COMPREHENSIVE MCH-BASED FAMILY PLANNING IN RURAL AREAS: A RESEARCH-DEMONSTRATION PROJECT

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Paper prepared for the World Health Organization Seminar on Development of Field Training Areas, Their Needs and Advantages for the Teaching of MCH and Family Planning to Health Personnel, Isfahan, May 1975.

The rationale for a family planning program focussed on women in the maternity cycle through programming at maternity institutions has been proven sound - highly successful results at little cost. Though the rationale seems obvious, the use of the maternity setting characterized very few family planning efforts until April 1966, when the Population Council established the International Postpartum Family Planning Program. Initially, this was to be a demonstration project of two years' duration involving 26 U.S. and non-U.S. hospitals in 15 countries. Because of the international appeal for this type of demonstration and its success, the Postpartum Program continued beyond the two years and expanded to over 200 non-U.S. hospitals. Much important research data has been obtained on many aspects of the demonstration and there have been over 100 scientific publications in relevant journals and books.

In addition to the Council-supported program, several countries have undertaken, at their own expense, national postpartum family planning programs the largest of these being India which now includes over 300 hospitals. The Council had assisted the Government of India in the initial phases of this innovative effort. Further, largely due to the excellent results obtained in the seven U.S. hospitals participating in the Postpartum Program, the United States Government, the American College of Obstetricians and Gynecologists, local U.S. institutions, and Planned Parenthood have encouraged and supported the U.S. expansion of the program's concepts to the point where most teaching hospitals (over 300) and other institutions in the United States now have postpartum family planning as a routine service.

The International Postpartum Family Planning Program has spearheaded the development of similar programs with the largest effort initiated by the World Health Organization in 1971, now called The Maternity-Centered Family Planning

Programme. The beginning was in the summer of 1970, when WHO convened a consultation on family planning services in relation to maternity/child care. That Consultation made three recommendations to WHO (1) extension and expansion of the postpartum program concepts to a large number of hospitals in the developing world; (2) extension of the same concept to small maternity-care centers and (3) particular attention should be paid to utilize the same concepts in rural areas where maternity facilities are lacking or absent.

Though there have been family planning research efforts in rural areas, some connected with MCH, the results have not been impressive - except for unusual situations. What is needed are realistic action-research-demonstrations in rural areas in various cultural-economic settings, thoroughly evaluated to determine whether or not MCH-based family planning can bring about significant reductions in fertility and improvements in health - and at what cost. There are an increasing number of agencies, institutions and governments who have become interested in organizing and supporting such demonstrations. These include the Population Council, WHO, UNFPA, USAID, IDRC, and others, as well as the national governments of Indonesia, the Philippines, Bangladesh Turkey, Nepal, Afghanistan, India, Nigeria, Mexico, Colombia, and others.

In 1970, a study was done by the Population Council in eight countries and two India states. The basic question posed in this study by Drs. Taylor and Berelson was. 'What would it take in everything required - in personnel physical facilities, training, transport, supplies and equipment, and funding - to bring some minimal professional and paraprofessional attention to every rural pregnant woman before, during, and after delivery, for the double purpose of promoting maternal/child health and family planning?"

Though much useful data was accumulated to try to answer that complicated question, it soon became obvious that the only way to determine the answers would be to attempt several field demonstrations in rural areas. Accordingly with funding assistance provided by the World Bank and UNFPA, four countries have developed such demonstrations - Indonesia, the Philippines, Nigeria and Turkey. The Population Council provides technical assistance for both the health delivery system and the sophisticated research and evaluation measurement aspects of the program. In the Philippines, technical assistance for the health delivery system is being provided by WHO.

The evaluation system has been designed to provide answers to the following major questions:

What levels of maternal, child care, and family planning are actually delivered by the program?

To what degree does the program improve maternal and child health and reduce infant mortality and morbidity?

What levels of acceptance and continued use of family planning are achieved by the program?

What levels of child-spacing and fertility reduction are achieved?

How can an effective MCH-based family planning program be organized and maintained?

What is the overall cost and the costs of various aspects of the program?

To what extent can health and family planning achievements be directly attributed to the program, beyond improvements due to other social-economic developments?

In each of the four demonstrations, an MCH-FP delivery system has been developed which utilizes both existing and new categories of non-medical personnel. All personnel are given initial formal training and continued training on-the-job by means of close supervision. The underlying theme is to provide total 100% health coverage of all pregnant women and their newborn infants by a system that can be replicated throughout the country should the demonstration prove successful. Hence, unlike other demonstrations, only limited inputs are being made. Functional reclassification and training of personnel is a major aspect of these demonstrations.

The demonstrations have started at varying times, but all will be funded and assisted for a minimum period of five years. Indonesia was the first, starting in 1973; two others started in 1974 and one is starting this June 1975. Accordingly, I have no results to report.

However, there are nine guiding principles that are worth mentioning here at this Seminar.

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

   Besides the obvious fact that most people in developing countries live in rural areas, most previous MCH and FP programs have concentrated efforts in urban situations. Hence, in these demonstrations, attention is given to where the need is greatest and the means have been least studied.

2. <u>The population of these demonstrations should be about 250,000 - 500,000 people</u>.

   Small population size areas might lead to unrealistic inputs of facilities and personnel, while large population size areas would be inappropriate for the degree of study precision proposed for this program.

3. The integration of family planning with MCH should be complete from the top level of administration to the delivery of services to the individual client.

Unlike other projects of this nature, integration must be complete in order to provide the health service and, i rt. tly, to study and evaluate the results of this integrated approach.

4. The target population of the project is to be all women delivered within the demonstration area and their children, during at least their first two years of life.

As the objective is 100% coverage, these projects differ from others that have tended to be located in more favorable areas or limited in their expected coverage. One measure of program success will be to what extent coverage has been provided.

5. The target population will be subdivided into three major groups - (a) women coming to hospitals for delivery, (b) women delivered by trained midwives at home or in health centers without physicians; (c) women delivered at home by untrained traditional birth attendants.

The subdivisions reflect the actual situation in most rural areas. The evaluation must consider these three categories in terms of levels of health care provided, levels of family planning acceptance and continuation, differences of health improvement achieved and differences in fertility reduction achieved.

6. The plan of operation and the levels of inputs must be such that the projects are replicable.

These projects are not intended to be merely theoretical. The intent is to plan the programs to be as consistent with practices already developed and with predictable future development in the health care delivery system

of the region, so that if successful, these projects will be expanded on a provincial or national scale.

7. The evaluation of the health services delivered and the health improvement achieved must receive the same detailed attention as that given to family planning services and fertility change.

The study is devised to explore basic questions concerning the reciprocal effects of health and family planning. Consequently, the evaluation procedures and analysis must deal with health and with family planning.

8. The evaluation system must be of the highest quality.

Too often in the past demonstrations in health and in family planning have not provided much new and useful information because of inadequate evaluation processes and systems. In these projects, great detailed attention will be given to the whole system of evaluation, both on the health side and on the family planning/fertility side.

9. The evaluation will require data comparisons covering four major program areas.

a. Success in Providing Health Services.

b. Health Improvements.

c. Family Planning.

d. Costs.

Conclusion

MCH-based family planning research demonstration projects of major size are just beginning in rural areas of developing societies. Unlike other demonstrations, the Population Council's project is devoted both to the operational aspects of these efforts - "how to do it" - and to the evaluation and analysis

of the results - "what have we accomplished". We hope to provide some answers in as short a period as five to seven years, so that women and children living in rural areas can benefit from improved health care systems, as their urban counterparts have done.