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ABSTRACT

The functional integration of maternal and child health (MCH) services with family planning programs in rural areas is discussed in this report. Suggestions for the successful implementation of research demonstration projects are provided. Evaluation procedures are discussed in terms of collection of pre-project information, service statistics, follow-up survey on acceptors of health services and family planning, surveys of women of childbearing age, special studies, birthrate and death-rate registration or estimation procedures, special efforts to obtain information on reasons for use or nonuse of the program services, cost analysis, and control areas. It was noted that MCH-based, family planning research demonstration projects of major size are just beginning in rural areas of developing societies. A major conclusion is that careful planning of the evaluation of these projects is essential. (PS)

THE INTEGRATION OF FAMILY PLANNING AND MATERNAL-CHILD HEALTH PROGRAMS IN RURAL AREAS: A DEVELOPING APPROACH

by

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I. INTRODUCTION.

During the 1960s, a number of developing societies placed varying emphasis on national family planning programs, under which attempts have been made to provide initial and continuing family planning services to childbearing couples, in the interest of reducing human fertility rates and improving the quality of human life. Depending on the criteria used to define program success, and to define a "national program", these family planning programs have produced results that range from very good in countries such as Korea, Taiwan, and Mauritius, to much lower levels of performance in a number of other nations (Lapham and Mauldin, 1972). These national program efforts continue and are expanding in the early 1970s, with new ideas also being tried.

The improvement of maternal and child health (MCH) is also an important goal in many developing societies, and there is now growing interest in the functional integration of MCH services with family planning programs, particularly in rural areas.

A major question for both action and research is the following: What are the benefits and improvements - in maternal health, in child health, and in family planning acceptance and continued use - that can be obtained from rural area programs linking the delivery of MCH and family planning services? This paper briefly summarizes the philosophy of the integrated MCH-family planning approach, suggests some important principles for planning MCH-family planning research-demonstration projects, and then focuses primarily on the means to measure and evaluate the utility and effectiveness of integrated MCH-family planning programs in rural areas.

II. THE POSTPARTUM APPROACH TO FAMILY PLANNING.

The postpartum approach to family planning is based on the idea that the best times to talk to a woman (or a couple) about family planning are those when the woman is pregnant and just after she has delivered a baby. This approach has centered on women delivering their babies in hospitals and maternity homes, and it began in a substantial way in a number of developing countries in the mid-1960s (Zatuchni, 1970; Forrest, 1971). The antepartum, delivery, and postpartum periods are times when motivation for effective family planning is high, when the health benefits of spacing and/or limitation may be more meaningful, when the woman is relatively easily reached for education and motivation (if the delivery is institutionalized), and before the woman is pregnant again following delivery. The postpartum approach centers on an institutionalized system that is generally trusted and appreciated by the clients, and that offers good opportunity for follow-up care. The clients are women of proved fertility. (See Taylor, 1966, and Taylor and Berelson, 1968, for more complete discussions of the advantages of postpartum family planning.) Some women accepting family planning under this approach are provided contraceptives before leaving the hospital for home (including immediate postpartum insertion of the IUD in some cases); other acceptors receive contraceptives a few weeks later when returning for maternal and child check-ups.

Sivin (1972) has shown that first-method continuation rates for IUD and pill acceptors in a large international, hospital-based postpartum family planning program (data based on 62 hospitals in 11 countries participating in the program since September 1969 or earlier) compared very favorably with continuation rate data available from national programs, and that post-acceptance fertility levels, in all age groups, parity groups, and marriage duration groups, are lower than would be expected in the absence of the program.

III. THE INTEGRATION OF MCH AND FAMILY PLANNING SERVICES IN RURAL AREAS.

An institution-based postpartum family planning program offers many advantages, but most institutionalized deliveries take place in hospitals and maternity centers in urban areas, where the institutions both exist and are reasonably accessible to urban populations. What about rural areas? Is it possible to adapt the postpartum family planning concept to rural settings, and to expand it for the joint purpose of providing (1) maternal and child health services, and (2) family planning services, without waiting for the years, and probably decades in some places, before adequate maternity care institutions are available to rural populations in developing societies?

One program attempting to answer this and related questions is the "MCH-Based Family Planning Demonstration Program" sponsored by the Population Council, major donor agencies, and the host governments. Another program is the World Health Organization's "Maternity-Centered Family Planning Program". variations for linking family planning to the general health delivery systems are under consideration by other organizations as well. An important hypothesis underlying most of these programs is that there are mutual benefits to the linkage of MCH and family planning services. That is, the use of family planning is important for improving the health of mothers and existing children, and the improvement of maternal health and especially child health (lower child morbidity and mortality) is conducive to more acceptance and continued use of contraception.

Taylor and Berelson (1971) reported on a feasibility study they and 15 collaborators undertook to review the possibility for a world program that would integrate MCH and family planning services, especially in rural areas. The question Taylor and Berelson undertook to answer is the following:

> "What would it take in everything required - in personnel, physical facilities, training facilities, transport, supplies, equipment and funding - to bring some minimal professional and paraprofessional attention to every pregnant woman in a number of

> developing countries before, during, and after delivery, for the double purpose of promoting maternal/child health and family planning?" (Ibid, p. 22)

These authors concluded that integrated MCH/family planning programs are feasible in the nine countries studied, with estimated costs per capita varying from $0.32 in Punjab, India, to $0.93 in Ghana (with an exceptional $1.65 in Kenya) and averaging about $0.60.

One result of the Taylor-Berelson study has been the development of the MCH-Based Family Planning Demonstration Program mentioned above; under that program, projects should start soon in a rural province in East Java, Indonesia, in part of a province in the delta area of the Arab Republic of Egypt, and projects are planned for about four or five other countries. The WHO program includes projects just starting in Thailand and Iran. These and similar efforts are substantial research demonstration projects, involving several years of activity, sizeable populations in several cases, and with the intent of learning as much as possible about the operation and services provided, the nature of difficulties to be overcome and how to overcome them, the health and family planning benefits that can be achieved, the costs (financial, administrative, and personnel), and the reasons for use or non-use of the services offered. Several principles are important, if not crucial, for the successful implementation of these research demonstration projects.

1. <u>The area should be chiefly rural</u>.

The selection of a reasonably typical rural area is essential for the research demonstration project. The area should not be the suburb of a major city, it should be largely rural, about on the same level of social and economic development as other rural areas, with a population large enough to allow a good test of problems associated with program administration, obtaining and training personnel, solving transportation and communication difficulties, etc..

Probably a quarter of a million persons should be a minimum population size for the research demonstration area, although in special situations, such as those involving sparsely populated areas or those with severe transportation difficulties, the minimum population size might be 125,000 to 150,000.

2. The integration of family planning with MCH should be complete from the top level of administration to the delivery of services to individual mothers and children.

The three program components - maternal care services, child care services, and family planning services - should be built into the project design and then maintained. For example, a fair test will not be achieved if over time all of the emphasis shifts to the family planning services. The maternal care should include contacts before and after delivery, and some level of assistance by trained personnel at delivery (plus a back-up system of potential services by more highly qualified personnel when needed). The child care should include (a) preventive care in the form of immunizations and routine check-up visits up to about the age of two years, and (b) some minimum level of curative service when needed. The family planning services should include information, education, and contraceptive services (initial and follow-up care) as regular, routine parts of the MCH services.

The MCH-based approach to family planning provides in particular for a gradual introduction of the idea of family planning during the antepartum period, somewhat stronger recommendations during the postpartum period, and encouragement to continue during visits for child care. It is hypothesized that repeated and reassuring reference to the idea of family planning, over a series of contacts incidental to visits for health measures, will be effective in terms of acceptance and continued use of contraception.

3. The "target population" of the project is to be all women delivered in the area within the period of the demonstration and the children born in this time, during at least their first two years of life.

An attempt should be made to provide services to every pregnant or recently delivered woman (and her child) in the project area. This does not mean that all women will be reached; however, one measure of project success will be the proportion of women and their children actually utilizing the offered services for maternal care, child care, and family planning.

4. Three major types of service provided at the time of delivery should be considered.

a. Hospitalization with delivery attended by a doctor, trained midwife, or assistant midwife. In small towns, or in densely populated rural areas, it may be possible to develop small regional hospitals or maternity centers. However, in many rural areas, the difficulties of cost, personnel, transportation, and the willingness of people to utilize facilities for institutional deliveries will make it impractical to consider large-scale service delivery systems of this type.

b. Home deliveries by trained midwives or assistant midwives. This type of service can provide very good care, and it offers good opportunities for family planning education and services, but it requires large numbers of trained staff.

c. Home deliveries by indigenous midwives with back-up and supervision by fully trained and/or qualified personnel.

In any major demonstration area, or in a given country, there will probably be a mixture of these three types of service. In Indonesia, for example, at least during the next several years, it will be necessary to rely heavily on indigenous midwives, whereas in some countries, it may be possible to recruit adequate numbers of professionally trained personnel. The incorporation or cooperation of indigenous midwives into MCH-based family planning efforts raises interesting problems. Official health authorities often frown upon programs

that involve local, non-professionally trained personnel. Another facet is that in some countries indigenous midwives enjoy high social status in the villages while in other places they stand rather low in social prestige. The longstanding confidence local women have in indigenous midwives is also important. For most rural areas in developing countries, it is likely that the utilization of indigenous midwives will be necessary in the coming years in integrated MCH-FP programs, for both care at the time of delivery and for some of the educational work and follow-up care.

5. The demonstration should be replicable.

This is one of the most important principles, and one easy to forget in the enthusiasm of planning a good demonstration effort. It is absolutely essential that research demonstration projects involving integrated MCH and family planning services be designed so that they are replicable in other rural parts of the countries in which they are established. It may be possible, for example, to obtain adequate numbers of trained midwives and/or assistant midwives to cover one province, but a research demonstration project involving only trained personnel of this sort should not be undertaken unless it is possible to replicate this personnel pattern in many other provinces within a short time period, say, three to five years. The same applies to costs. Funds might be obtained for a special effort in one area, but the projects should be designed in ways that make it feasible for the governments of developing societies to finance this type of program in many other areas of their countries, if the research demonstration projects show that the benefits obtained from the integrated program are substantial.

6. The evaluation system should be of high quality.

These projects will be undertaken jointly by several governments and agencies and are intended (a) to produce information concerning how to organize

and best operate integrated MCH-based family planning efforts, and (b) to answer questions related to improvements in maternal health and child health, to family planning acceptance and continued use, and to fertility declines. It is, therefore, essential that the evaluation of the projects be carefully planned, carried out, and reported.

Some records will be collected and kept at the clinic level (service delivery point), both for statistical purposes and in order to provide and maintain adequate care for clients. In addition, a centrally located evaluation unit will be necessary, to receive reports, organize and carry out the evaluation activities, analyze data, and prepare summary reports. Probably one objective should be to keep to a minimum the workload for statistics gathering at the clinic level.

The remainder of this paper will focus on some of the evaluation methods and procedures that might be useful for these research demonstration projects. Much more could be said about the actual organization and operation of these projects. However, I will bypass here discussion of program infrastructures, physical facilities, numbers of each type of personnel per 1000 or per 10,000 population, the levels of preventive and curative child health services to be offered, the problems of hiring and training program personnel, the numbers of antepartum and postpartum visits to be aimed for, the types of family planning information and education to be included, the types of contraceptives to be utilized, the relationships among the various local and national administrative bodies that must be worked out, and many other operational aspects of these programs.

IV. EVALUATION.

During the next several years, the world will probably see at least a dozen, and perhaps three times this number, major research demonstration projects

testing the utility and effectiveness of integrated MCH and family planning service delivery systems in rural areas of developing societies (and perhaps also rural areas of so-called developed societies). These projects will involve many millions of dollars, and point to the possibility of much larger expenditures in the not-too-distant future. The time to plan and organize the most productive project evaluation systems is now, when most projects are just starting or in the initial planning phases. One basic hypothesis to test has been noted earlier. Another is that integrated MCH-family planning programs are feasible in rural areas, and that substantial benefits, in terms of improved maternal and child health and reduced fertility, are obtainable at replicable costs. There are also a number of major questions to be answered.

A. Important Questions.

1. What levels of maternal care, child care, and family planning services can reasonably be aimed at, and what levels of care are actually delivered by the program? How well does the program provide the critical contacts with the mother during the antepartum period and during the child care phase?

2. To what degree does the MCH-based family planning program improve maternal and child health and reduce infant mortality and morbidity?

3. What levels of acceptance and continued use of family planning are achieved by this program, and what are the characteristics (age, parity, etc.) of the acceptors and continuing users? What are the differential acceptance rates among women delivered under various circumstances (hospital, midwife, trained indigenous midwife, untrained indigenous midwife), among women who make use of the child care services to varying degrees and among women of varying age, parity, education, and other differentiating characteristics?

4. What levels of child spacing and fertility reduction are achieved?

5. How can an effective MCH-based family planning program be organized

and maintained? What are the chief problems and how can they be solved?

6. What is the overall cost of organizing and maintaining the program, and what are the costs of the various parts of the program?

7. What methods, procedures, staffing patterns and other arrangements can be instituted to improve the program as it develops? That is, in what ways and by what means can the program achieve better results?

8. For what reasons do some families use and other families not use the offered services?

9. To what extent can health and family planning achievement be directly attributed to the program, and to what extent are improvements due to other economic, social and health improvements in the project area?

Obtaining adequate answers to these questions requires substantial effort, especially since statistical data to establish benchmarks and subsequent changes are often inadequate or totally lacking in rural areas of developing countries. To take just one example, the measurement of change in fertility requires valid data on numbers of births women in various age categories are having, and valid estimates of the numbers of women in each age group. In places lacking reliable and complete or nearly complete birth registration systems, the information on numbers of births will have to be obtained via special surveys or special registration/reporting systems (or both), and special efforts to obtain the denominators in this example (the number of women ages 20-24, 25-29, etc.) will be necessary in the absence of reliable census data or population estimates. Thus, considerable attention to evaluation planning, procedures, and measurement techniques is both necessary, and highly desirable during initial planning phases of these projects.

B. Evaluation Methods and Procedures.

To further specify the types of information required to adequately answer the above questions, several components of an evaluation system are outlined

below. Additional useful items will certainly arise as the projects develop, and allowance is made for these in the data collection methods and procedures discussed. It is important to note that these groups of evaluation measures form a minimum, without which it would appear difficult to assess the impact of each MCH based planning research demonstration project. Some of the suggested methods and procedures attempt to answer particular questions in more than one way; to answer other questions data will be necessary from two or more of the suggested procedures. The ideas that follow all refer to central evaluation unit responsibilities except where specified that the form or procedure applies to the clinic level. The term "clinic" refers to any service outlet that provides program services.

1. Collection of pre-project information.

Data on conditions at the beginning of the project will be necessary for later comparison with other projects, and as a baseline for measurement of changes that occur in the project area during the project period. Examples include data on geography, economic conditions, population density, fertility, mortality and other demographic characteristics, health and health delivery systems, present family planning practices, and cultural and social characteristics. Maps showing locations of towns and villages, roads, administrative districts and sub-districts, and locations of existing and planned service outlets should be prepared. Other types of pre-project information are: existing health services; existing family planning services; existing research projects in or concerning the area; birth registration data and infant mortality estimates; and data on knowledge of, attitudes towards, and use of contraception, plus data on recent fertility histories of women in the area.

Personnel from the evaluation unit or a special team can assemble, record, and tabulate much of the necessary information, although in most cases special

studies are probably necessary, such as the KAP (Knowledge, Attitudes, and Practices related to family planning) studies described below. All original records and notes should be retained for future reference and analysis. Although seemingly a minor point, records often get misplaced or lost, to the detriment of project evaluation some years later. Administrative attention to the provision of adequate filing and storage of documents, questionnaires, field reports, and other project information materials is appropriate and essential.

A related point, going beyond the pre-project plan, is to maintain a careful recording of the initial plan of infrastructure development, and of the extent of services available at various time points, e.g., the number of each type of personnel in place each month, the numbers of contacts they have with clients, etc..

2. Service Statistics.

This term refers to the set of methods used to record the day-to-day and month-to-month activities occurring in the service delivery outlets and by the project personnel. In these projects, two types can be distinguished: (a) health statistics and (b) family planning statistics.

To clarify the terminology utilized below, a "client record form" is a record filled out at a clinic and kept there for reference each time a client returns for services. A "monthly report" is a report prepared by clinic personnel summarizing the activities of a clinic during a particular month (or quarter). "Summary tabulations" are reports prepared by the central evaluation unit that bring together in summary form the information obtained from the clinics and other relevant information available at central administrative offices.

a. Health Statistics.

These include the basic forms and reporting procedures necessary to maintain a good record of the health services actually provided. The following

are a few of the main items:

i. Maternal care forms and reporting.

(a) Client record form: For each woman coming for maternal care, a client record form should be filled out at the time of the first visit. This form should contain a few items on social and economic phenomena (age, numbers of living and dead children, education, etc.) and some health information items (numbers of months pregnant, who delivered previous child, etc.).

(b) Register: A basic register to record all maternal care visits (initial or subsequent) should be kept in the clinic. This can be simple and limited to such items as date, name, type of service rendered, by whom, etc., and it should be designed so that monthly or quarterly reports can be made by simply adding up check marks in various columns of the register.

(c) Quarterly or monthly summaries: These reports of maternal care services rendered in the clinics can be made from the register. They will indicate the number of repeat visits for antepartum care, postpartum care, etc., and the number and types of special services that have been provided during those visits.

(d) A set of summary tabulations for each reporting period.

ii. Pregnancy reporting forms.

Pregnancy reporting forms, for pregnancies that are known to exist and/or that are delivered by an indigenous midwife, can be used to report to the trained midwives or assistant midwives working in the program. This form will be very simple and probably limited to six or eight basic items such as name, address, date of delivery, or number of months pregnant on a certain date, etc. It is probable that many

indigenous midwives are illiterate; they will have to turn to some local literate person to help fill out this simple form.

iii. Child care form.

The basic format for these can be similar to that under the maternal care forms described above and these should include a client record form, a register, and monthly or quarterly summaries.

b. Family Planning Statistics.

A good set of family planning statistics reporting forms and reporting procedures is essential to maintain a good record of the family planning services actually provided, and to provide information on characteristics of acceptors. The basic set of forms and procedures suggested for the research demonstration projects includes a client record form, a clinic register, a clinic monthly report, and a set of summary tabulations prepared by the demonstration evaluation unit.

c. Processing Health Statistics and Family Planning Statistics.

It is necessary to plan for processing data generated by the health statistics and the family planning statistics so that clinic monthly reports are compiled into summary tables as soon as possible after they are received by the central evaluation unit. A system for processing all or perhaps just periodic samples of information on the characteristics of acceptors of maternal care services, child care services, and family planning services will also be useful.

3. Follow-Up Survey on Acceptors of Health Services and Family Planning.

A follow-up survey usually is a study designed to answer questions on continued use of contraception following initial acceptance, using interview procedures and with a random sample based upon persons who have accepted some

method of contraception, such as the IUD or pill. In the evaluation system discussed here the follow-up survey can also be used to answer some questions concerning users of the health services, e.g., do the family planning educational efforts during child care visits lead some women to seek contraceptives in the private sector, from doctors or local pharmacies in small towns?

The carefully planned and executed, random-sample follow-up survey of persons accepting health services and family planning services (particularly the latter) in the research demonstration projects will involve fairly major undertakings approximately two years after the programs actually get started, and again after four or five years. The basic questions included in the interview schedules should be designed to determine rates of continuation of contraception, to identify which clients have experienced pregnancy and, among these, the rates of abortions and live births, to try to identify changes in levels of maternal and child health (although this will be difficult), and to obtain reasons for satisfaction or dissatisfaction and reasons for continued use or non-continuous use of the services offered. Note that this important evaluation method refers to samples of persons who have used the services under the research demonstration projects.

The acceptor follow-up survey should provide data for the calculation of sets of continuation rates, using life table methods:

a. Continuation rates for each first method adopted by acceptors.

b. Contraceptive continuation rates, all segments, all methods, including method changes (i.e., how many acceptors are still using any form of contraception at stated periods following acceptance).

c. Percentage of acceptors who have avoided pregnancy.

d. Percentage of acceptors who have avoided childbearing following acceptance.

This part of the total evaluation effort should probably be done at a time when it will be possible to calculate the rates under (a) and (b) for periods of up to two years. When the second follow-up survey is done during year four or five of the project, there should be an attempt to get good information on (c) and (d) for periods up to three and hopefully four years following acceptance, in addition to new information on the rates specified in (a) and (b).

The information obtained in follow-up studies will be extremely important for the evaluation of the research demonstration projects and this activity should definitely be planned in the project budget and evaluation personnel needs.

4. KAP Surveys.

A KAP or KAP/fertility survey consists of a random-sample survey of women of childbearing age (and sometimes of husbands and or special groups such as school teachers, religious leaders, and unmarried persons) to determines levels of knowledge of family planning and child bearing processes; attitudes towards family planning, child bearing, numbers of children, abortion, etc., and information on use of contraception and abortion. Often recent or complete fertility history data are also collected. Note that this type of survey refers to a random sample of all women (and possibly others) of child-bearing age in the project area, rather than only to those who have accepted services under the project. The method proposed here is to conduct two KAP/fertility surveys, one at the beginning and the second towards the end of the project period, i.e., about four years later.

a. Initial Baseline KAP Survey.

The initial baseline KAP/fertility survey can be carried out during the first year of the project, perhaps while any necessary construction of

facilities in the project area and/or training of personnel is being done. When planning KAP surveys, particular attention should be given to field operations as well as to adequate sample design. The planning, control, and supervision of the field operations are most crucial elements in producing good results from a KAP survey, and it is our opinion that the field phases of KAP surveys produce the greatest amount of error, i.e., much more than the sampling error in most major surveys. (See Caldwell, et al., 1970.)

b. Subsequent KAP Surveys.

The second KAP/fertility survey should be similar to the first baseline survey, with the addition of questions concerning knowledge and use of the MCH and family planning services offered under the program, contacts with various personnel connected with the program, etc., and reasons for use on non-use of the program facilities. The analysis of the original survey data and the discussions of evaluation procedures and problems will undoubtedly lead to other ideas regarding the subsequent KAP/fertility survey.

c. Sampling.

Stratified random sampling is probably the best procedure. The actual size of the sample will depend in part on the number of strata included in the project design. Two general comments might be made. First, from the field procedure standpoint, a reasonable working model might be to try to design the sample so as to have a maximum of 2000 to 2500 interviews with about 60-80 sampling points. For example, one model to work from insofar as the field procedures are concerned is to have 75 sample points, with about 30 interviews at each. The second comment is that the services of a highly skilled survey sampling person should be obtained to help design the actual sample for the survey. Included in the job description given to him should be the suggestion that, if at all possible, the sample should be self-weighting. Many substantial

survey efforts go astray because of inadequate sample design.

5. Special Studies.

It would be useful to consider special studies to be done throughout the several years of the project. Numerous operational and research questions will arise to which attention should be devoted in order to learn as much as possible about how the program works best and why. The general nature of these special studies will be that they are fairly inexpensive and involve a reasonably short time frame and minimum field personnel requirements. The following are a few examples:

a. A concerted evaluation of midwives or other workers to try to determine how and why they are effective. Why and how are some more effective than others?

b. Systems for achieving indigenous midwife collaboration.

c. Changing (increasing or decreasing) the level of service coverage in one part of the demonstration area in order to determine its effect on program results.

d. Effects of additional education inputs, or additional personnel training or re-training efforts.

e. Effects of elimination of fees on MCH clinic and maternity bed utilization.

f. Effectiveness of special home visiting field workers keeping careful records of their monthly visits to households.

g. In one sub-area, a special study on child morbidity.

h. Effects of provision of dietary supplements to the pregnant woman and later to her child on clinic attendance and other utilization of services offered.

Since these special, operational studies will be carried out in parts of the research area only (with other parts as controls), it will be essential to know much about the characteristics of different parts of the research demonstration area in order that operational studies can be carried out in reasonably typical areas.

6. Birth and Death Rate Registration or Estimation Procedures.

Where feasible, a system should be established for regular and systematic collection and tabulation of births, and deaths, of infants and children especially. If current levels of registration completeness are not high, or if the levels of under-registration are unknown, either for the entire project area or for particular sub-areas, special attention will be necessary to try to ascertain the actual numbers and rates of births and/or deaths, most likely by means of special surveys or by sample registration zones within the project area. It will be particularly important to try to obtain good estimates of infant and child mortality. This requirement may form the basis of a special study during the early phases of a project. Obtaining viable estimates of birth and death rates may turn out to require considerable undertaking, and if this is the case, alternative approaches should be explored. For example, special attention might be given to using the KAP/fertility survey instruments and subsequent analysis of data to estimate levels of births and infant mortality.

7. Special Efforts to Obtain Information on Reasons for Use or Non-Use of the Program Services.

Some information on this subject of use or non-use of program services will be collected in the various surveys described earlier, but special attention to this set of questions will probably be necessary. For example, perhaps as a special study, the evaluation team might compare the sub-districts or areas

of greatest use of health and family planning services with those areas where use of services offered is least.

One special effort could be to have a skilled anthropologist live in the project area and try to ascertain how the offered maternal health, child health, and family planning services are viewed by the potential recipients and others in the project area. The anthropologist should not be directly connected with the project, and he or she would need a good command of the local language and knowledge of its culture. It will be important to obtain reasonably valid information on how the program is viewed from the "other side", and it is easy to overlook this facet of the evaluation.

8. Cost Analysis.

Beginning with the planning phase, careful cost records must be kept. These cost data should be by area, time period, and by function. Estimates of indirect costs should also be made while the project progresses. It is quite possible that one evaluation unit staff member will have to devote most of his time to this aspect of project evaluation.

9. Control Area.

It may be useful to consider a control area, in which the normal family planning and health development inputs continue, but not the special integrated MCH-based family planning program. The evaluation methods could then be applied to both the experimental (demonstration) area and the control area. There are obvious advantages to the use of control areas, provided that a control area reasonably similar to the experimental area can be located and studied, but there are costs and disadvantages also. For example, a limited evaluation budget spread over both experimental and control areas may lead to fewer evaluation efforts in the experimental area. Perhaps an even more important disadvantage is the general lack of skilled research personnel (demographers, survey researchers, etc.) in developing countries. Another is the problem of more data to collect,

process and analyze.

There is no easy answer to the "control area" question; probably each project will respond to this question on the basis of local circumstances - personnel, funds, and individual importance attached to the utility of a control area. Perhaps one potential solution is to consider the rest of the concerned country (or, if it is a large country, the region containing the project area) as the "control area", and make use of whatever data may be available from national or regional service statistics and surveys.

Two general points might be added to this discussion of evaluation methods and procedures. First, it is clear that an evaluation staff is vital and that it should include skilled research personnel along with clerks and assistants who can perform routine tasks. Second, careful attention must be given to data processing, tabulation, and analysis and preparation of reports and findings. Groups and individuals in many countries will want to know the results of these major MCH/family planning projects in rural areas.

V. CONCLUSION.

MCH-based family planning research demonstration projects of major size are just beginning in rural areas of developing societies. Much attention is currently devoted to the operational aspects of these efforts, and rightly so, given the importance of the program goals and the size of the planned projects. Careful planning of the evaluation of these projects is also essential, so that as much as possible can be learned as soon as possible. Many participants in this Congress have been involved in rural area research, in social change research, in health care and family planning programs, in the study of methodological problems, and in studies of the implementation and acceptance of new ideas and services. It would seem beneficial to have this knowledge and experience shared with those who will be guiding the development of integrated MCH/family planning endeavors. The

ideas and experiences of those attending this Congress can certainly be of value in the implemertation and evaluation of MCH-based family planning research demonstration projects.

RJL:sz
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REFERENCES

Caldwell, John C., et al., 1970. A Manual for Surveys of Fertility and Family Planning: Knowledge, Attitudes, and Practice, The Demographic Division, The Population Council, New York.

Forrest, Jacqueline, 1971. "Postpartum Services in Family Planning: Findings to Date", Reports on Population/Family Planning, Number 8.

Lapham, Robert J. and W. Parker Mauldin, 1972. "National Family Planning Programs: Review and Evaluation", Studies in Family Planning, 3:3, March, 29-52.

Sivin, Irving, 1971. "Fertility Decline and Contraceptive Use in the International Postpartum Family Planning Program", Studies in Family Planning, 2:12, December, 248-256.

Taylor, Howard C., 1966. "A Family Planning Program Related to Maternity Service", American Journal of Obstetrics and Gynecology, 95:726-731.

Taylor, Howard C. and Bernard Berelson, 1968. "Maternity Care and Family Planning as a World Program", American Journal of Obstetrics and Gynecology, 100:885-893.

_____, 1971. "Comprehensive Family Planning Based on Maternal/Child Health Services: A Feasibility Study for a World Program", Studies in Family Planning, 2:2, February, 21-54.

Zatuchni, Gerald I., editor, 1970. Postpartum Family Planning, New York: McGraw-Hill.

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