Pakistan's Administrative Approach for a Family Planning Program

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FAMILY PLANNING has been recognized as necessary to the advancement of less developed countries, and the question now arises as to the most expeditious approach to an effective, nationwide program. Inevitably, governments have adopted a variety of approaches consistent with their political, geographic, economic, and administrative climates. Several patterns have emerged: programs under health department supervision, as in India and Ceylon; programs financed with government funds but delegated to private agencies, as in Hong Kong; programs financed and administered by private organizations, as in Taiwan; and programs conducted by new, independent government agencies, as in Pakistan. This paper deals with the organization and administration of the Pakistani pattern.

The need for control of population growth in Pakistan is urgent. Demographers estimate the growth rate to be about 3 percent per year, resulting from a death rate near 20 per 1,000 population and a birth rate of 50 per 1,000 population (*1*). It is estimated that the present population is 110 million and that it will double by 1985.

Concomitantly the country has an illiteracy rate of 85 percent in the rural population and an average annual per capita income of $70–80. Since any rate of economic progress is inversely related to population growth, stimulation for a family planning program rests on an economic rather than a health basis.

The urgency of the problem, recognized in the second 5-year plan implemented in 1960–65, forced the Government of Pakistan to establish a family planning program. At first, family planning clinics were to be established in existing health centers and the administration of the program was to be placed with already overworked medical personnel. It was then realized that extra help would be needed for health education to motivate eligible persons. Families were conscious of the impact of family planning but had little knowledge of techniques and did not know where to obtain services. Programs based in clinics only brought meager results.

Organizational Setup

Realizing the need for a greatly expanded educational effort and the promise of intrauterine devices and other contraceptives, the Pakistan Government launched a PRs 280 million ($60 million) family planning program as part of its third 5-year plan (1965–70). The program was entrusted to the National Family Planning Council, an autonomous agency with a full-time commissioner of family planning (fig. 1). The health minister is chairman of the council, and the commissioner is its secretary. The commissioner is also joint secretary (the

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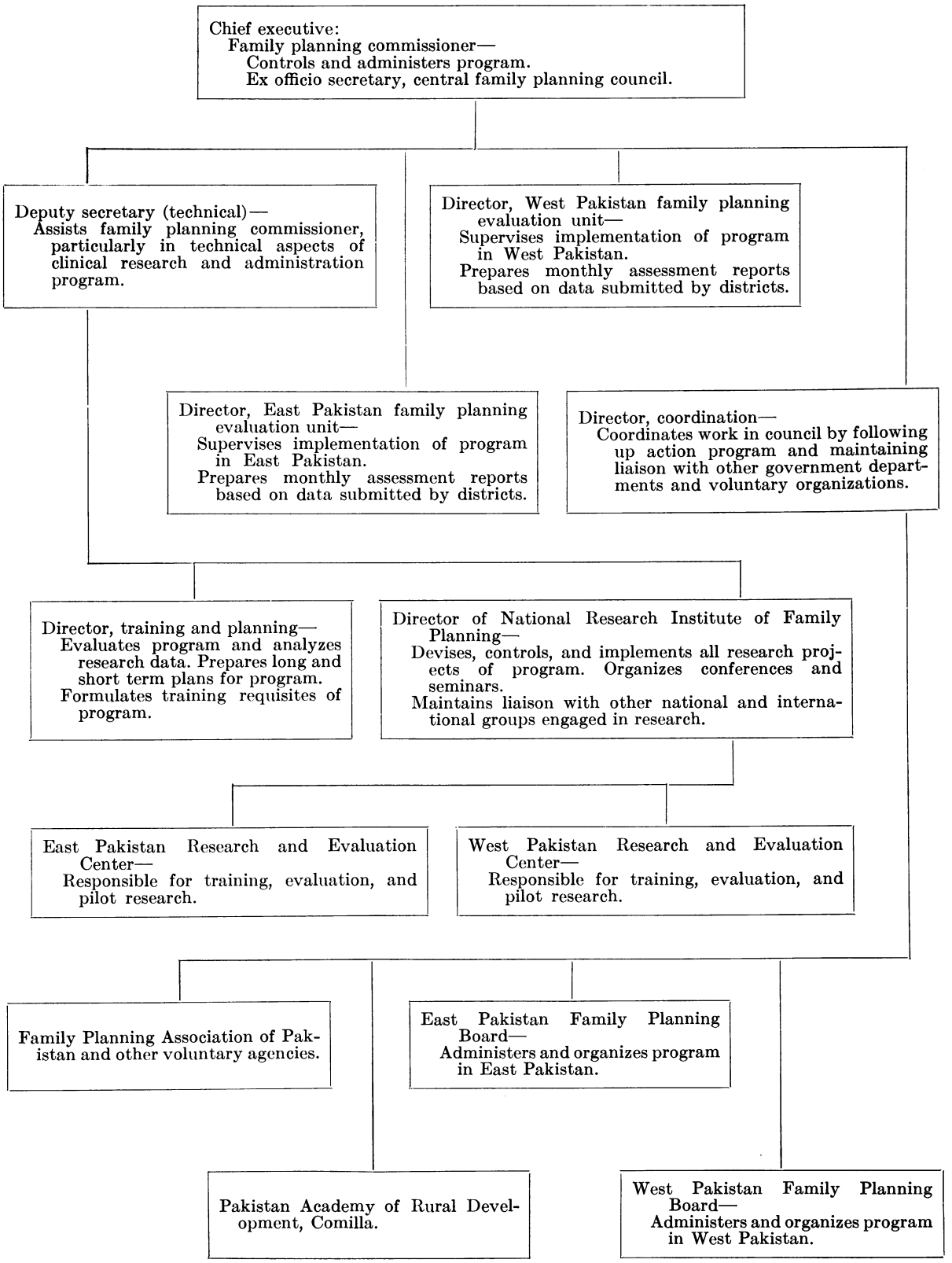
Figure 1. National Family Planning Council



second highest rank in the civilian administration) to the Government of Pakistan in the new division of family planning in the Ministry of Health, Labour, and Social Welfare (*2*).

The National Family Planning Council is responsible for policy and implementation of the family planning scheme including coordination, assessment, and evaluation of activities, research, foreign aid, and consultation. The organization consists of deputy secretary (technical), directors of planning and training, and directors of coordination of the national research institute of family planning and of the two evaluation units. Hiring of personnel is direct. The council has established an independent system of retirement, health, and welfare benefits. However, arrangement for an independent civil service system meant that personnel transferring from the established system would lose their benefits. These people, did not, therefore, readily choose to transfer.

Organization of the program is similar in each of Pakistan's two provinces, consistent with the decentralization of nation building functions in Pakistan's Constitution.

Responsibility for implementation is further decentralized through district family planning boards. East Pakistan has 17 districts, averaging about 3.5 million population each; West Pakistan has 53 districts, averaging about 1 million each. However, only 85 percent of the system is now set up. Each board is set up with the deputy commissioner, the highest ranking district official, as chairman, and the medical officer, district health officer, and two prominent citizens as members. This board makes local arrangements to carry on the program. The district family planning officer, who is secretary of the board, is responsible and accountable for the program (figs. 2 and 3).

Smaller sections of the district are supervised by family planning officers who supervise local organizers and agents at the village level. The village organizer is usually a woman well known in the community or an indigenous midwife. She receives a retainer of PRs 15 ($3) per month. In addition she receives PRs 2.50 (50 cents) for each client referred for an IUD insertion and a commission on the sale of conventional contraceptives.

The district board establishes clinics, appoints physicians and other personnel, furnishes supplies, undertakes publicity, and has fiscal control of payment for operating expenses. The clinical portion of the program is under the technical guidance of the district health officer or civil surgeon of the district. A district technical officer of the board acts as liaison with physicians and clinics.

Program Monitoring

The national council has one evaluation unit for each province, with a technical staff to assess the progress and success of the program. Each unit has an administrator, medical officer, health educator, statistician, interviewers, and clerical staff. Performance is measured in terms of quantity, such as number of personnel on the job, IUD insertions, and amount of conventional contraceptives sold. The progress of the program is also followed through a continuous national sample survey on knowledge, attitude, and practice of family planning. Fertility pattern studies reveal long term use of various methods. Reports are sent to the evaluation center for each province, which in turn issues directives for program implementation or credits for program accomplishment.

In addition to reports from the evaluation units, a further check is made by the commissioner to analyze evaluation data. A government inspection team visits one-third of the districts quarterly to check on records and services rendered. The district and field family planning officers are questioned on methods of motivating clients, publicity, sale of conventional contraceptives, number of IUD insertions, and finances. Problems and points of weakness are referred to the district commissioner for correction. An implementation officer is stationed permanently in each province to insure that recommendations are carried out.

Since the second 5-year plan, research and evaluation of operational difficulties and development of new approaches to program accomplishment have been given great importance. For example, new procedures are introduced on a wide-scale basis only after they have been tested in pilot programs in urban and rural areas. This experimental work is carried out by the National Research Institute in Family Planning (NRIFP), research and evaluation centers

Figure 2. West Pakistan Family Planning Board

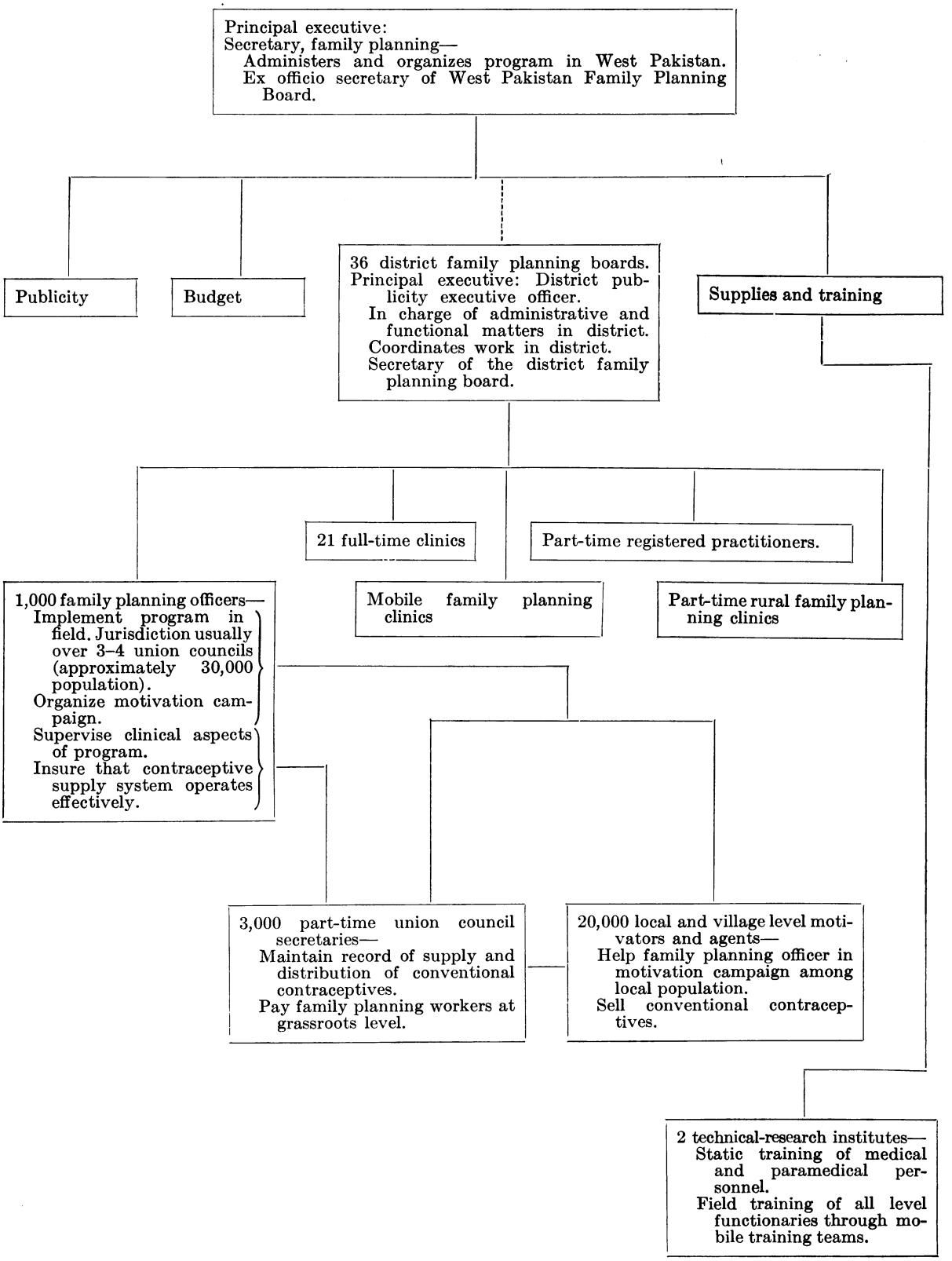
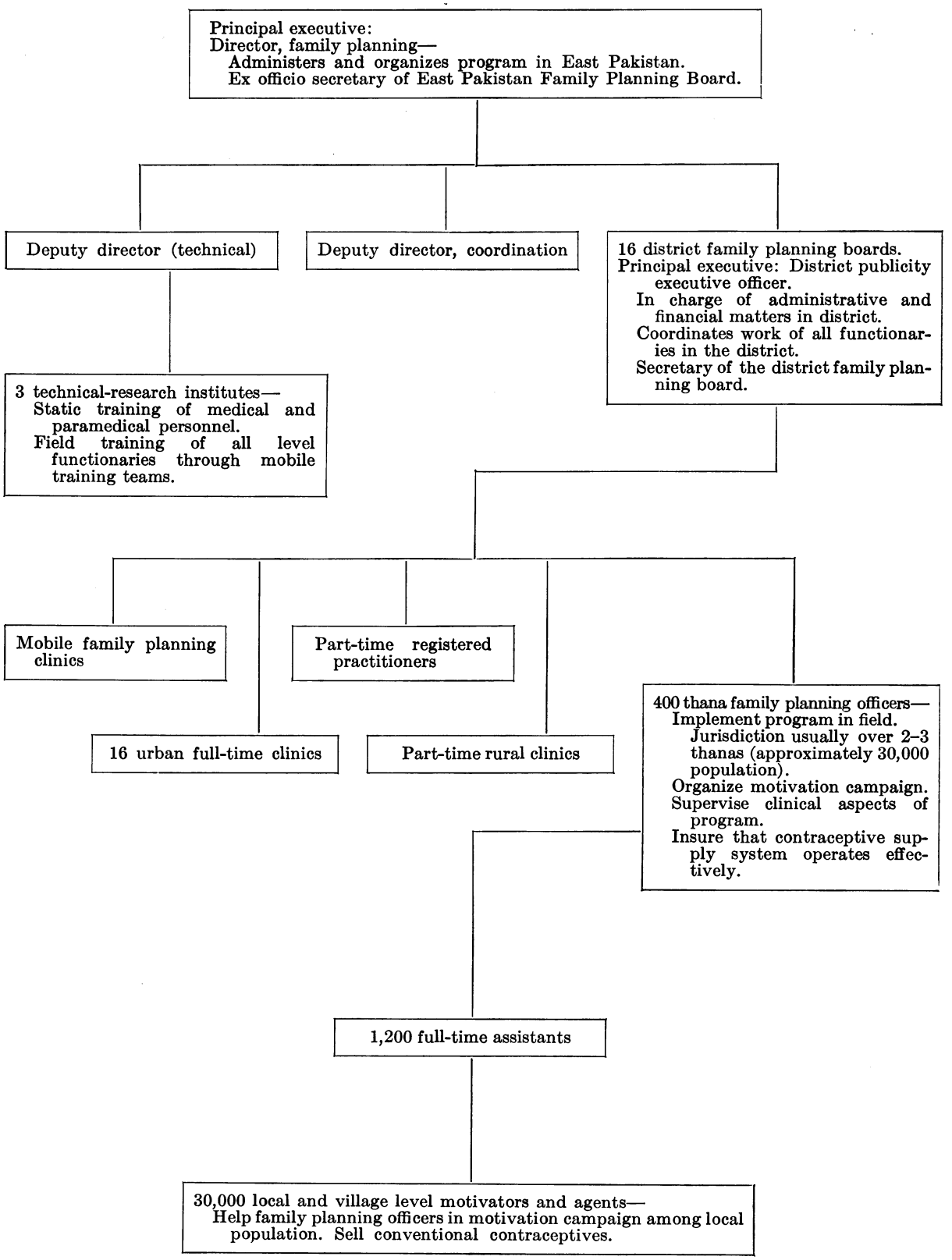


Figure 3. East Pakistan Family Planning Board



in each province, and a network of training and research institutes (*3*).

During the second plan, one group established an IUD program pilot study. The information from this work was used in writing that portion of the scheme for the third plan. Presently, studies are being carried out to provide answers to social, economic, and medical problems found in family planning operations, to discern factors influencing the retention of the IUD, and to evaluate the use of lady family planning visitors to insert IUD's. A program has been established to develop educational standards and methods for training workers. The NRIFP was created to promote research in family planning methods, communication, and reproduction physiology. A laboratory was set up to test contraceptive products for the program.

Special Inputs to Reach Goals

The aim for the third 5-year plan is to reduce the crude birth rate by 20 percent, from 50 to 40 per 1,000. Goals were set for each district based on the number of fertile females in the population, available help, and local conditions. Coverage is being measured by couple-years of protection, and monthly targets are established. Each month a check is made through supervisory channels to see if targets are met. The targets are a provisional working base to judge the performance of each district, and are reviewed in the light of experience.

Generally a target is expressed in terms of couple-years of protection by type of birth control measures used by fertile couples. The estimate for the plan is about 20 percent IUD's, 35 percent condoms, 25 percent foaming tablets, 15 percent foaming liquids, and 5 percent surgical sterilizations. Nationwide reports through August 1967 show about 30.2 percent couple-years of protection attributed to loops, 66.4 percent to conventional contraceptives, and 3.4 percent to surgical sterilization (fig. 4). To calculate annual estimates of achievement, credit is given for 75 of 100 IUD's reported inserted, for 1 year of protection for 100 conventional contraceptives sold, and for each surgical sterilization performed.

Training is a province responsibility carried out by the training institutes and mobile training teams (*4*). The emphasis is on training in techniques, motivation, and reporting systems. In addition, physicians and paramedical personnel favor the use of IUD's and vasectomy.

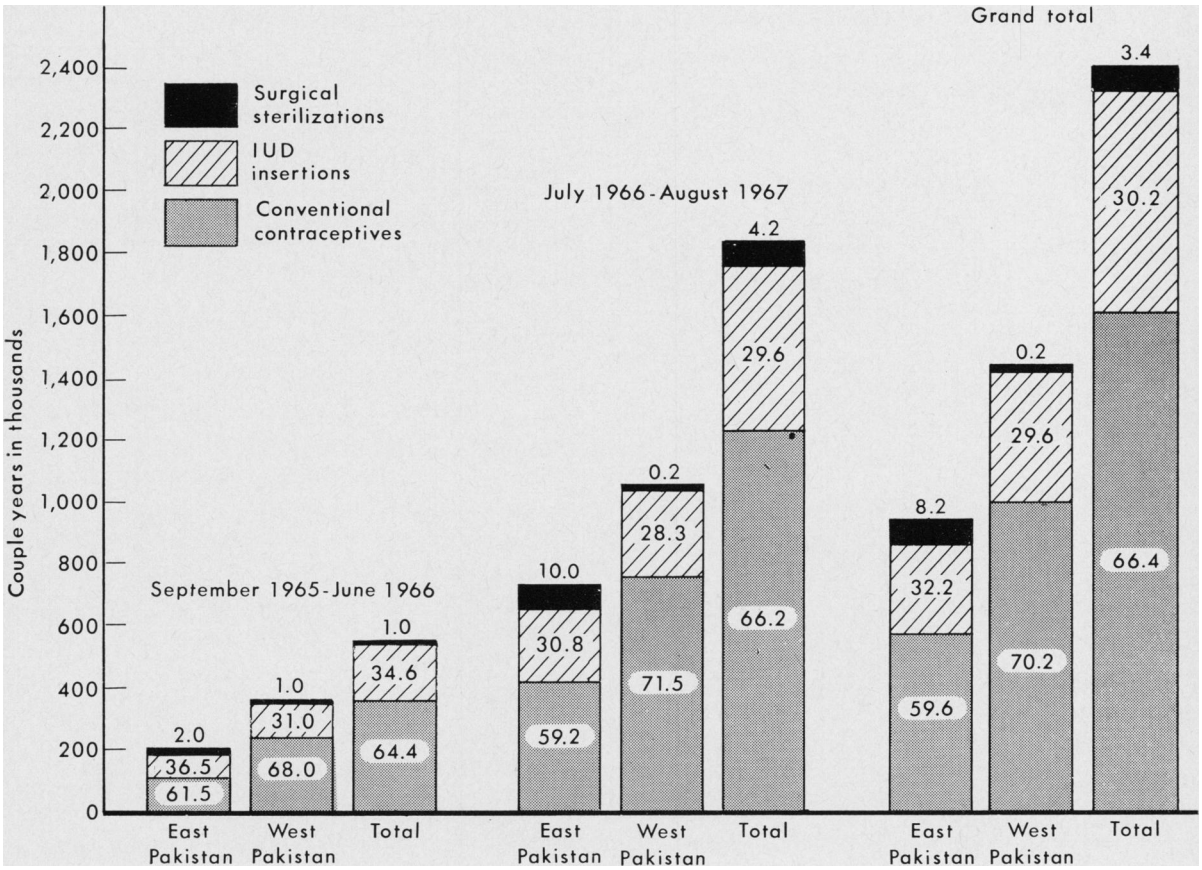
Because of a dearth of medical personnel, special 1-year courses have been established to train girls with high school educations to insert IUDs. These girls, called lady family planning visitors, undergo a comprehensive residential and field training program in theory and practice. Following this comprehensive course and supervised fieldwork, they are placed in rural areas to provide family planning services. The lady family planning visitors provide the patient detailed information on the subjects raised by the organizer. In addition, she treats minor complaints of IUD insertion such as malaise, pain, and vaginal bleeding by following standing medical orders, thus strengthening patient support.

The clinical program is carried out through full-time urban clinics, private physicians on a fee-for-service basis, and mobile teams. Both medical and paramedical personnel doing IUD insertions are paid a fee—PRs 6 ($1.20) for physicians and PRs 3 (60 cents) for paramedical personnel. PRs 25 ($5) is paid to both patient and physician for tubal ligation. PRs 25 is paid the patient and PRs 15 ($3) the physician for vasectomy. A person who brings in a patient for an IUD receives PRs 2.50 (40 cents).

Foreign financial aid is supplied by private and governmental sources. The Ford Foundation supports the research and evaluation centers with advisers, library assistance, and travel awards for out-of-country study. The U.S. Agency for International Development (AID) has furnished jeeps, and is currently providing advisers and long and short term fellowships, and is purchasing commodities such as transport, audiovisual materials, and contraceptives. AID is prepared to assist upon request any friendly country in the elements of a family planning program. The Swedish Government has supplied advisers and such materials as condoms, plastic material, and newsprint. UNICEF has supplied motor vehicles.

Paramount in any foreign aid program are

Figure 4. Result of family planning program in couple-years of protection, September 1965–August 1967



the institution-building aspects so that a host country can carry on after the groundwork has been laid (*5*). Technical assistance is required because a developing country does not have adequately trained personnel.

Fellowships are awarded to professional persons who will occupy positions upon which the success of the program will depend. These awards can be for courses of study or research activity. Travel awards permit recipients to attend meetings, seminars, and short course programs which will make a definable contribution to the success of the project.

In 24 months 2 million of the 5 million couples projected to be reached by 1970 had received IUD's, surgical sterilizations, and conventional contraceptives. The effectiveness of the program is to be measured by immediate knowledge, attitude, and practice studies. More reliable measurement of progress is possible through population growth estimates, and long term effects will be observed following the national census to take place in 1971.

Discussion

The benefits of an independent governmental agency are chiefly in expediting the start of a national family planning program. In Pakistan, a plan was formulated, a budget prepared, and personnel recruited in about 3 months. Much government redtape, such as salary scales, civil service lists, and multiple approvals, was circumvented.

This approach meant recruiting scarce professional and nonprofessional help in the open market. In some instances, government workers in professional, executive, and administrative positions would not apply because they anticipated losing civil service rights. However, this difficulty was offset by several factors. Ad-

ministrative help was hired without great delay due to the easy labor market. Some professional staffs were attracted by larger salaries in lieu of the already established merit system or fringe benefits. Clinical staff, especially physicians and midwives, were attracted by incentive payments for services on a patient-by-patient basis.

Besides incentives to physicians and midwives, fees were paid to organizers who referred clients for service and also to the clients who were surgically sterilized. Patients returning for followup after IUD insertions were referred to the outpatient clinics of the health department. The technical officer who has liaison with physicians and clinics enlisted the cooperation of physicians after clinic service was rendered. Supplemental arrangements in rural areas involved the services of specially trained aides.

Before the plan was in operation, a recruitment and training drive was made for the personnel needed for the program. A total of 33 district officers, 885 supervisors, 1,200 physicians, and thousands of village workers had to be trained in the elements of a family planning program. Training manuals were written and courses for trainers held. Later peripatetic teams were sent into the field to instruct all levels of workers.

Supplies of materials such as loops, conventional contraceptives, and drugs were expedited by manufacture or purchase in the private sector. When loops were needed, the council negotiated with a private plastic company for manufacture. The same approach was made to pharmaceutical houses for drugs.

Mobilization of forces to reduce the birth rate is based on a chain of events affecting the client.

The village organizer explains to the client the reasons for family planning and the fact that fertility control is possible. With the visual aids and other health education materials provided, the organizer can describe the various family planning methods, how they work, and where they can be obtained. She is supplied with condoms, foaming tablets, and foaming liquid for sale. At this writing, oral contraceptives are not officially accepted as part of the government program.

Factors are beginning to appear which favor smaller families. There now seems to be some increase in agricultural output. As a result of mechanized planting and harvesting of new high-yield seeds, a small family can work the same amount of land as a larger one. Thus, a balance between production and consumption is better appreciated. In addition, women are beginning to realize that if they have fewer children, each child will be better fed, have a greater chance to survive, and be more likely to receive an education.

As more clients are preventing pregnancy, word gets around that there are successful means of birth control. The methods or ideas of family planning are seen as legitimate and social approval is displayed. As this is accomplished, more and more persons commit themselves to enter the program.

Tabulation of the clinic card reports indicate that about 10 percent of the women having IUD's inserted are under 25 years old. This is a higher percentage of younger women coming for service than encountered before 1965.

Experience has shown that patients must be counseled periodically about their questions and complaints regarding methods. It is important to keep committed persons in the program. If one method does not prove satisfactory, then alternative methods should be recommended. Plastic loops and oral contraceptives can be added to the list of devices offered along with condoms, foaming tablets, and foaming liquids.

Since general use of the loop was advocated in October 1964, many developing countries have organized programs to bring services to the doorstep of the client. The programs in South Korea and Formosa are examples of the mobilization of a new effort based on use of the loop. The Indian and Pakistani programs are examples of the broadening of an ongoing program through introduction of the loop.

No one approach or person can prove the acceptability of family planning. Each individual family has to develop a feeling for its necessity. At any one time various persons may be in stages of the adoption process ranging from ignorance to the sustained use of family planning methods.

A mass media program can effectively increase public awareness of family planning.

However, it takes additional efforts to instill a thorough knowledge of practices and keep the patient as a program participant. There is no one ideal method. Proper guidance and interpretation of pain and bleeding with the loop can sustain the patient's commitment. The same is true of complaints of nausea and increased weight from oral contraceptives and of burning sensation from foaming tablets or liquids.

Program administrators are under great pressure to show a degree of success. Evaluation of a program is based on how much is being done, the effort expended, and its effect. There are, however, no short cuts to reducing a birth rate by x percent. Success should be measured by the organization of a program, number of persons working in it, and adequacy of financing, all of which influence the number of persons practicing family planning.

The Pakistani program was unique in being functionally set up outside the health ministry. This arrangement permitted workers to focus their efforts exclusively on family planning. Alternatively, the program could have been set up within the health ministry—similar to programs for malaria, smallpox, or tuberculosis control—by adding necessary personnel and financial resources.

Each government must decide which administrative approach to take in establishing a family planning program. Judgment of the success of a family planning program, within an established government agency or outside of it, must await future evaluation.

REFERENCES

(1) Bean, L. L., Kahn, M. R., and Rukanuddin, A. R.: Population projections for Pakistan 1960–2000. Monographs in the Economics of Development No. 17. Pakistan Institute of Development Economics, Karachi, 1968, pp. 1–93.

(2) Ministry of Health, Labour and Social Welfare, Government of Pakistan: Family planning scheme for Pakistan. Rawalpindi, 1965, p. 1.

(3) Secretary, District Family Planning Board: National workshop on administration, research and evaluation in family planning. Karachi, 1967, p. 28.

(4) Pakistan Family Planning Council: Manual of training. Karachi, 1967, pp. 1–4.

(5) Gant, G. F.: The institutional building project. International review of administrative science. Vol. XXXII, 1966, p. 1.

Center for Population Research

A Center for Population Research has been established at the National Institute of Child Health and Human Development, Public Health Service.

Dr. Philip Corfman, formerly assistant to the director for population research, NICHD, heads the Center. An obstetrician-gynecologist, Dr. Corfman ranks as an associate director of the Institute.

The Center will direct, coordinate, and conduct a national program of research and training in the population area.

Specific responsibilities will include study of contraceptives, investigation of the social, psychological, and demographic aspects of family planning programs, and study of the causes and treatment of sterility. Of primary concern to the Center will be the examination of health factors related to the use of various contraceptive techniques and possible health hazards to mothers and their progeny.

In addition, the Center will develop and administer a research contract program concerned with contraceptives, the application of behavioral sciences to family planning, and the causes and treatment of infertility.