Family Planning Programmes Review

Eleanor Randall

January 2012
# Table of Contents

- Introduction .................................................................................................................. 3
- Bangladesh .................................................................................................................... 4
- Brazil ............................................................................................................................. 9
- Indonesia ....................................................................................................................... 13
- Iran ............................................................................................................................... 18
- Kerala ........................................................................................................................... 21
- Singapore ....................................................................................................................... 25
- South Korea .................................................................................................................. 29
- Vietnam ......................................................................................................................... 33
- Conclusion ..................................................................................................................... 38
Introduction

According to the UN family planning allows individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. It is achieved through use of contraceptive methods and the treatment of involuntary infertility. A woman’s ability to space and limit her pregnancies has a direct impact on her health and well-being as well as on the outcome of each pregnancy.¹

In this body of work I will analyse and discuss examples of the governments of specific countries which have succeeded in their methods of family planning. I examine the public rationales for the reasons behind the efforts of these countries to curb family planning, as well as the social, economic and political background of these family planning activities. Moreover I evaluate the differences in the total fertility rates after the governments put family planning methods into place and I determine whether or not the government used any coercive measures. I chose to base my case studies on specific countries which have managed to reduce their fertility and birth rates through successful and innovative family planning programs.

¹ http://www.who.int/topics/family_planning/en/
Bangladesh

Public rationale for the campaign

In the mid-1970s, a Bangladeshi woman had more than six children on average, in combination with poor nutrition and lack of access to quality health services; this high fertility rate jeopardized the health of both the woman and her children. Beyond the health impact, high fertility and rapid population growth represented a major constraint to the country’s economic development and social progress.

Relevant social, economic and political background

The history of successful family planning in Bangladesh started with resounding failure, in the early 1960s, when Bangladesh was an eastern province of Pakistan. The result of the 1947\(^2\) partition of India, the Pakistani government instituted a heavy-handed family planning program that went against local needs and preferences. The coercive approaches used eventually led to a popular backlash, contributing to the 1968\(^3\) collapse of the government. It was not until 1975, after a deadly famine and growing concerns about the demographic pressure on the country’s natural resources and economic prospects that the now-independent Bangladesh embarked on a renewed family planning program. As it did so, leaders recalled the cautionary tale of how attempts to affect the most profound decisions in families and communities led to political conflict.

The main challenges facing the program at the start, in 1975\(^4\), were low levels of knowledge about family planning, a prevailing belief that large families were best (typical of agrarian societies), low levels of women’s status, and lack of access to family planning services among the predominantly rural population particularly among women who had limited mobility. Each of these constraints was addressed through the program and through complementary public sector actions.

Details of government/ NGO family planning activities - quantified if possible

Bangladesh Family Planning Program evolved through a series of development phases that took place during the last 52 years. Family planning efforts in this country began in the early 1950s with voluntary efforts of a group of social and medical workers. Categorical family planning programs emerged during 1965-95 with the objective to control population growth as a strategy of economic development. The Family Planning Program in Bangladesh has undergone a number of transitional phases. The phases may be illustrated as follows:

Phase I\(^5\): 1953-59: Voluntary and semi-government efforts
Family Planning Association initiated family planning program in 1953 as a voluntary effort.

---

\(^3\) ibid
\(^4\) Ibid
\(^5\) http://www.dgfp.gov.bd/history_populationpro.htm
The effort was limited to the small-scale contraceptive distribution services in urban areas particularly through hospitals and clinics.

Phase II\(^6\): 1960-64: Government sponsored clinic-based Family Planning Program
In 1960 the government sponsored clinic-based family planning activities under health services started. The Government set up a target of providing family planning services to 6.7 percent of eligible couples and opened a family planning center in every hospital and Rural Dispensary.

Phase II\(^7\): 1965-70: Field-based Government Family Planning Program
The family planning program was launched throughout the country as a priority program. Full time field staff and part-time village organizers known as dai (a female village mid-wife) were recruited and trained to provide motivation and service close to the doorsteps of the rural people. Selected clinical and non-clinical methods were offered. (The program came to a standstill during the Liberation war in 1971.)

Phase IV\(^8\): 1972-74: Integrated Health & Family Planning Program
Administrative process for decision-making was shifted from the autonomous Family Planning Board and the Council to the Ministry of Health and Family Planning. (MCH-FP) Family planning services were functionally integrated with health services at the field level. The oral pill was introduced in the family planning program as a method of contraception. The provision of part-time village level dais was abolished.

Phase V\(^9\): 1975-80: Maternal and Child Health (MCH)-based Multi-sectoral Program
In August 1975, a separate Directorate of Family Planning and an independent Division of Population Control and Family Planning in the Ministry of Health were created. (MCH-FP) A National Population Council, the highest policy making body was constituted with the President of the People’s Republic of Bangladesh as the chairman and development-concerned ministries as members. A Central Co-ordination Committee was also formed with the Minister for Health and Family Planning to coordinate implementation and review the progress of multi-sectoral population activities under different ministries.
In January 1976, the Government declared the rapid growth of population as the number 1 problem of the country. In June 1976, the Government approved a National Population Policy outline. Full-time male and female field functionaries were recruited on regular basis to cause a thrust of the MCH-FP program in rural Bangladesh.

\(^6\) http://www.dgfp.gov.bd/history_populationpro.htm
\(^7\) ibid
\(^8\) ibid
\(^9\) ibid
Phase VI: 1980-85: Functionally Integrated Program
Delivery of MCH-FP services were functionally integrated with Health at Upazila level and below. MCH-FP became also a function of health officials.
The National Population Council (NPC) was reconstituted into high-powered National Council for Population Control (NCPC) headed by the President of the Council of Ministers.
An Executive Committee headed by the Minister for Health and Population was formed.
A unified command had been established at the top by the merger of the two divisions of Health and Population Control under one Secretary of the Ministry of Health and Population Control.
Upazila Family Planning Committee had been formed to be chaired by the Chairman of Upazila Paris had for facilitating implementation of the program at the local level.

Phase VII: 1985-90: Intensive Family Planning Program
A broad-based multi-dimensional intensive MCH-based family planning program was launched.
Improved family planning and MCH services were provided.
Satellite clinic, an outreach activity –was introduced to deliver MCH-FP services in remote & rural areas.
Involvement of community leaders and NGOs was increased.
Branch of National Council for Population Control was setup in each district under the chairmanship of District coordinator.
FP-MCH program as “Social Movement” was launched.

Phase VIII 10, 1990-95: Reduction of rapid growth of population through intensive service delivery and community participation
Expansion of MCH-FP service delivery with enhanced quality of care.
Increased resource allocation for program implementation.
Promoting family planning as an integral part of development activities through inter-sectoral collaboration.
Mobilizing community support and participation.
Increased involvement of NGOs and private sectors for supplementing and complementing government efforts.

Details of government and NGO family planning activities-quantified if possible

The early messages of the family planning campaign—“a small family is a happy family”—were not hitting the mark, so market researchers were asked to look at the problem. They found that almost all Bangladeshi women were in favor of family planning but for cultural reasons could not use contraception if their husbands objected to it. It was the men’s attitudes, rather than the women’s, that were the obstacle. Recognizing this, a mass media campaign was designed with minidramas for radio, television, movies, and mobile vans to appeal to male audiences. Within one year, male attitudes

10 http://www.dgfp.gov.bd/history_populationpro.htm
showed a change, with a much larger share of men doing what they were urged to do in the media campaign: talk with their wives about contraceptive options.\(^{11}\)

Mass media also were used to solve a problem the program faced: Harassment of the female outreach workers. In the program’s early days, before family planning was widely accepted, many outreach workers faced the threat of violence from irate villagers, primarily men. Thus, two of the country’s most renowned writers were asked to create a storyline that would show the value of the outreach workers’ efforts, in both urban and rural environments. A compelling soap opera heroine named Laila was created; in the drama, she eventually took a job as a family planning outreach worker. This gave an entertaining platform to convey messages both about family planning and about the importance of respecting the outreach workers\(^{12}\).

The third element of the program was the family planning clinics established in rural areas to provide clinical contraceptive services, to which outreach workers could refer clients who wished to use long-term or permanent methods such as sterilization. Eventually, about 4,000 government facilities and 200 nongovernment clinics were established. (Nongovernmental organizations cover something on the order of one fifth of family planning clients.) In the early days of the program, most of the clinics were dedicated only to the provision of family planning services. More recently, efforts have been made to develop an integrated approach, where health workers provide both family planning and basic maternal and child health services, such as immunization services.\(^{13}\)

The fourth element was the information, education, and communication activities that were intended to change norms about family size and provide information about contraceptive options. In particular, state-of-the-art use of mass media proved to be effective\(^{14}\).

Anecdotal information on family planning activities

The Bangladesh family planning program has depended on a large cadre of female outreach workers going door to door to provide information, motivate clients, and provide commodities; the program has used mass media to stimulate a change in attitudes about family size. The program both contributed to and benefited from improvements in women’s status in Bangladesh during the past 30 years.\(^{15}\)

Quoted results

Over the past three decades, Bangladesh has made impressive gains in indicators related to population and family planning. The total fertility rate (TFR) declined from 6.3 births per woman in 1970-1975 to the current rate of 3.3, a decline of 48% in just 25 years. However, there is a discrepancy between rural


\(^{12}\) ibid

\(^{13}\) ibid

\(^{14}\) ibid

\(^{15}\) ibid
and urban areas, with women in rural areas bearing one more child on average (3.5) than their counterparts in urban areas (2.5). The age at first marriage in Bangladesh is still young, although it is rising. Legal age of marriage for women has been increased from 14 to 18 years; the minimum for men is 21. In 2000, about 50% of women in Bangladesh were married by the time they were 15 years old, down from 60% just three years before. Still, 80% of Bangladeshi women marry during adolescence.

Among married women, 59% would prefer a two-child family and 22% consider a three-child family ideal. Overall, the mean ideal number of children is 2.5 among women, and 2.4 among men, indicating that men are not more pronatalists than women. Still family planning is practiced later in marriage, and newly wed couples continue to have children roughly at the same rate, as did their predecessors. Additionally, nearly half of users in Bangladesh discontinue their contraceptive method within 12 months of starting, with side effects or health concerns cited as the primary reasons. Nevertheless, birth intervals are generally long in Bangladesh; the median birth interval is 39 months.

A high level of public awareness and knowledge of family planning does not translate into an equivalent level of contraceptive use. There is still a social preference for larger families and a male offspring. Abortion is illegal except to save a woman’s life, and unsafe abortion is a major contributor to Bangladesh’s high rate of maternal mortality.

The public sector remains the primary source of family planning methods. Sixty-four percent of current users of modern methods obtain their methods from a public-sector source; 36% do so from a public facility and 28% from a government field worker. In 2000, 64% of pill users relied on government supplied brands, which are provided free of charge. Bangladesh’s NGOs are among the most active in the world. The government is currently encouraging NGOs to increase their level of family planning services provision. Experiences with private-public partnerships will be used.

Changes in the fertility rate

As a result of the program, virtually all women in Bangladesh are aware of modern family planning methods. The current use of contraceptives among married women increased from 8 percent in the mid-1970s to about 60 percent in 2004, and fertility decreased from an average of more than six children per woman in 1975 to slightly more than three. Although social and economic improvements

---

16 http://www.searo.who.int/LinkFiles/Family_Planning_Fact_Sheets_bangladesh.pdf
17 ibid
18 ibid
19 ibid
20 ibid
21 ibid
have played a major role in increasing demand for contraception, the provision of services and information has been shown to have had an independent effect on attitudes and behavior. Bangladesh’s family planning program demonstrated success in reaching its objectives of informing couples about contraceptive options, increasing the use of contraception, and decreasing fertility rates. By 1991, when a contraceptive prevalence survey was conducted, almost all Bangladeshi women had some knowledge of modern contraception. Between 1975 and 1997, the proportion of married women who had ever used contraception increased fivefold, from about 14 percent to nearly 70 percent. The current use of contraception (also known as the contraceptive prevalence rate, or CPR) increased by more than six times.

According to the United Nations the fertility rate in Bangladesh has dropped from 6.36 in 1955 to 2.16.

Judgment on whether or not there were coercive elements

I did not find any methods of coercion related to family planning in Bangladesh

**Brazil**

**Public rationale for the campaign**

Forty years ago in the rural areas of Brazil, families not infrequently had between ten and twenty children. In recent years that number has decreased, especially in the large cities. The average number of children in a family has gone from 6.3 in 1960 to 2.8 in 1993. Brazil is a good example of a country where a strong demand for smaller families arose spontaneously from previous declines in child mortality and changes in aspirations and opportunities. Unwittingly, the spread of television and its immensely popular soap operas, featuring small families, might have been crucial in the spread of new ideas favoring family planning.

**Relevant social, economic and political background**

In 1960, Brazil had a total fertility rate of 6.2 and a high rate of illegal abortion. From 1964 until 1985, the country was governed by military regimes that had no interest in attempting to curb population growth. Only in 1985 was family planning made available within the government health services, but supplies from this source remain erratic. The vacuum was filled in three main ways. First, BEMFAM

24 http://esa.un.org/unpd/wpp/unpp/panel_indicators.htm
25 http://www2.hu-berlin.de/sexology/IES/brazil.html
was created in 1964 as an affiliate of the International Planned Parenthood Federation by doctors concerned at the high rate of illegal abortions. By 1970, the organisation, with international funding, had agreements with many local municipalities to provide family-planning services. Second, the pharmaceutical industry, realizing that the market for contraceptives was growing, started selling oral contraceptives through pharmacies. Third, public-health doctors circumvented a law prohibiting tubal ligation by offering the procedure together with elective caesarean section, with costs of ligation subsumed by the costs of caesarean section, supplemented by under-the-table payments.

Details of the government, NGO and family planning activities

Officially, the Brazilian government had no action plan to meet the demand for methods of fertility control and birth spacing. In the absence of a policy guaranteeing access to contraceptive methods, the market (drugstores, health system and private institutions) started to fill this “void”.

In 1965, in order to fill the void created by the absence of public policies on reproductive health, the Family Well-Being Civil Society, known as BEMFAM, was created, which began offering family planning services. In 1967, BEMFAM joined the International Planned Parenthood Federation (IPPF). Other non-governmental, non-profit making organizations operating in the country included the Research Center for Integrated Mother and Child Health Care (CPAIMC), set up in 1975 and the Brazilian Association of Family Planning Agencies (ABEPF), established in 1981. However, the combined efforts of these entities only covered a limited portion of domestic demand for fertility regulation.

It was only after the World Population Conference in Bucharest in 1974 that the Brazilian government started to consider family planning as a right of individuals and couples. The Mother & Child Health Program, launched by the Ministry of Health in 1977, was the first action by the State in terms of the provision of family planning and included the prevention of high-risk pregnancies.

With the advent of political openness and the process of democratization at the beginning of the 1980s, the family planning issue started to be argued within a context of comprehensive women’s health. The result was the launch of the Program for Women’s Comprehensive Health Care (PAISM), launched in 1983, which viewed the context of family Planning in Brazil, the issue of women’s health in a comprehensive fashion, and did not limit itself exclusively to the issues of conception and contraception.

The PAISM was proposed to care for women’s health during the life cycle, and not just during pregnancy and breastfeeding, paying attention to all aspects of their health, including cancer prevention, gynecological care, family planning and infertility treatment, pre-natal care, as well as

28 ibid
during and after childbirth, diagnosis and treatment of Sexually Transmitted Diseases (STDs), as well as occupational and mental illness.

In the environment of the early 1980s, the notion of “comprehensive women’s health” was the concept employed to articulate those aspects related to biological and social reproduction, within the boundaries of citizenship.

Brazil succeeded in implementing legislation governing the practice of family planning. This is not to say that the country adopted a population policy based on birth control. The Brazilian State continued to reaffirm a position that was in conflict with the demographic goals, but there was recognition that the population was demanding a means of making its own reproductive decisions. In fact, the family planning law in Brazil relied upon the transfer of the Reproductive Rights concept approved at the International Conference on Population and Development (ICPD) in Cairo in 1994, and it was sanctioned at a time when fertility transition was already well underway.

In fact, the demand for contraceptive methods had been growing gradually larger since the 1960s when the average number of children per woman in Brazil began to fall. In around 40 years, the Total Fertility Rate (TFR) that had been over 6 children per woman reached the replacement level (2.1 children) in 2005 and is now in the range of 1.8 to 1.9 children per woman, according to the National Demographic and Health Survey and the National Household Survey, respectively. Nevertheless, the national average rides socio-economic differences in fertility rates that exist in the country.

The Brazilian Parliament began to debate legislation on the topic, and in 1996, the National Congress approved Law 9263. This law incorporates much of what had been previously discussed within the country about family planning in terms of the rights of women, men and couples, being part of a package of global and integral healthcare actions and it also prohibits any coercive measures.

**Anecdotal information on family planning activities:**

Lucelia Carvalho, 34, who lives with her six-month-old daughter in Rio de Janeiro’s largest slum, says she will restrict her family to only one more child, following in her mother’s footsteps.

“My grandmother had 10 children but didn’t have radio or television,” she said. Television, including the wildly popular novelas or soap operas, has had a huge influence on lifestyle choices. Novela families have just one or two children.

Despite long-standing opposition from the Catholic Church, President Fernando Henrique Cardoso endorsed the program earlier this year. Advocates of the plan have passed it off as a means of reducing abortions.

---

30 ibid
31 http://pulitzercenter.org/projects/brazil-family-planning-birth-rate-women-health
True to form, the population-control plan applies to men and women over 25, or who already have two children. Sterilizations will be paid for at taxpayer expense in public hospitals. Currently a bill to legalize abortions in cases or rape or “risk” to the mother is working its way through Congress[^32].

**Quoted results**

The Brazilian woman is having fewer children than in the past. The average number of children for Brazilian women has been steadily decreasing over the last four decades. The 1991 Census reported an average of 2.7 children as compared to 6.28 children in 1960, 5.76 children in 1970, and 4.35 children in 1980[^33].

The decrease may be attributed to several factors, including the use of contraceptives, sterilization, and abortion, as opposed to the worldwide economic and social reasons for the decline. Government campaigns carried on television and in newspapers inform people on the need to prevent an excessive growth of the population that does not have the necessary infrastructures, especially work and food supplies, to support it.

The small family model has been in place in the large Brazilian cities since 1960, when the average of 6.3 children per family started to drop to the current 2.8[^34] children per family. In rural areas, which comprises the largest area of the country, the average number of children in a family is still high at 5.7[^35]. However, we can assume that an accentuated drop in fertility in Brazil has resulted from the family planning campaigns. Reports tell us that 65 percent of the Brazilian couples of reproductive age use some type of contraceptive, with female surgical sterilization predominating. In Brazil, female surgical sterilization accounts for 27 percent of the contraceptive usage[^36].

**Changes in the total fertility rate**

The fertility rate in 1955 was 6.15 which was reduced to 1.90 in 2010[^37].

**A judgement of whether there were coercive elements**

There weren’t any coercive elements.

[^33]: Books.google.co.uk/books?isbn=0826414885
[^34]: http://www2.hu-berlin.de/sexology/IES/brazil.html
[^35]: ibid
[^36]: ibid
[^37]: http://esa.un.org/unpd/wpp/unpp/p2k0data.asp
Indonesia

Public rationale for the campaign

Today, Indonesia is recognized as an international leader in family planning and reproductive health. It has one of the world’s most successful programs. In the 1960s, Indonesian women routinely had six children, at least two of whom would die before reaching school age. Realizing that preventing rapid population growth was important to both Indonesia’s future and to its family’s wellbeing.

Social economic and political background

In 1956 The U.S. Agency for International Development funds Indonesian doctors to train in family planning techniques in New York. President Sukarno refuses to consider government support for family planning.

In 1957 The Voluntary Indonesian Planned Parenthood Association is established as a private, nonprofit, nongovernmental organization to offer contraception to women through a network of largely urban clinics.

In 1965 An attempted coup triggers the fall of the Sukarno regime and the emergence of the New Order government of General Suharto, who becomes acting president in March 1967. Under the so-called New Order (new regime) that came to power in 1966, President Suharto signed the World Leaders’ Declaration on Population in 1967 and set up a family planning program. By the mid-1980s Indonesia had achieved nearly universal primary education, a feat made possible as a result of a concurrent and very successful birth control program which slowed population growth 2002. The program was called, the PKBI (“Perkumpulan Keluarga Berencana Indonesia” – the Indonesian Family Planning Association), and was founded specifically to aid families in planning the number of children they’d like to have. During its initial years of operation, its primary activities included advocacy and broad information program that included marriage counseling, infertility therapy, and birth spacing clinics. The program was initially supported by the actions of individuals and international sponsors, and opposed by the national government.

But when Suharto declared population control and family planning to be a key element of his New Order government the PKBI was formalized and supported by the national government, and its well-established framework became extraordinarily amenable to the diffusion of what was now official government policy regarding population planning.

The New Order was concerned with economic growth and political stability, with the stress on

39 Books.google.co.uk/books?isbn=0821369512
40 ibid
41 books.google.co.uk/books?isbn=0821369512
economic restructuring and social control. 42

**Details of govt /NGO family planning activities**

President Suharto’s central role in the formation of the family planning program and his unswerving support for its implementation was internationally recognized in 1989, when the United Nations gave him its Population Award. While Suharto clearly made an outstanding contribution to the program over two decades, the details of the events surrounding the initiation of the government program are important because of the insight they provide into the difficulties of overcoming government inertia and hostility toward family planning. They also clarify some of the dynamics encountered in Indonesian politics at a time when the structures of governance were undergoing substantial renovation 43.

Sadikin was the first political leader to commit those resources. The Jakarta Pilot Project, the country’s first government-funded family planning program, was up and running by April 1967. The governor frequently assisted its activities by making strong speeches of support at the opening of clinics and seminars and by encouraging the integration of family planning activities with activities under taken by the city’s Health Department. Between 1966 and 1968, most official family planning initiatives were taken under the aegis of the city government, and later, as programs began in other areas, the example of Jakarta was cited as proof that strong, responsive leadership could overcome the problems of religious opposition and community intransigence 44.

Concentrating on actions by individuals such as Suharto and Sadikin prevents an understanding of the environment in which the debate took place and changing attitudes in the broader community. One example illustrates how fragile the situation was and how important the political factor was in the development of family planning in Indonesia. One of the key activities leading to the establishment of an official family planning program in 1968 was the compilation and publication of a pamphlet on “Views of Religions on Family Planning” 45.

Based on a panel discussion that included government representatives and religious leaders in February 1967, the purpose of the pamphlet was to document the general acceptance of principles of family planning by four of the five officially recognized religions: Islam, Protestant Christianity, Catholic Christianity, and Balinese Hinduism. The consultations did not include Buddhists, as at that time many Indonesians did not recognize Buddhism as a religion. The discussion and the pamphlet captured an important moment in social change, a tipping point when national consensus around the morality of birth control was turning from strongly negative to strongly positive 46.

42 ibid
45 ibid
46 ibid
One very important ingredient was national leadership. There were many things wrong with Suharto, and the man was responsible for countless human rights violations, but one of the things the dictator apparently got right was that any possibility of development would be choked by unrestrained population growth. As Jose Ferraris, the United Nations Population Fund (UNFPA) representative in Indonesia, put it, “Suharto had vision. He saw things thirty years down the road, and he provided the high-level political will.”

Second, the population program became a mass movement. “It began as a top-down movement, but it soon became a bottom-up movement,” says Ferraris. Innovative organizing at the village level sustained the momentum of the program, and central to this process was a charismatic individual named Haryono Suyono, who was described as a “cross” between Juan Flavier, the dynamic Filipino civil society figure, and Meechai Viraidya, a central figure in the history of family planning in Thailand. Highly motivated field workers promoted the idea of “small, healthy, prosperous and happy family.” Signs proclaiming, “Two Children are enough” were planted everywhere, and blue chromatic circles were imprinted on houses whose residents were practicing contraception.

Third, the program was integrated into income-support programs. One of the major reasons for successful expansion of village family planning groups in Indonesia was the ability of National Family Coordinating Board (BKKBN) to come up with innovations to make these groups more attractive to village women that served as incentives for women to limit births. Making micro-credit available was one such initiative, analyst Ashok Barnwal claims, “The BKKBN provided funds with low interest rates to the groups for micro-credit purposes…requiring family planning use for a specific period of time before they could have access to these low interest loans. This worked like an incentive to use the family planning methods. This intervention also helped in strengthening the government–society link.”

A fourth reason was an active government effort to recruit religious leaders to support the process. The role of the ulamas or Muslim leaders trained in Islamic doctrine and laws was critical in convincing Indonesia’s majority Muslim population, so the BKKBN initiated a sustained dialogue with them. The decisive outcome of this effort was the ulamas’ issuing of a fatwa, or religious opinion, supporting the use of contraceptive methods except for vasectomy. As a result, about 90 per cent of the Muslim community now supports family planning, according to Eddy Hasmi, head of BKKBN’s Center for International Training and Collaboration.

The family planning leaders were aware of possible problems with the minority Catholic community, so, as they did with the Muslim leaders, they placed a special effort on a constructive dialogue with the Catholic hierarchy. According to Hasmi, the Church in Indonesia supports family planning, and though

47 http://goodnewsfromindonesia.org/2011/07/19/indonesia-a-lesson-for-the-philippines/
48 ibid
49 http://goodnewsfromindonesia.org/2011/07/19/indonesia-a-lesson-for-the-philippines/
50 ibid
it does not endorse the use of contraceptives, it does not actively oppose it. According to UNFPA’s Ferraris, there is dialogue between the State and the Catholic Church, and the process has been made easier by the “relative independence of the Indonesian Catholic Church.” The attitude of the Indonesian Church is that family planning is a matter of moral choice by the individual, and this moral choice can only be exercised “if it is based on information.” The liberal attitude of the Indonesian Catholic hierarchy is evident in its approving the distribution of a government family planning booklet titled “Building a Prosperous and Responsible Family: the Catholic Perspective,” which has 11 pages that describe in detail the different methods of artificial contraception.

Quoted results

For most women in Indonesia first sexual intercourse occurs at the time of marriage. While in 1997 half of women aged 25-49 married at 18.6 years, by 2002/3 the age at first marriage had risen to 19.2 years. The average woman in Indonesia has become a mother or is pregnant by the age 21. Women in urban areas tend to have fewer children compared to women in rural areas. 60.3% of currently married women were using contraception in 2003. Injectables, which account for almost half of all family planning methods used, followed by oral contraceptives are the most widely used methods in Indonesia. The current contraceptive method mix also includes the IUD, whose popularity is decreasing, and implants. The use of permanent methods such as sterilization (male and female) remains low, as does condom use. The most common reasons for choosing a specific method include side effects of other methods (27%), convenience (22%), and the desire for a more effective method.

Based on data from surveys and in-depth studies, women who would prefer to avoid pregnancy do not use contraception because of: Constraints in access to and quality of family planning services. Shortages or an unreliable supply of contraception, method failure, Health concerns about contraceptives and side effects, lack of information, opposition from husband, family and community as well as little perceived risk of pregnancy. (18%). Nevertheless, the total demand for family planning in Indonesia is 70%, of which 88% is currently satisfied.

Changes in Total Fertility Rate

According to the UN fertility was 5.49 and has decreased to 2.06 in 2010.

51 http://goodnewsfromindonesia.org/2011/07/19/indonesia-a-lesson-for-the-philippines/
52 http://www.searo.who.int/LinkFiles/Family_Planning_Fact_Sheets_indonesia.pdf
53 http://www.searo.who.int/LinkFiles/Family_Planning_Fact_Sheets_indonesia.pdf
54 ibid
55 http://esa.un.org/unpd/wpp/unpp/p2k0data.asp
During the Suharto regime, a family planning policy that began in the early 1970s was practically forced, with program counselors knocking on doors to ask people, mostly women, to use contraceptives. The counselors would chase people down to join the program, and those who refused to join were threatened with, among other punishments, forced transmigration to rural areas of Indonesia, according to the Urban Poor Consortium, a nongovernmental organization based in Jakarta.

The country at that time had a high fertility rate of 5.6 children per family. Population experts issued dire warnings about the effects of a huge population on the country’s economy. “We were given a target to find a certain number of couples every week to join the program. It was kind of embarrassing if we didn’t make it,” said Robiyatun, 51, who has worked as a family planning counselor in East Jakarta since 1985. The New York-based Lawyers Committee for Human Rights, now called Human Rights First, reported in 1995 that military officers were also deployed to recruit people to use contraceptives.

Hundreds, even thousands, of contraceptive distribution points and posyandu, or child health care posts, were established throughout the country and staffed with counselors. Even though sex education in Indonesian schools is limited, students nationwide had to learn a song called “Keluarga Berencana” (Family Planning), a military-style marching tune regularly played on national television and radio stations with the lyrics, “The family planning program is important for a bright future. Healthy, strong and smart children are the nation’s hope.” Couples that ignored the song’s message, however, were scolded by government officials, subjected to whispering campaigns and singled out in their communities.

Civil servants who had more than two children were denied the education tuition subsidies that were part of their employment packages. Despite criticism of the Gestapo-like tactics used to enforce the two-children limit and the basic suspension of women’s reproductive rights — couples were not allowed to select which form of contraception best suited their needs Suharto’s family planning program was an unqualified success. Indonesia’s fertility rate dropped from 5.6 percent in the 1970s to 3 percent in 1991, and is presently 2.3 percent. The program was hailed as one of the world’s best by various international organizations, and Indonesia became a model for other countries with booming populations.

---

58 ibid
Iran

Any public rationale for the campaign

Having convinced many top policymakers of the importance of family planning, the Plan and Budget Organization as well as the ministry of health and medical education decided to launch a publicity campaign to convince other members of the policy elite and the general public about the need for a national population policy. The much-publicized three-day Seminar on Population and Development was held in Mashad in September 1988. The Iranian media helped disseminate the seminar’s main message: Iran’s population growth rate was too high and, if left unchecked, would have serious negative effects on the national economy and the welfare of the people.

Any relevant social, economic or political background

At a press conference at the end of the Mashad seminar, the minister of health and medical education reiterated the late Imam Khomeini’s fatwa regarding family planning, and announced that the Islamic Republic of Iran would establish a family planning program. In December 1988, the High Judicial Council declared, “there is no Islamic barrier to family planning.” The Mashad seminar was mainly a professional and technical gathering; the influential clergy (ulama) outside the central government were not involved in the seminar’s deliberations. To ensure that the proposed policy would have the clergy’s support, family planning was singled out for special consideration and discussion at the February 1989 seminar on “Islamic Perspectives in Medicine,” which was attended by eminent clergy and physicians.

Details of the government, NGO family planning activities- quantified if possible

The family planning program, officially inaugurated in December 1989, had three major goals: to encourage families to delay the first pregnancy and to space out subsequent births; to discourage pregnancy for women younger than 18 and older than 35, and to limit family size to three children. The ministry of health and medical education has been given almost unlimited resources to provide free family planning services to all married couples, promote small families as the norm, and help couples prevent unplanned pregnancies.

All modern contraceptive methods are available to married couples, free of charge, at public clinics. In

60 ibid
61 ibid
1990, to remove continuing doubts about the acceptability of sterilization as a method of family planning, the High Judicial Council declared that sterilization of men and women was not against Islamic principles or existing laws.\textsuperscript{62}

In 1993, the legislature passed a family planning bill that removed most of the economic incentives for large families. For example, some allowances to large families were cancelled, and some social benefits for children were provided for only a couple’s first three children. The law also gave special attention to such goals as reducing infant mortality, promoting women’s education and employment, and extending social security and retirement benefits to all parents so that they would not be motivated to have many children as a source of old age security and support.

In 1989, the government restored its family planning programme. In May 1993, a national family planning law was passed. The resources of several government ministries, including education, culture and health, were mobilized to encourage smaller families.\textsuperscript{63}

Iran Broadcasting was given responsibility for raising awareness of population issues and of the availability of family planning services. Television was used to disseminate information on family planning throughout the country, taking advantage of the 70\% of rural households with TV sets. Religious leaders were directly involved in what amounted to a crusade for smaller families.\textsuperscript{64}

Some 15,000 “health houses” or clinics were established to provide rural populations with health and family planning services. Iran introduced full panoply of contraceptive measures, including the option of vasectomy – a first among Muslim countries. All forms of birth control, including the pill and sterilization, were free of charge. Iran even became the only country to require couples to take a course on modern contraception before receiving a marriage license.\textsuperscript{65}

Improvements in female education have also contributed to increased use of contraceptives. The percentage of rural women who were literate increased from 17 percent to 62 percent between 1976 and 1996; more than 75 percent of Iranian women are literate. The rate of secondary school enrollment has more than doubled for girls, from 36 percent in the mid-1980s to 72 percent in the mid-1990s, while boys’ enrollments have increased from 73 percent to 81 percent over the same time span. In 2000, more women than men entered universities. The longer women stay in school, the higher the standard of living they want for themselves and their families. The quality of children’s lives also becomes more important.\textsuperscript{66}

\textsuperscript{62} http://www.prb.org/pdf/IransFamPlanProg_Eng.pdf
\textsuperscript{63} http://www.prb.org/pdf/IransFamPlanProg_Eng.pdf
\textsuperscript{64} http://www.guardian.co.uk/global-development/2011/apr/14/smart-family-planning-reduces-poverty
\textsuperscript{65} ibid
\textsuperscript{66} http://www.prb.org/pdf/IransFamPlanProg_Eng.pdf
Anecdotal information on family planning activities

Population education is part of the curriculum at all educational levels; university students, for example, must take a two-credit course on population and family planning. Family planning is also included in the country’s adult literacy campaign. Couples who are planning to marry must participate in government-sponsored family planning classes before receiving their marriage license. The classes are mandatory for both prospective brides and grooms, supporting the family planning program’s goal of increasing male involvement and responsibility in family planning. The family planning program, which is attempting to increase men’s participation in family planning, uses more than just education to support men’s involvement: Additionally, The Middle East’s only condom factory operates in Iran. Men are encouraged by religious leader to practice family planning. If family planning programs are to succeed in Muslim countries, religion must be addressed carefully and in a culturally sensitive manner.67

Quotes results
The decline in fertility has mainly been due to the increase in contraceptive use among married women: In 2000, 74 percent of married women practiced family planning, up from 37 percent in 1976. The change in marriage patterns has also affected fertility: Women’s average age at first marriage increased from 19.7 in 1976 to 22.4 in 199668. Iran has experienced one of the most successful family planning programs in the developing world, with 64 percent decline in total fertility rate (TFR) between 1986 and 2000. Iran has experienced one of the fastest fertility reductions in the world. A fertility decline of more than 50% in a single decade is not only unique for a Muslim country but has never been recorded elsewhere69

Changes in fertility rate
According to the UN, in 1950 the fertility rate was 6.93, this has decreased to 1.59 in 2010.70

A judgement on whether there was coercive elements
There weren’t any coercive measures used in my findings.

67 http://www.defendersfje.org/dpi/id15.html
69 http://lake.k12.fl.us/files/iran_family_planning.pdf
70 http://esa.un.org/unpd/wpp/unpp/p2k0data.asp
Kerala

Public rationale for the campaign

The Indian government, anxious to hold the galloping population growth, launched the programme immediately after the country gained freedom. The programme evoked far greater response in Kerala than elsewhere in the country.

Historically Kerala was fortunate in having enlightened rulers in the states of Cochin and Travancore, which were amalgamated in 1956 to form the state of Kerala. Both ruling families encouraged the development of education and health services, and this has been continued under successive state governments.71

Any relevant social/ economic/ political background

Population growth has long been a concern of the government, and India has a lengthy history of explicit population policy. In the 1950s, the government began, in a modest way, one of the earliest national, government-sponsored family planning efforts in the developing world. The annual population growth rate in the previous decade (1941 to 1951) had been below 1.3 percent, and government planners optimistically believed that the population would continue to grow at roughly the same rate. Implicitly, the government believed that India could repeat the experience of the developed nations where industrialization and a rise in the standard of living had been accompanied by a drop in the population growth rate.

In the 1950s, existing hospitals and health care facilities made birth control information available, but there was no aggressive effort to encourage the use of contraceptives and limitation of family size. By the late 1960s, many policymakers believed that the high rate of population growth was the greatest obstacle to economic development. The government began a massive program to lower the birth rate from forty-one per 1,000 to a target of twenty to twenty-five per 1,000 by the mid-1970s.72 The National Population Policy adopted in 1976 reflected the growing consensus among policy makers that family planning would enjoy only limited success unless it was part of an integrated program aimed at improving the general welfare of the population. The policy makers assumed that excessive family size was part and parcel of poverty and had to be dealt with as integral to a general development strategy.73

72 http://countrystudies.us/india/34.htm
73 http://countrystudies.us/india/34.htm
The fall in the birth rate in the early sixties could have been the consequence of the decline in infant and child mortality rates during the latter fifties, following the extension of primary health centres and other public health measures over a period of time. It is also seen, on the basis of available data and 'guesstimates' with respect to the pattern of changes that might have taken place in birth, death and infant mortality rates during the period from 1951 onwards, that such demographic evidence as there is for this period is not inconsistent with the trends actually observed in enrolment to the first year of primary schooling.

During the 1980s, an increased number of family planning programs were implemented through the state governments with financial assistance from the central government. In rural areas, the programs were further extended through a network of primary health centers and subcenters. By 1991, India had more than 150,000 public health facilities through which family planning programs were offered. Four special family planning projects were implemented under the Seventh Five-Year Plan 1985-8974. One was the All-India Hospitals Post-partum Programme at district- and subdistrict-level hospitals. Another program involved the reorganization of primary health care facilities in urban slum areas, while another project reserved a specified number of hospital beds for tubal ligature operations. The final program called for the renovation or remodeling of intrauterine device (IUD) rooms in rural family welfare centers attached to primary health care facilities. Despite these developments in promoting family planning, the 1991 census results showed that India continued to have one of the most rapidly growing populations in the world75.

Details of government/ NGO family planning activities - quantified if possible

The Centre for Development Studies at Thiruvananthapuram with the help of United Nations, conducted a case study of selected issues with reference to Kerala in 1970s. The results and recommendations of this study came to be known as the 'Kerala Model' of equitable growth, which emphasized land reforms, poverty reduction, educational access and child welfare. Professor K. N. Raj, a renowned economist who played an important role in India's planned development, drafting sections of India's first Five Year Plan, and a member of the first UN Committee for Development Planning in 1966, was the main person behind this study.

This miraculous fall in population growth was a measure of the success of the family planning programme. The Indian government, anxious to hold the galloping population growth, launched the programme immediately after the country gained freedom. The programme evoked far greater response in Kerala than elsewhere in the country.

The basis for the state’s impressive health standards is the statewide infrastructure of primary health centres. There are over 2,700 government medical institutions in the state, with 330 beds per 100,000 populations, the highest in the countries. With virtually all mothers taught to breast-feed, and a state-
supported nutrition programme for pregnant and new mothers, infant mortality in 2001 was 14 per thousand, compared with 91 for low-income countries generally\^76\%.\(^1\)

The historical factors, in a way, prompted the successive democratically elected governments in Kerala to continue to invest in education, health, and other social development sectors. Consequently, the literacy in the state increased continuously, and the health indicators showed much progress towards attaining the World Health Organization’s target of Health for All by 2000. The overall social change brought in by these measures resulted in higher social equity and capillarity, higher age at marriage for girls and boys, and lower son preference. In other words, a much-needed social norm for smaller families began to emerge among all sections of Kerala society. These factors, along with intensive family-planning campaigns since the 1970s, resulted in higher rates of contraceptive prevalence.

Women are being educated. Around half of all Indian women cannot read or write (illiterate). However, in Kerala 85% of women are literate. Better-educated women are more likely to keep their children healthy. Therefore infant mortality has dropped. This has led to a drop in birth rates. If children are surviving families no longer have to have a couple of extra children to replace those that die. Contraception is more widely available. The status of women has improved significantly. Women are no longer seen as a burden they are regarded as an asset. Traditionally in India when a woman gets married the family have to pay money to the bridegroom’s family. This is called a dowry. However, in Kerala it is the bridegroom's family who pay a dowry to the bride's family.

More powerful, perhaps, has been the spread of education across Kerala. Literate women are better able to take charge of their lives; the typical woman marries at 22 in Kerala, compared to 18 in the rest of India. On average around the world, women with at least an elementary education bear two children fewer than uneducated women. What's more, they also want a good education for their children. In many cases that means private schools to supplement public education, and people can't afford several tuitions. Kerala's remarkable access to affordable health care has provided a similar double blessing. There's a dispensary every few kilometers where IUDs and other forms of birth control are freely available, and that helps. But the same clinic provides cheap health care for children, and that helps even more. With virtually all mothers taught to breast-feed, and a state-supported nutrition program for pregnant and new mothers, infant mortality in 1991 was 17 per thousand, compared with 91 for low-income countries generally\^77.

Anecdotal information on family planning activities:

One of the reasons that the birth rates have fallen so successfully in Kerala compared to the rest of India is that the Kerala government empowers women, has a good health care system and tries its best to eradicate poverty. Kudumbashree, which means prosperity of the family, is the name of the women oriented, community based, State Poverty Eradication Mission of Government of Kerala.

---


\(^77\) [http://www.ashanet.org/library/articles/kerala.199803.html](http://www.ashanet.org/library/articles/kerala.199803.html)
The mission aims at the empowerment of women; through forming self help groups and encouraging their entrepreneurial or other wide range of activities. The purpose of the mission is to ensure that the women should no longer remain as passive recipients of public assistance, but active leaders in women involved development initiatives. Kudumbashree project for poverty reduction launched on 17 May 1998.78

The mission of Kudumbashree is “to eradicate absolute poverty in ten years through concerted community action under the leadership of local governments, by facilitating organization of the poor for combining self-help with demand-led convergence of available services and resources to tackle the multiple dimensions and manifestations of poverty, holistically”.79

The specific objectives are: identification of the poor families through risk indices based surveys, with the active participation of the poor and the communities to which they belong. Empowering the poor women to improve the productivity and managerial capabilities of the community by organizing them into CBOs. Encouraging thrift and investment through credit by developing (community development societies) CDSs to work as informal bank of the poor. Improving incomes of the poor through improved skills and investment for self -employment. Ensuring better health and nutrition for all. Ensuring basic amenities like safe drinking water, sanitary latrines improved shelter and healthy environment. Ensuring a minimum of 5 years of primary education for all children, belonging to risk families. Enabling the poor to participate in the decentralization process through the CDS, as it is subsystem of the local government, under which it works.

To achieve the specific objectives of the Mission, several auxiliary objectives are pursued methodically80.

Quoted results

In Kerala the birth rate is 40 per cent below that of the national average and almost 60 per cent below the rate for poor countries in general. In fact, a 1992 survey found that the birth rate had fallen to replacement level.1 Kerala’s birth rate is 14 per 1,000 females and falling fast. India's rate is 25 per 1,000 females and that of the U.S. is 16. Kerala’s infant mortality rate is 12 per 1,000 births versus 53.0 for India and 7 for the US.81 Its adult literacy rate is 94.59 per cent compared to India’s 65 and the US's 99. Life expectancy at birth in Kerala is 75 years compared to 64 years in India and 77 years in the US. Female life expectancy in Kerala exceeds that of the male, just as it does in the developed world. By contrast, Kerala's maternal mortality rate is poor: 262 for every one live births, compared

78 indiagovernance.gov.in/files/kudumbashree-casestudy.doc
79 http://www.kudumbashree.org/?q=vision
80 http://charitiesinindia.net/kudumbashree-kerala-empowering-the-poor-women-to-improve-the-productivity
81 dictionary.sensagent.com/kerala+model/en-e
with 60 in Sri Lanka\textsuperscript{82}.

Changes in the total fertility rate

In 1950 the fertility rate was 5.90 and it is now 1.7\textsuperscript{83}

A judgment of whether there were coercive elements.

There were no findings on coercive elements related to family planning in Kerala

**Singapore**

Public rationale for the campaign:

Singapore’s post-war baby boomers were in their productive years by the 1940s and the country experienced exponential rates of population growth. This led to social problems such as food and housing shortages, and raised concerns over the welfare of mothers who underwent multiple pregnancies (some as many as 19 pregnancies) and the unwanted children produced by families without the means to support them. Up till then, family planning was perceived as a personal family matter rather than a national concern\textsuperscript{84}. Pioneers advocating the practice of family planning identified the problem as being the number of children produced in excess of their families’ financial means. Hence, in early 1949, several concerned volunteers suggested that family planning advice be made available to mothers at infant welfare clinics. With permission from the municipality, a weekly family planning session was introduced at three of five municipal clinics, but it soon became evident that the service should be expanded to address the problem and that a voluntary body akin to the Family Planning Association of Great Britain should spearhead the work.

The first family planning campaign began in October 1960. The three-month campaign aimed to raise awareness of the disadvantages of large, unplanned families and the need for family planning. The campaign also began s in order to direct those in need of family planning advice to sources available at clinics, hospitals and private dispensaries.

Social, Economic and political background

\textsuperscript{82} dictionary.sensagent.com/kerala+model/en-e
\textsuperscript{83} http://mohfw.nic.in/NRHM/State%20Files/kerala.htm
\textsuperscript{84} http://infopedia.nl.sg/articles/SIP_1650_2010-02-26.html
Concerned with alleviating the burden of mothers due to the endless cycle of child-bearing and raising, and the multitude of children who were poorly provided for, a meeting was held at the Young Women’s Christian Association (YWCA) on 22 July 1949, presided over by Sir Percy McNeice (head of the Social Welfare Department), that led to the formation of the SFPA. Present at this historic meeting were two women who are today regarded as pioneers of the family planning movement in Singapore: Mrs Goh Kok Kee, first chairman of the SFPA, who subsequently co-founded the International Planned Parenthood Federation; and Celeste Amstutz, president of the YWCA. Following this, the atmosphere of crisis after the 1965 separation from Malaysia, led the government in 1966 to establishing the Family Planning and Population Board, which was responsible for providing clinical services and public education on family planning.

Details of the govt / NGO family planning activities

In the initial years, the SFPA targeted mainly mothers. Those who welcomed the idea of family planning nonetheless had unfounded doubts about the safety of contraceptive methods, the sinister motives of family planning workers, and the morality of using contraception. Referrals from professionals, volunteers and SFPA staff, either formally or informally, were the most effective way of drawing potential patients to the clinics. Those who accepted family planning methods themselves also spread the word, making informal referrals an effective means of disseminating the family planning cause.

On their first visit to the clinic, patients were introduced to the major methods of contraception - the diaphragm, condom, foam tablet, and applicator and paste. They were then asked to indicate their preferred contraceptive and would receive a detailed explanation of the method. Supplies would then be given and a follow-up visits for an update on the acceptability of the selected method. Acceptors often tried several methods before settling on one.

A follow-up programme was implemented to monitor an acceptor’s attitudes towards contraception and their use of the contraceptives provided. Prior to the introduction of the oral pill in 1961, the most popular contraceptive methods were the diaphragm, the condom and the foam tablet. Patients who failed to revisit the clinics for supplies or check-ups after six months were sent a reminder letter, followed by a second letter if necessary. If these measures failed, a visit would be made to the home. Home visits were effective in persuading patients back to the clinics and to the use of contraceptives.

One reason was that some found their own home environment more comfortable than the clinic and hence could better understand the family planning advice given by the staff. However, making

85 http://infopedia.nl.sg/articles/SIP_1650_2010-02-26.html
86 ibid
home visits was not easy as addresses in rural areas were difficult to locate and, unknown to SFPA staff, patients sometimes moved and resettled elsewhere. The perseverance of the family planning workers in following up with their patients showed their dedication to the family planning cause.

Besides contraceptives, the SFPA also offered sterilisation services. As this was a drastic measure, it was clearly conveyed to patients and conducted only after careful consideration of their profile. Many pregnant women sought abortion services at the SFPA’s clinics, but the practice was illegal until 1970 and hence not available. Family planning becomes a national concern In 1964; the SFPA requested that the Ministry of Health take over all family planning activities conducted by the SFPA at government clinics. In 1966, the Family Planning and Population Board was established and assumed the duties of the SFPA in overseeing family planning services in 26 government clinics, signaling that family planning was now a national concern. By this time, the SFPA had provided family planning services to 88,000 women in the two decades of its existence, and was registering close to 10,000 new cases annually.

The Family Planning and Population Board (FPPB) was established, initially advocating small families but eventually pushing for zero population growth into what became popularly known as the Stop at Two programme, also referred to in academia as the "anti-natalist" era.

Anecdotal information on family planning activities:

In the late 1960s, Singapore was a developing nation and had not yet undergone the demographic transition; though birth rates fell from 1957 to 1970, in 1970, birth rates rose as women who were they the product of the postwar baby boom reached maturity. Fearing that Singapore's growing population might overburden the developing economy; Lee started a vigorous Stop at Two family planning campaigns. Abortion and sterilization were legalized in 1970, and women were urged to get sterilized after their second child. Women without a O-level degree, deemed low-income and lowly-educated, were offered by the government seven days' paid sick leave and $10,000 SGD in cash incentives to voluntarily undergo the procedure.

A historical poster from the widespread "Stop at Two" campaign, which created many posters across different languages that were displayed in schools, hospitals and public workplaces.

The government also added a gradually increasing array of disincentives penalizing parents for having more than two children between 1969 and 1972, raising the per-child costs of each additional child:

- Workers in the public sector would not receive maternity leave for their third child or any subsequent children

87 http://infopedia.nl.sg/articles/SIP_1650_2010-02-26.html
88 wn.com/eugenics_in_Singapore
89 siteresources.worldbank.org/.../GlobalFamilyPlanningRevolution.pdf
• Hospitals were required to charge incrementally higher fees for each additional child.
• Income tax deductions would only be given for the first two children.
• Large families were penalized in housing assignments.
• Third or fourth children were given lower priorities in education.
• Top priority in top-tier primary schools would be given only to children whose parents had been sterilized before the age of forty.\textsuperscript{90}

The government created a large array of public education material for the Stop at Two campaign, in one of the early examples of the public social engineering campaigns the government would continue to implement (e.g. the Speak Mandarin, Speak Good English, National Courtesy, Keep Singapore Clean and Toilet Flushing Campaigns) that would lead to its reputation as "paternalistic" and "interventionist" in social affairs. The "Stop at Two" media campaign from 1970 to 1976 was led by Basskaran Nair, press section head of the Ministry of Culture, and created posters with lasting legacy: a 2008 Straits Times article wrote, "many middle-aged Singaporeans will remember the poster of two cute girls sharing an umbrella and an apple: The umbrella fit two nicely. Three would have been a crowd." [This same poster was also referred to in Prime Minister Lee Hsien Loong's 2008 National Day Rally speech. Many other posters from the "iconic" campaign included similar themes of being content with two girls, in order to combat the common trend in developing Asian societies for families with only daughters to continue, "trying for a boy".\textsuperscript{91}

\textbf{Quoted results}

The crude birth rate peaked in 1957 at 42.7 per thousand. Beginning in 1949, family planning services were offered by the private Singapore Family Planning Association, which by 1960 was receiving some government funds and assistance. By 1965 the crude birth rate was 29.5 per 1,000 and the annual rate of natural increase had been reduced to 2.5 percent.\textsuperscript{92}

\textbf{Changes in the fertility rate:}

According to the United Nations the fertility rate in 1950 was 6.61 and has gone down in 2010 1.25.\textsuperscript{93}

\textbf{Judgement on whether or not there were coercive elements:}

Between 1969 and 1972, a set of policies known as "population disincentives" were instituted to raise the costs of bearing third, fourth, and subsequent children by the Family Planning and Population Board. Civil servants received no paid maternity leave for third and subsequent children; maternity

\textsuperscript{90} ibid
\textsuperscript{91} http://wn.com/Eugenics_in_Singapore_Stop_at_Two
\textsuperscript{92} http://www.photius.com/countries/singapore/society/singapore_society_population_control_p~11008.html
\textsuperscript{93} http://esa.un.org/unpd/wpp/unpp/panel_indicators.htm
hospitals charged progressively higher fees for each additional birth; and income tax deductions for all but the first two children were eliminated\(^94\). Large families received no extra consideration in public housing assignments, and top priority in the competition for enrollment in the most desirable primary schools was given to only children and to children whose parents had been sterilized before the age of forty. Voluntary sterilization was rewarded by seven days of paid sick leave and by priority in the allocation of such public goods as housing and education. The policies were accompanied by publicity campaigns urging parents to "Stop at Two" and arguing that large families threatened parents' present livelihood and future security. The penalties weighed more heavily on the poor, and were justified by the authorities as a means of encouraging the poor to concentrate their limited resources on adequately nurturing a few children who would be equipped to rise from poverty and become productive citizens.

**South Korea**

**Public rationale for the campaign**

Following the Korean War in the early 1950s, South Korea's population remained primarily rural and agricultural. Its total fertility rate (TFR) exceeded six children per woman. South Korea began its national family planning campaign to reduce women’s unwanted births through a program of information, basic maternal and child health services, and the provision of family planning supplies and services. The program was seen as essential if the goals of economic growth and modernization were to be achieved\(^95\).

**Any relevant social/economic/political background**

Following the Korean War in the early 1950s, South Korea's population remained primarily rural and agricultural. Its TFR exceeded six children per woman. In 1962, South Korea began its national family planning campaign to reduce women's unwanted births through a program of information, basic maternal and child health services, and the provision of family planning supplies and services.\(^96\)

**Details of the government, NGO and family planning activities**

In 1962, South Korea began its national family planning campaign to reduce women's unwanted births through a program of information, basic maternal and child health services, and the provision of family planning supplies and services. The program was seen as essential if the goals of economic growth and modernization were to be achieved. Overall, the public responded well to the idea of a "small and prosperous family."

\(^94\) http://www.mongabay.com/history/singapore/singapore_11364.html

\(^95\) http://agevipnetwork.com/zone/agevipnetwork/2010/06/17/did-south-korea’s-population-policy-work-too-well/

\(^96\) ibid
By 1970, the TFR had fallen to 4.5 against a background of rapid industrialization and the waning of the country's largely agrarian character. A 1974 poster exhorted, "Sons or daughters, let's have two children and raise them well." In 1981, the government, buoyed by its success up to that point, set a target of a two-child, "replacement" level fertility by 1988 with a program of economic incentives. There was even some mention of a one-child family: "Even two children per family are too many for our crowded country". While such a saying may have seemed at least somewhat extreme at the time, it proved to be surprisingly prophetic. The two-child target was met remarkably quickly: The TFR was down to 1.74 by 198497.

**Quoted results**

"It seems like young mothers don't want to have more than one baby. They even consider not having children, because it costs a lot of money to raise children in South Korea," said Lee, explaining why she thinks there are fewer students in today's schools compared to the old days98.

The economic burden of raising children presents a major hurdle to improving the country's birth rate. According to a report by the Bank of Korea, education spending accounted for 7.4 percent of household consumption last year, nearly three times higher than 2.6 percent in the United States. With everyone pouring money into their children's education, many parents feel the pressure to do the same in this highly competitive society99.

**Changes in the total fertility rate**

The fertility rate had gone down from 5.4 in the 1950’s100 to 1.22101 in 2010.

**A judgement of whether or not there were coercive elements**

I did not find any coercive elements regarding family planning in South Korea.

**Public rationale for the campaign**

In the international Conference on Population and Development (ICPD), reproductive health policies were reviewed by the National Family Planning Committee. In 1997, the Minister of Public Health set forth the National Reproductive Health Policy, which includes family planning and maternal and child

101 (http://www.indexmundi.com/g/g.aspx?c=ks&v=31)
Any relevant social/ economic/ political background

Mechai Viravaidya founded the Population and Community Development Association in 1974 (PDA), at which time it was named the Community-Based Family Planning Service. He began his work with rural communities in Thailand in 1965 when he returned to Thailand from studying at the University of Melbourne in Australia. After studying he got a job working for the National Economic and Social Development Board and later became the Minister of Industry. As part of his job, Mechai Viravaidya spent time visiting rural areas of Thailand. Relative to other government officials, he spent a lot of time in discussion with villagers and farmers. Viravaidya then began writing a weekly column that was published in a Bangkok newspaper. He also taught at Thammasat University and had a nightly radio show during the same time period. Later he played a leading role on a television soap opera series. These experiences helped him gain the attention of the media and the support of a wide variety of audiences. When the Thai government created a national family planning policy, Viravaidya worked as secretary-general of the Family Planning Association of Thailand for two years. Viravaidya then switched to the non-profit sector when he founded the CBFPS in 1974. Today, Viravaidya continues to work as chairman of the PDA.

Details of government/ NGO family planning activities - quantified if possible

The original mission of the Population and Community Association was to supplement the efforts of the Thai government to reduce poverty by promoting family planning. To accomplish this, the PDA has focused on targeting remote rural communities where government outreach has not been viable. Realizing that a high population growth rate is a barrier to economic development, the PDA’s focus has been on implementing family planning programs to lower the population growth rate. It has sought to do so through community-based, participatory approaches to educate and empower village residents. Since its inception, the program mission has expanded to include rural development and the improvement of overall health conditions. Engaging in a “people-centered approach,” the PDA has worked to empower communities to identify its own needs and then work to improve conditions based on those needs - a form of self-help. Today, the PDA works to address a multitude of issues that affect poverty levels. Some of these activities include: health care, HIV/AIDS services and awareness, access to clean water resources, reliable means of income, environmental conservation, gender equality, youth education and services, democratic engagement, and small-scale business initiatives, including village owned banks providing micro-credit loans.

102 www.akha.org/content/forestry/mechai.html

103 www.akha.org/content/forestry/mechai.html
Anecdotal information on family planning activities

Mechai Viravaidya established a high profile public education campaign, staging such events as a condom balloon-blowing contest featuring village headmen competing for condom-inflating glory. Viravaidya’s and other PDA workers could be found handing out condoms at movie theaters and traffic jams - anywhere where there was a crowd. Even the traffic police were given boxes of condoms to distribute on New Year's Eve in a program known affectionately as "cops and rubbers."104

Although condoms - now commonly called "mechais" in Thailand - became the natural trademark of his publicity campaign; Mechai used a variety of other family planning tools as well. Under his direction, birth-control carts sporting pills, IUDs, spermicidal foam, and condoms sprouted up at bus stations and public events105.

The Thai government has supported Mechai's efforts by making a wide range of new contraceptive technologies available to the public. Thailand was among the first countries to allow the use of the intravenous, injectable contraceptive DMPA, and remains one of its largest users. Thai physicians have also developed simplified methods of female sterilization, and now operating room nurses are trained to perform the procedures. Non-scalpel vasectomies are available at festivals and other public events, and in a characteristically celebratory manner, PDA offers free vasectomies on the King's birthday. Integration as well as development programmes, including agriculture, education, and community development, has increased the demand for family planning106.

The Thai program was designed to prevent coercion. Money was not subtracted from a loan fund if contraceptive prevalence fell; shares in the loan fund and the right to borrow were not taken away from those who chose not to continue using contraceptives. And interest rates were similar to those prevailing in the Thai government’s rural credit program107.

Quoted results

Thailand's highly successful government-sponsored family planning program has resulted in a dramatic decline in population growth from 3.1% in 1960 to less than 1% today108.

Changes in the total fertility rates

The United Nations Department of Economic and Social Affairs has quoted that the constant fertility

104 http://www.context.org/ICLIB/IC31/Frazer.htm
105 ibid
106 ibid
107 ibid
108 http://www.state.gov/r/pa/ei/bgn/2814.htm
variant in 1960 was 6.14 compared to 2010 where it is 1.63.  

Judgment on whether or not there were coercive elements  

I did not find any coercive elements related to Thailand’s family planning programs.  

Vietnam  

Public rationale  

The early 1990’s was also the time that, with the government recognizing that large families, especially in rural areas like Songbe, threatened to foreclose any possibility of sustained economic growth, family planning was set in stone as official policy. In the historic words of the Population and Family Planning Strategy to the year 2000, the objective of the program was to “have small, healthy families in order to make favorable conditions to have a prosperous, happy life.”  

Relevant social, economic and political background  

In 1986, the government of Viet Nam launched the Doi Moi, a controlled transition towards a market economy. The ongoing reforms have produced a positive impact on the country’s development: the gross national product per capita is increasing, and reached US$375 in 2000; GNP growth was one of the strongest in the world by the mid-1990s, at around 9.5 percent in 1996.  

Details of government/NGO family planning activities  

Promulgated at the same period as Doi Moi was the government’s new family-planning programme (referred to as the one-to-two child policy), which has resulted in later marriages and smaller family sizes. In addition to increased information, education and communication efforts, a wide range of family-planning services has been made available from the central to local levels. Furthermore, the first National Population and Development Strategy, from 1993-2000, set a target to reduce the population growth rate from 2.2 per cent to 1.7 per cent, with a focus on the one-to-two child policy. The total fertility rate (defined as the average number of children a woman has) declined from 3.8 in  

109 http://esa.un.org/unpd/wpp/unpp/p2k0data.asp  
110 http://opinion.inquirer.net/11231/vietnam-fighting-inequality-not-enough  
111 http://www.unfpa.org/gender/docs/studies/vietnam.pdf
1989 to 2.3 in 1999. Findings from the 2006 survey show that fertility now stands at 2.09 children per woman, which is just below the level of replacement

Under the current implementation of the law, government employees who have a third child are denied access to pay rises and promotions. Under the new draft ordinance, the Ministry of Health's General Department of Population and Family Planning is proposing to reprimand Communist Party members and civil servants, as opposed to parents, for their failure to enforce the law. The draft does not explain what punishment will be implemented. Ethnic minorities, however, will be exempt, with couples from ethnic minority groups with populations of less than 10,000 people allowed to have more than two children per family, according to the deputy director of the General Office for Population and Family Planning Duong Quoc Trong. Couples with two children will also be allowed to have a third if one child is disabled.

First of all, there was always a sense that abolishing inequality, which is the primordial objective of revolutionary movements like the Viet Minh, is not enough to promote social welfare. Even when the country was still North Vietnam and fighting to incorporate “South Vietnam” in the period 1961-75, family planning was promoted, aiming at smaller sized family with three children, longer birth spacing, and delayed births in order to achieve “better maternal health, good nurturing of children, as well as happiness and harmony in the family,” as one early family planning guidebook described it.

Second, national support for the program was consistent and deepened over time. Following the expulsion of the US in 1973-75, family planning became a central concern of the now unified nation, with the National Committee for Population and Birth Control established in 1984. In 1993, the program was institutionalized in both government and civil society, with the landmark document referred to earlier, Population and Family Planning Strategy to the Year 2000, setting the goal of persuading families to limit their size to “two children on the average in order to stabilize the population size by the middle of the 21st century.”

Anecdotal information on family planning activities

In 1993, the National Committee for Population and Family Planning (NCPFP) created the Vietnamese network of family planning collaborators to help implement the national family planning program. Collaborators encourage married women of reproductive age to use modern contraceptive methods and collect vital statistics on married couples. In 2000, the network was composed of about 147,000 collaborators who reached every commune in the country.

113 http://www.rhrealitycheck.org/blog/2008/12/17/vietnams-twochild-policy-bad-women-bad-country
114 http://opinion.inquirer.net/11231/vietnam-fighting-inequality-not-enough
115 http://www.ipas.org/Publications/asset_upload_file534_2462.pdf
With encouragement from the NCPFP, in a study I explored the role of the collaborator network and the potential for collaborators to provide more comprehensive and higher-quality reproductive health information, especially related to contraceptive and abortion care.

At its inception in 1993, the purpose of the collaborator network was to assist couples to use contraception, so that they could comply with the government’s policy of limiting families to two children. Collaborators met with married women of reproductive age, especially those who had already given birth to one or two children, and encouraged these women to use modern contraceptive methods. The collaborators also kept records on their assigned families regarding the births, deaths, abortions and contraceptive methods used.\(^{116}\)

Today, each collaborator is responsible for 150 to 250 families in their village. The collaborator must maintain a record for each family, and health planners report that the statistics provided by the collaborators are generally accurate. The functions of the collaborators are to: Promote contraception to married couples of reproductive age, distribute condoms and contraceptive pills, submit reports on the vital statistics of assigned families and attend monthly meetings and training courses.\(^{117}\)

Collaborators receive minimal stipends meant to cover work-related expenses. The stipend of less than US$2 a month, which is more symbolic than compensatory, reflects the voluntary nature of the collaborator network.

Collaborators are selected within their own village, so they are familiar with the local women and the local concerns. Typically, collaborators are women and are among the more educated and respected people of the commune. Still, the educational level of collaborators varies greatly: 7% have competed elementary school, 57% are educated to the secondary school level, 36% have completed high school, and 0.8% have bachelor degrees. According to a senior program manager in NCPFP, a small number of collaborators are illiterate (0.7%), and the rate of illiteracy is greater among the ethnic minorities who reside in the mountainous areas.

Each commune has a full-time family planning coordinator who supervises the work of the commune’s collaborators. The number of collaborators is based on the commune’s population, but no commune may have fewer than 9 collaborators or more than 20 collaborators. There are about 12 collaborators for one commune with 7,000 people. No consideration is made for communes where the mountainous terrain or scarcity of population makes each client visit time-consuming. As a result, the workload for each collaborator can vary greatly. The regularity of visits to clients varies as well, and this can affect the reliability of using methods that depend on regular distribution, such as contraceptive pills and condoms.\(^{118}\)


\(^{117}\) ibid

\(^{118}\) ibid
Most of the collaborators fulfill several community functions. According to a report by the United Nations Population Fund, collaborators work in other social organizations such as the women’s union (42%), nutrition programs (32%), health care (19%), and heads of village (17%) (1999). These other activities, although not unrelated, can limit the time collaborators devote to specific family planning duties.\textsuperscript{119}

In general, the assessment found that collaborators are dedicated to their work, familiar with local communities and clients, desirous of more training, and amenable to expanded duties. And almost all clients, rural and urban, regard the collaborators as useful to their community and hard working. But operating problems limit the potential for collaborators to perform a wider mission. These problems include:

Minimal quality of care. The original objective of the collaborator network was to advocate contraceptive awareness and contribute to lowering the population growth rate. In this respect, the network has been largely successful. However, the quality of care provided to women with reproductive health needs is uneven and at times poor. According to some administrators, collaborators tend to focus on meeting population goals, and neglect client-focused reproductive health counseling.

According to information presented in the interviews with women clients and collaborators, collaborators stop visiting women who adopt a long-term method, such as an IUD, because these women are less at risk of becoming pregnant. The collaborators do not reach unmarried adolescents because of the stigma associated with premarital sex.

“I cannot talk about family planning anywhere, anytime. If I provide this information to unmarried women, their mothers think that it will spoil their daughters.”\textsuperscript{120}

—Collaborator and retired accountant, Thuy Nguyen district

Collaborators also ignore older married women, even though these women may have needs for contraception. And collaborators generally do not work with men, even though participation from men is necessary for some methods, and men often influence couples’ contraceptive choice and use.

Irregularity of visits to clients. The clients interviewed reported that at times visits from collaborators are so irregular that they cannot depend on collaborators for reliable contraceptive services. This lack of dependability is especially detrimental in rural areas where access to other health care services is limited. In fact, a 1998 government report found that 60% of collaborators spend only two to five days per month on family planning duties.\textsuperscript{121}

One of the reasons for the irregularity of visits may be that collaborators are busy fulfilling other community functions or doing other work to earn their living. Also, in mountainous or sparsely populated regions, visits may be difficult to accomplish because of the terrain or distance between clients.

“She reminds me to come to her to take condom; sometimes she brings those to me, sometimes she forgets. But I feel very shy to go to her house. It takes me a lot of time to get there. Therefore, I

\textsuperscript{119} ibid
\textsuperscript{120} http://www.ipas.org/Publications/asset_upload_file534_2462.pdf
\textsuperscript{121} ibid
stopped using it.”
—Client and farmer, 34 years old, 3 children and 3 abortions, Thuy Nguyen district

An assessment by NCPFP showed one family planning coordinator from Son Lo commune as commenting: “My area is very large, 25 km long and 4 km wide. The terrain is up and down all the way. Traveling is very hard. It takes us one day to walk from the center of the commune to the most remote village.”

**Quoted results**

Seven years after introducing a two child per family policy, Vietnam’s population control programme has become one the most effective in the world.

In the late 1980s Vietnamese women had an average of 3.8 children - that compares with 2.3 children today.

Officials say that reduction has been a crucial element of the economic and social development programmes introduced in the era of Doi Moi or renovation.

"They have been very successful,” said Omar Ertur the UN Population Fund’s Representative in Hanoi. "They have achieved a tremendous reduction in a very short period of time.”

**Changes in the total fertility rate:**

According to the UN the fertility rate has decreased from 6.20 in 1940 to 1.75 in 2010.

**A judgement on whether or not there were coercive elements**

A degree of coercion was used to enforce the two-child policy.

Communist Party members who have more than two face automatic expulsion and parents are often asked to pay the health and education costs of a third child. More serious sanctions include having land confiscated.

---

122 ibid
123 [http://news.bbc.co.uk/1/hi/world/asia-pacific/1011799.stm](http://news.bbc.co.uk/1/hi/world/asia-pacific/1011799.stm)
124 ibid
125 [http://esa.un.org/unpd/wpp/unpp/p2k0data.asp](http://esa.un.org/unpd/wpp/unpp/p2k0data.asp)
Conclusion

We have seen that by allowing women the freedom to control the number and spacing of their births, family planning helps women preserve their health and fertility and also contributes to improving the overall quality of their lives. Committing human and financial resources to improving family planning services will not only improve the health and wellbeing of women and children, but it will also support efforts to achieve a sustainable global population. A country's economic stability, infant mortality rates, opportunities for women and education levels have consistently improved when there is birth control education, as well as safe, reliable, low-cost birth control options. Most countries expect their governments to help curb population growth, but governments continue to struggle with how active a role they should take in helping families make family planning decisions.

Family planning encompasses all aspects pertaining to a couple's decisions as to when to begin having children and how many children they will have. Deeply personal matters such as birth control, abortion and sterilization all belong in this area, which is why government interference is often viewed as overly intrusive.

In some of the case studies analyzed, such as in Vietnam, governments have used coercive elements in family planning. Nevertheless from the declining fertility rate it is possible to infer that countries such as these, although they used some level of coercive measures, they have developed to a certain degree successful and modern family planning programs which have resulted in low birth rates.

Coercive measures used by governments violates natural law and there are ways to achieve a population-size sustainability without implementing measures such as “one-child policies”. There are alternative means. Countries such as Kerala set a good example having achieved broad declines in fertility without state coercion or occasional brutality. Coercive measures may produce a number of “unintended” negative consequences, including severe human rights violations. Governments should not resort to coercive measures as long as non-coercive measures are available to reduce fertility rates.