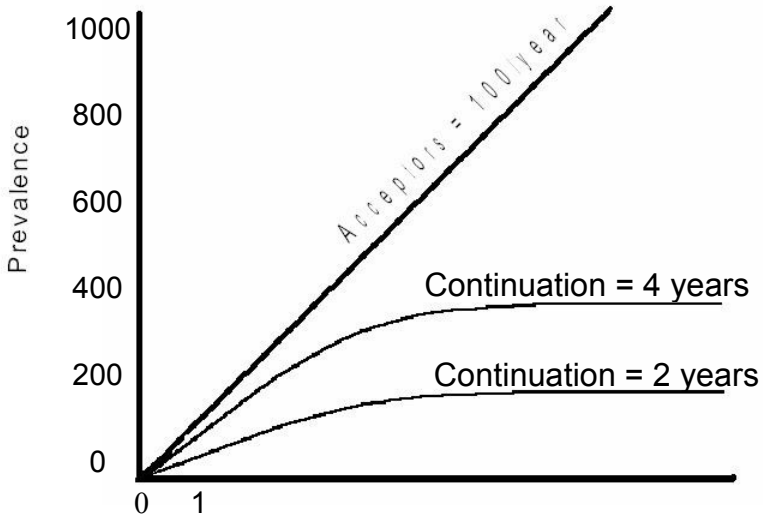
Relationship of Discontinuation Rate to Duration of Use

(Duration of use = 1/Discontinuation rate)

Discontinuation rate/year	Duration of use
5% (or 0.05)	20 years
10% (or 0.10)	10 years
20%	5 years
30%	3.3 years
40%	2.5 years

Relationship of Contraceptive Prevalence to Variations in Continuation Rates

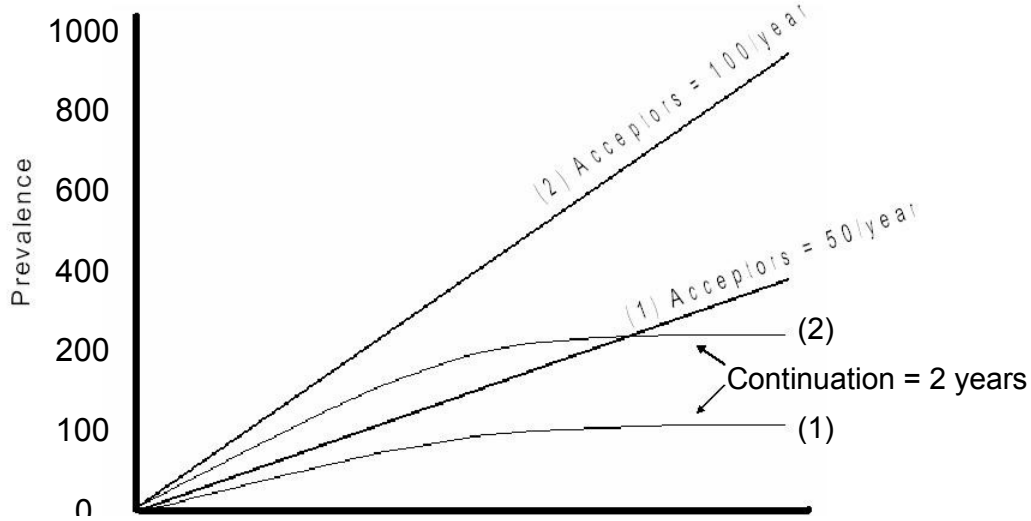
(Prevalence = Acceptance rate x Continuation)

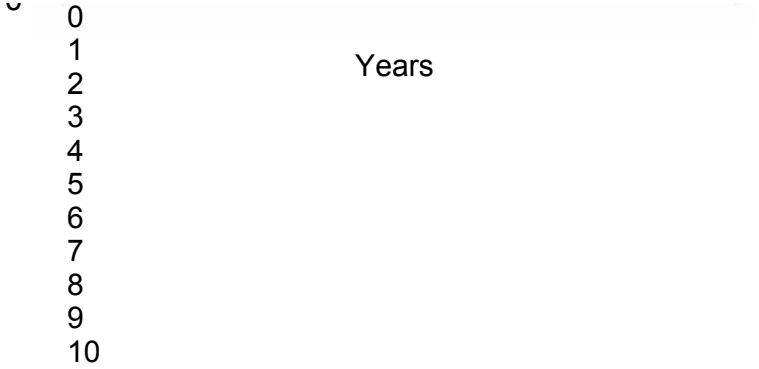


2
3 Years
4
5
6
7
8
9
10

Relationship of Contraceptive Prevalence to Variations in Contraceptive Acceptance Rates and Continuation

(Prevalence = Acceptance Rate x Continuation)




0
1
2
3
4
5
6
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8
9
10
Years

Contraceptive Failure

Definition contraceptive failure (F) is a measure of the proportion of women conceiving in a given time period (usually one year) while using a method.

In general, one can consider the annual failure rate (F) as roughly equal to (1- e) where (e) is contraceptive effectiveness. For example of 100 women using a contraceptive that is 95% effective, 5 (5%) will experience a pregnancy in a year.

Contraceptive Failure (Continued)

Reported contraceptive failure rates vary widely according to:

Method all methods have an intrinsic failure rate, for example, <0.1% for sterilizations, 0.1% for combined orals, 0.8% for CuT 380A, 2% for condoms, 4% for withdrawal, etc.

Characteristics of users - User-dependent methods like condoms, withdrawal and pills, however, can show wide variations in use-effectiveness depending on the motivation, education, cultural background, etc., of the users. For example, pill failure is generally

users. For example, pill failures generally range from 3% to 6% and condom failures from 5% to 15%.

Contraceptive Failure (continued)

Because of the need for extended periods of contraceptive use (i.e. 10 years or more), women using contraceptives of relatively high effectiveness (<90%) will actually have a high risk of an unintended pregnancy in their reproductive lifetime.

This is because the probability of remaining non-pregnant (P) for (n) years with a contraceptive of effectiveness (e) is an exponential function: $P_n = e^n$.

Contraceptive Failure (continued)

Example: $P_n = e^n$.
where: n = 10 years

Contraceptive Effectiveness (e)	P_n	Probability of pregnancy (%) in 10 years = 1 - P_n
.96	.66	33%
.90	.35	65%
.85	.20	80%

Couple Years of Protection (CYP)

Question how can one add up all of the *different types of contraceptive services provided by various service delivery points to get a comparable indicator of performance.*

Answer Use the measure of CYP.

Definition CYP is a composite person-time measure of the total amount of protection conferred by all methods to all acceptors practicing for any length of time.

Standard Values of Units Per CYP

METHOD	UNITS PER CYP
Oral contraceptives	15 cycles per CYP
CuT 380-A IUD	3.5 CYP per IUD
Norplant (implant)	3.5 CYP per implant
Depo-Provera (inject.)	4 doses per CYP
Noristerat (inject.)	6 doses per CYP
Sterilization	10 CYP per procedure
Condoms	150

Condoms 190 condoms per CYP

Family Planning Policies and Programs

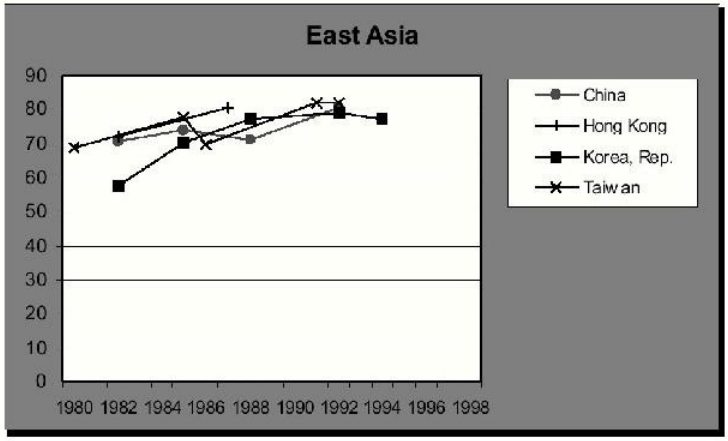
Henry Mosley

Session 2 Supplementary Slides

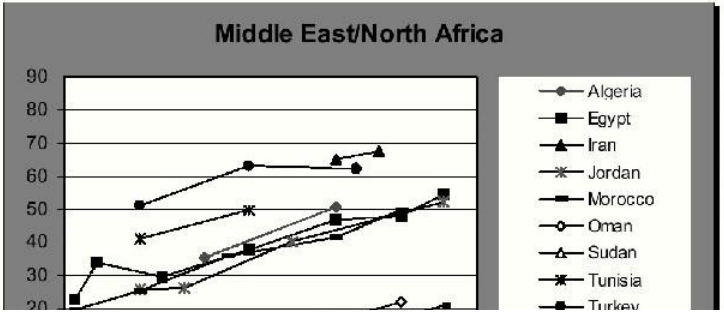
Global Trends in Contraceptive Use

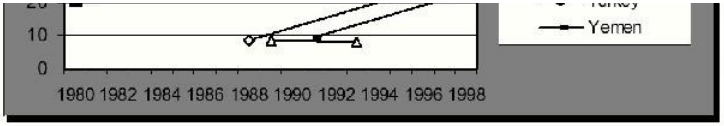
W. Henry Mosley
Family Planning Policies and Programs

Trends in Contraceptive Prevalence 1980-1998



(Source:Ross, Stover and Willard, *Profiles for Family Planning and Reproductive Health Programs* , 1999)

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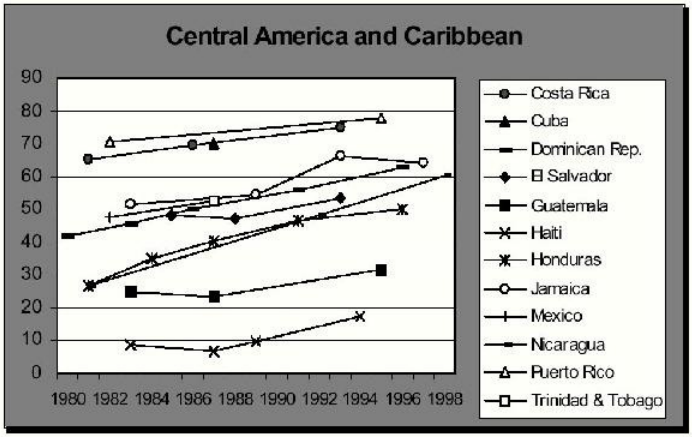
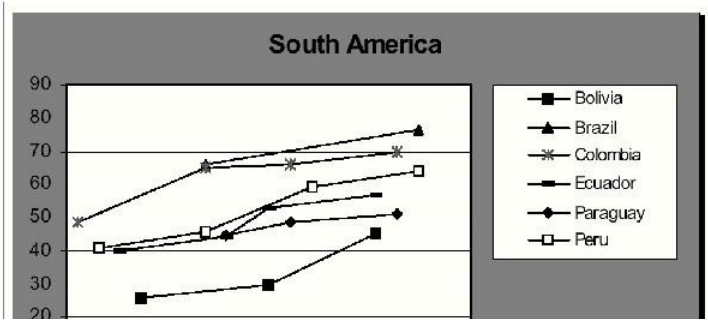
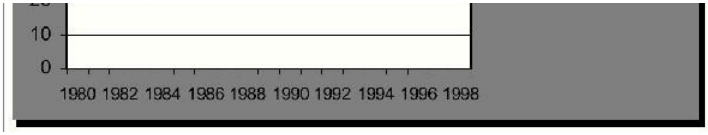
0
1980 1982 1984 1986 1988 1990 1992 1994 1996 1998
Yemen

Trends in Contraceptive Prevalence 1980-1998



(Source:Ross, Stover and Willard, *Profiles for Family Planning and Reproductive Health Programs* , 1999)

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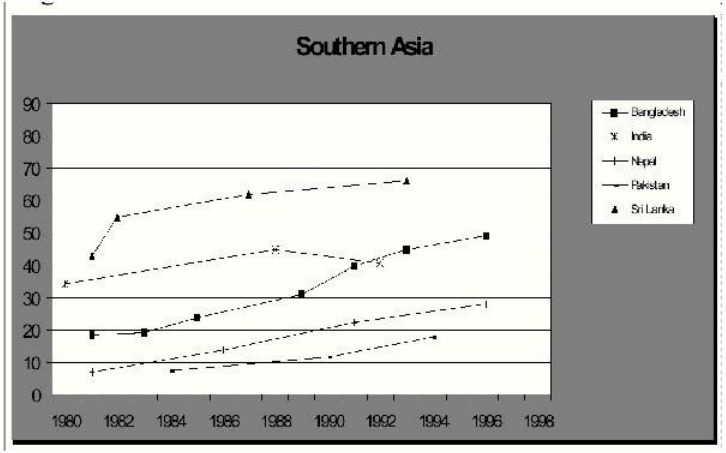
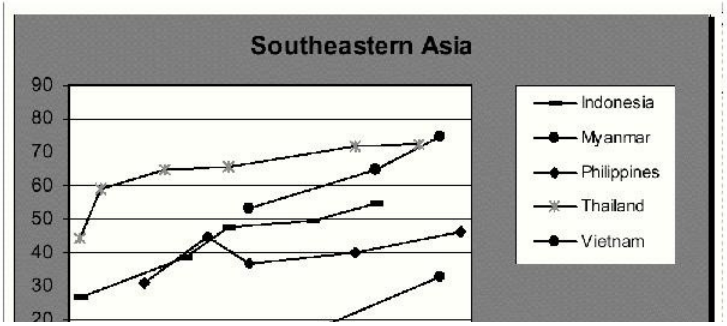
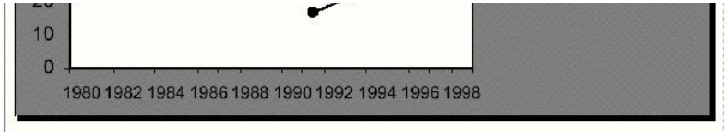
Trends in Contraceptive Prevalence 1980-1998

(Source:Ross, Stover and Willard, *Profiles for Family Planning and Reproductive Health Programs* , 1999)



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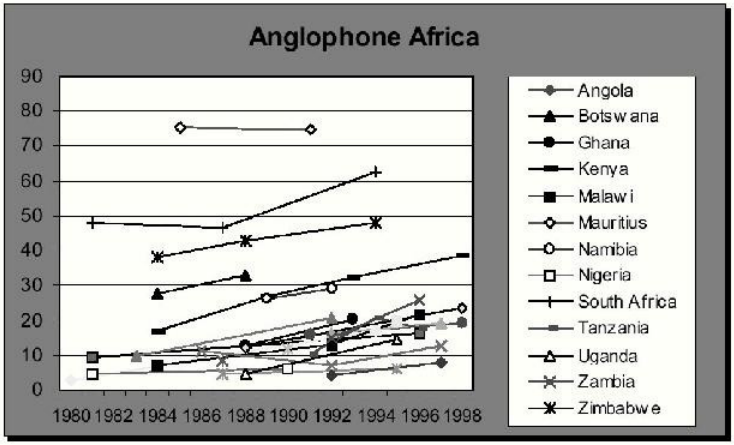
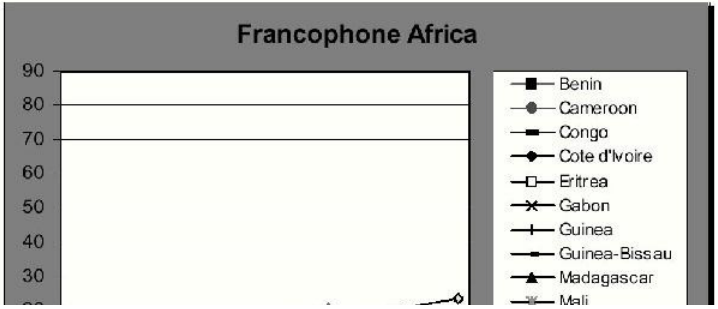
1980 1982 1984 1986 1988 1990 1992 1994 1996 1998

Trends in Contraceptive Prevalence 1980-1998



(Source:Ross, Stover and Willard, *Profiles for Family Planning and Reproductive Health Programs* , 1999)



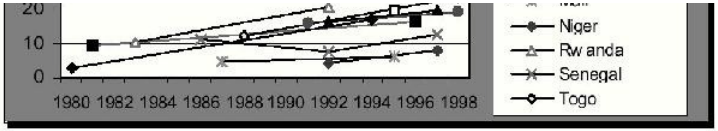

20
10
0
1980 1982 1984 1986 1988 1990 1992 1994 1996 1998
Niger
Rwanda
Senegal
Togo

Table 5.1. Percent of Countries Making Contraceptive Methods and Combinations of Methods Available as of 1994

	Asia	Latin America	Middle East/ North Africa	Sub-Saharan Africa	Total
Pill	69.6	70.8	85.7	46.7	64.8
IUD	73.9	62.5	71.4	23.3	53.8
Female sterilization	52.2	75.0	21.4	16.7	41.8
Male sterilization	52.2	33.3	7.1	10.0	26.4
Condom	78.3	83.3	71.4	60.0	72.5
Pill and IUD	65.2	54.2	71.4	23.3	49.5
Pill and female sterilization	43.5	54.2	21.4	16.7	34.1
IUD and female sterilization	43.5	54.2	28.6	13.3	34.1
Pill, IUD, female sterilization	43.5	45.8	21.4	13.3	30.8
Pill, IUD, female sterilization, condom	43.5	45.8	21.4	13.3	30.8
At least one long-term method	73.9	87.5	78.6	26.7	62.6
At least one short-term method	65.2	70.8	85.7	46.7	63.7
At least one long-term method and at least one short-term method	65.2	66.7	71.4	26.7	53.8
No. of countries	23	24	14	30	91

Note: Table contains 91 countries; 3 Central Asia Republics are omitted.

(Source:Ross, Stover and Willard, *Profiles for Family Planning and Reproductive Health Programs* , 1999)

Useful Link

World Contraceptive Use (UN document)

http://www.un.org/esa/population/unpop.htm

PFHS 380.665 FAMILY PLANNING POLICIES AND PROGRAMS

Intermediate Fertility Variables
A Framework for Fertility Analysis and Program Planning

W. Henry Mosley

A. Definitions:

1. natural fertility

2. proximate determinants

B. Intermediate Fertility Variables:

1. Kingsley Davis and Judith Blake framework (1956)

2. Variables used in reproductive models

    a. proportion of females married

    b

b.
contraception
c. induced abortion

d. postpartum infecundability

e. frequency of intercourse

f. spontaneous intrauterine mortality

g. permanent sterility

C. Relative Importance of the Intermediate Variables

D. The Bongaarts Model

E. Applications of the proximate determinants model

1. decomposition of determinants of fertility for policy/program analysis (Beijing case study)

2. setting goals and allocating resources for programs (SPECTRUM computer model)

References

Required Reading:

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Figure 1- Intermediate Variables Affecting Fertility*

I. Factors affecting exposure to intercourse

A. Those governing the formation and dissolution of unions in the reproductive period

1. Age of entry into sexual unions

2. Permanent celibacy; proportion of women never entering sexual unions

3. Amount of reproductive period spent after or between unions

   a. When unions are broken by divorce, separation or desertion
   b. When unions are broken by death of husband

B. Those governing the exposure to intercourse within unions

4. Voluntary abstinence

5. Involuntary abstinence (from impotence, illness, and unavoidable but temporary separations

6. Coital frequency (excluding periods of abstinence)

II. Factors affecting exposure to conception

7. Fecundity or infecundity, as affected by involuntary causes

8. Use or non-use of contraception

   a. By mechanical and chemical means
   b. By other means

9. Fecundity or infecundity, as affected by voluntary causes (sterilization, subincision, medical treatment, etc.)

III. Factors affecting gestation and successful parturition

10. Foetal mortality from involuntary causes

11. Foetal mortality from voluntary causes

* Source: Kingsley Davis and Judith Blake. Social Structure and Fertility: An Analytic Framework, Economic Development and Cultural Change 4:211-35, 1956.

The BongaartsModel

$$TFR = TF \times C_m \times C_c \times C_a \times C_i$$

where: TFR = Total Fertility Rate

TF = Total natural Fertility rate

C_m = index of non-marriage

C_c = index of contraception

C_a = index of induced abortion

C_i = index of lactational infecundability

The value of each index ranges between 0 and 1; the lower the index value, the greater the inhibiting effect of the variable. Each of these indices can be estimated from survey data to assess the relative contribution of each of these proximate determinants to the level of fertility.

Index of Non-Marriage

This index (C_m) expresses the effect of non-marriage in terms of reduction in fertility per woman. By definition the index of non-marriage is the ratio between the total fertility rate (TFR) and the total marital fertility rate (TM). That is:

$$C_m = TFR/TM$$

The proportion of women of reproductive age who are married can be used as an approximation of C_m. That is:

$$C_m \sim MWRA/WRA$$

Index of Contraception

The index of contraception varies inversely with prevalence and use effectiveness of contraception practiced by couples. The index of contraception is calculated according to the following formula:

$$C_c = 1 - (1.08 \times u \times e)$$

Where: u = the overall proportion of married women currently practicing contraception

e = the weighted average of contraceptive use effectiveness using the proportions of current contraceptive users of each method as weights

1.08 is a sterility correction factor

Index of Induced Abortion

Computation of the index of induced abortion requires first the estimation of the age-specific induced abortion rates from which one can calculate the total abortion rate (TA). The total abortion rate is then used to estimate the total number of births

averted per woman (A) as follows:

$$A = b \times TA$$

$$= .4(1 + u) \times TA$$

where: b = births averted per induced abortion

0.4 is an estimate of births averted per induced abortion in the absence of contraception

u = the prevalence of contraception

After the total number of births averted per woman (A) is estimated, the index of induced abortion is calculated as:

$$C_a = TFR/(TFR + A)$$

Index of Lactational Infecundability

The effect of lactational infecundability on fertility operates entirely through modification of the birth interval. The equation to estimate the index of infecundability is as follows:

$$C_i = 20.0/(18.5 + i)$$

where: (18.5 + i) is the average birth interval with lactation

i = average duration of postpartum infecundability

This equation implies that 20 months is the birth interval in the absence of lactational infecundability, allowing 7.5 months as waiting time to conception, 2 months to account for spontaneous fetal wastage, 9 months for term gestation, and 1.5 months for infecundability without lactation.

Estimation of Total Fertility

The total fertility rate is estimated from the indices according to the Bongaarts model:

$$TFR = {}_{m}X_{C} \; {}_{c}X_{C} \; {}_{a}X_{C} \; {}_{i}X_{C} \; 15.3$$

15.3 is an average estimate of TF that Bongaarts has derived based on data from multiple studies. It is generally used for this analysis unless there is specific data from the population under study to derive a better estimate, which is not usually the case.

PFHS-380.665 FAMILY PLANNING POLICIES AND PROGRAMS

Contraceptive Technologies: Continuation and Failure Rates

W. Henry Mosley

A. Couple-Years of Protection (CYP)

1. Definition: "A composite person-time measure of the total amount of protection conferred by all methods to all acceptors practicing for any length of time." (Wishik and Chen, 1973)

2. Data sources and utility

3. Strengths and weaknesses

B. Contraceptive Continuation and Prevalence

1. Relationship between fertility and contraceptive prevalence from population surveys

2. Relationship of acceptance and

2. Relationship of acceptance and continuation to prevalence

a. Basic formula from epidemiology:

$$P = I \times D$$

where: P = prevalence
I = incidence /year
D = duration in years

b. The contraceptive prevalence rate (C) is a function of:

incidence rate = acceptors /year (A)
duration = average "life expectancy" of contraceptive use (D)

So: $C = A \times D$ (1)

3. Average life of contraceptive use (D) is a function of the annual dropout rate (r). If there is a constant annual dropout rate, then the proportion (P) of acceptors still practicing at time (t) is:

a. $P_t = e^{-rt}$ (2)

where e = base of the natural logarithm.

If there are some immediate dropouts, then:

$P_t = ae^{-rt}$ (3)

where: 1-a = proportion dropping out immediately, and

a = proportion remaining after immediate dropout.

Using calculus, the "life expectancy" (or average duration) of contraceptive use becomes:

$$D = \frac{1}{r} \text{ (with no immediate dropouts)} \quad (4)$$

$$D = \frac{a}{r} \text{ (with } 1-a \text{ immediate dropouts)} \quad (5)$$

4. In a steady state situation contraceptive prevalence (C) can be related to acceptance (incidence) rate (A) and drop-out rate (r) as:

$$C = A \cdot \frac{1}{r} \qquad (6)$$

or,with immediate dropout :

$$C = A \cdot \frac{a}{r} \qquad (7)$$

C. Contraceptive Failure

1. Definitions of contraceptive "efficacy"

a. Effectiveness (e) = proportion (percent) reduction in the monthly probability of (live-birth) conception by contraception

b. Failure rate (f) = proportion (percent) of contracepting women conceiving in a specified interval

$$f = c\,(1-e) \qquad (8)$$

where: f = monthly failure rate
c = monthly probability of conception with unprotected intercourse (fecundability)
e = effectiveness

c. Annual failure rate (F) may be approximated as 12 x the monthly failure rate:

$$F \sim 12f = 12c\,(1-e) \qquad (9)$$

Note: F does not equal (1-e), that is,
effectiveness (e) does not equal (1-F)
But: if fecundability (c) = 0.0833 or 1/12,

then F ~ 12f = 12 (1/12) (1-e) = (1-e). (10)

Therefore: Because fecundability is close to 1/12 in healthy women in the mid reproductive years, the observed annual failure rate is taken as a measure of effectiveness, e.g. if 5% of contracepting women conceive a live birth in 1 year (F=0.05), the contraceptive effectiveness (e) is estimated at 0.95 or 95% (e=0.95).

D. Covariates (determinants) of failure

a. age and marital status

b. education and cultural background

c. concomitant use of other methods

d. motivation to delay versus prevent

e. gravidity

f. previous failures

g. method

E. Significance of Contraceptive Failure for Program Strategy

1. Cumulative risk of failure by duration of use

2. Relative significance of contraceptive failure in high fertility (low contraception prevalence) versus low fertility (high prevalence) populations.

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PFHS-380.665 FAMILY PLANNING POLICIES AND PROGRAMS

Demand-Supply Framework for Family Planning Program Analysis and Unmet Need for Contraception

W. Henry Mosley

A. Supply of, and demand for children with socio-economic development (Easterlin model)

1. Demand = number of surviving children parents would have if fertility regulations were costless.

2. Supply = number of surviving children couples would have if they made no deliberate attempt to limit family size.

3. Cost of fertility regulation = economic, psychic, health and social costs of acquiring and using contraception and abortion.

B. Demographic indicators of the demand-supply framework

1. *Contraceptive prevalence* as a measure of met demand for fertility limitation .

2. *Unmet need for family planning* measured as proportion of women in a sexual union desiring to space or limit childbearing and not using contraception

3. *Total potential demand for family limitation* measured by contraceptive use plus unmet need.

4. *Latent demand* (for controlling childbearing) measured as difference between achieved fertility and desired fertility, or as level of *unintended, or unwanted childbearing.*

5. *Overt demand* for controlling childbearing as measured by the *total abortion rate*

C. Unmet need for family planning

The unmet need group includes all fecund women who are married or living in union - and thus presumed to be sexually active - who are not using any method of contraception and who either do not want to have any more children or who want to postpone their next birth for at least two more years.

The unmet need group also includes all pregnant married women, and women who have recently given birth and are still amenorrheaic if their pregnancies/births are unwanted or mistimed because they were not using contraception.

D. Levels and trends in unmet need

Changing patterns with declines in desire for children and with increasing levels of contraceptive prevalence. Unmet need is highest in the early post-partum period and falls as the time since last birth gets longer.

E. Expanded formulations of unmet need

1. As it relates to contraceptive methods:
    - using ineffective methods
    - using an effective method incorrectly
    - using a method that is unsafe or unsuitable for them
2. As it relates to risk groups:
    - unmarried women
    -sexually active youth
    -separated, divorced, widowed

F. Reasons for unmet need

1. Provider constraints
    - Limited access to services
    - Medical barriers
    - Quality of care
2. Client constraints
    - Lack of information
    - Health concerns
    - Opposition from family and community
    - Ambivalence

G. Intention to Use a Method

Intention to use a contraceptive method in the future is also measured in the DHS surveys based on women's own statements. Not all women with an "unmet need" express and intention to use in the future (for reasons given above), while many women who do not have an unmet need will express and intention to use in the future. In fact, the women without an unmet need who intend to use outnumber the women with an unmet need who intend to use in many countries. (Ross and Heaton, 1997). This "discrepancy" relates to the procedure for defining unmet need.

H. Implications of unmet need for family planning

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Family Planning Policies and Programs

Henry Mosley

Session 3 Slides

Family Plannng Policies and Programs

Supply, Demand and Unmet Need for Contraception

W. Henry Mosley

Supply of, and Demand for Children with Socio-economic Development (Easterlin Model)

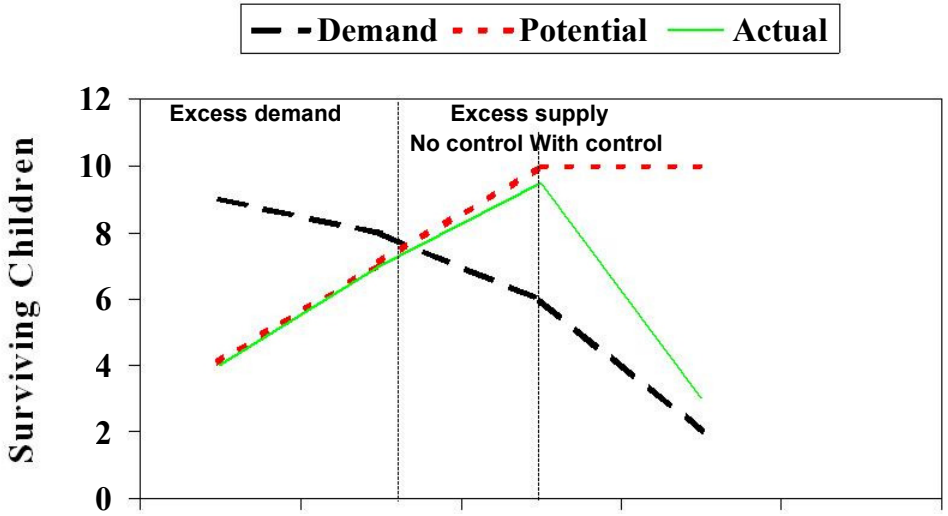
1. Supply = number of surviving children couples would have if they made no deliberate attempt to limit family size.

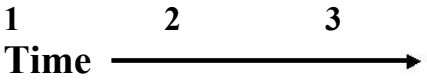
2. Demand = number of surviving children parents would have if fertility regulations were costless.

3. Cost of fertility regulation = economic, psychic, health and social costs of acquiring and using

contraception and abortion.

Illustrative Trends in Demand for Children and the Potential and Actual Supply of Children During the Demographic Transition





Data from: Easterlin

Demographic Indicators of the Demand-Supply Framework

a. Measured by contraceptive use/non-use

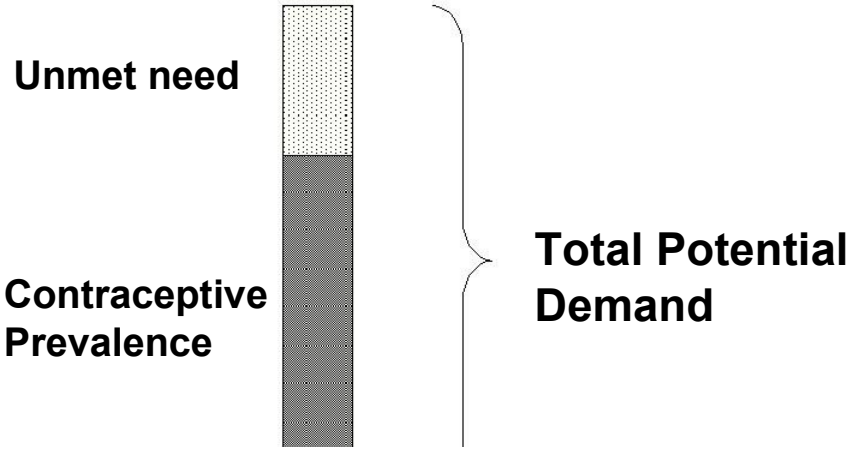
1. Contraceptive prevalence is a measure of met demand for fertility limitation .

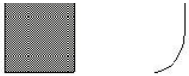
2. Unmet need for family planning is measured as the proportion of women in a sexual union desiring to space or limit childbearing and not using contraception

3. Total potential demand for family limitation is measured by contraceptive use + unmet need.

Demographic Indicators of the Demand-Supply Framework

a. Measured by contraceptive use/non-use





Demographic Indicators of the Demand-Supply Framework

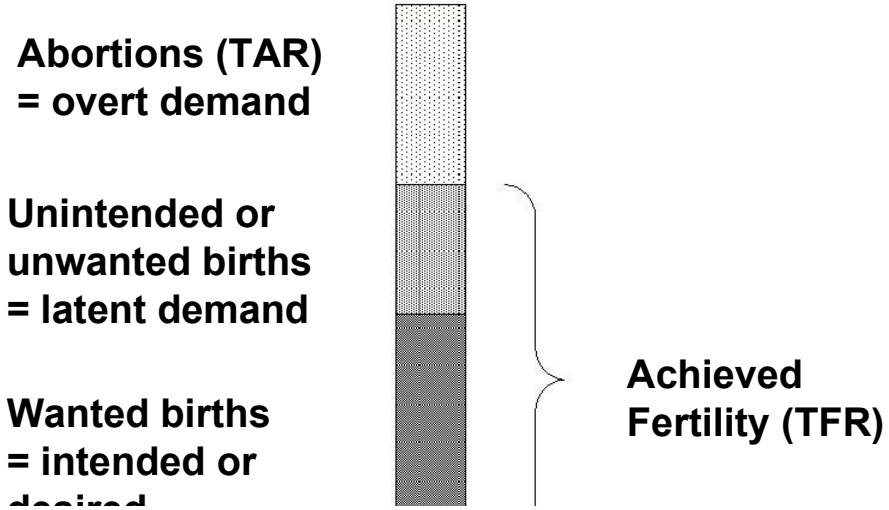
b. As measured by fertility and abortions

1. Latent demand (for controlling childbearing) is measured as the difference between achieved fertility and desired fertility, or as level of unintended, or unwanted *childbearing*.

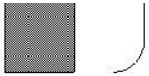
2. Overt demand for controlling childbearing is measured by the total abortion rate

Demographic Indicators of the Demand-Supply Framework

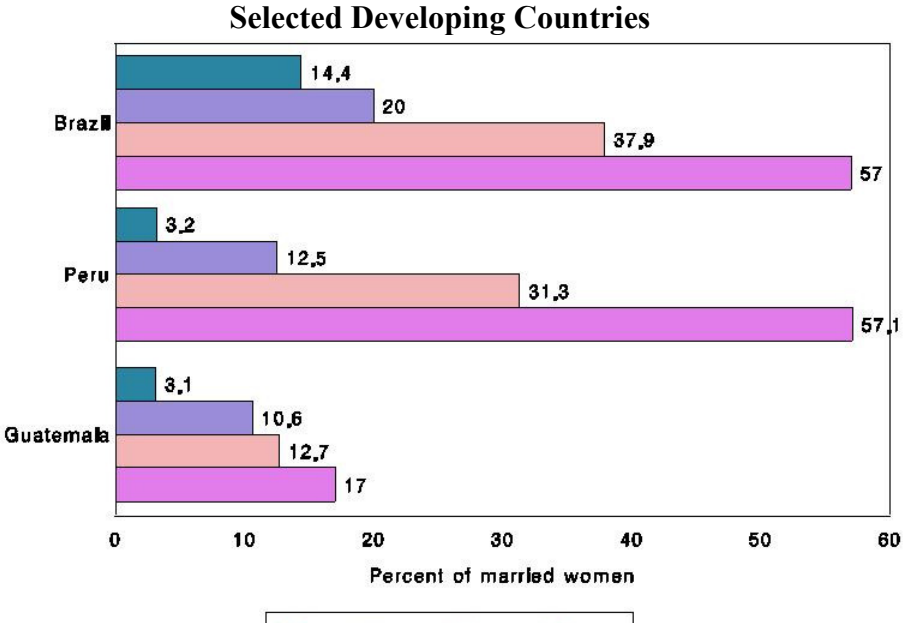
b. As measured by fertility and abortions



desired
fertility

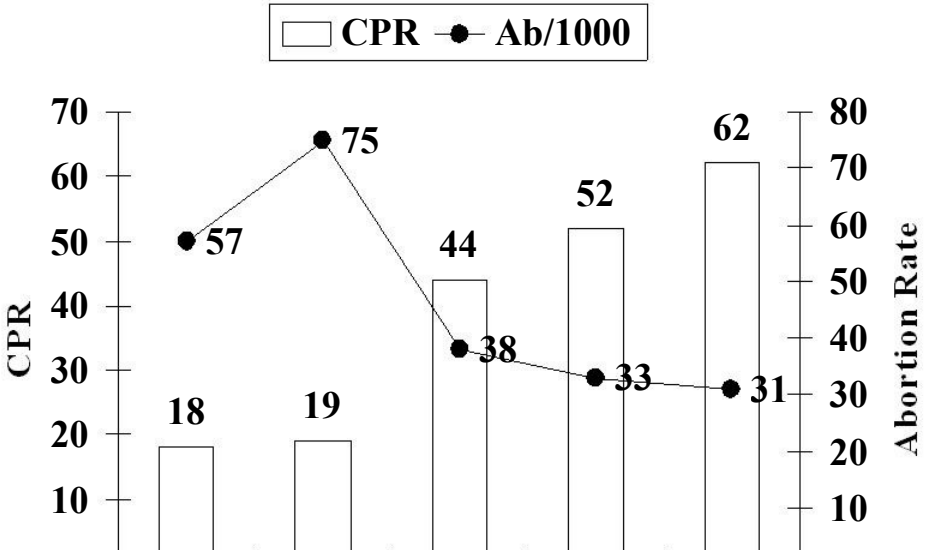


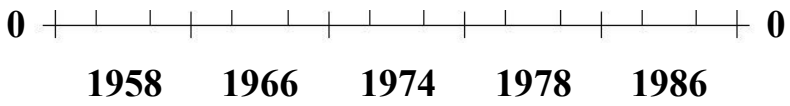
Percent of Women Who Do Not Want Last Birth, by Number of Living Children



Source: Demographic and Health Surveys (DHS)

Relationship of Contraceptive Prevalence to Abortion, Hungary

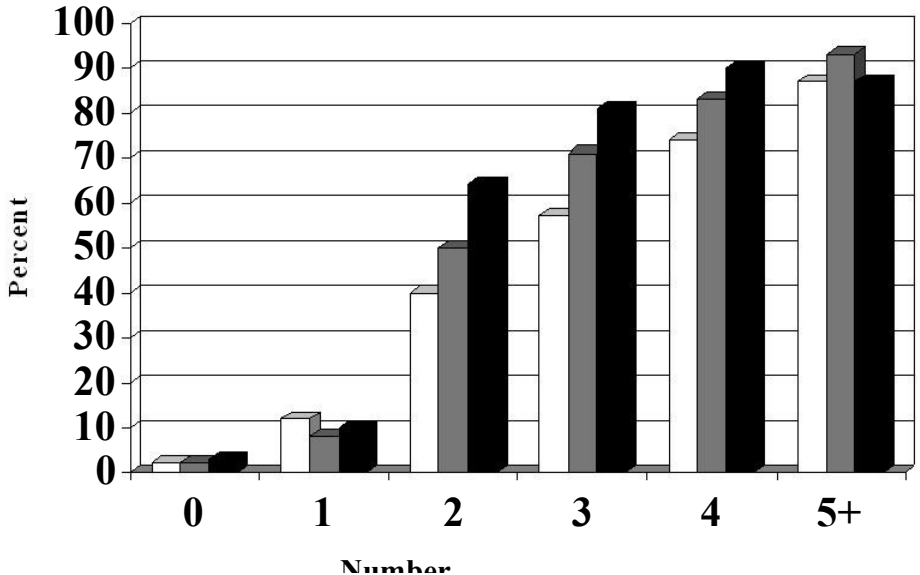



0
0
1958
1966
1974
1978
1986

Desire for More Children vs. Unmet Need and Demand for Contraception

1. Desire for more children is directly measured, and is an essential component in estimating unmet need.
2. Unmet need is only measured indirectly among a subgroup of women not using contraception.
3. Demand for contraception combines the unmet need plus the contraceptive prevalence

Bangladesh Percent of women wanting no more children by number of living children, 1983, 1989, 1996




Number of living children
1983
1989
1996

Unmet Need for Contraception

Women are defined as having an unmet need if they are:

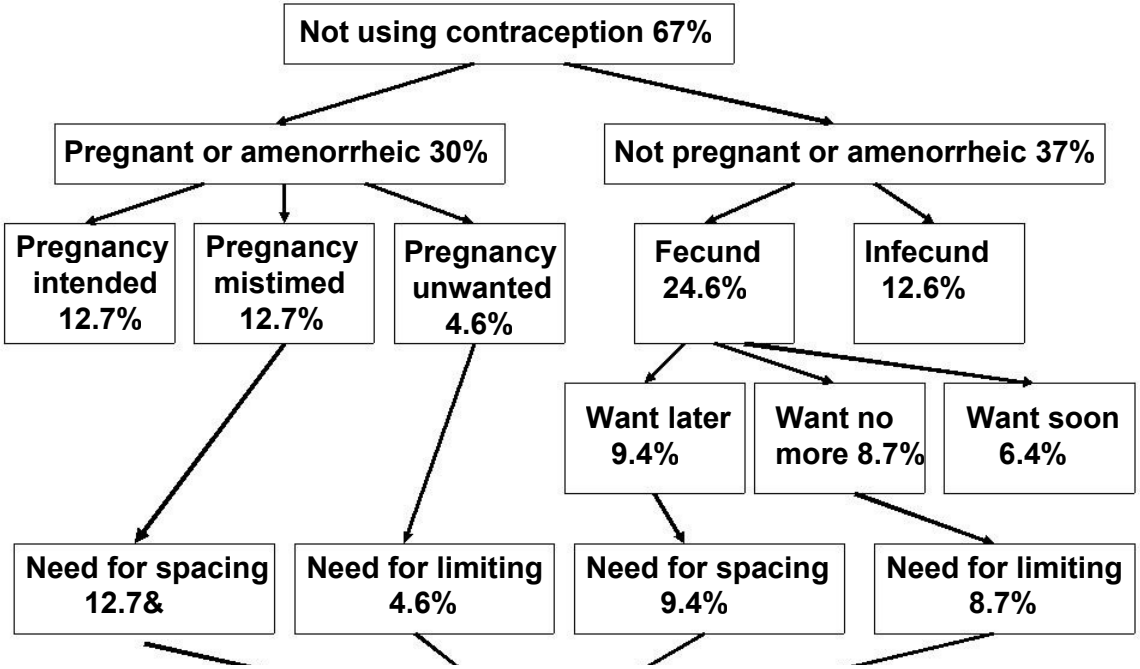
- fecund
- married or living in union
- not using any contraception
- do not want any more children, or
- want to postpone for at least

two
years

Unmet Need for Contraception

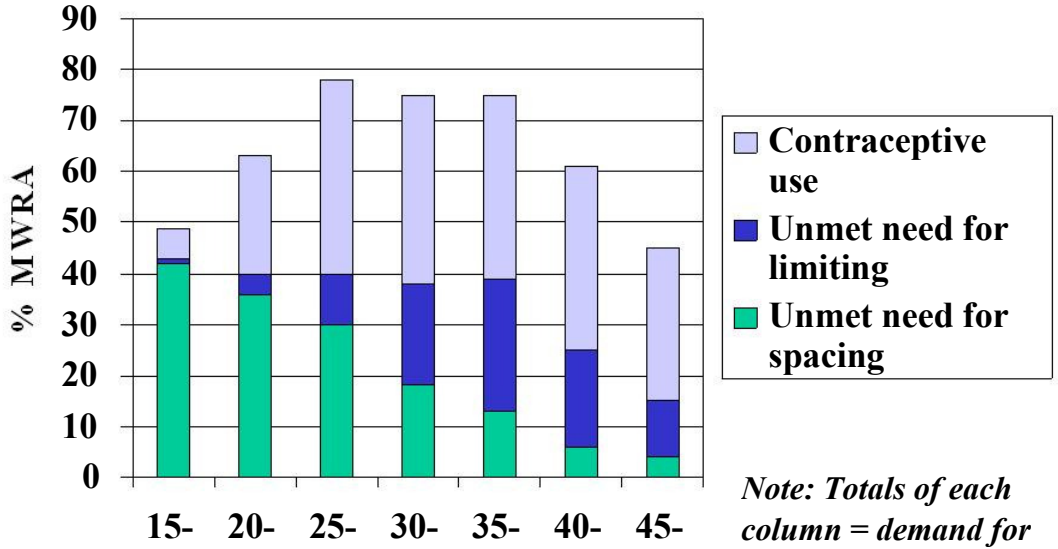
Unmet need also includes:
pregnant or amenorrheic women
with unwanted or mistimed pregnancies/births, and
not using contraception at time of last conception

Defining Unmet Need - Kenya, 1993




Total unmet need 35.5%

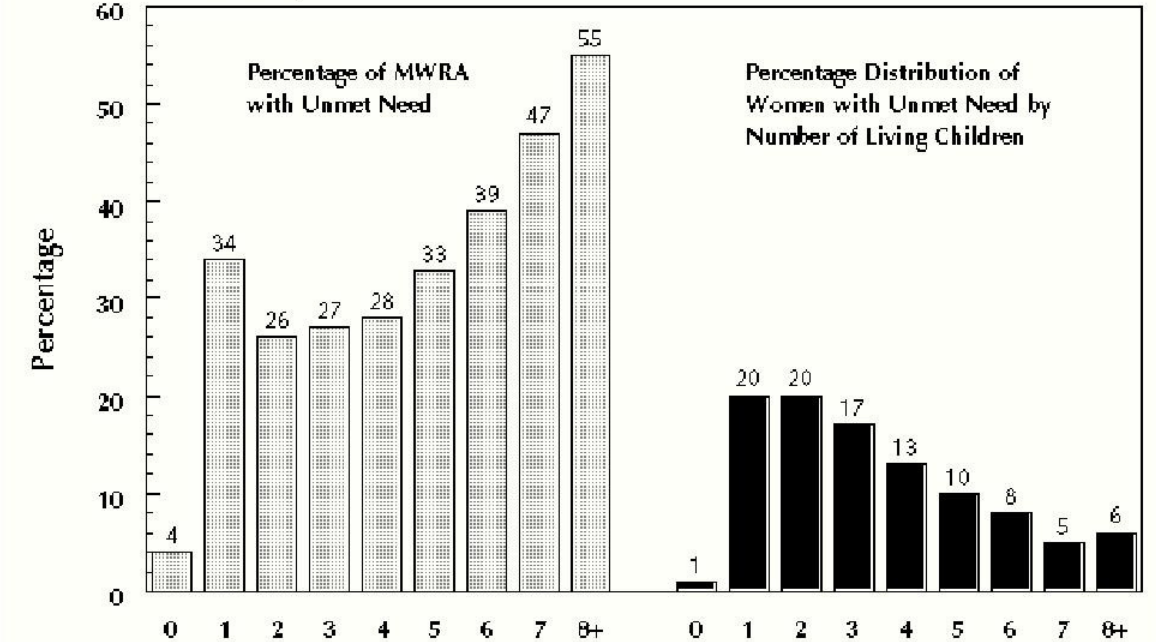
Demand for Contraception by Womens Age. Kenya, 1993



Note: Totals of each column = demand for

19 24 29 34 39 44 49 ***contraception***

Figure 12. Number of Living Children and Unmet Need, Vietnam, 1988

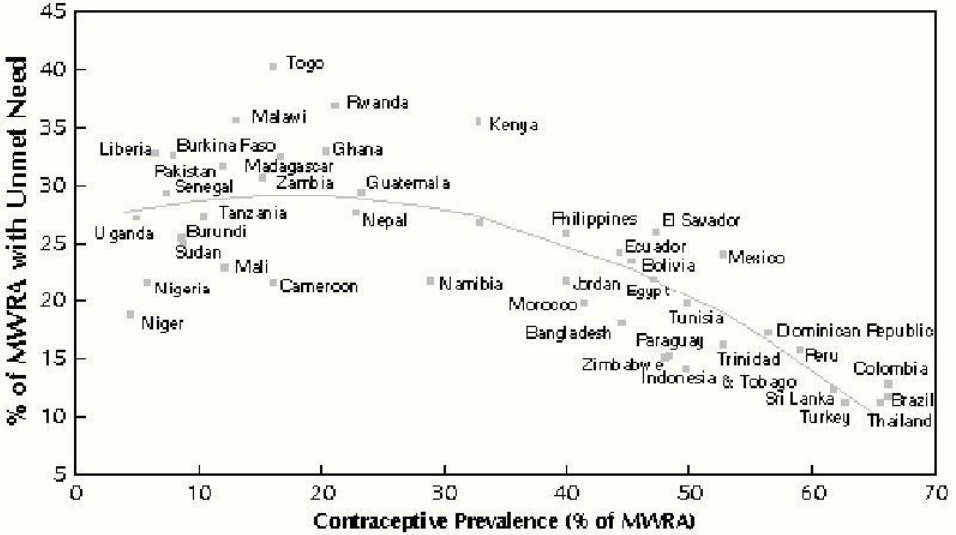


Number of Living Children

MWRA = married women of reproductive age
Source: Ross 1994 (178)

Population Reports

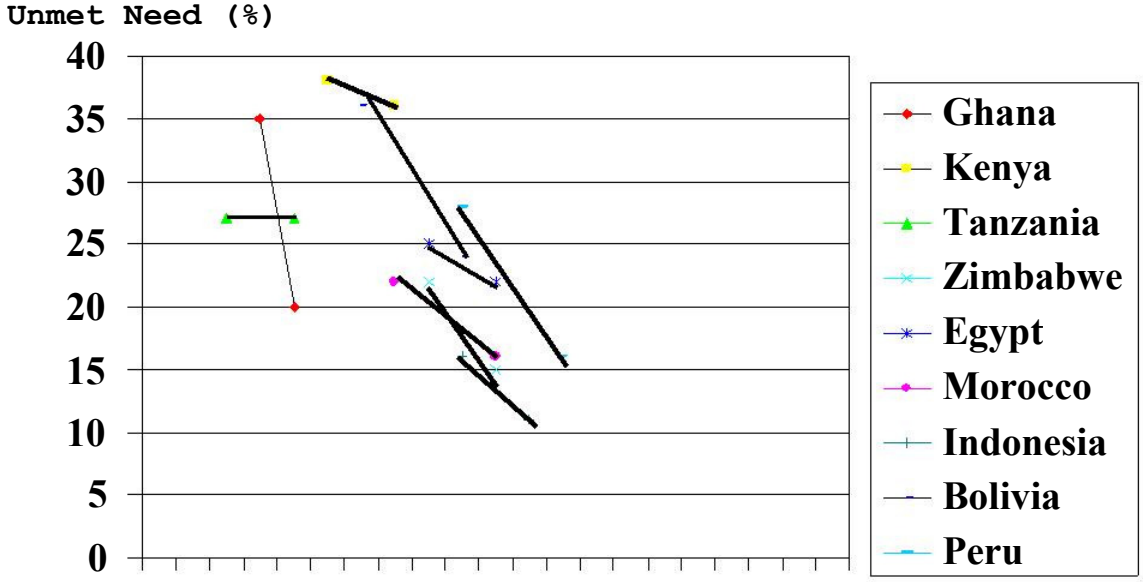
Figure 2. Relationship Between Contraceptive Prevalence and Unmet Need



Note: A curved regression line (the solid line) fits the data significantly better than a straight line.
MWRA = married women of reproductive age Source: Demographic and Health Surveys

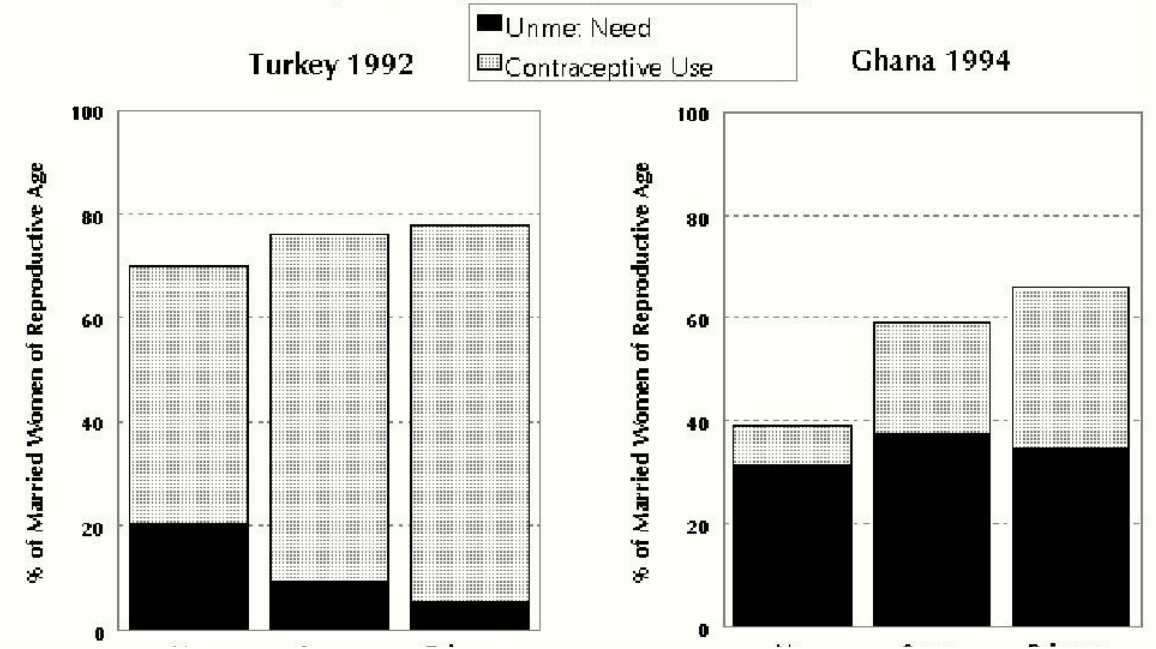
Relationship of Unmet Need to Contraceptive Prevalence

(Countries with two data points)




0
15
30
45
60
75
90
Contraceptive Prevalence Rate (%)

Figure 10. Unmet Need and Contraceptive Use by Women's Educational Level, Turkey, 1992, and Ghana, 1994



	No Education	Some Primary Education	Primary or More Education		No Education	Some Primary Education	Primary or More Education
Source: Demographic and Health Surveys						*Population Reports*	

Expanded Definitions of Unmet Need

May include women who:

are using an ineffective method
are using a method incorrectly
are using an unsafe method
are using an unsuitable method

Reasons for Unmet Need

1. Lack of access
   to preferred method
   to preferred provider

Physical distance may not be of major importance, but other costs are, such as monetary, psychological, physical.

physical,
and
time.

Reasons for Unmet Need

2. Poor quality of services provided.
   This includes:

   choice of methods
   provider competence
   information given to clients
   provider-client relationships
   related health care services
   follow

-
up
care

Reference: Judith Bruce Framework

Reasons for Unmet Need -cont.

3. Health concerns
   - actual side effects
   - fear of side effects

4. Lack of information and misinformation about:
   - available methods
   - mode of action/how used
   - side

side effects/cost of methods

Reasons for Unmet Need -cont.

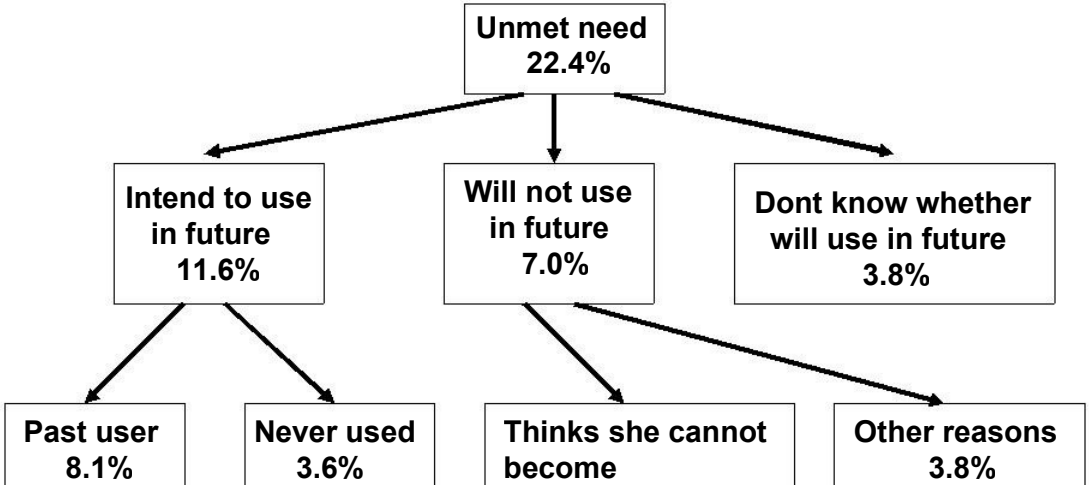
5. Family/community opposition (power relationships in the household)
    - pronatalist
    - concerns about unfaithfulness
    - fear of side effects
    - objections to male providers
    - religious objections

Reasons for Unmet Need -cont.

6. Little perceived risk of pregnancy

7. Ambivalence

Intention to Use Contraception Among Women with Unmet Need, Jordan, 1990



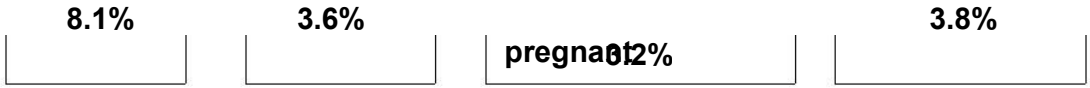
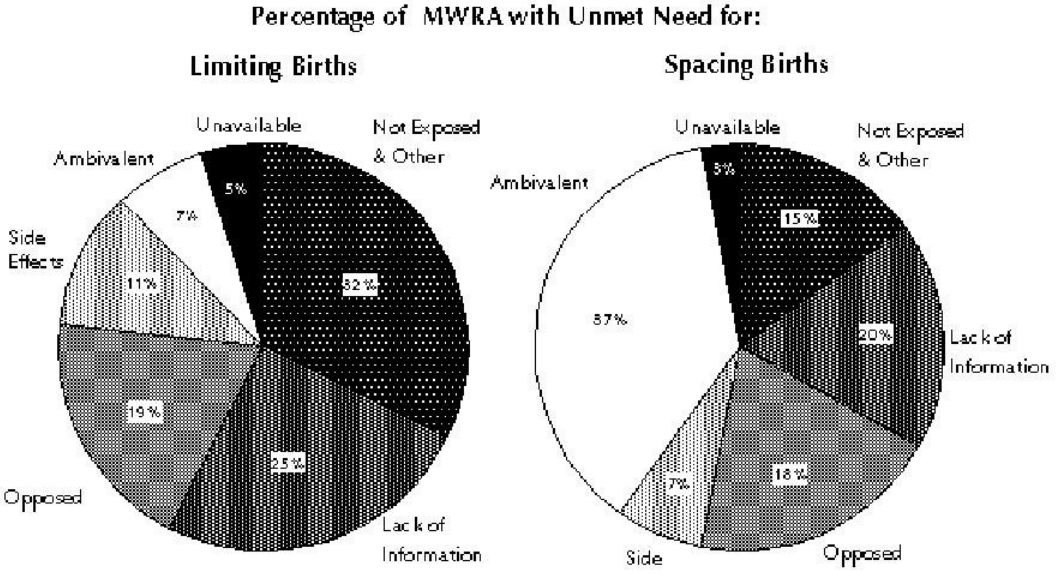

8.1%
3.6%
pregnan
3.8%

Figure 7. Distribution of Main Reasons for Not Intending to Use Contraception Among Subgroups of Women with Unmet Need in 24 Countries Surveyed by the DHS



Note: Unweighted averages for 24 countries, 1990-94
MWRA = married women of reproductive health
Source: Westoff & Bankole 1995 (234)

Effects

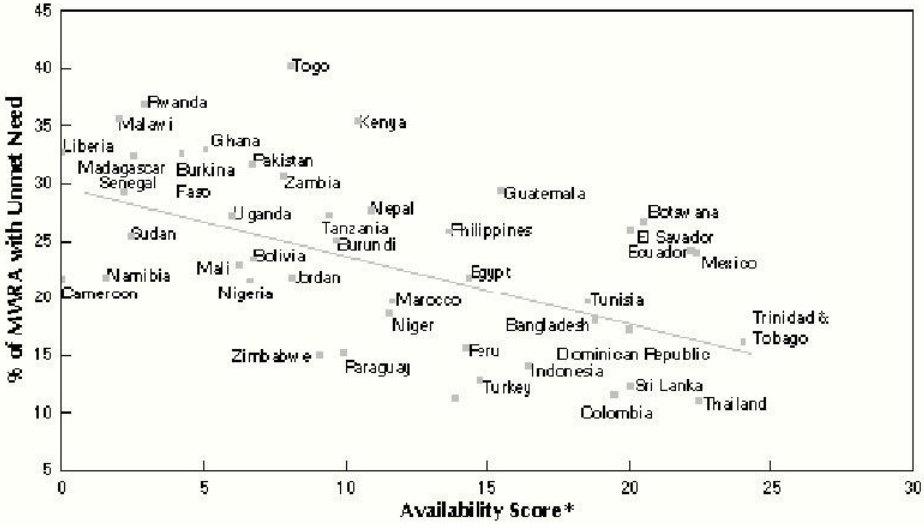
Population Reports

Meeting Unmet Need

1. Improve access to good quality services
   - offer choice of methods
   - eliminate medical barriers
   - expand service delivery points
     - home delivery
     - social marketing
   - provide

provide
confidentiality

Figure 3. Relationship Between the Number of Contraceptive Methods Available and Unmet Need



The more contraceptive methods available in a country, the lower the level of unmet need.

Note: The solid line is the best fitting statistical regression line. MWRA = married women of reproductive age

*Scores calculated on the basis of judgments about the availability of contraceptive methods by senior family planning personnel and observers in each country.

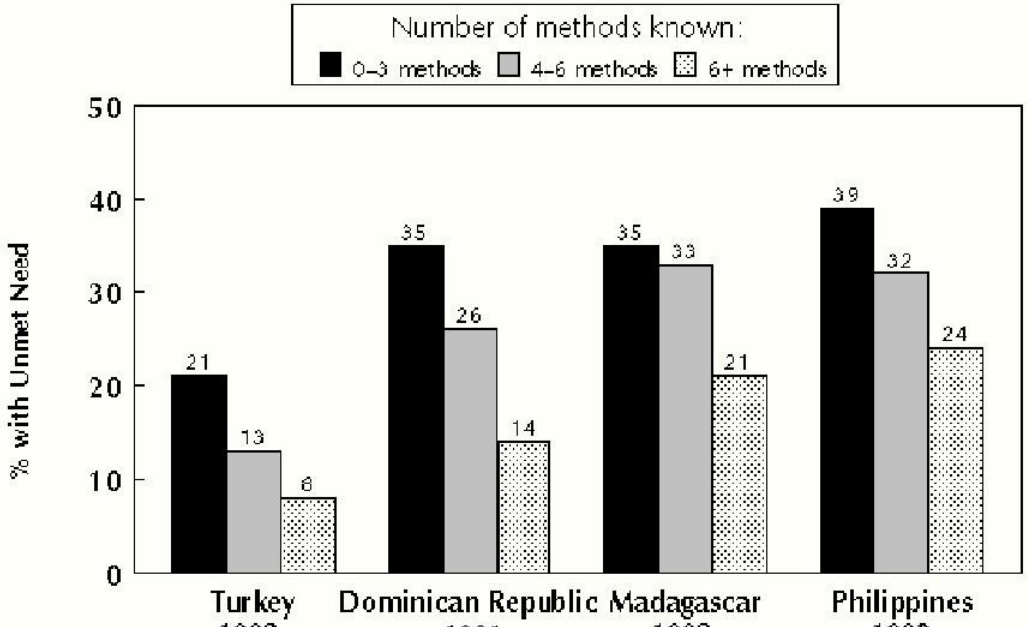
Source: Mauldin and Ross 1991 (122). Percentage with unmet need from Demographic and Health Surveys.

Meeting Unmet Need

2. Improve communication about:
legitimacy of family planning
source of FP information and
and supplies
misinformation and rumors
regarding effects/side-effects
risks of contraception

risks of
pregnancy

Figure 4. Unmet Need by Number of Family Planning Methods Known to Married Women of Reproductive Age in Four Countries



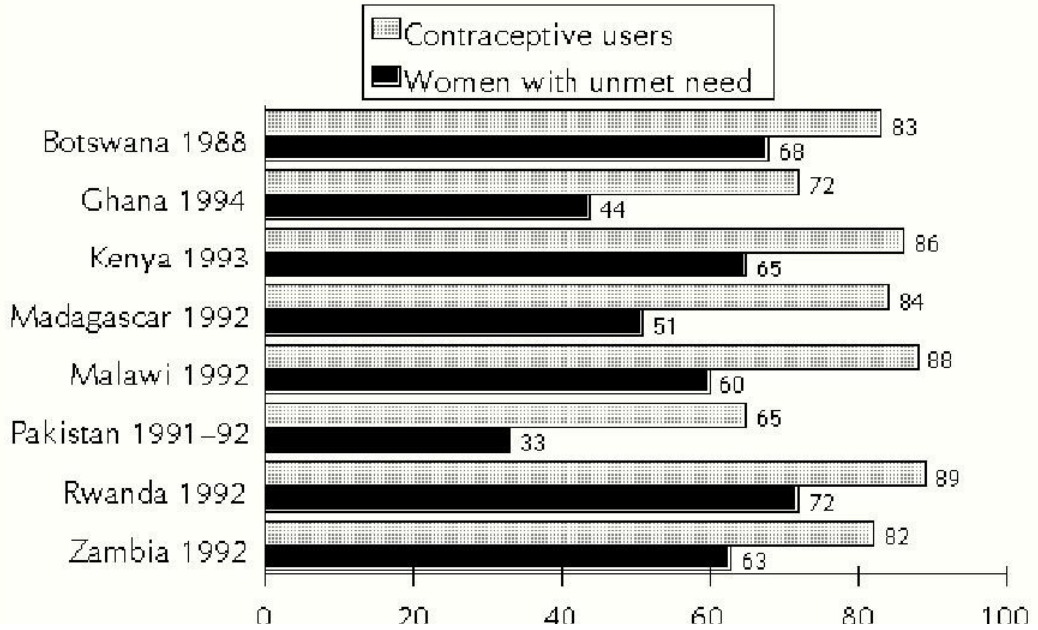
1992	1991	1992	1993

Source: Bhushan 1996 (19) from Demographic and Health Surveys *Population Reports*

Meeting Unmet Need

3. Involve men/husbands as well as women

Figure 6. Husband-Wife Communication: Contraceptive Users and Women with Unmet Need Compared



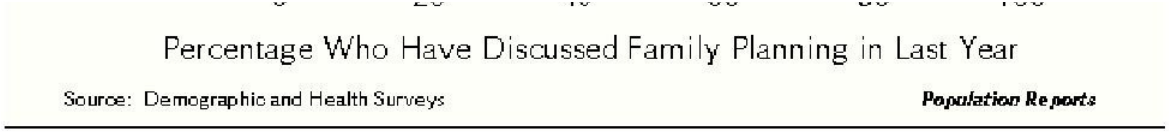
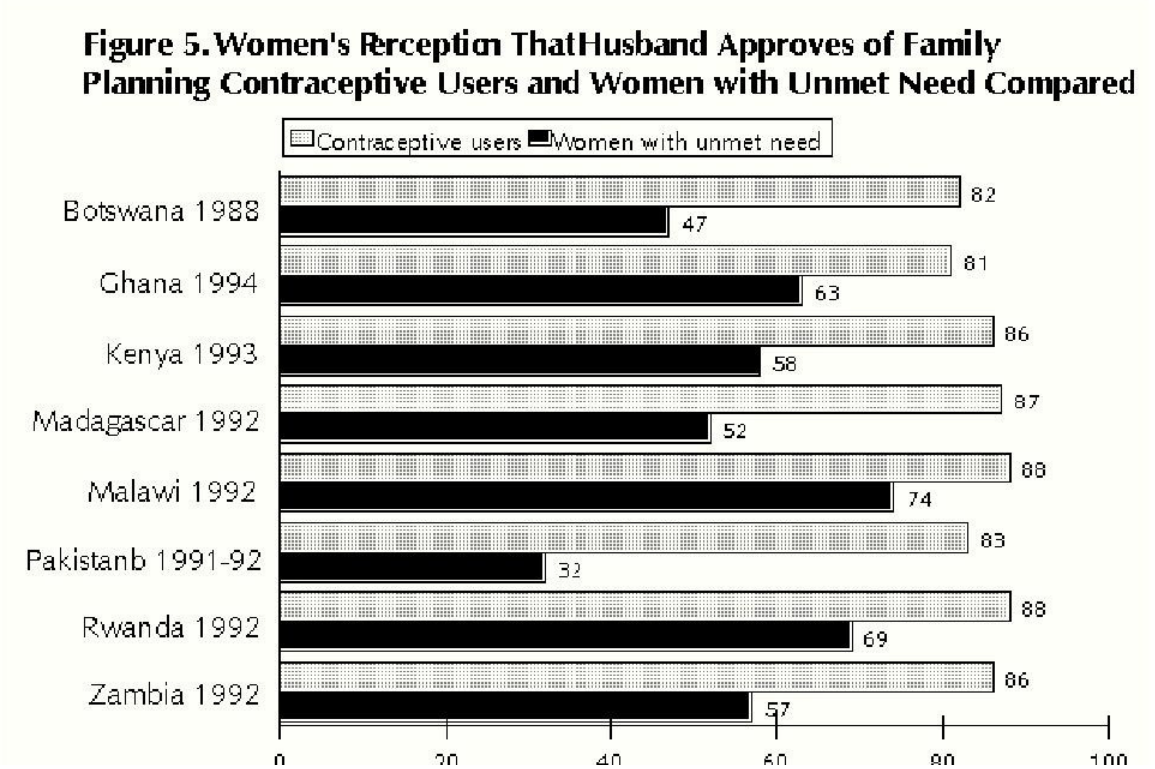
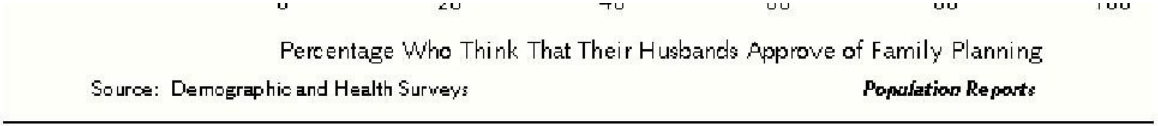

Percentage Who Have Discussed Family Planning in Last Year
Source: Demographic and Health Surveys
Population Reports

Figure 5. Women's Perception That Husband Approves of Family Planning Contraceptive Users and Women with Unmet Need Compared




Percentage Who Think That Their Husbands Approve of Family Planning
Source: Demographic and Health Surveys
Population Reports

Meeting Unmet Need

4. Link FP to other services
   prenatal care
   post-partum care/breastfeeding
   immunization
   post-abortion care
   child health services

JOHNS HOPKINS BLOOMBERG SCHOOL of PUBLIC HEALTH

PFHS 380.665 FAMILY PLANNING POLICIES AND PROGRAMS

Unwanted Fertility and Induced Abortion
Implications for Family Planning Programs

W. Henry Mosley

A. The context of unwanted pregnancies and fertility (1999 estimates)

	World	LDCs	MDCs
Women of childbearing age	1.38 billion	1.127 billion	0.253 billion
Pregnancies	210 million (100%)	182 million (100%)	28 million (100%)
Miscarriages/stillbirths	**31 million (15%)**	**27 million (15%)**	**4 million (15%)**
Induced abortions	46 million (22%) rate 35/1000	36 million (20%) rate 34/1000	10 million (36%) rate 39/1000
---Legal abortions	---26 million	---17 million	---9 million
---Illegal abortions	---20 million	---19 million	---1 million
Live births	123 million (63%) rate 89/1000	118 million (65%) rate 105/1000	14 million (49%) rate 55/1000
---Wanted births	---99 million (47%)	---89 million (49%)	---10 million (36%)

---	---		
Unwanted births	---33 million (16%) --- 29 million (16%) --- 4 million (13%)		

B. Measures of unwanted fertility

The World Fertility Surveys (WFS) and the Demographic and Health Surveys (DHS) generally included questions on:

--- desired family size
--- whether more children are wanted or not
--- the wanted status of the most recent (or every) birth or pregnancy
--- the number of additional children wanted

A number of direct and indirect indicators of desired family size or wanted fertility can be derived from responses to these questions on reproductive preferences. Unfortunately several of the estimates are severely biased because of factors conditioning the types of responses including rationalization of the current situation, non-numeric responses, etc. (see Bongaarts, 1990).

C. Demographic indicators of unwanted fertility

Three common indicators are:

1. The Total Wanted Fertility Rate (TWFR) constructed like a TFR by deleting all birth that were reported as unwanted or ill timed in each age group.

2. The percent of recent births that were wanted then, not wanted , or wanted later.

3. The percent of women saying that they want no more children generally tabulated according to number of living children.

D. Empirical observations on unwanted fertility from developing countries
(See Charts and Tables from Ross, Stover and Willard, 1999)

1. Relationship of TWFR to TFR
2. Regional indicators of excessive fertility

E. Trends in unwanted fertility with development and rising contraceptive prevalence. (Bongaarts, 1997)

Unwanted fertility *increases* with increasing socio-economic development, as desired family size diminishes, even though contraceptive prevalence increases. The reasons for this paradoxical finding are:

1. An increasing proportion of women wanting fewer children who therefore have a longer exposure time for risk of pregnancy.
2. Incomplete "preference implementation" in terms of successful contraceptive use because of economic, social and psychological obstacles.
3. Contraceptive failure.
4. Restricted access to safe abortion services
5. Variations in other proximate determinants (marriage, breastfeeding)

F. Abortion - the incidence of abortion worldwide (Henshaw, Singh and Haas, 1999a)

1. Data sources
2. Measures of abortions - rates per 1000 MWRA vs. ratio per 100 live births
3. Legal status and abortions performed

G. Patterns of abortions by age, parity and marital status in different countries (Bankole, Singh and Haas, 1999)

H. Relationship of abortions to contraceptive use (Henshaw, Singh and Haas, 1999b; Marston and Cleland, 2003))

I. Sex-selective abortion (Junhong, 2001; Arnold, Kisher and Roy, 2002)

Required readings

Bongaarts, J. Trends in unwanted childbearing in the developing world. *Studies in Family Planning 28 (3): 267-277, 1997.*

Marston, C and Cleland, J. Relationships between contraception and abortion: a review of the evidence. International Family Planning *Perspectives 29 (1): 6-13, 2003.*

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Bongaarts, J and Westoff, CF. The potential role of contraception in reducing abortion. *Studies in Family Planning* 31(3): 193-202, 2000.

Dulaire, N, Leidl, P, Mackin, MA, Murphey, C and Stark, L. *Promises to Keep: The Toll of Unintended Pregnancies on Womens Lives in the Developing World.* Global Health Council, Washington, DC, 2002.

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Senlet, P, Curtis, Sl, Mathis, J and Raggers, H. The role of changes in contraceptive use in the decline of induced abortion in Turkey. *Studies in Family Planning* 32(1) 41-52, 2001.

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Singh S and Sedgh G. The relationship of abortion to trends in contraception and fertility in Brazil, Colombia and Mexico. *International Family Planning Perspectives* 23:4-14, 1997.

Tsui AO, Wasserheit JN, and Haaga, J. Intended Births. Chapter 4 in *Reproductive Health in Developing Countries. Expanding Dimensions, Building Solutions.* National Acdemy Press, Washington DC,1997.

Varga, C. Pregnancy termination among South African adolescents. *Studies in*

Westoff, C. F. et al. *Replacement of Abortion by Contraception in Three Central Asian Republics.* *Family Planning Perspectives* 33: 283-298 (2002). The Policy Project (Washington, D.C.) and Macro International (Calverton, MD) , 1998.

Family Planning Policies and Programs

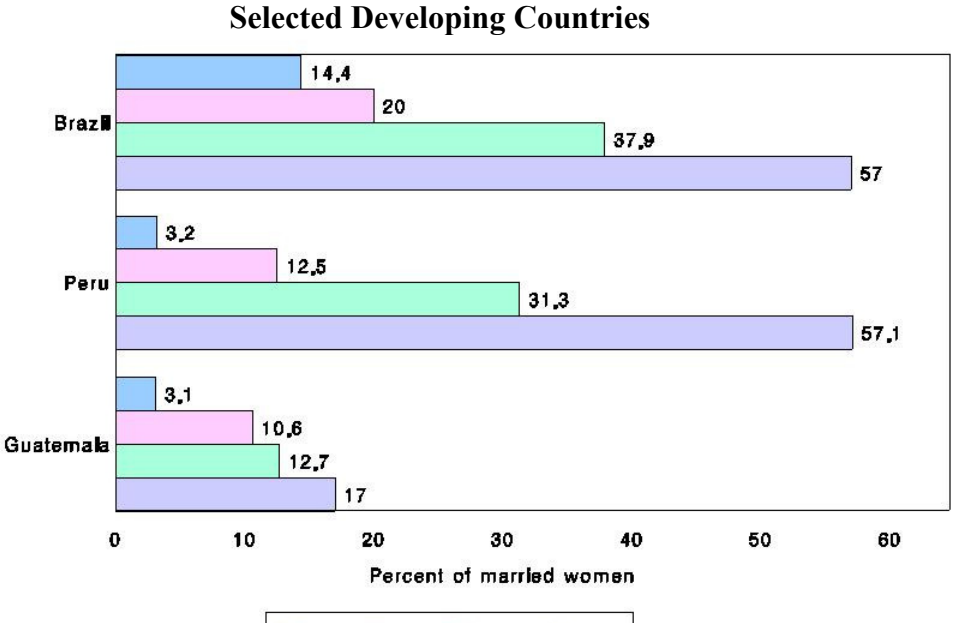
Henry Mosley

Session 6 Slides, Part I

Unwanted Fertility and Induced Abortion Part 1

W. Henry Mosley

Percent of Women Who Do Not Want Last Birth, by Number of Living Children



Source: Demographic and Health Surveys (DHS)

The context (1999 estimates)

	World	*LDCs*	*MDCs*
Reproductive age women	**1.38 billion**	**1.127 billion**	**0.253 billion**
Pregnancies	**210 million (100%)**	**182 million (100%)**	**28 million (100%)**
Miscarriages/ stillbirths	**31 million (15%)**	**27 million (15%)**	**4 million (15%)**
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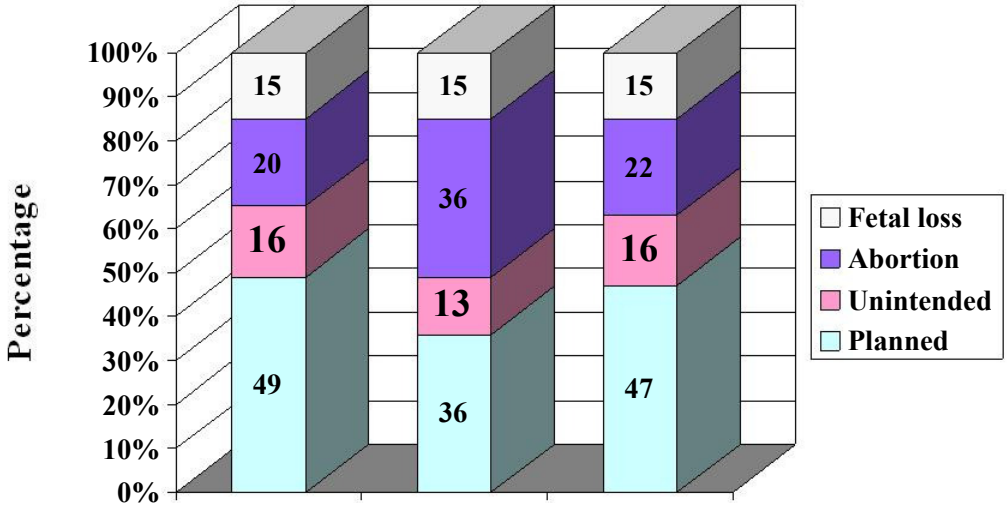
Live births	**123 million (63%) rate 89/1000**	**118 million (65%) rate 105/1000**	**14 million (49%) rate 55/1000**
-	-	-	-

-	(47%)	(49%)	(36%)
- *Unwanted births* - *Wanted births*	- 33 million (16%) 99 million	- 29 million (16%) 89 million	- 4 million (13%) 10 million

Pregnancy Outcomes

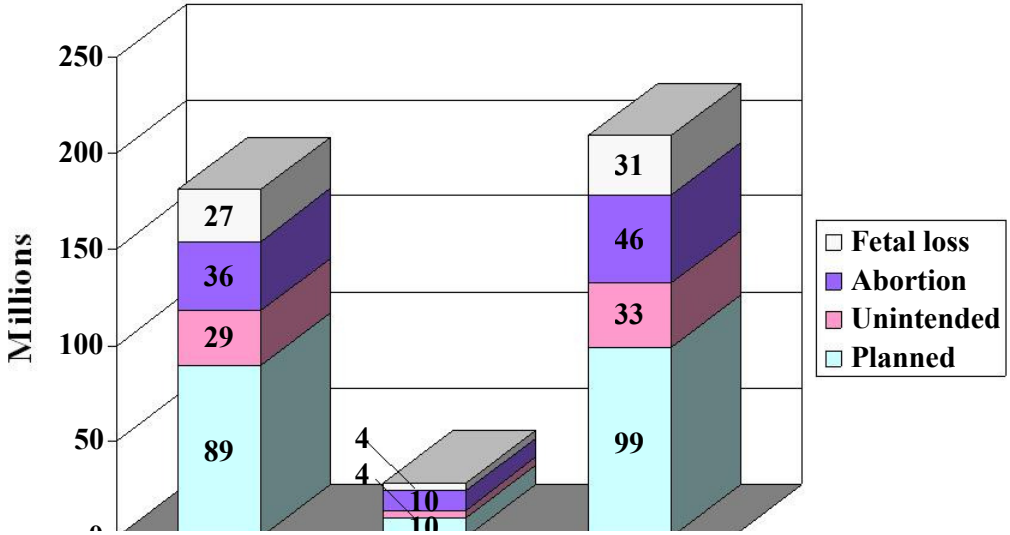
Women Ages 15-44



	LDCs	MDCs	WORLD

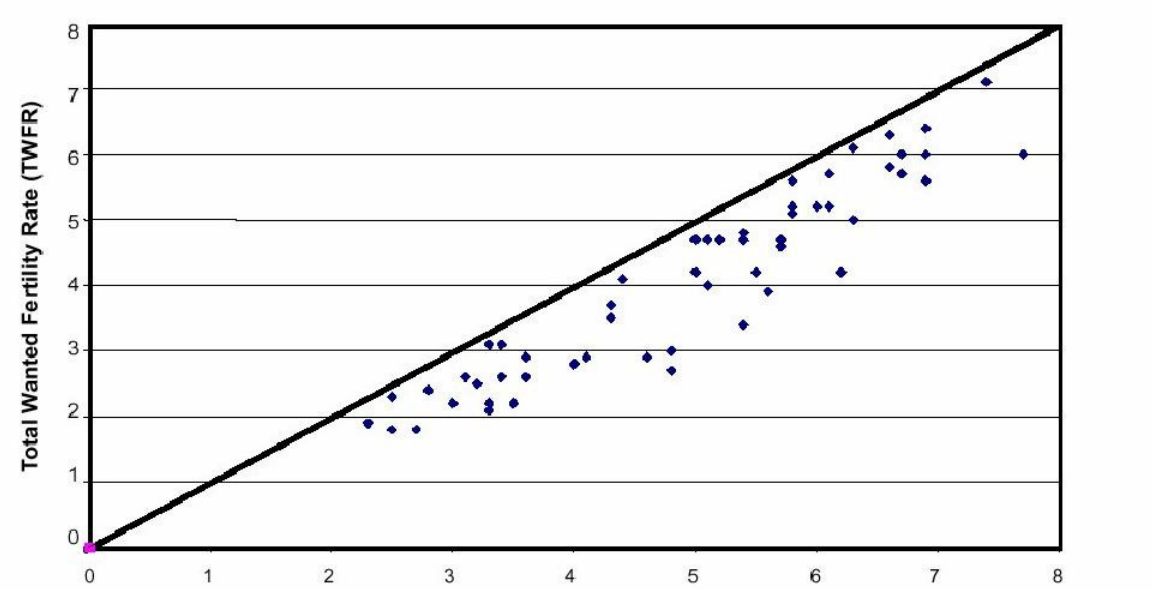
Pregnancy Outcomes

Women Ages 15-44




0
LDCs
MDCs
WORLD

Figure 5.9. Wanted Fertility Rate and Actual Fertility Rate: 55 Developing Countries



Total Fertility Rate (TFR)
(No. of Births)

Source: Ross, Stover, Willard: *Profiles for Family Planning and Reproductive Health Programs.* The Futures Group International, 1999.

Table 5.6. Regional Mean Values for Indicators of Excessive Fertility

				Planning Status of Births		
	TFR	TWFR	Gap	Wanted Then	Not Wanted	Wanted Later
Asia	3.5	2.7	0.75	69.5	17.3	12.6
Latin America	3.7	2.9	0.84	59.7	20.3	19.7
Middle East/North Africa	4.6	3.5	1.11	68.8	15.1	16.0
Sub-Saharan Africa	6.0	5.2	0.80	68.8	21.4	8.4
Central Asia Republics	3.1	2.8	0.23	88.3	6.1	5.0

Source: Ross, Stover, Willard: *Profiles for Family Planning and Reproductive Health Programs.* The Futures Group International, 1999.

Table 5.7. Trends in the Total Fertility Rate (TFR) and Wanted Fertility Rate (TWFR) Over the Past Decade, Selected WFS and DHS Surveys

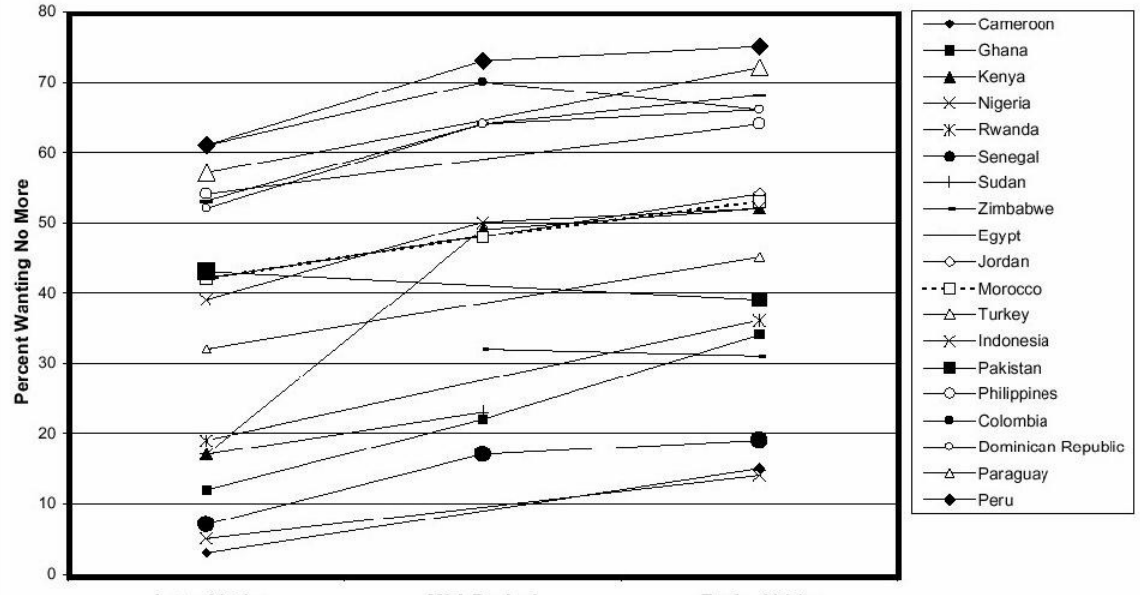
	WFS			DHS			Percent Decline	
Country	Year	TFR	TWFR	Year	TFR	TWFR	TFR	TWFR
Sub-Saharan Africa								
Ghana	1979/80	6.1	6.0	1988	6.4	5.3	+(5)	12
Kenya	1977/78	7.9	7.6	1988/89	6.4	4.5	19	41
Senegal	1978	7.1	6.9	1986	6.6	5.6	7	26
North Africa								
Egypt	1980	5.0	3.6	1988/89	4.4	2.8	12	22
Morocco	1979/80	5.5	4.4	1987	4.6	3.3	16	25
Tunisia	1978	5.5	4.1	1988	4.1	2.9	25	29
Asia								
Indonesia	1976	4.3	4.0	1987	2.9	2.4	32	40
Sri Lanka	1975	3.4	2.9	1987	2.6	2.2	23	24
Thailand	1975	4.3	3.2	1987	2.2	1.8	49	44
Latin American/ Caribbean								
Colombia	1976	4.6	3.4	1986	3.1	2.1	33	38
Dominican Republic	1975	5.2	3.8	1986	3.6	2.6	31	32
Ecuador	1979	5.2	4.1	1987	4.3	2.9	17	29
Mexico	1976	5.7	4.5	1987	4.0	2.9	30	38
Peru	1977/78	5.3	3.5	1986	4.0	2.3	26	34
Trinidad & Tobago	1977	3.2	2.5	1987	4.0	2.2	6	12

Note: The total fertility rate is based on the period 1-24 months prior to the survey. The wanted fertility rate is calculated by deleting births (in the two years preceding the interview) of women whose actual number of living children exceeds the number desired.

Source: Westoff, 1991.

Source: Ross, Stover, Willard: *Profiles for Family Planning and Reproductive Health Programs.* The Futures Group International, 1999.

Figure 5.12. Trends in Desire for No More Children



Late 1970s	Mid-Period	Early 1990s

Source: Ross, Stover, Willard: *Profiles for Family Planning and Reproductive Health Programs.* The Futures Group International, 1999.

PFHS 380.665 FAMILY PLANNING POLICIES AND PROGRAMS

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e. Clients receive information on method options, as well as information on contraindications, common side effects, follow-up requirements, and duration of effectiveness of the method selected.

f. Providers solicit information about clients' background, reproductive goals, attitudes, prior experience with contraceptives, and preferences to assist clients' choice process.
g. Clients receive information on the possibility of switching methods or source of supply.
h. Clients make a specific appointment for a follow-up visit or a specific plan for re-supply with providers.
i. Clients are afforded privacy for examinations, information sharing, and personal interviews.
j. Providers treat clients with dignity and respect.

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Points for discussion:

Why: Why was this research done - what was the rationale for this study. Why was this considered to be an important problem.

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PFHS 380.665 FAMILY PLANNING POLICIES AND PROGRAMS

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PFHS-380.665 FAMILY PLANNING POLICIES AND PROGRAMS

Paying for Family Planning: Costs, Cost Recovery, and Cost-effective Investment Strategies

W. Henry Mosley

A. Why subsidize family planning services. (Ref: Lewis, M., 1986)

Reduced fertility has high social benefits as well as individual benefits. But even though individuals have a desire for fewer children, their demand for family planning is constrained by their resources, both material (money) and non-material (time, knowledge, beliefs, values, etc.). Because of these constraints, the free market price for contraceptives will generally not meet the social welfare objective. Therefore government subsidies are required to equalize individual and social preferences.

B. What are the User costs.

1. Search costs for acquiring correct information

a. about methods

b. about reliable and trustworthy sources of supply

2. Time costs

a. travel (including multiple trips for

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b. waiting times for services
closed/empty clinics)
3. Method variety costs (not getting choice)
a. limited methods available
b. provider biases
c. provider incompetence (technical)
4. Administrative costs
a. age, parity, marriage requirements; spousal consent
b. needless examinations
c. regulatory/bureaucratic restrictions
d. unpleasant/unfriendly environment (lack of privacy)
5. Social/cultural costs
a. cultural insensitivity (no female providers)
family opposition
6. Health and psychic costs
a. anxiety due to contravening cultural norms
b. physical side effects of the contraception
7. Monetary costs
a. for travel
b. for services
c. for commodities

C. What are usual provider costs. (Ref: Barberis and Harvey, 1997)

Mode of service delivery	Average Cost per CYP US$
Social marketing	2.14
Sterilization	1.85
Clinic services with sterilization	3.89
Clinic services without sterilization	6.10
Community-based distribution	9.99
Clinic services with CBD	14.00

D. What is Elasticity of Demand to Price Changes.

Definition: The price elasticity of demand for a good is the proportional change in the quantity demanded of the good relative to the proportional change in the price.

Example: Matheny (2004) cites 5 studies of the overall price elasticity of demand for contraceptives which showed elasticities in the range of 0 to 0.15. That is, for every 100% increase in the mean price of contraceptives, the contraceptive use

decreased by 9% to 15%.

Price elasticity is influenced by many factors including:

1. Type of contraceptive
2. Initial price versus cumulative cost
3. The role of substitutes
4. Non-monetary costs
5. Economic situation
6. Perceptions of value

E. What is the cost-effectiveness of investments in alternative interventions to improve FP use. (Matheny, 2004)

1. Depends on the elasticity of alternative investment strategies e.g., what will be the proportional change in FP use with a given investment in a FP strategy.:

2. For the most part, data are very poor or not available at all.

3. Where data are available, Matheny (2004) provides the following estimates:

a. The low elasticities of contraceptive demand with contraceptive price subsidies (as summarized above) lead to an estimate of $61 per couple year of protection in Indonesia, if investments are just made in price subsidies.

b. Media campaigns in Egypt, Turkey, and Zimbabwe have given estimates of $3.26, $1.36 and $3.57 per CYP.

c. Strategies to improve quality appear to be very cost-effective, but good empirical data are lacking.

F. Social Marketing Engaging the private sector to promote and distribute a public good.

Definition: the design, implementation, and control of programs calculated to influence the acceptability of a social idea and involving considerations of product planning, pricing, communications, distribution, and market research.

1. Contraceptive social marketing:
    a. uses existing commercial/retail channels
    b. subsidizes prices (by government/donors) or recover partial costs
        to:
        achieve high distribution
        reach low income groups
2. Coverage and costs
3. Issues
    a. management must fit local circumstance
        examples of managers
            family planning organizations
            private sector organizations established specifically
                for

quasi-governmental agencies
government agencies

b. potential customers
market segmentation

c. products
condoms, orals, spermicides, IUDs, injectables

d. pricing
a balance between assuring wide availability, retailer profitability and cost recovery

e. promotion
promote products (brands) and providers
target promotion to consumers and providers
continuous promotion

f. evaluation
sales
couple-year-of-protection (CYP)
coverage
cost/CYP

Required Readings:

Haws J, Bakamjian L, Williams T, Lassner KJ. Impact of sustainability policies on sterilization services in Latin America. Studies in Family Planning 23(2):85-96, March/April, 1992.

Janowitz B, Suazo M, Fried DB, Bratt JH, Bailey PE. Impact of social marketing on contraceptive prevalence and cost in Honduras. Studies in Family *Planning 23(2):110-117, March/April 1992.*

Schuler, SR, Bates, L, Islam, MK. Reconciling cost recovery with health equity concerns in a context of gender inequality and poverty: findings from a new health initiative in Bangladesh. International Family Planning *Perspectives 28: 196-204, 2002.*

Supplementary Readings

Matheny, G., Family planning programs: getting the most for the money. *Internatinal Family Planning Perspectives 30 (3): 134-138, 2004.*

Meekers, D, and Rahaim, S. The importance of socioeconomic context for social marketing models for improving reproductive health: Evidence from 555 years of program experience. BMC Public Health 5:10, 2005 (available at

http://www.biomedcentral.com/1471-2458/5/10

Recommended Readings:

Barberis M and Harvey PD. Cost of family planning programmes in fourteen developing countries by method of service delivery. *Journal of Biosocial Science 29* : 219-223, 1997.

Bratt JH, Forheit J, Vargas T. Three strategies to promote sustainability of CEMOPLAF clinics in Ecuador. *Studies in Family Planning* 29(1): 58-68, 1998.

De Silva V, Thapa S, Wilkens LR, Farr MG, Jayasinghe K, McMahan JE. Compensatory payments and vasectomy acceptance in urban Sri Lanka. *Journal of Biosocial Science 20* (2):143-156, 1988.

Forheit KG, and Levine R. Cost recovery and user fees in family planning. *Policy Paper Series No. 5.* OPTIONS for Population Policy II, The Futures Group, Washington, DC, 1993

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Harvey PD. The impact of condom prices on sales in social marketing programs. *Studies in Family Planning 25* (1):52-58, January/February 1994.

Hubacher D, Cardenas C, Hernandez D, Cortes M, Janowitz B. The costs and benefits of IUD follow-up visits in the Mexican Social Security Institute. *International Family Planning Perspectives* 25(1): 21-26, 1999.

Huber SC and Harvey PD. Family planning programmes in ten developing countries: cost effectiveness by mode of service delivery. *Journal of Biosocial Science 21*:267-277, 1989.

Janowitz B, Nunez J, Covington D, Colven C. Why women don't get sterilized: a follow-up of women in Honduras. *Studies in Family Planning 16* (2):106-112, 1985.

Janowitz B, Chege J, Thompson A, Rutenberg N, and Homan R. Community-based distribution in Tanzania: Costs and impacts of alternative strategies to improve worker performance. International Family Planning Perspectives 26(4): 193-195, 2000.

Knodel H, Bennett T, Panyadilok S. Do free pills make a difference. Thailand's experience. *International Family Planning Perspectives 10* (3):93-97, 1984.

Lande RE and Blackburn R. Pharmacists and family planning. *Population Reports* Series J, Number 37. Baltimore, MD: The Johns Hopkins University Center for Communication Programs, November 1989.

Lande RE and Geller JS. Paying for family planning. *Population Reports* , Series J, Number 39. Baltimore, MD: The Johns Hopkins University Center for Communication Programs, November 1991.

Lewis MA. Do contraceptive prices affect demand. *Studies in Family Planning 17*(3):126

Lewis MA. Cost recovery in family planning. *Economic Development and Cultural Change* 35 (1):161-182, October, 1987.

Mitchell MD, Littlefield J, and Gutter S. Costing reproductive health services. *Internatonal Family Planning Perspectives.* 25 (Supplement): S17-S21 & S29, 1999.

Population Information Program. Contraceptive social marketing: lessons from experience. *Population Reports* Series J, Number 30. Baltimore, MD: The Johns Hopkins University Center for Communication Programs, July-August 1985.

Robinson W, Cleland J. The Influence of Contraceptive Costs on the Demand for Children. Pages 106-122 in JF Phillips and JA Ross (eds) *Family Planning Programs and Fertility.* New York: Clarendon Press Oxford, 1992.

Ross JA and Isaacs SL. Costs, payments, and incentives in family planning programs: a review for developing countries. *Studies in Family Planning 19* (5):270-283, September/October 1988.

Sheon A, Schellstede W, and Derr B. Contraceptive social marketing. Pages 367-390 in RJ Lapham and GB Simmons (eds) *Organizing for Effective Family Planning Programs* . Washington, D.C.: National Academy Press, 1987.

Simmons GB, Baik D, and Faiz KK. A cost effectiveness analysis of family planning programs in rural Bangladesh: evidence from Matlab. *Studies in Family Planning* 22 (2): 83-101, 1991.

Thapa S, Abeywickrema D, and Wilkens LR. Effects of compensatory payments on vasectomy acceptance in urban Sri Lanka: a comparison of two economic groups. *Studies in Family Planning 18* (6):352-360, November/December, 1987.

Tsui AO and Donaldson PJ. The role of private physicians and clinics in Third World family planning. Pages 391-411 in RJ Lapham and GB Simmons (eds) *Organizing for Effective Family Planning Programs* . Washington, D.C.: National Academy Press, 1987.

Vach TH, Bishop A, Hoa VT, Hien LX, Chien TD, and Nguyen TI. The potential impact of introducing pregnancy testing in menstrual regulation services in Vietnam. *International Family Planning Perspectives* 24(4): 165-169, 1998.

Winfrey, W, Healton, L, Fox, T, Adamchak, S. Factors Influencing the Growth of the Commercial Sector in Family Planning Service Provision. *Working Paper Series No. 6,* The POLICY Project, 2000. http://www.policyproject.com/pubs/workingpapers/wps-06.pdf

Paying for Family Planning Costs, Cost Recovery, and Cost-effective Investment Strategies

Family Planning Policies and Programs

W.
Henry
Mosley

Essential Definitions

Costs versus Prices

Cost-benefit versus Cost-**effectiveness**

Why Subsidize Family Planning Services.

- Fertility control has social benefits as well as individual benefits
- Individual demand for family planning services is constrained by resources (material and non-material)
- Free markets cannot meet social welfare objectives

What has been the historical pattern of public sector contraceptive pricing and subsidies.

See the following slides.

What is the experience with social marketing.

Definition: the design, implementation, and control of programs calculated to influence the acceptability of a social idea and involving considerations of product planning, pricing, communications, distribution, and

market
research.

Social Marketing

1. Contraceptive social **marketing:**
   a. uses existing commercial/retail channels
   b. subsidizes prices and recovers partial costs to:
      - achieve high distribution
      - reach low income groups

Social Marketing Issues

1. Management must fit local **circumstances**(examples of managers)
   - family planning organizations
   - private sector organizations established specifically for CSM
   - quasi-governmental agencies

-
government
agencies

Social Marketing Issues

2. Potential customers
   - market segmentation
3. Products
   - condoms, orals, spermicides, IUDs, injectables
4. Pricing
   - a balance between assuring wide availability, retailer profitability and cost recovery
5. Promotion
   - promote products (brands) and providers

- target promotion to consumers and providers
- continuous promotion

Social Marketing Issues

6. Evaluation measures

-sales

- couple-year-of-protection (CYP)

  - coverage

  - cost/CYP

What Are the Financial Issues of Concern.

- Program sustainability in the presence of:
  - Rapidly growing demand for contraception
  - Diminishing donor support
  - Constrained national budgets
  - Competing priorities
- Demand for program accountability
  - Growing interest in evidence-based decision making

Need for performance improvement indicators

Case Study

Impact of Contraceptive Social Marketing (CSM) on Contraceptive Prevalence and Cost in Honduras by Janowitz, et al., SFP 1992: 2, pp 110-117.

Key point: Introducing CSM may not make an NGO program more efficient if:

- Community-based distribution (CBD) users switch to CSM but CBD program still expands
- Private sector users switch to CSM

What are the user costs.

Search costs for information

Time costs

Method variety costs (not getting choice)

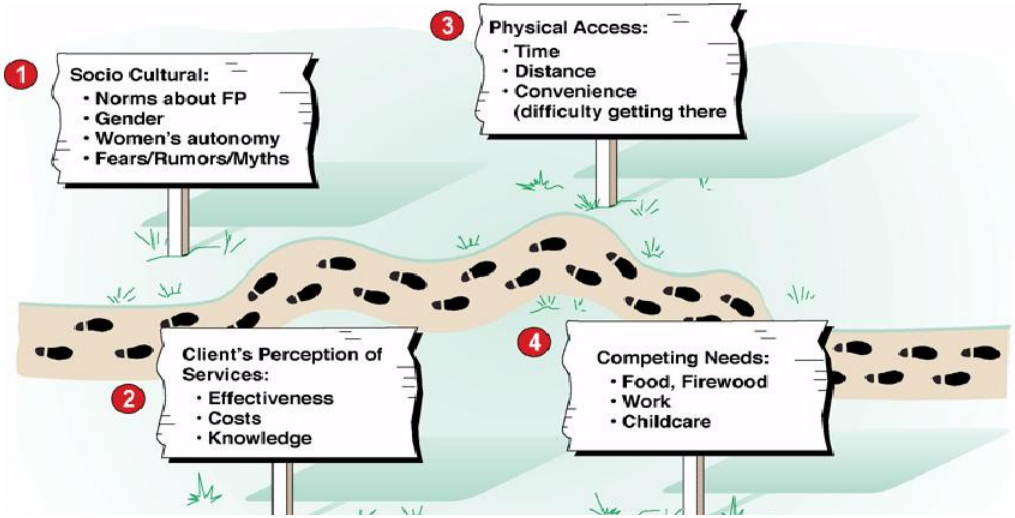
Administrative costs

Social/cultural costs

Health and psychic costs

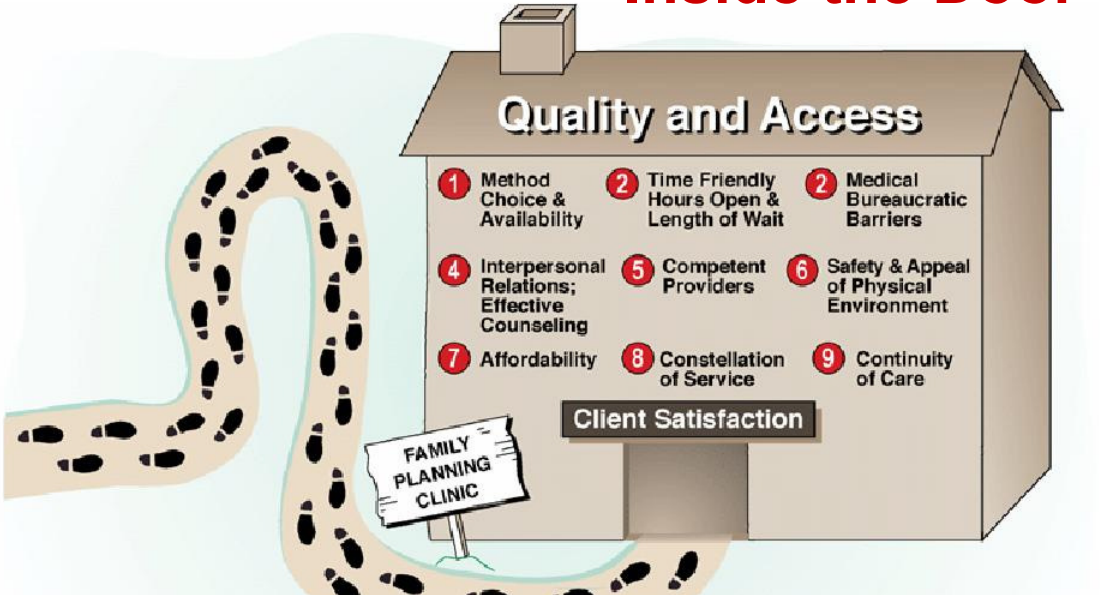
Monetary costs

The Clients Perspective: Getting to the Door



(Source: http://www.maqweb.org)

The Clients Perspective: Inside the Door



(Source: http://www.maqweb.org)

What is the Elasticity of Demand to Price Change.

Definition: The price elasticity of demand for a good is the proportional change in the quantity demanded of the good relative to the proportional change in the price.

Example: Matheny (2004) cites 5 studies of the overall price elasticity of demand for contraceptives which showed elasticities in the range of 0 to 0.15. That is, for every 100% increase in the mean price of contraceptives, the contraceptive use decreased by

contraceptive use decreased by
0% to 15%.

Elasticity of Contraceptive Demand to Price Changes

Sources of variation:

- Type of contraceptive
- Initial price vs. cumulative costs
- The role of substitutes
- Non-monetary costs
- Economic situation

Perceptions of value

Key Points Regarding Contraceptive Costs and Prices

1. Costs of service delivery vary widely:
   a) across countries
   b) by program strategy within countries
2. Prices to consumers for services vary widely from very high to negative (subsidies).
3. Consumer uptake of services is price sensitive, but has never been systematically studied.

Key Points Regarding Contraceptive Costs and Prices

4. Empirical observations of price elasticity indicate that:

a) As prices go up

- overall uptake may go down, but elasticity is sensitive to many external factors
- poorer consumers may drop out with high prices

b) Negative prices (subsidies) are an inducement to poor consumers *(What are the ethical issues.)*

What is cost-effectiveness of alternative strategies to promote contraceptive use.

The low elasticities of contraceptive demand with contraceptive price subsidies (as summarized above) lead to an estimate of $61 per couple year of protection in Indonesia, if investments are just made in price subsidies.

Media campaigns in Egypt, Turkey, and Zimbabwe have given estimates of $3.26, $1.36 and $3.57 per CYP.

Strategies to improve quality appear to be very cost-effective, but good empirical data

cost effective, but good empirical data are lacking.

Ref. Matheny, 2004

Conclusion

Programs should conduct marketing research to identify local barriers to contraceptive use and determine the most cost-effective ways to lower these barriers.

The Keys to ProgramSustainability

(Resource Allocation, Not Cost-Recovery)

1. Cost-benefit analyses to compete for funds across all development sectors in national budgets.
2. Cost-effectiveness analyses to compete for funds *among alternative health sector investments in* MOH budgets (e.g., using DALYs).
3. Cost-effectiveness analyses within the FP program to best allocate funds among alternative service delivery program strategies (e.g., using CYP)
4. Cost-accounting analyses in every service delivery program to

program to maximize efficiencies.

PFHS-380.665 FAMILY PLANNING POLICIES AND PROGRAMS

Ethical Issues in Population Policy

W. Henry Mosley

Over the last three decades many papers have appeared dealing with a wide range of ethical issues concerned with population policy. These concern not only fertility control in the context of family planning, but also a broader range of topics extending from migration to euthanasia. This discussion session will look broadly at the concerns with human rights and reproductive choice, and then focus on the ethics of incentives and disincentives in influencing family size and contraceptive behavior.

1. Human Rights and Reproductive Choice

The article by Freedman and Isaacs (1993) places the right of reproductive choice in legal and historical contexts, and specifically examines two key issues: the tension between demographic priorities and reproductive choice, and the tension between international standards and local custom/religion. The following are questions to discuss in reviewing this article:

1. Why do the authors introduce their article with the notion that health policies and programs cannot treat reproduction as mere mechanics, as isolated biological events of conception and

isolated biological events of conception and birth, rather they must treat it as a lifelong process inextricably linked to the status and roles of women it their homes and societies. Specifically, what does this mean for health professionals. Give examples.

2. What basic principles do the authors distill from a women-centered approach to reproductive health.
3. Trace chronologically the connections between human rights and reproductive rights as these evolved in international declarations, statements, resolutions, conventions and treaties since World War II.
4. The authors list 5 kinds of incentives/disincentives often used in population and family planning programs and then say that incentives can be analyzed from a number of different perspectives and give 9 examples. Give your views on examples 4, 5, and 7.
5. The authors observe the fact that in many developing countries, particularly Muslim states in South Asia and sub-Saharan Africa, there is a more complex interplay of state, religious and customary law. What are some consequences of this.
6. With reference to the issues raised in question 5, the authors identify the promotion of womens reproductive autonomy as a central value as the a central question in the development of a reproductive health strategy. Without disagreeing with the authors, can you identify any other values that that should also be taken into account in the development of a reproductive health strategy.

2. Incentives, Disincentives and Reproductive Choice

The article by Warwick (1990) has been selected because it provides a brief but useful overview of many of the key issues surrounding the use of incentives and or disincentives along with references to many case studies. The article is instructive in that it approaches these issues from an ethical perspective. It is important to note that this article provides only the briefest summary of a very extensive literature, primarily from the perspective of one author. Students interested in exploring these issues in depth are referred to the original articles cited and critiqued by Warwick. Questions 1- 5 should be answered as you study Warwick's article.

1. What is the relationship between how the "population problem" is defined and the government actions that may follow.
2. What are the two broad approaches that are generally taken in studies on the ethics of population control.
3. Describe the five ethical principles that Warwick uses in his analysis of the issues.
4. What are some conditions that must be present if women are to truly have "free choice" in choosing a contraceptive method.
5. How can incentive payments to persons who accept contraceptives actually limit freedom and violate justice.

6. Can government pressure to limit family size for socio-economic reasons be justified as actually liberating women from family and community pressures to marry early and restrict their role to childbearing and childrearing.
7. Can coercive measures for population control ever be ethically justified. Why or why not.

Isaacs (1995) also addresses the ethical issue of incentives. This article follows his earlier article with Freedman that is discussed above, and also follows three world conferences dealing with human rights/womens rights/reproductive rights held in 1993, 1994 and 1995. Answer the following questions, referring to Isaacs article:

1. What three world conferences does Isaacs refer to, and what are the conflicts in values that have arisen.
2. Are Isaacs 5 principles related to restricting reproductive choice in accord with Warwick's 5 ethical principles. Why or why not.
3. In the section on Next Steps Isaacs raises the question of who should determine the standards What is the problem of depending upon a group of people to set universal ethical standards. What are the alternatives.

Required Readings:

Freedman LP, Isaacs SL. Human rights and reproductive choice. Studies in *Family Planning 24(1):18-30, January/February 1993.*

Isaacs S. Commentary. Incentives, population policy, and reproductive rights: ethical issues. Studies in Family Planning 26(6): 363-367, 1995.

Warwick, Donald P. The Ethics of Population Control. In Godfrey Roberts (ed) *Population Policy: Contemporary Issues. New York, Westport, London:* Praeger, 1990.

Recommended Readings:

Archives: Judith Blake on fertility control and the problem of voluntarism. *Population and Development Review 20* :167-177, 1994.

Berelson B, Lieberson J. Government efforts to influence fertility: the ethical issues. *Population and Development Review 5* (4):581-613, 1979.

Boland R, Rao S, Zeidenstein G. Honoring human rights in population policies: from declaration to action. Pages 89-106 in G Sen, A Germain, LC Chen (eds) *Population Policies Reconsidered: Health, Empowerment and Rights* . Boston, MA: Harvard University Press, Harvard Series on Population and International Health, 1994.

Cleland J, Robinson W. The Use of Payments and Benefits to Influence Reproductive Behavior. Chapter 9, pages 159-177 in JF Phillips and JA Ross (eds) *Family Planning Programmes and Fertility* . Oxford: Clarendon Press, 1992.

Cooney, RS and Li, J. Sterilization and financial penalties imposed on registered peasant couples, Hebei Province, China. *Studies in Family Planning* 32(1): 67-78, 2001.

David HP. Incentives, reproductive behavior, and integrated community development in Asia. *Studies in Family Planning 13* (5):159-173, May 1982.

David HP. Incentives and Disincentives in Family Planning Programs. Pages 521-542 in RJ Lapham and GB Simmons (eds) *Organizing Effective Family Planning Programs* . Washington, D.C.: National Academy Press, 1987.

Ethics and Global Population. *Report from the Institute for Philosophy & Public Policy 13* (4), College Park, MD: School of Public Affairs, University of Maryland, Fall 1993

Ethics and Human Values in Family Planning. In: Z Bankowski, J Barzelatto, AM Capron (eds) of XXII CIOMS Conference (highlights, papers, and discussion) Bangkok, Thailand, 19-24 June 1988.

Finkle JL, and McInntosh CA, eds. The New Politics of Population: Conflict and Consensus in Family Planning . *Population and Development Review* (20) Supplement, 1994.

Greenhalgh S. The evolution of the one-child policy in Shaanxi Province, 1979-88. Working Paper No. 5, New York: Population Council, 1989.

Hardin, Garrett. The Tragedy of the Commons. Pages 11-16 in Reining and Tinker (eds) *Population: Dynamics, Ethics, and Policy.* Washington, D.C.; American Association for the Advancement of Science, 1975.

Klitsch M. The bumpy road from Cairo to now and beyond. *International Family Planning Perspectives* 25 (4):196-199, 213, 1999.

Legal Analysis and Population Control: The Problem of Coercion. *Harvard Law Review 84*(8):1856-1911, June 1971.

Ross JA and Isaacs SL. Costs, payments, and incentives in family planning programs: a review for developing countries. *Studies in Family Planning 19* (5):270-283, September/October 1988.

Satia JK and Maru RM. Incentives and disincentives in the Indian Family Welfare Program. *Studies in Family Planning 17* (3):136-145, 1986.

Stoeckel J, Fisher AA, Viravaidya M, and Pattalung RN. Maintaining family planning acceptance levels through development incentives in northeastern Thailand. *Studies in Family Planning 17* (1):36-43, January/February 1986.

United Nations. Principles. In: *Report of the International Conference on Population and Development, Cairo, September 5-13, 1994* . New York: United Nations Population Division, 1994.

UNFPA, *The State of the World Population. Report 1997. The Right to Choose: Reproductive Rights and Reproductive Health.* New York: United Nations, 1997.

PFHS 380.665 FAMILY PLANNING POLICIES AND PROGRAMS

Case Studies - Incentives, Disincentives and Coercion in Family Planning

W. Henry Mosley

Introduction

Government intervention in fertility behavior of a population is considered when there is a divergence between the level of fertility that may be considered in the best interests of individuals *versus* the best interests of the society. Note that this may lead to governmental actions that are either pronatalist or antinatalist. Here we focus on antinatalist incentives.

Incentives or disincentives are usually in the form of payments (compensation) or taxes and, and may be considered as an "adjustment" for the economic benefits or costs of having or not having children. Coercion involves the direct government intervention in a couples reproductive life, typically enforced with stringent penalties. There is an extensive literature on the ethical issues related to incentives, disincentives and coercion in population policy that will be addressed later in this course. For this session, there are two case studies, one from Bangladesh and one from China.

studies, one from Bangladesh and one from China,
looking at contrasting approaches to the issue of incentives, disincentives and coercion in population policy.

The following questions are to guide your reading and for class discussion of the Bangladesh case study:

1. What is the difference between incentive payments and compensation payments, and why is this an issue for family planning programs.
2. What was the study design for the Bangladesh case study. Why did the investigators consider a case-control study to be necessary.
3. Cleland and Mauldin viewed cash payments to family planning acceptors as raising four distinct issues relating to informed consent, motive, access and satisfaction. What were their findings in regard to each of these issues.
4. What ethical issues do the authors see arising out of making payments - to acceptors. - to agents.
5. What did the authors conclude, and what did the donors subsequently do.
6. Based on the additional charts showing trends in contraceptive acceptance and use in Bangladesh, what have been the consequences of changing the incentive structure. Is this good or bad. Explain.

The following questions are to guide your reading for the China case studies:

A. Short and Fengying article

1. **How has the one-child policy evolved in China, and why would one** expect there to be local variations in enforcement.
2. **How were data obtained for this study.**
3. **Under what conditions were local exceptions made to the one** child policy. Were local changes in these exceptions rare or common.
4. **What incentive and disincentives were used to encourage** compliance with the one-child policy. Which were used more incentives of disincentives, and why.
5. **Do the authors raise andy ethical issues. Why or why not.**

B. Ping and Smith article:

1. **What is the evidence that abortion plays an important role in** Chinas family planning program.
2. **How were the data gathered for this study.**
3. **Why were the three factors sex of the first child, the womans age** at pregnancy, and the length of the index birth-second pregnancy

interval - the major determinants of the probability of abortion. (How did this relate to policy.)

4. **What ethical questions were raised in this study, and how do you** believe they can be resolved.

Class Discussion Readings:

Cleland J and Mauldin WP. The promotion of family planning by financial payments: the case of Bangladesh. Studies in Family Planning 22(1):1-18, January/February 1991.

Ping, T and Smith, HL. Determinants of induced abortion and their policy implictions in four counties in north China. Studies in Family Planning 26 (5):278-286, 1995.

Short SE and Fengying Z. Looking locally at Chinas one-child policy. Studies in *Family Planning 29(4): 373-387, 1998.*

Recommended readings

Archives: Judith Blake on fertility control and the problem of voluntarism. *Population and Development Review 20* :167-177, 1994.

Cleland J, Robinson W. The Use of Payments and Benefits to Influence Reproductive Behavior. Chapter 9, pages 159-177 in JF Phillips and JA Ross (eds) *Family Planning Programmes and Fertility* . Oxford: Clarendon Press, 1992.

David HP. Incentives, reproductive behavior, and integrated community development in Asia. *Studies in Family Planning 13* (5):159-173, May 1982.

David HP. Incentives and Disincentives in Family Planning Programs. Pages 521-542

in RJ Lapham and GB Simmons (eds) *Organizing Effective Family Planning Programs* . Washington, D.C.: National Academy Press, 1987.

Greenhalgh S. The evolution of the one-child policy in Shaanxi Province, 1979-88. Working Paper No. 5, New York: Population Council, 1989.

Isaacs S. Commentary. Incentives, population policy, and reproductive rights: ethical issues. *Studies in Family Planning 26* (6): 363-367, 1995.

Junhong, Chu. Prenatal sex determination and sex-selective abortion in rural China. *Population and Development Review* 27(2): 259-281, 2001.

Kaufman J. The cost of IUD failure in China. *Studies in Family Planning* 24 (3): 194-196, 1993.

Kaufman J, Zhirong Z, Xinjian Q, Yang Z. The quality of family planning services in rural China. *Studies in Family Planning* 23 (2): 73-84, 1992.

Ping T. IUD discontinuation patterns and correlates in four counties in north China. *Studies in Family Planning* 26 (3): 169-179, 1995.

Satia JK and Maru RM. Incentives and disincentives in the Indian Family Welfare Program. *Studies in Family Planning 17* (3):136-145, 1986.

Stoeckel J, Fisher AA, Viravaidya M, and Pattalung RN. Maintaining family planning acceptance levels through development incentives in northeastern Thailand. *Studies in Family Planning 17* (1):36-43, January/February 1986.

PFHS 380.665 Family Planning Policies and Programs

Gender Relations and Family Planning

W. Henry Mosley

A. An evolution in thinking about reproductive health (Drennan, et al., 1998)

More attention is being given to men and couples in reproductive health programs in recent years for a variety of reasons including:

- Growing concern about the spread of HIV/AIDS and other STDs
- Evidence of the ill effects of some mens risky sexual behavior on the health of women and children
- Survey findings that many men approve of family planning
- Greater recognition that in many cultures man make decisions that affect womens reproductive health as well as their own.
- Increasing awareness that gender mens and womens differing social roles and power associated with these roles affects sexual behavior, reproductive decision making and reproductive health in many different ways
- Demands from female health care

Demands from female health care clients that men become more involved and included in family planning and other reproductive health care

B. Mens family planning knowledge, attitudes and practices

C. Gender relations, couple communication and family planning practices

Couple discord and unmet need
Covert contraceptive practice

D. Case Studies

The case studies given here were selected from a large literature to give some recent practical illustrations of problems and issues that confront family planning service delivery programs in different countries, and how these are identified, analyzed and interpreted. You are encouraged to read all of the required case studies, however, for the class discussion, each group is required to read only one and be prepared to present the findings to the class.

The case assignments for each group are given on a separate **Assignment Sheet.**

Required Readings:

Bawah, AA, Akweongo, P, Simmons, R, and Phillips, JF. Women's fears and men's anxieties: the impact of family planning on gender relations in Northern Ghana. Studies in Family Planning 30 (1): 54-66, 1999.

Biddlecom, AE and Fapohunda BM. Covert contraceptive use: prevalence, motivations and consequences. Studies in Family Planning 29(4): 360-372, 1998.

Pallilto, CC and OCampo, P. The relationship between intimate partner violence and unintended pregnancy in Colombia. International *Family Planning Perspectives 30(4): 165-173, 2004.*

Ratcliff AA, Hill AG, Walraven G. Separate lives, different interests: male and female reproduction in the Gambia. Bulletin of the World Health Organization 78(5): 570-579, 2000.

Recommended Reference:

Blanc, AK. The effect of power and sexual relationships on sexual and reproductive health: an examination of

Family Planning Studies 32(3): 189-213, 2001.

Recommended:

Bankole A. Desired fertility and fertility behavior among the Yoruba of Nigeria: a study of couple preferences and subsequent fertility. *Population Studies* 49 (2): 317-328, 1995.

Bankole A, and Singh, S. Couple's fertility and contraceptive decision making in developing countries: Hearing the man's voice. *International Family Planning Perspectives* 24 (1): 15- , 1998.

Bawah, AA. Spousal communication and family planning behavior in Navrongo: a longitudinal assessment. *Studies in Family Planning* 33: 185-194, 2002.

Becker, S. Couples and reproductive health: A review of couple studies. *Studies in Family Planning* 27 (6): 291-306, 1996.

Becker, S, and Robinson, JC. Reproductive health care services oriented to couples. *International journal of Gynecology and Obstetrics* 61 (3): 275-81, 1998.

Becker, S. Measuring unmet need: Wives, husbands or couples. *International Family Planning Perspectives* 25 (4): 175-180, 1999.

Castle, S, Konate, MK, A qualitative study of clandestine contraceptive use in urban Mali. *Studies in Family Planning* 30 (3): 231-248, 1999.

Drennan, M. Reproductive Health: New Perspectives on Men's Participation. *Population Reports* , Series J, No. 46. Population Information Program, Johns Hopkins University School of Public Health. October, 1998

Ezeh AC. The influence of spouses over each other's contraceptive attitudes in Ghana. *Studies in Family Planning* 24(3):163-173, 1993.

Ezeh AC, Seroussi M and Raggers H. Men's fertility, contraceptive use and reproductive preferences. *DHS Comparative Studies No. 18.* Macro International, Calverton, MD, 1996.

Greene, ME and Biddlecom, AE. Absent and problematic men: Demographic accounts of male reproductive roles. *Working Papers No. 103,* Policy Research Division, The Population Council, NY, 1997.

Jejeebhoy, SJ. Convergence and divergence in spouses perspectives on womens autonomy in rural India. *Studies in Family Planning* 33: 299-308, 2002.

Mason, KO and Taj, AM. Differences between women's and men's reproductive goals in developing countries. *Population and Development Review* 13(4): 611-638, 1987.

Mbizvo MT, and Adamchak DJ. Family planning knowledge, attitudes and practices of men in Zimbabwe. *Studies in Family Planning* 22 (1): 31-38, 1991.

Varga, CA. How gender roles influence sexual and reproductive health among South African adolescents. *Studies in Family Planning* 34 (3): 160-172, 2003

Wegner, MN, Landry, E., Wilkinson, D and Tzanis, J. Special Report. Men as partners *International*

in ... *Perspectives* 24 (1): 38-42,1998.

Wolfe B, Bland AR, Ssekamatte-Ssebuliba J. The role of couple negotiation in reproductive health ... *Family Planning* unmet need for contraception and the decision to stop childbearing in Uganda. *Studies in Family Planning* 31 (2): 124-137, 2000.

PFHS 380-665 FAMILY PLANNING POLICIES AND PROGRAMS

Community-Based Distribution
Pakistan, Bangladesh and Africa

Henry Mosley

Introduction

Community-based distribution (CBD) is one method of family planning service provision that has been used for over three decades to reach populations with limited access to information and contraceptives (Huber, et al, 1975; Kols and Wawer, 1982; Wawer, et al., 1985). Most of the early experiences in the 1970's and 1980's in Asia and Latin America were generally successful, primarily because there was a growing demand for smaller families that was not being met with clinic-based services (Ross, et al., 1987).

The article by Shelton, et. al (1999), summarizing recent experiences in Pakistan, is illustrative of how CBD programs can be effective in a setting where there is dormant demand for actual contraceptive services waiting to be satisfied. Answer the questions below as you read this article:

1. **How would you describe the design of the data gathering process for this** report. What are its strengths and weakness. How would you improve it.
2. **What are the authors major conclusions. Are they supported by the** available data.
3. **What is the significance of this study for Pakistan. For other developing** countries.

In recent years, there has been a shift away from CBD in well established programs for several reasons, but mostly because of the relatively high monetary and management costs of maintaining a large cadre of field workers. Making this shift has not been easy however, because of concerns that a change in program strategy would result in a fall off in contraceptive acceptors and users. This question was specifically addressed in a study by Routh, et al. in Bangladesh (2001). As you read the article, consider the following questions:

1. **What were the hypotheses that the authors were testing.**
2. **What were the findings of the research, and how do the authors interpret** these in terms of program prospects for the future.

More recent experiences with CBD in sub-Saharan Africa have shown a mixed record (see for example, Chege and Askew, 1997). A comprehensive and critical analysis of the experiences with community-based distribution of family planning in Africa has recently been completed by Phillips, Greene and Jackson (1999). The questions below

are provided as a guide for reading the attached article and class discussion.

1. **How do the authors define CBD. What kinds of services may be provided.** Who are the providers and how are they organized.
2. **What are fundamental assumptions underlying CBD programs.**
3. **In Africa, what is the evidence that CBD programs: increase contraceptive** use; reduce fertility; reduce unmet need; increase demand for contraception; or improve the status of women.
4. **What is meant by Type I, Type II and Type III CBD programs. What** assumptions underlie each of these types, and what are the organizational issues.
5. **What are three possible roles for the impact of CBD on reproductive** behavior.
6. **What are the concerns regarding CBD as they relate to "social costs" and** "constrained demand".
7. **What are the principles lessons learned from case studies in: Kenya; Nigeria;** Zimbabwe; and Ghana.
8. **Elements of successful CBD management are ---**
9. **Factors contributing to CBD failure are ---**

Required reading (attached):

Phillips JF, Greene W, and Jackson EF. Lessons from Community-based

Distribution of Family Planning in Africa, Working Paper No. 121, Policy Research Division, Population Council, New York 1999.

Routh, S, Ashraf, A, Stoekel, J, and Barkat-e-Khuda. Consequences of the shift from domiciliary distribution to site-based family planning services in Bangladesh. International Family Planning Perspectives 27(2): 82-89, 2001

Shelton JD, Bradshaw L, Hussein B, Drexler T, and McKenna MR. Putting unmet need to the test: community-based distribution of family planning in Pakistan. International Family Planning Perspectives 25 (4): 191-195, 1999.

Recommended readings:

Bates, LM, Islam, MK, Al-Kabir, A, and Schuler, SR. From home to clinic and from family planning to family health: client and community responses to health sector reforms in Bangladesh . *International Family Planning Perspectives* 29 (2): 88-94, 2003.

Binka,FN, Nazzar A, and Phillips JA, The Navrango community health and family planning project, *Studies in Family Planning* 26(3): 121-139, 1995.

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Huber SC, Piotrow P, Potts M, Isaacs SL and Ravenholt, RT, Contraceptive Distribution: Taking Supplies to Villages and Households, *Population Reports* Series J, No. 5, 1975.

Kaler, A, Watkins, SC. Disobedient distributors: street-level bureaucrats and would-be patrons in community-based family planning programs in rural Kenya. *Studies in Family Planning* 32(3): 254-269, 2001.

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Nazzar A, Adongo PB, Binka FN, Phillips JE, Debpuur C. Developing a culturally appropriate family planning program for the Navrongo experiment. *Studies in Family Planning 26* (7): 307-324, 1995.

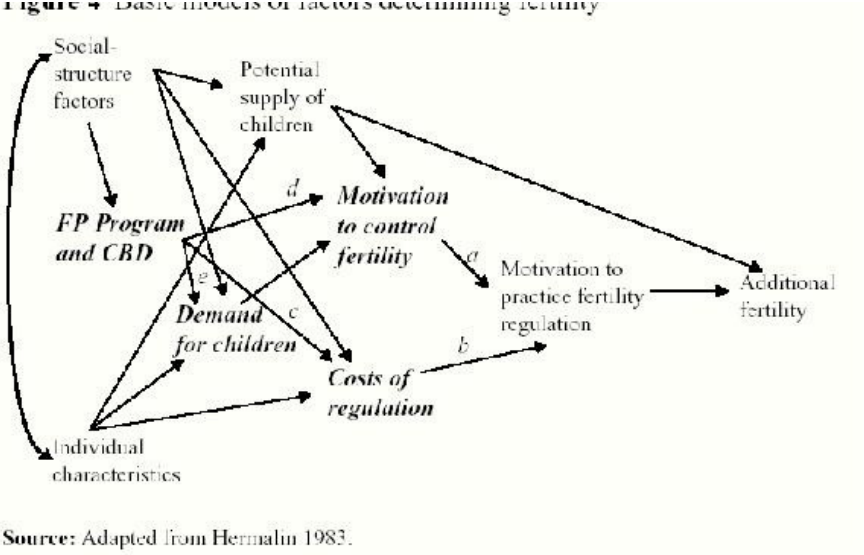
Wawer M, Huffman S, Cebula D, and Orborn, R, eds. *Health and Family Planning in Community-Based Distribution Programs.* Westview Press, Boulder, CO, 1985.

Ross J, Lauro D, Wray J, and Rosenfield A, "Community based distribution" In *Organizing for Effective Family Planning Programs* , eds RJ Lapham and GB Simmons, National Academy Press, Washington, D.C., 1987.

Schuler, SR, Bates, LM, and Islam, MK. The persistence of a service delivery culture: findings from a qualitative study in Bangladesh. *International Family Planning Perspectives* 27(4): 194-200, 2001.

The Potential Roles of CBD Programs in the Fertility Transition

Figure 4. Basic models of factors determining fertility



Source: Adapted from Hermalin 1983.

(Source: Phillips, et al., 1999)

PFHS 380.665 FAMILY PLANNING POLICIES AND PROGRAMS

Integration of Family Planning with Health Services

W. Henry Mosley

A. Definitions

1. **Integration** - brings previously separated and independent functions or organizations into a **unitary structure**, with loss of previous identities.

2. **Coordination** - alters and smoothes **relationships** of continuing **independent** organizations/staffs/resources.

B. Examples

1. Mergers of pre-existing family planning agencies and health programs
   a. Administrative integration - at the top (planning)
   b. Service integration - at the bottom (physical and/or functional)

2. Add selected health services to a family planning program

3. Fully combine the delivery of health, MCH and FP services

C. Rationales

1. For integration
    a. Political
    b. Economic
        for health programs
        for family planning programs
    c. Health benefits
        direct
        synergistic
        resource savings
    d. Family planning benefits

2. Against integration
    a. Loss of "visibility" of family planning
    b. Service tasks are more complex
    c. Management/training more complex
    d. Work overload diffuses impact (competing priorities)
    e. Results difficult to monitor
    f. Family planning resources dissipated

D. Case Studies

1. Effective integration -- congruence and efficiencies
    a. **Global** - adding family planning to maternity/postpartum care (Castadot, et al.)

b. **Thailand** -- add family planning to midwifery programs (demedicalization of contraception) (Rosenfield)
c. **Indonesia** -- add child survival interventions to a family planning program (Sumbung)
d. **Bangladesh** (Matlab) -- add maternal and child health to family planning program (DeGraff, et al.; Phillips, et al.)
e. **Chile** -- introduce family planning in health care systems to reduce abortion mortality (Armijo and Monreal)
f. **Mexico** -- add family planning to health systems as a cost-effective intervention (Nortman, et al.)
g. **Malaysia** -- integration of MCH (MOH) and NFP Board)
h. **Togo** - add family planning to an immunization program (Huntington)

2. Ineffective integration -- competition and rivalries
   a. **India** -- the multipurpose worker (MPW) scheme
      -- the community health worker (CHW) scheme(Simmons and Phillips)
   b. **Bangladesh** -- the integration of the national family planning program into the Ministry of Health (Feldman)

E. Issues regarding integration of STI and HIV Services with Family Planning

1. An entire issue of International Family Planning Perspectives (Vol. 28, no. 2, June 2002) deals with these issues. (See http://www.guttmacher.org/journals/toc/ifpp2802toc.html)

2. Some concerns are:
   a. In many settings FP clients are not at highest risk for STDs, HIV
   b. FP clinics do not effectively reach at risk groups such as males, unmarried sexually active persons, adolescents, etc.
   c. Most females with STIs are asymptomatic and practical diagnostic tests are not available
   d. FP services are mostly not set up for diagnosis, treatment and follow up of STI and HIV cases, including partner follow up.
   e. Providing such services may be far beyond the qualifications of staff and budget of the FP service delivery unit

3. Major recommendation integrate with FP services into HIV and STI service delivery programs

F. Costs and Benefits of Integration

1. Basic issues: effectiveness - efficiency - equity

2. Questions to consider
   a. **Who** are the clients.
   b. **What** services are being provided (for what conditions).

c. **Where** are the services being delivered.
. clinics
. community/not-for-profit sector
. commercial/for-profit sector
d. **How** are the services being managed.
e. **How** will services be financed.
f. **How** will performance be monitored.

Required Readings:

Dehne KL, Snow R, OReilly KR. Integration of prevention and care of sexually transmitted infections with family planning services: what is the evidence for public health benefits. Bulletin of the World health Organization 78(5): 628-639, 2000

Stewart JF, Stecklov G and Adewuyi, A. Family planning program structure and performance in West Africa. International Family Planning Perspectives 25 (Supplement): S22-S29, 1999

Recommended:

Aitken I and Reichenbach L. Reproductive and sexual health services: expanding access and enhancing quality. In: Gita Sen, Adrienne Germain and Linclon Chen, Population Policies Reconsidered. Health, Empowerment and Rights. Chapter 13, pp.177-192, Harvard Series on Population and International Health,

Cambridge: Harvard University Press, 1994.

Armijo R and Monreal T. Epidemiology of provoked abortion in Santiago, Chile. Pages 137-160 in M Muramatsu and P Harper (eds) Population Dynamics. Baltimore, MD: Johns Hopkins Press, 1965.

Begley CE, McGill L, Smith PB. The incremental cost of screening, diagnosis and treatment of gonorrhea and chlamydia in a family planning clinic. Sexually *Transmitted Diseases 16:63-67, 1989.*

Castadot RG, Sivin I, Reyes P, Alers JO, Chappel M and Russell J. The international post partum family planning program: eight years of experience. Reports on *Population/Family Planning No. 18:1-56, 1975.*

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Feldman S. Overpopulation as crisis: redirecting health care services in rural Bangladesh. International Journal of Health Services 17:113-132, 1987.

Files, Laurel A. A re-examination of integrated population activities. Studies in Family *Planning 13(10):297-302, October 1982.*

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Foreit, KF, Hardee, K, and Agarwawl, K. When does it make sense to consider integrating STI and HIV services with family planning services. International *Family Planning Perspectives 28: 105-107, 2002.*

Hardee K and Yount K. From Rhetoric to Reality: Delivering Reproductive Health *Promises Through Integrated Services. Family Health International Working* Papers, No. WP-95-01, Research Triangle Park: Family Health International, 1995.

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Helzner, JF. Transforming family planning services in the Latin American and Caribbean region. Studies in Family Planning 33: 49-60, 2002.

Huntington D, Aplogan A. The integration of family planning and childhood immunization services in Togo. Studies in Family Planning 25(3):176-183, 1994.

Ickis J. Structural issues related to delivery systems. Pages 145-160 in RJ Lapham and GB Simmons (eds) Organizing for Effective Family Planning Programs. Washington, D.C.: National Academy Press, 1987.

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Kols AJ and Wawer M. Community-based health and family planning. Population *Reports, Series L, No. 3. Baltimore, MD: Johns Hopkins University Population* Information Program, 1982.

Lush, L. Service integration: an overview of policy developments. International Family *Planning Perspectives 28: 71-76, 2002.*

Mitchell M (ed). Managing integrated services. The Family Planning Manager III(3):1-22, May-June 1994.

Mosley WH and Siragеldin I. Effects of family planning on improving efficiency and effectiveness of health services. Paper prepared for the conference Better Health for Women and Children through Family Planning, October 5-9, 1987, Nairobi, Kenya, 1987.

Nortman DL, Halvas J, Rabago A. A cost-benefit analysis of the Mexican Social Security Administration's family planning program. Studies in Family Planning *17(1):1-6, 1986.*

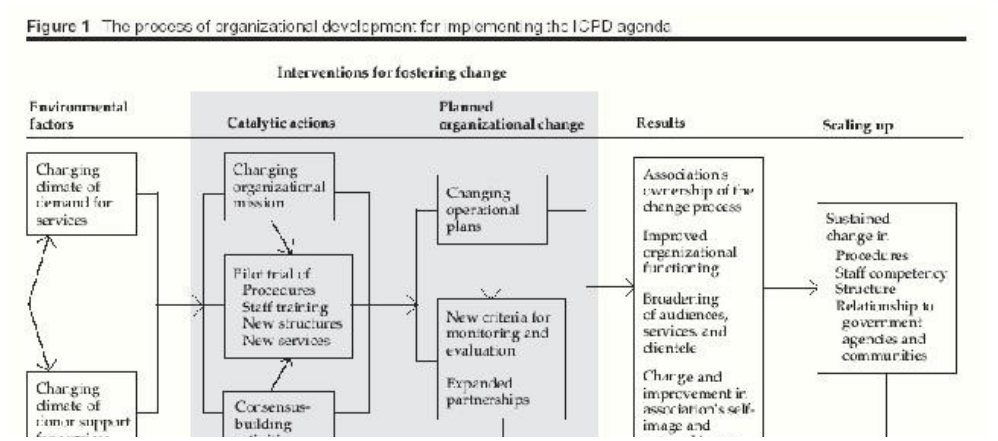
Phillips JF, Simmons R, Chakraborty J, and Chowdhury AI. Integrating health services into an MCH-FP program: lessons from Matlab, Bangladesh. Studies in Family *Planning 15(4):153-161, 1984.*

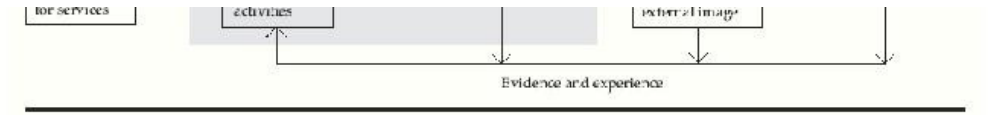
Potter JE, Mojarro O, Nunez L. The influence of health care on contraceptive acceptance in rural Mexico. Studies in Family Planning 18(3):144-156, May/June 1994.

Simmons R and Phillips JF. The integration of family planning with health and development. Pages 185-212 in RJ Lapham and GB Simmons (eds) Organizing *for Effective Family Planning Programs. Washington, D.C.: National Academy* Press, 1987.

Zeitlin J, Govindaraj R, and Chen L. Financing reproductive and sexual health services. In: Gita Sen, Adrienne Germain and Lincoln Chen, Population Policies *Reconsidered. Health, Empowerment and Rights. Chapter 17, pp. 234-*248,Harvard Series on Population and International Health, Cambridge: Harvard University Press, 1994.

Integrating New Elements into Family Planning Programs





(Source: Helzner, 2002)