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Preface

Dr. Gigi Santow and I were the founding editors of the *Health Transition Review* and remained its sole editors until we were joined by Dr. Shail Jain for Volume 5, No. 2. By that time Gigi and her husband, Dr. Michael Bracher, had left the Australian National University to join the Demography Unit of the University of Stockholm, Sweden. We had at first believed that electronic editing would be possible, but found that the communications revolution has not wholly conquered the problem of physical distance. Gigi has reluctantly stepped down from the editorship. We will miss her. She is a first-rate academic journal editor, and had previously edited the *Journal of the Australian Population Association* with distinction. Much of the success of the *Health Transition Review* can be credited to her.

After the publication of Volume 5, No. 2, Jo Healy-North left our production team for a period in North America, and Nikki Braybrook joined Wendy Cosford in very efficiently getting out *HTR*, Vol. 6, No. 1, and Supplements to Vols. 5 and 6. As 6(1) goes to press, Nikki leaves and Wendy is joined by Jeff Marck, who will be in charge of production, and Sandi Goddard.

So, like health, the *Health Transition Review* is in transition.

This issue is special in that it contains an unusually large Forum devoted to the aftermath of the International Conference on Population and Development, Cairo, 1994 and to its *Plan of Action*. This is justified because of the significance of the conference for the health field. Indeed we anticipate returning to the matter in the next issue (see page 123).

Jack Caldwell

Health Transition Review 6, 1996, 3–23

Reasons for the decline in mortality in Sri Lanka immediately after the Second World War: a re-examination of the evidence*

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Abstract

Newman estimated that 42 per cent of the decline in mortality in Sri Lanka between 1930-1945 and 1946-1960 was attributable to DDT-spraying; Molineaux estimated 27 per cent; Gray judged that 23 per cent of the decline between 1936-1945 and 1946-1960 was due to DDT. Here the Newman-Gray-Molineaux approach is criticized, the main point being that they ignored a significant improvement in mortality in the early 1940s, before DDT-spraying. Bearing this, and certain other complexities of the situation, in mind, an attempt is made to assess the impact of DDT on mortality.

Immediately after the Second World War Sri Lanka (then Ceylon) embarked on a program of DDT-spraying designed at least to suppress, and if possible even to eliminate, malaria, by killing the adult mosquitoes responsible for spreading the disease. Until then malaria had figured very prominently in Sri Lankan morbidity and mortality. Death rates then improved considerably in the late 1940s, prompting the suggestion by some that DDT-spraying had been largely responsible. However, others disagreed and a debate ensued about the relative importance of the DDT campaign, on the one hand, and improved provision of health services or a variety of social and economic factors, on the other. The population of Sri Lanka, according to the 1946 census, was 6.7 million.

DDT-spraying had begun in earnest in November 1945, after a few small-scale experiments earlier that year utilizing supplies provided by the military authorities, and covered all malarial areas by 1947 (Rajendram and Jayewickreme 1951:22; Visvalingam 1961:64). According to Cullumbine the effect was dramatic: noting a marked drop in the crude death rate in Sri Lanka from 20.3 deaths per 1000 population in 1946 to 14.3 in 1947, and 13.2 in 1948, he observed: 'This sudden drop in the rate can be attributed almost entirely to the near-eradication of malaria following the successful use of D.D.T. as a control measure for mosquitoes' (Cullumbine 1950:120). Sarkar, however, disagreed, arguing that mortality was already following a long-run downward trend in Sri Lanka from well before the Second World War, and that the postwar decline might well be largely a continuation of this (Sarkar 1957:121-125). Sarkar was

> ...inclined to believe that the low death rate of today has been the result of a number of factors of which D.D.T. spraying is one, which have been operating with a cumulative effect ... The operation of this process has probably been accelerated recently by the improvement in curative and preventive medicine, in the political status of the country and in the economic situation generally (Sarkar 1957:124-125).

* This article is based upon work carried out with the support of a grant from the Economics and Social Research Council (ESRC Award R-000-23-2579).

Coale and Hoover (1958:62-67) concluded that DDT-spraying was responsible for 'something less than half' (p.66, footnote 13) of the decline in mortality in Sri Lanka between the period 1936-1945 and the period 1950-1952. Newman estimated that 42 per cent of the fall in the average annual crude death rate in Sri Lanka between the periods 1930-1945 and 1946-1960 was attributable to DDT-spraying, though possibly aided by quinine use (Newman 1965:3,48-49; 1970:157, note 17; Newman and Meegama 1969:285).

Meegama (1967) believed that Newman's analysis overstated the significance of the DDT campaign. He argued that Newman had overlooked a very important point: that in the immediate postwar period the malarial areas of Sri Lanka had profited not only from DDT-spraying but also from a disproportionate improvement in health services, as well as possibly in nutrition. Meegama also expressed the view, though this point was put less strongly and not pressed by him in the subsequent debate, that mortality in Sri Lanka was already clearly falling in the late 1930s and the early part of the war, so that the postwar decline in mortality should in part be seen as the resumption of an earlier trend which had then been interrupted by various difficulties in the latter part of the war.

Meade (1968) did not accept this second point of Meegama's and found it difficult to make a judgement in the case of the first. He concluded that although health measures of one kind or another were responsible for the fall in mortality in Sri Lanka (and some other countries) after the war 'the relative importance of malaria eradication by residual spraying as against other general and less specific health measures is to some extent an open question' (p.109). Very similar views to Meade's were expressed in a leading article in *The Lancet* at the time (1968, 1:899-900).

Frederiksen (1970) believed, like Meegama, that Newman had overestimated the impact of DDT in Sri Lanka. He saw the postwar improvement in mortality as largely the resumption of a long-run downward trend after an interruption in the latter part of the war; and felt that fluctuations in standard of living and especially in food availability might well be an important element in the situation (Frederiksen 1960, 1961, 1962, 1966). He thought that no more than 19 per cent of the decline in the crude death rate in Sri Lanka between 1944, the last year before spraying began, and 1954, which he considered the appropriate comparison to make, could have been due to DDT-spraying (Frederiksen 1970).

Gray (1974) estimated that 23 per cent[1] of the postwar decline in the crude death rate in Sri Lanka was attributable to DDT-spraying. His approach followed that of Newman (1965) but with two modifications. Newman's estimation depended on a linear regression equation linking the absolute fall in the average annual crude death rate between the periods 1930-1945 and 1946-1960 in the 21 districts of Sri Lanka, as dependent variable, to the average so-called 'spleen rate' in the districts for the period 1938-1941. The 'spleen rate', the proportion of school children found in surveys to have an enlarged spleen, was taken as an indication of the level of malaria in a district, an enlarged spleen being one of the possible symptoms of malaria; the years 1938-1941 were the last for which this information was available before to the DDT campaign. Since spleen rates effectively became zero throughout Sri Lanka not many years after the Second World War (Newman 1965:91-92) the rates for 1938-1941 also represent the improvement in spleen rates that took place over this period. Gray modified Newman's approach, first, by using as dependent variable in the linear regression the *proportional* rather than absolute decline in the crude death rate, which he argued was more appropriate, and secondly, by considering changes not between 1930-1945 and 1946-1960 but between 1936-1945 and 1946-1960: this latter change was because there was a very serious malaria epidemic in Sri Lanka in 1934-1935 which Gray believed might distort the analysis.

[1]According to Newman (1977:260), given Gray's approach, this figure should have been 22 per cent.

Newman subsequently seemed implicitly to accept this second point of Gray's in that he too compared the periods 1936-1945 and 1946-1960 when he re-examined this question using a Box-Cox approach; however his 'best' estimate of the contribution of the DDT-campaign to the fall in the crude death rate in Sri Lanka between these two periods, using this approach, was still 44 per cent; with his original regression approach but the periods suggested by Gray, Newman's estimate would have been 48 per cent (Newman 1977). Molineaux, on the other hand, felt that Gray's regression approach, relating the proportional decline in the district crude death rates to the 1938-1941 spleen rates, was the more realistic, though he preferred the periods of time employed originally by Newman; on this basis he calculated that 27 per cent of the reduction in the crude death rate in Sri Lanka between 1930-1945 and 1946-60 was attributable to DDT-spraying (Molineaux 1985).

Both Gray (1974) and Newman (1977) specifically rejected Meegama's assertion that in the immediate postwar period malarial areas in Sri Lanka enjoyed a disproportionate improvement in health services and possibly in nutrition. Neither of them seriously dealt with Meegama's other point, that there was a noticeable drop in mortality just before and in the early part of the Second World War, and that this must be taken into account in considering the possible reasons for the postwar mortality decline. Gray's analysis simply did not point to such a dip in mortality (Gray 1974). Newman, responding to observations made by Frederiksen about a mortality decline in that period, spoke of the 'well-known dangers in basing trends in a fluctuating series on such a short time series' (Newman 1970:153).

In what follows, the whole question of the possible reasons for the decline in mortality in Sri Lanka after the Second World War is re-examined. Possibly the most important point to emerge is that Meegama was right that there was a noticeable fall in mortality in the late 1930s and early 1940s which must be taken into account in judging subsequent developments. This is demonstrated by a more detailed analysis of year-by-year changes in mortality in Sri Lanka than has hitherto been attempted, involving the consideration of infant and maternal as well as overall mortality, and the examination of changes in different parts of the country, supported by some completely new analysis of a whole range of data relating to public health activities in Sri Lanka. A number of other significant points, overlooked in previous work, are also brought out. It should be emphasized that this matter does not just have historical significance, though that would make it important enough. Views about what happened in Sri Lanka may well inform and therefore influence present-day approaches to malaria control (see, for example, the recent review by Bradley 1993).

Malaria and malaria control in Sri Lanka before DDT-spraying

Sri Lanka is an island not far north of the equator ($5^{o}55'$ - $9^{o}50'$N), just off the south-east tip of India. It is about 140 miles across at its widest point and 270 miles from north to south. The south-central part of the island is mountainous, ranging from about 1000 feet to more than 7000 feet above sea level; this is the so-called hill country where most of Sri Lanka's tea is grown. The south-western coastal districts of the island together with this adjoining hill country are well watered and make up the 'wet zone' of Sri Lanka; the remainder of the island, which has much less rainfall, constitutes the 'dry zone' (see map presented as Figure 1). Some accounts refer also to an 'intermediate zone' on the fringes of the other two zones. Whereas the wet zone of Sri Lanka tends to experience rainfall both during the south-west monsoon, which typically blows from May to September, and the north-east monsoon, which typically blows from November to March, the dry zone usually experiences rainfall only in connection with the north-east monsoon; moreover, the south-west monsoon is generally more reliable and associated with heavier rainfall than the north-east monsoon. Both zones tend to experience thunderstorms in the inter-monsoon periods.

Figure 1
Districts of Sri Lanka subdivided into wet zone and dry zone districts

Malaria is spread by female anopheline mosquitoes: a person becomes infected when bitten by a mosquito which has itself taken in malaria parasites some time before by biting an infected person. The particularities of malaria transmission in Sri Lanka were established by Carter in the 1920s and early 1930s. He was a medical entomologist appointed by the Government of Ceylon in 1921 to study the problem. Carter discovered that although there were 15 or more species of anopheline mosquitoes in Sri Lanka, several of which were, moreover, known to be implicated in malaria transmission elsewhere, only one species was involved in malaria transmission in Sri Lanka: *Anopheles culicifacies*[2] (Carter 1927; Gill 1935; Visvalingam 1961). This was essentially a dry zone species, though in particular circumstances it proliferated in parts of the wet zone.

The dry zone of Sri Lanka had (indeed has) a very large number of water storage 'tanks' with associated irrigation systems. This, and some other features of the dry zone, meant that the kinds of pools, and puddles, and slow-moving streams in which *A. culicifacies* could breed were fairly common. Hence malaria was endemic in the dry zone, though with seasonal upsurges in the aftermath of rain. In the wet zone, on the other hand, in the ordinary course of events there were few opportunities for *A. culicifacies* to breed, though it was always present, hence little malaria. However, if there was a prolonged drought in the wet zone, pools would form in river beds, because of the fall in water levels, which provided ideal breeding sites for *A. culicifacies*, and a malaria epidemic would ensue; the impact of such an epidemic would be the greater because of the relative lack of previous exposure and therefore immunity of the population to the disease. There tended to be such epidemics of malaria in the wet, and especially the 'intermediate', zone of Sri Lanka about every five years; the worst of these came as a result of the complete failure of the usually relatively reliable south-west monsoon. Since the breeding capability of *A. culicifacies* is markedly reduced at altitudes over 2500 feet, the more elevated parts of the hill country were, however, completely free of the disease, or at least of locally-generated cases of it (see Carter 1927; Briercliffe 1935; Gill 1935; Rajendram and Jayewickreme 1951; Visvalingam 1961).

According to Rajendram and Jayewickreme (1951:2) there were malaria epidemics in Sri Lanka in 1906, 1911, 1914, 1919, 1923, 1928-1929, 1934-1935, 1939-1940, 1943 and 1945-1946.

The fact that malaria is transmitted by mosquitoes had been known since the very end of the nineteenth century following work by Ross. In Sri Lanka, from the beginning of the twentieth century, attempts were made to control malaria by eliminating mosquitoes' breeding places: through drainage of wet areas, through in-filling of depressions, through repair and proper maintenance of water channels, through thorough and regular removal of refuse, which might otherwise provide receptacles for water, etc. Later, in addition, mosquito breeding sites were sprayed with oil, or various other compounds, in order to kill mosquito larvae; larvivorous fish were introduced. There was also some use of insecticides. Beginning in a small way but increasingly as time went on, quinine was distributed, both for malaria treatment and for use prophylactically (see Rajendram and Jayewickreme 1951; Visvalingam 1961; see also the annual *Reports of the Principal Civil Medical Officer of Ceylon* and the later *Reports of the Director of Medical and Sanitary Services of Ceylon*).

The extent of such anti-malarial activity in Sri Lanka was relatively limited initially but increased during the 1920s and into the 1930s. The particularly severe malaria epidemic of 1934-1935 undoubtedly came as a shock and even an affront to Sri Lanka's Department of Medical and Sanitary Services. Following reports on this outbreak by Briercliffe (1935) and Gill (1935) the Malaria Control and Health Scheme was brought into operation in late 1936. This expressly provided for not only a whole battery of direct anti-malarial activities,

[2] *A. culicifacies* is still the only proved malaria vector in Sri Lanka.

including precautionary larvicidal spraying in areas judged to be showing pre-epidemic signs, but also a range of more general health measures: it embodied the notion that malaria could not be seen in isolation from more general health problems and that tackling these problems would also reduce the impact of malaria; the scheme was seen as having particular relevance for rural areas. In the words of the Director of Medical and Sanitary Services for Ceylon in his report for 1937,

> Malaria in rural areas cannot be dealt with in the same way as in urban areas. In the latter ... it is possible for intensive anti-larval work to be undertaken on a reasonably economical basis; but this is not possible in wide areas with scattered population and where rice cultivation depends generally on artificial irrigation. The work that is being carried out consists of direct and indirect methods for the amelioration of existing conditions in regard to malaria. The direct method is chiefly the treating of the disease and the control of the insect vector as far as possible and the indirect method deals with conditions the existence of which aggravate the incidence of malaria[,] by caring for the mother and child through maternity and child welfare work, by caring for the school child through school health work, by giving mass hookworm treatment, by treatment for parangi [yaws], by control of communicable diseases, general sanitary work, and by health education (Ceylon 1938: Part 4, C38).

The Malaria Control and Health Scheme continued in operation through the late 1930s and throughout the Second World War, though with varying activity, and was still in place at the time of the postwar DDT-spraying campaign. Beginning in 1943, and especially from 1944 onwards, in addition to larvicidal spraying of mosquito breeding sites, there was fairly extensive spraying of pyrethrum insecticide inside houses to kill adult mosquitoes.[3] This activity was superseded as the DDT-spraying campaign got under way. DDT was also used as an insecticide, in the domestic setting. However it was longer-lasting in its effect, being sprayed on walls and other surfaces and continuing to kill mosquitoes which landed there for some time, i.e. it was a 'residual' insecticide, so that much less frequent spraying was required than with pyrethrum (see Rajendram and Jayewickreme 1951; Visvalingam 1961; also the annual reports of the Principal Civil Medical Officer and the Director of Medical and Sanitary Services).

Trends and fluctuations in mortality in Sri Lanka, 1900-1954

All of the measures presented here have been calculated from Sri Lankan census and registration data. Census data were taken from the census reports: there were censuses of Sri Lanka in 1901, 1911, 1921, 1931, 1946 and 1953. Registration data were obtained from the annual *Reports of the Registrar General of Ceylon on Vital Statistics*.

Material is presented for the whole of Sri Lanka and for five areal subdivisions of the country, each subdivision comprising one or more of the (then) 21 administrative districts of the island. Sri Lanka was split first into 'wet' and 'dry' zones; the wet zone was then further subdivided into three areas and the dry zone into two areas (see Table 1 and map presented as Figure 1). The grouping of districts into wet and dry zones has been taken from United Nations (1976:35).

[3]In fact, there had been some, intermittent and small-scale, spraying of insecticide inside houses in Sri Lanka since 1934.

Table 1
Minimum, maximum and mean annual infant mortality rates over the period 1900-1944, and average spleen rates 1938-1941, for the districts of the wet zone and of the dry zone of Sri Lanka

Zone, sub-zone and district		Infant mortality rate[a]			Average spleen rate[b] 1938-1941%
		Min	Max	Mean	
Wet zone					
I	Kalutara	81	144	117	1.4
	Galle	100	159	133	2.9
II	Colombo	103	186	150	2.4
	Negombo	103	271	141	9.4
	Matara	96	178	135	16.0
III	Kandy	119	306	186	10.2
	Nuwara Eliya	121	254	193	10.7
	Ratnapura	113	254	175	12.2
	Kegalle	93	482	158	13.6
Dry Zone					
I	Jaffna	120	240	185	6.7
II	Matale	133	433	218	39.2
	Hambantota	152	393	235	62.6
	Mannar	215	574	346	35.4
	Mullaittivu[c]	200	581	298	65.3
	Batticaloa	164	306	224	37.8
	Trincomalee	164	462	245	39.5
	Kurunegala	131	716	243	39.6
	Puttalam	226	485	313	50.4
	Chilaw	99	329	153	17.3
	Anuradhapura	194	487	292	67.3
	Badulla	114	263	192	25.1

[a]Registered infant deaths in year divided by registered live births, expressed per 1000 live births.

[b]The spleen rate is the percentage of school children found in surveys to have an enlarged spleen. These figures come from Newman (1965:92).

[c]Mullaittivu district was subsequently renamed Vavuniya district and has now been split into Mallaittivu and Vavuniya districts.

This fivefold areal subdivision of Sri Lanka was adopted largely on the basis of what previous researchers had concluded about the differing importance of malaria historically in different parts of the country. The dry zone was distinguished from the wet zone since, as already noted, malaria had been found to be endemic in most of the dry zone but hardly at all in the wet zone. The district of Jaffna was, however, separated out from the rest of the dry zone, since previous work suggested that malaria levels there were more akin to those found in the wet zone than the dry zone. Kalutara and Galle districts were separated out together from the wet zone since historically these areas had been found to suffer little from malaria. The remainder of the wet zone, parts of which were subject to malaria epidemics, was divided into two, mainly on the basis of the mortality differences indicated by the data of Table 1 but also bearing in mind that one of the resulting areas, labelled as sub-zone III of the wet zone in Table 1, included many tea estates and so might have different experience from

other areas (see Carter 1927; Briercliffe 1935; Gill 1935, 1940; Abhayaratne 1950; Rajendram and Jayewickreme 1951; Visvalingam 1961; Newman 1965; Gray 1974).

The data shown in Table 1 by and large confirm the appropriateness of this subdivision of Sri Lanka. In general, dry zone districts had higher infant mortality than wet zone districts and higher spleen rates, suggesting more malaria. Jaffna, on the other hand, was more similar to some wet zone districts in these respects than to other dry zone districts. Kalutara and Galle were the most favoured districts in the island; even Colombo district, which like them had an extremely low 1938-1941 spleen rate, nevertheless had somewhat higher average infant mortality and higher peak mortality, the latter feature probably indicating a greater susceptibility to epidemic malaria. On the figures of Table 1, both Chilaw district and Badulla district might possibly have been dealt with separately from other dry zone districts. This would have complicated the analysis quite considerably, however, without any very great benefit; so this approach was not adopted.

The graphs presented in Figure 2 show changes in the crude death rate, infant mortality rate and maternal death rate for Sri Lanka over the period 1900-1954. The data on which these graphs are based are presented in an appendix; this is so for all graphs shown. Crude death rates were calculated by dividing the registered deaths in a year by the total population and expressing the result per 1000 total population; populations in non-census years were estimated by assuming a constant rate of growth between censuses. This method of estimating denominators was obviously not exact; however, the fact that, as may be seen from Figure 2, the resulting crude death rates correspond almost exactly with those produced for 1930 and later years by Newman (1965:89) using denominators estimated in a much more elaborate fashion, suggests that these data are, nevertheless, reasonable. Infant mortality rates were calculated by dividing the infant deaths registered in a year by the registered live births, and maternal death rates by dividing the maternal deaths, that is, deaths associated with pregnancy or childbirth, registered in a year by the registered live births, in each case expressing the result per 1000 live births.

It may be seen from Figure 2 that mortality in Sri Lanka fluctuated a great deal. Most of the upsurges in mortality were associated with outbreaks of malaria, though in 1918-1919 there was a very serious influenza epidemic, which was itself then further added to by a malaria outbreak (Langford and Storey 1993a). From 1900 until about 1920—attempting to set aside short-run fluctuations—the data seem to suggest a slight upward trend in mortality: this may be genuine but is more likely to be a reflection of improvements in data quality. From about 1920 onwards—again, disregarding short-run fluctuations—there was a general downward trend in mortality, though in the case of maternal mortality this might not have begun until the late 1930s. Marked fluctuations continued, however, the most notable being the terrible rise in mortality associated with the malaria epidemic of 1934-1935, until the immediate post-World War II period, when they apparently disappeared.

All of the data presented in Figure 2 indicate that there was a remarkable improvement in mortality in Sri Lanka after the Second World War. Mortality dropped in 1947 to lower levels than seen previously (since 1900) and there was further improvement subsequently. In some degree, however, the fall in 1947 is made to seem more precipitate than it truly was by the fact that mortality rose in Sri Lanka in the later years of the war and just afterwards. Moreover, before this rise, mortality in Sri Lanka had actually already been falling quite sharply, albeit only for a short period, to what were then unprecedentedly low levels, the crude death rate and infant mortality rate dropping to a low-point in 1942 and the maternal death rate in 1943. There had been a previous dip in the crude death rate, though apparently not noticeably in infant and maternal mortality, in the early 1930s.

Figure 2
Crude death rate, infant mortality rate and maternal death rate for Sri Lanka, 1900-1954

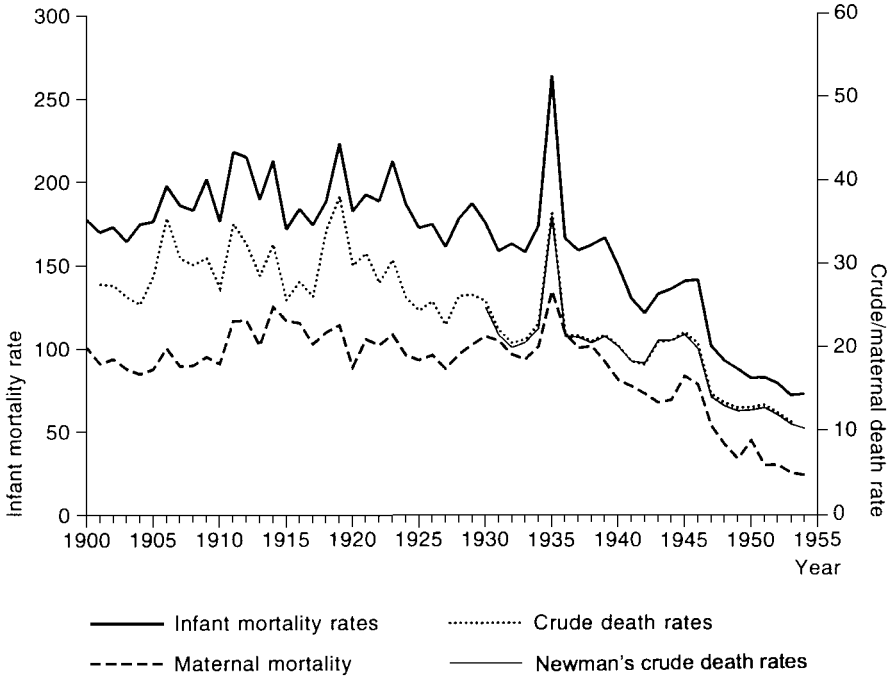

Figure 3 shows changes in the crude death rate over the period 1900-1954 for each of the five areal subdivisions of Sri Lanka; Figure 4 shows changes in the infant mortality rate. It may be seen that all these areas shared in the general downward trend in mortality after about 1920 in Sri Lanka. Areas differed, however, until the late 1940s, anyway, in terms of both the typical level of mortality and the extent of mortality fluctuations. In the wet zone, sub-zone II (see Table 1 for the districts this included) after about 1920 tended to have similar or slightly higher mortality than sub-zone I in 'good' years but a larger gap opened between the two areas when malaria struck, reflecting the greater susceptibility of sub-zone II to epidemic malaria; in sub-zone III of the wet zone mortality tended to be somewhat higher still and the fluctuations due to epidemic malaria even more marked. In the dry zone, Jaffna district had higher mortality, in general, than sub-zones I to III of the wet zone but fluctuations in mortality were not especially marked; this area seems to have been completely unscathed in the 1934-1935 malaria outbreak. The remainder of the dry zone had higher mortality generally than other areas of the island as well as marked fluctuations in mortality. In all parts of Sri Lanka, however, from 1947 onwards, fluctuations in mortality were small and differences between areas relatively slight.

Of special interest in the present connection is whether the fall in mortality in 1947 in Sri Lanka as a whole occurred also in much the same way in these different areas of the country. Considering the period from 1920 on, it may be seen from Figure 3 that, so far as the crude death rate is concerned, there is no real sign of a noticeable discontinuity of trend in 1947 in sub-zone I of the wet zone; moreover, if temporary upsurges in mortality are ignored, the same can be said in relation to sub-zones II and III of the wet zone. In the case of Jaffna

Figure 3
Crude death rate per 1000 population for the sub-zones of the wet zone and the dry zone of Sri Lanka, 1900-1954

Figure 4
Infant mortality rate per 1000 live births for the sub-zones of the wet zone and the dry zone of Sri Lanka, 1900-1954

district there was apparently some acceleration in the decline of the crude death rate in the post-World War II period, though if the improvement in the rate over the period 1934-1940 is used as a basis for judging likely future developments rather than the whole period from 1920 on, the postwar dip below trend seems rather slight. In the remainder of the dry zone there was, on the face of it, a clear downward shift in the crude death rate in 1947; however, even in this case, there is the question of whether the very short-lived, but quite marked, improvement in the rate in the early 1940s, to what was then the lowest level ever (since 1900), should be regarded as signalling the impending postwar improvement. There were, it may be noted, new low-points in the crude death rate in all the sub-zones of Sri Lanka except sub-zone I of the wet zone in the early 1940s.

The data on infant mortality presented in Figure 4 point even more strongly to the question of whether the downward trend in mortality in Sri Lanka might not have taken on a new impetus in the late 1930s or early 1940s, thus in some sense anticipating the postwar decline. There was apparently quite a noticeable fall in the infant mortality rate in the early 1940s, albeit very short-lived and rapidly reversed, in all parts of Sri Lanka except sub-zone I of the wet zone; even in that area there seems to have been some acceleration of the pre-existing downward trend in the late 1930s and early 1940s.

Changes in the intensity of public health activities in Sri Lanka, 1930-1954

A variety of data relating to public health activities in Sri Lanka over the period 1930 to 1954 is presented in Tables 2 and 3. These data have been compiled from material provided in the annual *Reports of the Director of Medical and Sanitary Services of Ceylon*, and the *Education* reports, together with some information from the census and from vital registration. Even at the very beginning of this period there was clearly a great deal going on: most infants seem to have undergone at least primary vaccination against smallpox[4]; a very large number of individuals were treated for hookworm infestation each year, that is, wormed (for an account of the debilitating effects of this disease in Sri Lanka see Langford and Storey 1993b); and the School Medical Service carried out a large number of medical examinations each year among children in schools. In the early 1930s government expenditure on health was cut, as part of a general response to the economic difficulties of that period, and there seems to have been a reduction in the number of primary smallpox vaccinations and in the number of medical examinations in schools; the anti-hookworm campaign, on the other hand, apparently increased its coverage during this time. In 1935 there was a considerable increase in government spending on health (strictly, this was in the 12-month period beginning on 1 October 1934). However, this was obviously largely, and possibly entirely, simply a response to the appalling malaria outbreak at that time. The number of malaria cases treated as inpatients in hospitals or, overwhelmingly, as outpatients in hospitals or dispensaries in 1935 (5,454,781) amounted to 97 per cent of the population of Sri Lanka at that time.[5] By contrast,

[4] Only data on primary vaccinations against smallpox have been shown in Table 2 even though numbers of secondary vaccinations are also provided in the official reports. It was felt that numbers of primary vaccinations give a better indication of the general level of vaccination activity, whereas numbers of secondary vaccinations tend to fluctuate more in response to actual or feared smallpox outbreaks.

[5] See *Administration Report of the Acting Director of Medical and Sanitary Services for 1935*, page C28. The number of cases reported is extremely high (though clearly labelled as such) and it is conceivable that the same individual could have been treated more than once in the same year, or even (as suggested by an anonymous reviewer) that the number of visits rather than cases has been reported. Even so, the number of malaria cases treated in 1935, and the expense of providing this treatment, must have been very high indeed.

Table 2
Some indicators of public health activities in Sri Lanka, 1930-1954

Year	Govt. spending on health[a] (millions)	Change from year before (%)	Govt. spending on school meals[b] (1000s)	Primary smallpox vaccinations[c]		Total hookworm treatments[d]		Typhoid inoculations[e] (1000s)	
				Number (1000s)	As % of last year's births	Number (1000s)	As % of population	1st	2nd
1930	10.7			170	86	1,294	25	5	2
1931	9.7	-9		149	73	1,406	27	4	2
1932	9.8	1		104	52	1,827	34	7	3
1933	9.3	-5		94	47	1,824	33	9	4
1934	9.4	2		143	6	1,992	36	13	7
1935	11.7	24		97	47	1,402	25	10	6
1936	11.0	-7		145	75	1,856	32	8	6
1937	11.1	1	242	163	85	2,163	37	25	18
1938	12.1	9	623	190	88	2,170	37	41	32
1939	12.9	7	972	150	72	2,112	35	-	-
1940	12.9	0	1,257	178	84	2,147	35	69	55
1941	13.4	4	1,284	177	83	1,899	31	72	56

1942	14.3	7	1,506	176	80	890	14	101	77
1943	15.7	9	1,674	196	89	813	13	122	94
1944	18.2	16	3,764	168	68	1,420	22	128	96
1945	21.6	19	5,229	153	66	1,332	20	54	39
1946	28.7	33	5,863	193	81	1,376	21	55	41
1947	37.2	30	7,049	192	75	1,806	26	87	59
1948	51.7	39	7,338	217	80	1,898	27	160	116
1949	57.0	10	8.785	225	78	1,902	26	82	61
1950	62.4	9	9,591	214	73	1,861	25	88	80
1951	67.6	8	9,492	233	77	1,880	25	77	56
1952	82.5	22	10,136	228	73	1,810	23	68	55
1953	87.0	6	10,126	237	76	1,728	21	90	66
1954	90.1	4	8	223	69	1,850		83	59

[a]Millions of rupees. Expenditure is in fact for year ending 30 September of year shown. Figures exclude cost of new buildings as well as improvement and maintenance of old buildings.

[b]Thousands of rupees. This expenditure is from education budget, not health budget. Probably for years ending 30 September rather than calendar years.

[c]Figures for 1932 and 1933 officially reported to be too low since primary vaccinations carried out as part of vaccination campaign then in response to smallpox outbreak omitted. 1941 figures may be similarly affected.

[d]These are largely what were terms ‘first’ but include subsequent treatments; hence treatments may exceed individuals treated in year.

[e]The figures for 1938 relate to inoculations carried out in schools only; no all-Sri Lanka figures were provided for that year. In the case of 1937 (first and second doses) and 1936 (second doses), disquietingly, though the figures are supposed to be for all-Sri Lanka, slightly higher numbers of inoculations were actually reported as occurring in schools alone.

the smallpox vaccination program, the anti-hookworm campaign and the activities of the School Medical Service all seem to have been curtailed in 1935. This was unquestionably due in part to the direct impact of the malaria epidemic itself, since many health workers were diverted from their usual tasks to help cope with the epidemic, and many others would no doubt have themselves suffered from malaria at that time, but it may well also have reflected continuing financial stringency.

Table 3
Number of government health centres providing maternity and child welfare services in Sri Lanka, clinics held there, and attendance at clinics by mothers and children, and number of medical examinations in schools carried out by School Medical Service, 1930-1954

Year	Number of health centres	Clinics held	Visits to clinics[a] by			School children medically examined (1000s)
			Expectant mothers (1000s)	Infants (1000s)	Pre-school children (1000s)	
1930	40	1,547	1	14	7	81
1931	59	2,089	3	18	17	74
1932	54	2,493	3	21	12	64
1933	73	3,199	5	30	16	61
1934	78	3,952	8	28	18	45
1935	86	4,702	10	28	17	36
1936	77	4,543	17	30	19	53
1937	207	8,395	40	88	40	85
1938	311	9,485	76	158	75	95
1939	408	16,354	101	224	98	69
1940	-	-	119	246	96	77
1941	-	-	155	259	88	72
1942	437	18,695	-	-	-	64
1943	444	15,655	-	-	-	78
1944	461	18,122	-	-	-	61
1945	503	17,227	-	-	-	55
1946	533	19,144	-	-	-	62
1947	572	16,591	324	173	67	90
1948	602	20,488	277	237	73	107
1949	662	23,971	296	330	97	102
1950	701	24,890	313	382	109	84
1951	714	25,509	413	361	168	87
1952	771	27,143	412	385	122	98
1953	755	26,151	333	370	105	128
1954	744	24,556	307	330	107	129

[a]The figure for visits to clinics by pre-school children in 1935 is that reported for the whole island; however, disquietingly, about 3,000 more such visits, almost 20,000, were separately reported for 'health unit areas' alone. The 1947 figures are those that appear in the 1947 Report of the Director of Medical and Sanitary Service of Ceylon; the 1948 report, without explanation, presents different figures for 1947: 289 instead of 324; 199 instead of 173; and 76 instead of 67.

In the years following the 1934-1935 malaria outbreak there was a general upsurge in public health activities in Sri Lanka (see Tables 2 and 3). Government spending on health in 1936, though somewhat lower than in the epidemic year 1935, was considerably higher than in the pre-epidemic period; moreover, this level of expenditure was maintained in 1937 and there were further increases in 1938 and 1939. The coverage of the smallpox vaccination

program improved during this period as did that of the anti-hookworm campaign. From 1937 onwards there was a noticeable increase in the numbers of anti-typhoid inoculations administered. So far as maternity and child welfare services were concerned, while there had been a steady increase in both provision and use of services between 1930 and 1936, in 1937 there was a considerable increase in activity, no doubt associated with the Malaria Control and Health Scheme, already referred to, which came into operation in late 1936. In 1937 there was a dramatic increase in the number of health centres at which maternity and child welfare services were provided, from 77 such centres in 1936 to 207 in 1937, and a considerable increase also in the number of clinics held at these centres; moreover, the numbers of visits to these clinics by expectant mothers more than doubled between 1936 and 1937, as did the number of visits by infants and by pre-school children. The extent of use of these facilities continued to grow quite strongly until at least 1941, after which there is unfortunately a gap in the data of some years. Beginning in 1937 (in fact, late 1936) the government made funds available to enable midday meals to be provided for children in schools.[6] According to the Director of Education for Ceylon in his report for 1937 this was to include (from February 1937) 'all the children in schools in distressed areas' (Ceylon 1938: Part 4, A10). This expenditure on midday meals for school children grew rapidly in the late 1930s and early 1940s.

During the early years of the Second World War public health activities in Sri Lanka were in most respects maintained or even extended; even later on, many activities continued at reasonable levels (see Tables 2 and 3). However, the coverage of the anti-hookworm campaign was drastically curtailed in 1942 and 1943 because of the lack of necessary supplies. The anti-malaria program was probably also constrained by shortage of supplies, at least before 1944. To some extent, moreover, the health of the population would undoubtedly have been undermined by the food shortages that developed following the Japanese invasion, in December 1941, of Burma, which had previously been an important source of rice imports for Sri Lanka. Unfortunately, there is no information on the very important matter of the extent of use of maternity and child welfare services during the period from 1942 to 1946.

At the end of and immediately after the Second World War, as regards most of the specific public health measures for which information is provided in Tables 2 and 3, there was apparently little or no sign of increased activity. The coverage of the smallpox vaccination program and of the anti-hookworm campaign, as well as the extent of inoculation against typhoid, were well below their earlier peak levels. In one very important respect where maternity and child welfare services are concerned there were signs of greater activity: the number of visits to clinics at health centres by expectant mothers in 1947 was substantially higher than in 1941, unfortunately the last year before 1947 for which this information is available, but having the highest recorded figure for any year up to that time. The numbers of visits to clinics by infants and by pre-school children, though, were still apparently somewhat lower in 1947 than their peak recorded levels early in the Second World War, and it was not until two or three years after 1947 that these earlier peak levels were surpassed.

It seems extremely likely, nevertheless, that there was an upsurge in public health activities in Sri Lanka towards the end of the Second World War and afterwards. The specific activities referred to in Tables 2 and 3 are only part of the picture; no data have been presented on the provision of inpatient and outpatient facilities at hospitals or dispensaries,

[6] Even before this time there were some local schemes for the provision of midday meals in schools, funded by municipalities or individuals; and post-1936 there was some local supplementation of government expenditure on school meals, as well as encouragement of school gardens to provide additional supplies.

for example, or the availability of trained public health nurses and midwives, or the involvement of these in visiting people in their homes, all areas where there might conceivably have been improvements in this period. Some data relating to these matters are available but problems of coverage and discontinuities of definition, as well as gaps in the material, make them difficult to interpret. The figures relating to government expenditure on health presented in Table 2 certainly do suggest very strongly that there were improvements in health provision towards the end of the Second World War and afterwards: it may be seen that spending grew especially rapidly in the period from 1944 (in fact, late 1943) until 1948. This does not seem to have been merely a reflection of increased expenditure on malaria eradication during this period: stripping out the costs of the anti-malaria campaign from total government spending on health affects the figures on annual percentage growth in expenditure only slightly.[7] It may also be seen from Table 2 that government spending on midday meals for children in schools, which had increased in successive years from the outset, then more than doubled between 1943 and 1944, and continued to grow quite strongly after that.

The effect of DDT-spraying on mortality in Sri Lanka

The Newman-Gray-Molineaux approach to the assessment of the effect of DDT-spraying on mortality in Sri Lanka is unsatisfactory for a number of reasons. This approach overlooks the fact that, as has been pointed out, over and above the general longer-run downward trend in mortality after about 1920 in Sri Lanka, there was also a fairly dramatic, albeit rather short-lived, fall in mortality in the early 1940s. This fall followed an upsurge in public health activities in Sri Lanka which came about as a result of the introduction of the Malaria Control and Health Scheme: this both attests to the likely genuineness of the fall and draws attention to the possible impact on mortality of such public health measures; moreover the fact that the fall occurred in every part of Sri Lanka, except perhaps sub-zone I of the wet zone, the healthiest part, strongly suggests that these measures could be effective even in the face of endemic malaria. Comparing a longish pre-DDT period of time with the post-DDT situation, which was the Newman-Gray-Molineaux approach—and Coale and Hoover's, for that matter—thus has the effect of concealing an important change in the pre-DDT period which is relevant to the interpretation of the post-DDT changes in mortality.

Another shortcoming of the Newman-Gray-Molineaux analysis is its reliance on the spleen rate as an indicator of the level of malaria in an area. A high spleen rate in an area will undoubtedly be a reflection of a high malaria prevalence in that area, but the latter will depend not only on the risk of malaria infection but also on the likelihood of an attack being serious and prolonged; this in turn will depend partly on the nutritional status and general state of health of the population, so that, in the words of Carter, 'The social status and economic conditions of ... communities ... also influence the rates'; Carter went on to observe that 'Malnutrition ... exerts an important effect in many parts of Ceylon upon ... the maintenance of high spleen rates' (Carter 1927:14). A corollary is that in some degree improvements in nutrition and general state of health would be expected to reduce spleen rates, and malaria morbidity, and malaria mortality, even if exposure to the risk of malaria remained unchanged.

[7] Visvalingam (1961:82) provides figures on the 'expenditure on anti-malaria campaign' from 1934 onwards. No source is given but he was Superintendent of the Anti-Malaria Campaign at the time he was writing. Removing these amounts from the total expenditures on health shown in Table 2 results in annual percentage changes in the remainder which are essentially the same as the percentage changes in total expenditure shown in Table 2.

A further weakness of the Newman-Gray-Molineaux approach is that, expressly or implicitly, it assumes that attempts at malaria control before DDT-spraying were ineffective. Gray simply states (1974:210): 'Before 1945 malaria control was limited to ineffectual larvacidal [sic] methods'. This judgement may well be incorrect. Particularly after the introduction of the Malaria Control and Health Scheme in late 1936, armed with the detailed knowledge of the habits and significance for malaria of *A. culicifacies* provided by Carter, an elaborate system of monitoring potential danger areas and of responding where necessary with larvicidal, and increasingly insecticidal, spraying was established; this was in addition to all the usual activities designed to avoid the formation of bodies of stagnant water, large and small. Those involved certainly did believe that these measures made a difference and in the view of Rajendram and Jayewickreme (1951:21), referring to the malaria outbreaks of 1939-1940, 1943 and 1945-1946, there was 'little doubt that if it were not for the control measures adopted in these years these epidemics might have assumed much larger proportions'. According to Visvalingam (1961:64) 'There is little doubt that the control measures adopted under the new scheme had reduced the problem of malaria and the severity of epidemics during these years'. If pre-DDT control measures did indeed have some effect, which seems very likely, this needs to be borne in mind in thinking about any possible impact that DDT might have had: first, in some degree DDT was merely supplanting earlier measures, so if these were effective then any impact of DDT would have been in some degree a replacement effect; secondly, had DDT not been available, there would undoubtedly have been a great upsurge in antimalarial activity of the pre-DDT type after the Second World War, which if such measures were indeed effective would itself have reduced mortality in some degree in any case.

Given this complexity, can any assessment be made of the impact of DDT-spraying on mortality in Sri Lanka? Consider first only the fall in mortality in the year 1947. It seems reasonable to suppose that, even in the absence of DDT-spraying, the crude death rate in Sri Lanka in 1947 would have fallen back at least to its previous minimum level, reached in 1942. The year 1947 was a favoured year in a number of respects: climatic conditions were not conducive to epidemic malaria[8] and there was a falling-back of mortality following the fairly serious malaria outbreak of 1945-1946, which may well also have 'brought forward' some deaths; in addition, by 1947 food and other wartime shortages had ended and, as noted previously, public health expenditure had noticeably increased. By contrast, the earlier low-point in the crude death rate in 1942 had been achieved despite wartime difficulties.

As may be seen from Table 4 the Sri Lankan crude death rate in 1947 was 14.4 per 1000 population whereas the previous minimum figure, reached in 1942, was 17.9. Thus, assuming that given the conditions in Sri Lanka in 1947 the crude death rate would have fallen at least to the 1942 level, even without DDT-spraying, the maximum possible reduction in the 1947 crude death rate attributable to DDT-spraying is 20 per cent. However, there was no spraying at all in sub-zone I of the wet zone at any stage; moreover, although spraying was carried out in parts of sub-zones II and III of the wet zone, this would have had little or no impact in 1947 since this was not a year with epidemic conditions. Taking account of the reduction in

[8] Rajendram and Jayewickreme (1951) might be thought to have suggested otherwise by stating that (p.46) 'in 1947 both south-west and north-east monsoons were failures'. However, elsewhere in the same article (p.31) they confined themselves to the expression 'partial failure' in relation to the south-west monsoon in 1947 by which they clearly meant that rainfall was considerably below average (their figures referred to the epidemic zone) in April and May (p.57). Since rainfall was well above average in January and in March of 1947 and reasonable, or in the case of August extremely heavy, from June to October, there would have been no real reason to expect epidemic malaria in 1947. Nor did Rajendram and Jayewickreme suggest that there were epidemic conditions in 1947; their argument was that the failure of the north-east monsoon in 1947 would have led to epidemic conditions in 1948.

mortality that occurred anyway in sub-zone I of the wet zone, which could not have been due

Table 4

The minimum crude death rate (CDR) during the period 1936-1944, the crude death rate in each year 1942-1947, and the average crude death rate over the periods 1948-1951 and 1947-1951, for Sri Lanka and the sub-zones of the wet and the dry zone of Sri Lanka[a]

Zone and sub-zone[b]	Year(s)								
	Min CDR	CDR						Average CDR	
	1936-1944[c]	1942	1943	1944	1945	1946	1947	1948-1951	1947-1951
Wet zone									
I	16.5	16.7	16.9	17.7	17.7	16.2	13.6	12.8	13.0
II	15.7	15.7	17.8	19.4	19.7	18.1	13.7	13.6	13.6
III	15.2	15.2	17.6	18.4	20.2	18.1	13.2	13.1	13.1
Dry Zone									
Jaffna	20.6	20.8	24.5	21.5	22.2	17.1	15.5	12.7	13.3
Rest	22.5	22.5	27.1	25.7	27.4	27.7	16.2	12.4	13.1
Sri Lanka	17.9	17.9	20.6	20.8	21.8	20.4	14.4	13.0	13.3

[a]See appendix for complete data.

[b]See Table 1 for the districts comprising the different sub-zones.

[c]This is also the lowest rate recorded up to that time (since 1900) except in sub-zone I of the wet zone where the CDR in 1932 was 16.4.

to DDT-spraying, the maximum possible reduction in the all-island 1947 crude death rate attributable to DDT-spraying falls to 18 per cent; assuming further that no part of the wet zone was affected by DDT in 1947 this figure falls to only 13 per cent. Moreover, even this low figure is very likely to be an overestimate since it assumes that all of the reduction in mortality occurring in the dry zone between 1942 and 1947 is attributable to DDT-spraying, which is clearly highly improbable.

All in all, then, it seems very unlikely that the striking fall in mortality in Sri Lanka in 1947 itself had very much to do with DDT-spraying. However, what of the period immediately following 1947? So far as the wet zone is concerned, it may be seen from Table 4 that mortality fell only a little further in the next four years, so on the face of it hardly requiring a radical explanation. However, this is to presume that the absence of conditions conducive to epidemic malaria characteristic of 1947 continued, whereas, at least according to Rajendram and Jayewickreme (1951:12, 22, 47, 49), both 1948 and 1950 were years in which epidemics would very probably have occurred historically, given the climatic conditions. This being so, it could obviously be argued that DDT-spraying had prevented these epidemics and hence the mortality they would have caused. However, making a judgement on this would require not only an assessment of the likelihood of a malaria epidemic in these years in the absence of any control measures but an assessment of that likelihood given only pre-DDT control measures, though possibly on a considerable scale; moreover, a judgement would also be required on the possible extent to which mortality in any epidemic which did occur might have been reduced, perhaps considerably, by the improvements in nutrition and in the availability of health services which very probably occurred in this period. So far as the dry zone is concerned, it may be seen from Table 4 that in the few years immediately following 1947 mortality fell distinctly further, below 1947 levels. Thus two questions arise in connection with the dry zone: first, what part did DDT play in reducing mortality to these new low levels? Secondly, rather as in the case of the wet zone, what part did DDT play in preventing any periodic malaria outbreaks, and consequent mortality, that would otherwise have occurred?

Suppose that, as argued previously, DDT-spraying did not affect mortality at all in the wet zone in 1947; and suppose further that one-half of the reduction in the crude death rate in the sub-zones of the dry zone between 1942 and 1947 was attributable to DDT-spraying, which seems unlikely to be an underestimate; then the crude death rate for Sri Lanka in 1947, in the absence of DDT-spraying, would have been 15.4 per 1000 population, rather than the observed rate of 14.4 per 1000. If, without DDT-spraying, the average crude death rate for Sri Lanka over the four years following 1947 would have exceeded 15.4 by the same proportion as the average crude death rate over 1943 to 1946 exceeded that for 1942, the average crude death rate for Sri Lanka over the period 1948 to 1951 would have been 18 per 1000, meaning that the average observed crude death rate for the five-year period 1947-1951 was 24 per cent below the average expected rate in the absence of DDT-spraying. However, this is likely to be a considerable overestimate of the impact of DDT-spraying in this period: as already suggested, there is every reason to believe that in the absence of DDT, pre-DDT antimalarial measures would have been deployed on a massive scale as epidemic conditions developed; moreover, for the very many reasons already given, mortality would almost certainly have been very much lower in any malaria outbreak that had occurred than during the wartime period. If the potential proportional rise in mortality in Sri Lanka during the period 1948-1951, over 1947, were judged to be half that which occurred during 1943-1946, over 1942, then the average observed crude death rate for 1947-1951 would have been 19 per cent below the average expected rate; if the potential rise were judged to be a quarter of the 1943-1946 rise, this would fall to 16 per cent. Even these figures will tend to be overestimates in that they overlook the fact that there were further noticeable improvements in mortality after 1947

in the dry zone, some part of which would undoubtedly have occurred, assuming favourable climatic conditions, even in the absence of DDT-spraying; meaning that, effectively, the baseline crude death rate of 15.4 per 1000 used in the calculations and hence also the estimates of the potential mortality in outbreaks of malaria are somewhat too high.

Conclusion

It is clearly no easy task to estimate the impact of DDT-spraying on mortality in Sri Lanka after the Second World War. The problem is not so much with the apparently dramatic fall in mortality in the year 1947 itself: it is very unlikely that DDT-spraying played much part in this. The problem is to assess its impact in the years that followed. This requires a whole range of judgements in relation to events which did not occur: the likelihood of a malaria outbreak given certain meteorological circumstances; the extent to which the probable mortality associated with such an outbreak would have been moderated by improvements in nutrition or health services; the extent and impact of the antimalarial measures that would have been adopted had DDT not been available; and so on. The results of illustrative calculations, on various assumptions, have been presented above; for what it is worth I personally suspect that the effect of DDT-spraying on the 1947-1951 crude death rate may well have been at or below the lowest assessment provided, that is, a reduction of 16 per cent; however, the hard truth is, regrettably, that there does not seem to be an adequate empirical basis for arriving at a reliable conclusion.

A number of comments should be added, finally, about analyses that were attempted without success or could not be attempted because of lack of data. Despite considerable effort, it has proved possible neither to verify nor refute Meegama's assertion that formerly malarial districts enjoyed a disproportionate improvement in health services after the war; it was concluded that there were simply too few data available on a district basis to permit this. Another potential area of analysis to which a great deal of attention has been given without success is causes of death. Although a large quantity of material on causes of death is available for Sri Lanka, it was concluded, very reluctantly, that it is not of sufficient quality to be helpful in this case; the main problem is the very large 'pyrexia' category (meaning, simply, fever); it was felt that whilst this might well often conceal largely malaria the relationship between malaria and 'pyrexia' could not be taken as fixed, indeed probably was not, over time and space. An area, lastly, where analysis which might have been important has not proved possible because of the complete absence of data, is that concerned with the timing of DDT-spraying in different parts of Sri Lanka. If information had been available, which does not seem to be the case, on the dates at which spraying began in different areas of the country, it might well have been possible to examine the relationship of this timing to changes in mortality, and so throw light on the question of a possible connection between DDT-spraying and mortality decline.

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Health and development: knowledge systems and local practice in rural Thailand

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> Thus, while all public health campaigns can be defined as altruistic efforts to improve society, some - but not all - can also be defined as efforts by the system to control the locus of change in ways deemed desirable by the change agency.
>
> Charles Salmon

Abstract

The specific framing of health within a development context has implications for constructions of wellness and illness and how people react in times of ill health. In Thailand, recent national HIV/AIDS education-prevention campaigns commonly use top-down relay of public health information. This pattern replicates numerous development projects that aim to bring useful and beneficial knowledge to rural villagers. How villagers integrate this information depends, in part, on previous experiences with development programs in general and public health programs in particular. This paper considers the political economy of medical knowledge and multiple local health strategies in rural Northeast Thailand as a background to the contingent response to public health directives.

HIV/AIDS has urgently focused a spotlight on sexuality and sexual practice in societies all over the world. Social attitudes to illness and generalized health-seeking behaviour have received less attention as factors that influence education and prevention programs. In this paper, I explore the political economy of medical knowledge in rural Northeast Thailand (Isan) using data from two villages, Don Han and Baan Khem, in Khon Kaen province.[1] The intention is to provide a background to understanding how people respond to public health campaigns of which HIV/AIDS education is a recent high-profile example. This paper is not about HIV/AIDS transmission nor prevention campaigns *per se* but rather about the forms of knowledge Isan villagers have at their disposal when health issues are evoked.[2]

National health education campaigns in developing countries commonly follow patterns dictated by generic top-down development programs, that is, they provide information and the template for a course of action and people, it is assumed, will respond in the desired fashion. Frequently funding stipulations by international development agencies encourage

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[1]Ethnographic fieldwork was conducted in Khon Kaen for 18 months between 1991 and 1992 during which time I, and a research assistant, lived in each village for seven months. Data has were collected by participant observation, in-depth interviews and questionnaires. Both villages, whose names I have changed in this article, were roughly 35 km outside the provincial capital, had similar populations of around 900 and consisted of 148 and 194 households respectively. Research methodology is discussed in detail in Lyttleton 1994a.

[2]For a more detailed consideration of specific responses to the increasing presence of HIV and campaigns to prevent its spread in rural Northeast see Lyttleton 1994a,b, 1995b.

formula-driven program operations (Foster 1987; Escobar 1988). As has been widely documented, top-down development policies are not always effective. Since the early 1960s, Thailand has had numerous development projects many of which have been incorporated into successive Five Year Plans. In a wide-ranging study of Thai values and behaviour patterns, Suntaree comments on the frequent failure of these projects:

> Take for example, in the Northeastern region which is the poorest and most arid region of Thailand, the peasants perceived water resources as their first priority development need, the government officials perceived public health as top priority, and so forth. It is evident that even the local government officials who were close to the reality, still showed a differential perception, let alone those development policy makers in Bangkok, who hardly set their foot in the rural community. It is therefore understandable, when asked about the impact of development projects, whether development projects have reached the village community, and whether they were congruent with what the peasants need, the results show about 40% replied that development projects did reach the community but were not needed (Suntaree 1990:240).

For decades, villagers in Thailand have been recipients of organized injunctions suggesting that by following instructions their lives will 'improve'. Primary Health Care policies adopted since the 1980s advocate local community participation but the entrenched bureaucracy hinders comprehensive involvement in the alleviation of social and economic factors aggravating morbidity. After 30 years of development programs, Isan villagers remain the poorest and least healthy in Thailand.[3] There are in Thailand several hundred non-government organizations (NGOs) many of which have also attempted to shift the locus of control of 'quality of life' to individual communities. Many of these work in rural development with an operating premise more firmly embedded in notions of participatory politics than the top-down government programs. But from either perspective, Isan villagers are frequently the target subjects of planned change and they are thoroughly familiar with receiving guidelines for how to behave.

While small locally based organizations are playing an ever-increasing role in community awareness and support programs, the primary sources of HIV/AIDS knowledge in rural Thailand[4] have been messages from the Ministry of Public Health and the Population and Development Association, a large NGO which uses the Ministry of Interior as the conduit of information. Much of the material sent through either the mass media or the government bureaucratic channels is in a medical framework. While a burgeoning discourse on morality, and HIV as a threat to the nuclear family, has informed more recent campaign material, for the large part HIV/AIDS has invariably been depicted as a health problem, a threat to life. Medical officials are presented as those who have the necessary knowledge to alert the Thai populace to the problem AIDS poses to society.

The influence of public health campaign material cannot be isolated from the continuing dynamic of village-state interaction and, to a large extent, the collective response to current

[3] A study in 1987 found a correlation between regional wealth disparity and disease rates: the regions with the highest wealth had the best health status, while the Northeast had the highest rates of death and disease (see Cohen 1989:170) See also Proceedings (1991) for many summary statistics that show the Northeast ranking persistently higher than national averages in certain endemic diseases such as pneumonia, dysentery, dengue fever and hepatitis.

[4] Thailand is rapidly urbanizing and has tremendous numbers of seasonal migrants (urban health issues are becoming an increasingly urgent problem), but the large majority of Thailand's 57 million maintain their primary residence in more than 60,000 rural villages.

campaign messages in rural Thailand is a product of previous experience with development projects in general and health programs in particular. Just as the HIV/AIDS campaigns adhere to certain patterns established by previous national development programs, so too, villagers accept new information in a preconditioned manner. At the same time, indigenous concepts of illness and health, and beliefs in the efficacy of institutionalized medical practice shape the reception of details of a new medical threat. Before focusing on health behaviour at the village level I will provide a brief overview of public health developments.

Medical systems in Thailand

The institution of traditional Thai medicine has a long and esteemed presence in Thailand's history. However, over the past 100 years, Western medical practice has become an integral part of systems of diagnosis and treatment in Thailand and over this time has predominated in terms of both government support and local patronage.[5] Towards the end of the nineteenth century, the adoption of Western medicine was started by the royal family's interest in 'modernizing' indigenous medical practices at a time when cholera epidemics were widespread in Bangkok. The first hospital and medical school, Siriraj, was opened in 1888 and during the first 16 years of operation traditional medicine was phased out of the teaching curriculum to make way for Western methods (Chantana 1989:69). In 1916, Prince Mahidol, the son of King Rama V and father of the present-day monarch King Bhumipol, went to Harvard University to study Public Health and subsequently persuaded the Ford Foundation to assist Thailand to develop a modernized medical program (Muangman 1987:73). The Foundation's advice and funding centred on the advocacy or 'selling' of modern Western medicine rather than training of junior doctors to meet the health needs of the Thai populace (Donaldson 1982:113). Over the first half of this century, the association of Western medicine with scientific knowledge, modernity and royal patronage led to its domination of the traditional Thai medical practice. Cohen notes:

> Thus, the history of the Thai medical profession closely parallels the development of medical professions in the West: elitist (in terms of class and status), capitalist, drug oriented, urban centred, and assertive of its dominance over other health practitioners by means of subordination or exclusion (Cohen 1989:165).

At the onset of the Five-Year Development Plans in the early 1960s, the emphasis in government health policy was firmly placed on curative rather than preventive measures (Tawatchai, Ora and Pisamai 1988:2). Epidemic diseases such as cholera and smallpox had virtually been eradicated and the crude death rate had dropped from around 30 per 1,000 before 1950 to 8.2 in 1983 (Apichat and Chintana 1986: 528). The development of a national health institution was primarily encouraged in the cities, particularly the primate centre of Bangkok that still has an overwhelming proportion of doctors and facilities. In the 1960s, health coverage reached only 30 per cent of Thailand's population (Tawatchai et al. 1988:17) Since then, the network of health facilities has been gradually extended across the country,[6] but research has indicated that the government health service is not heavily patronized. A 1980 study showed that 60 per cent of villagers went to drugstores to treat themselves and

[5]Modern forms of institutionalized medical treatment in Thailand are almost always associated with 'Western medicine' (Riley and Santhat 1974:36).

[6]Despite the establishment of widespread medical facilities and a relatively high national health budget, 5.1% of the total budget (Gohlert 1990:111), the ratio of doctors to local residents still shows huge disparities. For example, in Isan in 1990 there was one doctor to nearly 12,000 people compared with a national average of 1 doctor to 5,000 people (Pichet 1991:141; Suwit 1991:153).

there was a preference for private clinics over government health stations (MOPH 1988:3). Tables 1 and 2 show the increased number of health facilities and summarize a national survey of the rates of patronage.

Table 1
Public health care facilities in 1989

Administrative Division	Health Care Facility	Number	No. of Beds
Bangkok	University hospitals	5	1000-2300
	Institutions	15	150-500
	General hospitals	10	300-1000
Four regions	University hospitals	3	600-1000
	General hospitals	17	500-1000
72 Provinces	General hospitals	72	150-500
735 Districts	Community hospitals	673	10-60
6,754 *Tambons*	Health centres	7,764	
61,411 Villages	Drug co-operatives	38,744	

Source: Health Planning Division (1990:28).

In conjunction with public hospitals there were, in 1989, 354 private hospitals, 13 traditional medicine hospitals and 5,763 (in 1987) private clinics. These clinics are largely run part-time by government-employed doctors. A Village Drug Co-operative will generally provide certain types of medicine such as paracetamol and oral rehydration salts. In 1989, 64 per cent of villages in Isan had a drug fund (Suwit 1991:157).

Table 2
Utilization of health services (%)

Types of health servies	1970	1979	1985
Self-treatment (buy drugs)[a]	51.4	42.3	22.3
Health centres	4.4	16.8	13.3
Government hospitals	11.1	10.0	32.6
Private hospitals and clinics	22.7	20.4	20.8
Traditional healers[b]	7.7	6.2	2.4
VHVs, VHCs	-	-	2.1
None of the above	2.7	4.2	6.3

Source: Department of Family Health (1988:10).

[a]Self-medication has been reported at far higher rates in other studies. For example, a 1988 study of four Northeastern villages both close to and distant from district hospitals found that between 68% and 86% of illness episodes were self-treated by the villagers. In this study traditional healers treated between 0.5% and 3% of cases (Le Grand, Luechai and Stretland 1993:1029). It should be noted that these surveys do not discuss the categories of illness that are self-treated: in some instances, medical diagnoses would doubtless be unnecessary and the purchase of pharmaceuticals or traditional remedies is an appropriate strategy.

[b]Traditional medicine in Thailand is multiplex and includes a diverse range of therapeutic practitioners in distinct modes of treatment (see Riley and Santhat 1974) historically linked to major traditions of Ayurvedic and Chinese medicine.

Gradually, as government health services have become more accessible they are becoming more popular. An important drawcard is the pharmaceutical drugs dispensed with the consultation, although, despite government attempts to limit the sale of drugs without a prescription, self-medication also remains widespread. Many drugstores throughout Thailand readily sell most types of pharmaceuticals across the counter. Consequently, Thailand has one of the highest pharmaceutical drug consumption rates per capita in the world. This is abetted by persistent and successful advertising by the large drug companies. It is common in rural Thailand for travelling movie shows to screen free movies as hawkers sell a host of different medicines to the assembled audience. Data on drug use have shown that almost 50 per cent of health expenditure is used to buy drugs (Cohen 1989:164). These figures illustrate the extent to which medication is a fundamental component of medical practice and indicate a strongly embedded bias towards curative rather than preventive practice. This is not simply a product of the introduction of Western medicine but also stems from traditional forms of herbal treatment. As Riley and Santhat note, 'Medicines *per se* occupy a pre-eminent place within the Thai medical system (traditional and modern)' (1974:8). Thus, at the same time as attempting to limit self-medication, one of the major underpinnings of primary health care in Thailand has been the provision of essential drugs to all villagers (Office of Primary Health Care 1985).

Primary health care policy

Throughout the 1960s and 1970s, small pilot projects encouraged local participation in health schemes in order to widen the scope and efficiency of health promotion and use of government health services. During this period, the attempt to increase social and economic well-being was strongly influenced by international policy guidelines. In 1976, the Thai Government (RTG) established intense collaboration with the World Health Organization (WHO) through the operation of the RTG/WHO Co-ordinating Committee. Integrated planning was initially considered such a success that a secretariat was created in the early 1980s comprising middle-level Ministry of Public Health and WHO managers to oversee the effective use of WHO resources throughout Thailand.

Primary Health Care (PHC) emerged in the late 1970s as a development philosophy suggesting that health is linked to a range of social and economic factors and not simply an issue of specific morbidity levels (see Walt and Vaughan 1981; Rifkin and Walt 1986). When WHO advocated Primary Health Care as a global strategy, Thailand endorsed it with enthusiasm and the prime minister immediately signed it into policy (MOPH 1988:13). Thailand prides itself on being the first country to specifically organize a seminar on PHC only four weeks after WHO's inaugural Alma Ata charter in 1978. Some suggest that PHC was incorporated into national planning in response to the growing awareness that top-down development policies were, in fact, lowering the health status of the rural population by widening income gaps and increasing the dependence of the poor on central government support (Tawatchai et al. 1988:1). Cohen, however, argues that the Thai medical profession remains strongly tied to the capitalist sector and PHC policy was adopted as a result of pressure from both international agencies and prominent (albeit the minority) 'advocates of a rural oriented health policy' (Cohen 1989:159). And as Krasae notes, international direction is not always particularly helpful:

> Likewise in many health development projects (both government and non-governmental) where international funding agencies must be given immediate proof of 'success', the aim is usually towards short-term gains (outputs), i.e., quick increases using one or several evaluation techniques to measure changes in health status or levels of social development. These though are often conducted at the expense of long-term growth, i.e., ensured

> partnerships between the parties involved. Hence, while changes may be made their sustainability is in great doubt (Krasae 1990:100).

In the Fifth Five-Year Plan (1982-1986), bottom-up planning from the village and subdistrict level was encouraged in order to attack poverty more effectively. The National Rural Development Project and the Social Development Project were intended to do this through a process of intersectoral planning. Four key ministries, Interior, Education, Health and Agriculture were to co-operate in planning at various levels, national, provincial and district. Thailand's sprawling bureaucracy, however, has not been noted for its success in horizontal co-operation and planning. The Ministry of Public Health itself comments:

> In a country which has a long history of centralised government with an administrative machinery empowered by the legalised role and function of civil servants like Thailand, there are always difficulties in pursuing the decentralisation of government participation and achieving the required community participation for development activities (MOPH 1988:39).

In recognition of the need for a clearly defined strategy, the Basic Minimum Needs approach, alternatively called the 'Quality of Life' program, was adopted to determine and guide multisectoral village-level programming. Hand-in-hand with a shift in global planning from WHO and UNICEF, the Thai government felt that the establishment of concrete criteria was the best way to achieve primary health care goals.[7] Integrating health care with a wider level of rural development, the Thai government vigorously promoted essential elements of primary health care in the villages: health education, nutrition, Mother and Child Health (including Family Planning), safe water supply and sanitation, immunization, prevention and control of locally endemic diseases, and provision of essential drugs (Damrong 1987:27).

As a core aspect of primary health care philosophy, local self-management has been encouraged through the recruitment of Village Health Workers, called volunteers (VHV) and communicators (VHC), to supervise these projects (see Bender and Pitkin 1987). Not only are village health workers identified as key resource people, but, in conjunction with the Basic Minimum Needs strategy, the Ministry of Public Health-WHO collaboration linked the village community to the national PHC system through these volunteers. In 1982, the Office of the Primary Health Care was established as a division under the Office of Permanent Secretary, Ministry of Public Health. Subsequently regional centres were established in the four regions to undertake supervision and training of provincial, district and village health workers. By 1990, virtually all the villages in Thailand had some members trained to assume the liaison role between national public health initiatives and the village community. Various schemes of community-financing have also been organized in a large number of villages. Certain village co-operative organizations, such as drug co-operatives, rice banks, health card funds and fertilizer funds were founded with seeding money from various arms of the Government ministries.

Table 3 lists the recorded accomplishments of the National Primary Health Care program.

At the same time as village networks and co-operatives were being established, more health facilities were built. Since the 1980s, the *tambon* (subdistrict) health centre has become the nexus of government-village interaction (Chaichana 1990). At present, there is more than one health centre for every ten villages in Thailand. These health centres are

[7]There remains a continuing debate on whether the logistic strategies advocated within this development paradigm are an effective concentration of resources or a surrender to dominant biomedical perspectives (see *Social Science and Medicine* 1988).

usually staffed by at least two paraprofessionals, graduates of a Public Health College. It is from here that the various government health programs are initiated at the village level through both technical support and supervision.

Table 3
PHC project achievements

Activities	1982-1986	1977-1989
Training of VHCs	287,138	588,737
Training of VHVs	30,457	64,182
No. of village co-ops	23,216	38,744
No. of nutrition funds	24,450	24,450[a]
No. of sanitation funds	11,950	11,950[a]
No. of health card funds	15,961	15,961[a]

Notes: [a]from 1986 data. Source: Health Planning Division (1990:32)

Village-state interaction in public health

A key principle of primary health care is that government services are to provide learning opportunities to villagers (MOPH 1988:17) in the establishment of co-operative funds and the training of village health volunteers. As a health strategy this is, therefore, based fundamentally on effective communication between officials and villagers. Not all assessments of this approach are glowing, however, as Gohlert reviews the evolution of PHC as a development strategy:

> The principal challenge was how to induce government officials, particularly at the provincial level, to adopt new attitudes and acquire new skills...The principal lesson regarding government development programs concerns the inevitable and pervasive influence of bureaucracy. Its unwillingness or inability to go along, in this case, is symptomatic of bureaucratic behaviour in general. At issue is the bureaucratic mindset, which resists change even if it might ultimately enhance the effectiveness and, thus, the power of government officials themselves. Unsurprisingly, the 'Quality of Life' campaign under government auspices has not been as successful as anticipated - or hoped for (Gohlert 1990:52-53).

It has been suggested that since the inception of the Five-Year development plans, the Thai State, that is, the government bureaucracy, perceived itself as the 'patron' of the Thai people (Chantana 1989: 124). In this view,

> The relationship between state and society is seen as ‘the state above the society’ rather than ‘the society above the state’. To elaborate, in general, according to the evolution of Thai social history, the state and its apparatus, be it military power or ideology, not the societal thrust, have dominated and determined social change (Chai-anan Samudavanij quoted in Chantana 1989:124).

Aside from providing basic and essential health services, rural development and the extension of public health facilities can also be considered from the perspective of a government apparatus expanding into the smallest units of society, the villages (cf. Chairat 1988). When coupled with attempts to elicit popular participation as espoused in the more

recent Five-Year Plans and evident in the PHC programs, the result is that ‘people are bombarded by the number of group-activities belonging to different ministries’ (Chantana 1989:146).

Furthermore, villagers’ participation is controlled and monitored in these programs so that participation is, in reality, simply the nominal enlistment of villagers into development projects. Hirsch, writing of rural development in Central Thailand villages, notes:

> Yet supposed vehicles of 'popular participation' - sub-district and village councils, village meetings, training programs, and 'development days' - serve to legitimate state intervention in village affairs rather than articulate community interests (quoted in Cohen 1989:172).

Despite the lack of any real village-level control of the nature and implementation of health projects, some government programs have, by all objective criteria, been noticeably successful. The first was the success of the family planning program. Thailand is often cited as a glowing case study of successful health promotion. In 1987, the population growth rate was 1.5 per cent per year compared with over three per cent in 1970. As the frontispiece of a USAID publication report on Thailand's Family Planning notes:

> In just two decades, the total fertility rate in Thailand has dropped from over six children to just above two. The achievement is remarkable. That Thailand has achieved replacement fertility, and so rapidly, makes her unique among developing countries (Bennett et al. 1990:1).

While this report notes that it has been unable to establish why, in particular, the demand for family planning was so strong in Thailand ‘at least a generation before modern contraception was available’ (Bennett et al. 1990:67), it is certain that women's readiness to adopt methods for limiting family size was essential to the program's success. When the Ministry of Public Health began the National Family Planning Program in 1970 after nearly a decade of testing strategies, various factors contributed to its rapid acceptance by a huge percentage of Thai families. On the one hand, the Thai government readily acknowledged the World Bank's argument that economic development was tied to population control and, therefore, enthusiastically mobilized national programs through the Ministry. On the other hand, a ready supply of overseas funding was available to implement infrastructure development and personnel training. The growing Public Health infrastructure, assisted by the rapidly improving communications networks, especially the rural road coverage during the Vietnam War, made facilities and contraception available to the entire population by the early 1980s.

Coupled with this institutional expansion, the decision to allow paramedics, many of whom are women, to distribute pills, IUDs and injectables, significantly increased acceptance. Mass-media programs[8] and several key individuals in government and private sectors further contributed to the successful implementation of this particular health program. Of these, Mechai Viravaidya, the head of the Population and Community Development Association, stands out as the charismatic spokesman associated nationally and internationally with his private-sector programs[9] to raise awareness of family planning.

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[8]Throughout the 1970s, music and drama programs were aired nationally. As with the HIV/AIDS campaigns that were to follow 15 years later, surveys have shown that radio and television were the predominant sources of contraceptive knowledge during this period (Bennett et al. 1990:53).

[9]The Population and Development Association established a network of centres throughout Thailand to complement the MOPH programs. Innovative incentive programs were tested in several target

A second example of a nominally successful program was that which addressed nutritional disorders prevalent amongst the rural children. As with many other health programs, policy was developed in conjunction with international assistance, in this case, with design and financial support provided by UNICEF. The nutrition program adopted within the Fifth Plan (1982-1986) was termed the 'Nutrition in PHC program'. The program espoused the goal of reducing malnutrition to a level of not more than two per cent of infants and preschool children, and proposed that by 1991, 92 per cent of all school children would receive necessary nutrients (Health Planning Division 1990:19). To this end, subdistrict-level health workers mobilize the village health workers to conduct tri-monthly weighing of the village children under five years of age. Between 1982 and 1990 children registering a normal weight for age steadily increased from 49 to 81 per cent. In 1990, Isan reported that 75 per cent of more than one million children weighed were within the normal range (Chaanchai and Suwat 1991:34-35). The program has encouraged giving nutritional supplements to underweight infants, that is, those classified as suffering second and third degree malnutrition. A nutrition fund has been established in many villages to work in collaboration with other village development projects to provide a source of high-protein food (ostensibly seed money for such crops as beans and sesame) and food supplements to all the malnourished children under five years old (MOPH 1988:64).[10]

In many instances, rather than promoting the cultivation of local high-protein crops the nutrition program has instead inculcated the idea that bought products can solve problems. So well, in fact, has milk formula been marketed that by 1992, the international year of the Mother and Child, local medical officers were attempting to re-instil the idea in new mothers that breastfeeding is of more benefit to the baby than canned milk. The reliance on formula infant food is further evidence of a well-entrenched appetite for pharmaceutical remedies.

NGOs and village development

Despite the Ministry of Public Health reports citing statistics of improvements in the key categories earmarked as basic criteria, critics point to prevailing inequities in distribution of goods and services:

> Providing quality health care has thus far been mainly a matter of public policy pronouncements rather than policy implementation. ...Major responsibility for this inequity is placed on the government bureaucracy which is viewed as a conservative force monopolising authority and resources. The mentality of government officials is seen as that of rulers who are firmly in charge. Furthermore, presumably no serious efforts have been made to reform the system (Gohlert 1990:111).

The lip-service given to fundamental societal development fuelled by primary health care programs is sometimes no more than the manipulation of statistics that shroud the enduring factors that promote ill-health, as the poverty figures from rural Thailand attest: in 1989, with

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provinces. See Weeden et al. (1986) for a review of one such program where community-level cash loan incentives from a village fund were tied to contraception acceptance.

[10]While the recorded data cited above show marked nutritional improvements it would be wrong to assume these programs work smoothly in every case. In some villages with which I am familiar, the extent to which there was efficient monitoring of birth weight depended largely on the enthusiasm of the local *tambon* health officer. Some village women avoided the weighing sessions because they felt they were too meddling and critical if their children were underweight. In Don Han and Baan Khem every few months there is an organized school lunch prepared by the health volunteers: given its infrequency, it is unlikely that it contributes substantially to the nutritional intake of the children.

over a third of the population, Isan contributed just 13 per cent to the Gross Domestic Product (Hewison and Thongyou 1993:7). For several decades, various non-government organizations throughout Thailand have made attempts to generate more fundamental changes to social and political systems. In Thailand, there are some 200-300 NGOs which have set up operations in the past 15 years and these range in size, philosophy and scope of action. While some more actively challenge the dominant ideology than others, frequently activities are undertaken as correctives to what is perceived as inappropriate government policy. Health is usually considered within the broad perspective of integrated community development and, at face value, this is very similar to the goals of the government PHC program. But, as Cohen suggests, while espousing similar 'health for all' goals, operations unfold differently. In essence, the bureaucratic functioning of government projects 'manifests itself in a paternalistic and anti-democratic interpretation of PHC which fundamentally contradicts that of the Thai NGOs' (Cohen 1989:160).

Non-government organizations frequently act as co-ordinating bodies and it is in this capacity that there is some uniformity to their functioning. Virtually all their operations rely on the constant of 'facilitation'; they organize village meetings and the transfer of material and ideological support. In the process of calling for alternative means of development, these organizations' staff do not always avoid inculcating their own set of organized imperatives. Hirsch describes the response of an NGO director, who has become aware of the difficulties in encouraging effective local participation and control over livelihood:

> In the context of state-led rural development in Thailand, a key priority for increasing control in this sense is in clarifying the status and function of external developers *vis-a-vis* the local communities. The head of NKYFRD [Don Kha Yang Foundation for Rural Development] says that he would now prefer not to be known as a 'developer', for such a status has become ambiguous and tends to usurp moral responsibility that people have in deciding for themselves. He would rather be seen as an educator leaving it up to people to apply his teaching or otherwise Hirsch (1990:230).

Community organization, while obviously a potent tool for grass-roots change, in the hands of some non-government organizations becomes another hoop the villagers must jump through to receive donor assistance. I am not criticizing their philosophies—many NGOs perform a crucial role in fostering social mobilization—but, from the villager's point of view, the notion of assistance provided from outside, the arrival of 'help', usually involves the concept of planned change. Planned change, in turn, connotes the input of some facilitating contribution either material or structural. Jon Ungphakorn, who has spearheaded several NGO coalitions, comments:

> Unlike some other countries, there are practically no development projects in Thailand which attempt to carry out social development alone at the community level, with no material inputs except for the development worker (or catalyst) (quoted in Cohen 1989:172).

Local response to these networks determines the outcome of the projects every bit as much as village reaction to government mandates shapes the results of national programs. Seri Phongpit remarks about the success of two locally developed initiatives:

> In the 'champion' cases such as Srakoon and Kiriwong, the villagers are strong enough to make their own decisions. They dare to resist the proposals of the government and the NGOs, if those proposals do not fit with their situation. (Seri 1989:67).

Despite general opposition in philosophy, occasionally government and non-government organizations work together in specific areas. Such co-operation is increasing in response to specific government overtures. Hirsch notes that

> while differences in approaches and suspicions remain, many NGOs work directly with state officials such as teachers and health workers. In a move that, at once, makes NGO activity less precarious but also raised the suspicions of many NGO developers, the Government indicated a desire for much closer co-operation between the State and NGO sectors in the Sixth Plan (1987-91) (Hirsch 1990:24).

Joint co-operation has been further formalized by an increased government allocation of funds for NGO projects in the Seventh Five-Year Plan (1992-1996). One case in point is the movement to regenerate interest in and use of traditional healing methods. In the 1970s, several NGOs had begun to rekindle local community-level interest in traditional health-care knowledge.[11] In 1983, UNICEF backed a national government program called 'Project for the Development of Traditional Medicine for Primary Health Care' to promote cultivation and use of traditional herbal plants. In contrast to the government focus on the practical availability of traditional medicine, the NGOs sought to reinstate traditional lore and custom involved in health diagnosis (see Seri 1989; Chattip 1991).

Local sources of HIV/AIDS knowledge

The Thai populace has for several years been bombarded with information about the presence of HIV/AIDS. The villages in rural Thailand have, to date, been recipients of blanket top-down information dissemination about HIV/AIDS. Most of this is spread through the mass-media networks but it has been complemented by a steady flow of official documentation through bureaucratic channels, in particular the Ministry of Public Health and to some extent the Ministry of the Interior and the Ministry of Education (see Lyttleton 1995a). Many NGOs are also implementing prevention and education programs but apart from the Population and Development Association their work is generally focused on small target groups primarily in Bangkok and the Northern region. Table 4 reflects the respective concentration of national campaign directives reaching rural villages that are not part of more localized operations. The data and those in subsequent tables were collected from anonymous questionnaires distributed in late 1991 (Don Han) and early 1992 (Baan Khem) to all villagers between the ages of 16 and 60. My intention here is simply to show responses at the village level; further breakdown into sex and age sets shows little variation with the pattern.

Table 4
Sources of HIV/AIDS information (%)

Villagers citing...	Don Han (n=435)	Baan Khem (n=540)
Television or radio	92	88
Doctor or health clinic staff	57	60
Village news broadcast	11	35

[11]NGOs working with health-related and traditional medicine projects were active in my research area. One NGO, the Northeast Rural Development Program, organized, in 1991, the first meeting for traditional medicine practitioners specifically focusing on HIV/AIDS in the region. Villagers came from seven provinces to a two-day meeting and were addressed by both government and NGO health officials and educators.

Village health worker	16	25
Friends, family or neighbours	12	13

Villagers are increasingly both including AIDS in their personal vocabulary and using it as a metaphor for diseased bodies. During my stay, most described AIDS in abstract terms expressing general fear and dismay at its portrayed virulence but no sense of immediate threat. The metaphorical associations between AIDS and incidences of crop or animal disease are increasing, and the term's blanket application to situations of abnormality appears regularly in everyday village conversation. Informal discourse between family and friends must not be dismissed as a serious contributor of local ideas about HIV/AIDS despite the fact that it is not frequently cited by villagers as a source of information.

In Don Han there are ten health volunteers; in Baan Khem there are twelve. These teams are headed by one member, a Village Health Communicator who receives directives from the Ministry of Public Health chain of command. In keeping with the very strict bureaucratic hierarchy, there is a clear sequence of communication in both directions. Thus, the leader both receives and returns information to the subdistrict health clinic. From both villages, these volunteers said a large part of their time was taken up with fulfilling the seemingly endless appetite of the Ministry for statistics: for example, how many water containers were covered with mesh, and how many households have toilets.

Apart from the occasional district or subdistrict meeting some of these health workers attend, there are also periodic meetings in the village itself that encompass health and other development topics. At these sessions, government officials deliver ecumenical speeches designed to enthuse the villagers about this or that aspect of their lives that the bureaucracies feel needs amendment. At the meetings I attended, the tone was consistently akin to a school lesson. The villagers, who somewhat reluctantly attend, are exhorted to sing bawdy songs and listen to a series of admonitions about their daily lives as they fit into the government conception of Thai society as a whole. The meetings frequently have material relating to the general health of the population. Since 1991 AIDS has begun to appear as messages in these meetings.

The headmen in many Thai villages address the community through an amplifier and loudspeakers mounted on a centrally located tower. This address routinely begins just after dawn, both for personal use by the headman and for broadcasting radio news and cassette tapes. The Village Health Communicators are also able to broadcast details of health issues, but in both villages I was told AIDS was seldom mentioned. More commonly radio news broadcast through this system carries items about AIDS. The headman also receives tapes from the government that he is instructed to play. In the early 1990s, the Population and Development Association organized training sessions for virtually all District Officers and provided media materials intended to be distributed to villages throughout Thailand (PDA 1991). As a case in point, when we met in mid-1992, the District Officer had sent a cassette to 115 of the 123 villages in the district to which Don Han belongs. The headman had received this tape but only played it twice feeling it to be uninteresting to the villagers and only worthy of brief broadcast because of the technical nature of the language. Moreover, he considered broadcasting unnecessary, ‘because the villagers already know all about AIDS’.

Dr Thin, at a local clinic, told us that she never tells villagers about AIDS because ‘they all know about it, understand it and fear it enough already’. The head of the local hospital near Don Han felt that there was no point approaching the villagers directly because AIDS was not yet a serious threat in the local rural areas. In contrast, the doctor in charge near Baan

Khem felt the threat was indeed large[12] but had not yet organized for information to be taken to the village directly.

In place of locally devised village-level programs, documents, posters and ideas from Bangkok are employed. The few local programs target high schools, brothels and beauty parlours in nearby towns. Sometimes Village Health Volunteers, usually the elected leader and one or two other representatives, are invited to training sessions in the district town or Khon Kaen city; AIDS is discussed and condoms are demonstrated but this information is, according to Health Volunteers in Baan Khem and Don Han, not generally passed on within the village. It appeared that this breakdown occurs for several reasons: the incumbent Communicators or Volunteers are possibly not interested in the subject and assume others are not either (for example, one said she only wanted to hear about children's health, nothing else interested her); the Volunteers might have no communication skills or not be part of influential or dynamic village communication networks (cf. Voradej 1990).

Given the lack of any specific targeted programs, either government or non-government, many villagers explained that when they cited medical authorities as a source of knowledge on the questionnaire this meant having seen posters and stickers that are placed prominently at health clinics and local hospitals. The officer in charge of the AIDS division in Khon Kaen felt the posters were of little effect because of the minimal attention paid to them. But at the same time, there is no doubt that the posters serve to consolidate local village knowledge that there is a health threat newly included in medical discourse, and that there is obvious government desire that people know about it. They are placed alongside posters that have been well inculcated into village conceptions such as warnings of dietary risk. Liver cancer is widely found in Isan where the popular diet of raw fish introduces a liver fluke, that in high levels of infestation causes cancer (see Supranee et al. 1989; Doherty and Posanai 1990). For the past decade the government has mounted large-scale public health campaigns against this disease. In both Don Han and Baan Khem, villagers often compared recent HIV/AIDS campaigning with official attempts to alter local dietary habits. Over the past several years, villagers throughout Isan have been told that what they eat will kill them and evidence is on hand in many Northeast villages as people die slowly from liver cancer.[13] They are now being told that incautious sex will kill them.

Local patronage of health practitioners

How villagers' health problems are solved by medical institutions, and with what degree of efficacy, will colour the trust with which they accept messages detailing a new threat. Some statistics give an indication of the overall health status of the villagers in the two districts in which I stayed. Tables 5 and 6 show the types of illness most commonly treated by the local district hospitals.

This list is not meant as an absolute summary of morbidity rates as there are various forms of treatment and diagnosis followed by the villagers that do not appear here. It does, however, indicate certain trends. With the exception of tuberculosis, the more debilitating illnesses, pneumonia, malaria, hepatitis and dysentery - are declining. Diarrhoea and undiagnosed fever remain prevalent and form a large proportion of the illnesses for which villagers seek assistance. In contrast to official records, liver fluke ranks highly in local

[12]This district was one of two in the province chosen to send health staff to special training sessions because of the high number of local brothels.

[13]Testing for liver fluke is carried out in both villages by both the MOPH and NGOs. The results are publicly announced and posted, reinforcing both the presence of the disease and the villagers' lack of privacy in the face of bureaucratic control.

conceptions of disease prevalence. In local perceptions, the most common illnesses in the villages were as shown in Table 6.

The villagers have several choices as to the form of treatment they may seek for illnesses. To some extent, such decisions depend on the severity of the ailment, but not always. A small proportion of the villagers will seek local practitioners, either herbalists or spirit healers, for serious sickness but this was typically used as a recourse only after official (government) medical systems have been ineffective. In both villages, most went to hospitals, either locally or in Khon Kaen, in the case of incapacitating illness. Similarly, for more minor ailments Western medicine is the first recourse for the majority of villagers, although many will combine treatments, taking herbal remedies (*yaa samunprai*) in conjunction with pharmaceutical drugs.

Table 5
Rates of illness (number of cases)

	District 1 (Pop. 85,829)			District 2[a] (Pop. 105,032)		
Illness	**1989**	**1990**	**1991**	**1989**	**1990**	**1991**
Diarrhoea	726	926	747	1721	911	1143
Food poisoning	83	58	15	195	209	104
Dysentery	14	21	12	109	45	42
Fever (unknown)	131	476	526	418	545	600
Pneumonia	174	108	57	396	186	145
Tuberculosis	10	47	66	20	no info	61
Dengue fever	268	82	23	666	166	134
Malaria	11	10	4	19	-	-
Hepatitis	6	4	2	46	13	10
Chickenpox	10	10	9	27	4	10
Measles	4	11	3	46	51	24

Source: Registry, District Hospital in each of the two districts: Don Han is in District 1, Baan Khem in District 2.

[a]The higher figures from District 2 do not necessarily imply a population suffering more morbidity but rather indicate the higher profile the hospital plays in illness treatment and, therefore, the absolute numbers of patients treated.

Table 6
Ilnesses considered the most common (questionnaire answers)

Sickness	**Don Han**	**Baan Khem**
Cold	166	296
Liver fluke/worms	174	271
Dengue fever	159	151
Diarrhoea	109	148

For a vast range of ailments not considered life-threatening, the first choice the villager makes is whether to simply buy a package of prescription drugs (*yaa chut*) from the village stores or to go for medical diagnosis. Despite government campaigns to eradicate illegal dispensation of drugs, they are freely available in the villages and in the town drugstores for a

few Baht. In Don Han, one shopkeeper would buy bulk quantities of variously coloured and shaped pills from the nearby drugstore and package them in several recommended combinations. I took a sample I collected in Don Han to the Khon Kaen School of Public Health to identify the different drugs. Table 7 shows the different combinations the villagers consume.

I am uncertain of the specific function of several of these drugs, such as eleapropene and prednisolone. Buprofen is an anti-inflammatory painkiller prescribed specifically for arthritis and back-pain, one of the most common afflictions during the planting season. Periactin is an antihistamine and appetite stimulant; Dramamine is an antinausea medication. Dexedrine is an amphetamine which suppresses the appetite and Librium is an anxiety-reducing sedative. These last two appear together in three of the five packages.

Table 7
Pharmaceutical drugs available in the village

Package 1	Package 2	Package 3	Package 4	Package 5
Librium	Librium	Ampicillin	Librium	Dexedrine (3)
Dexedrine	Dexedrine (2)	Decolgen	Dexedrine	Iron
Co-trimax	Buprofen	Periactin	Dramamine	Multi Vitamin
Buprofen	Vit B1	Dramamine	Paracetamol	Vit B1
	Iron	Apracur	Buprofen	Calcium
	Aluminium Gel			Eleapropene
	Prednisolone			

The combination of amphetamines (Dexedrine) and sedatives (Librium) in several of these packages is an addictive and dangerous mix. In package 5, Dexedrine is sold in three different-coloured pills. In Baan Khem, pressure from the local hospital to ban these drugs has made them harder to obtain but one local store still sells them discreetly. The inclusion of addictive substances, amphetamines and sedatives, has made them an immediate and regular aid for many villagers,[14] particularly during the arduous rice-planting months when the number of people who take the time to visit either the government health facilities or the private clinics drops dramatically.

A second alternative is to consult a local village doctor (*mor pu'n baan*). As mentioned previously, these form a wide range of distinct practitioners: in the villages where I stayed there were local spirit or faith healers (*mor lam song*), masseuses (*mor nuat*), traditional herbalists (*mor yaa*), and injection doctors (*mor chiit yaa*). Neither the faith healers nor traditional doctors were frequently consulted and they usually formed an alternative source of aid when Western medicine proved unsuccessful. But 'injection doctors' are a popular alternative to visiting a clinic. In village society, injections are a highly valued means of taking pharmaceutical drugs because of their supposed efficacy in curing illness.

The local 'injection doctor' commonly performs both intravenous and intramuscular injections of medical drugs, vitamins and saline water for villagers. This 'doctor' is usually a villager, or sometimes retired government worker, who has acquired the skill by practice rather than any formal medical training. He (I am not aware of any female practitioners) offers the service to villagers who in many cases find it more convenient than having to go to a medical clinic. In most cases the 'doctor' will have a ready supply of drugs to inject on his diagnosis of the illness.

[14]During my stay, one man from Don Han was admitted to hospital suffering a severe ulcer of the stomach; he had been taking roughly eight packets of these pills a day for several months.

From Don Han it is only two kilometres to the nearest government health clinic (*sathaanii anamai*). However, when seeking an official diagnosis, from Don Han the majority of villagers will go to one of six private clinics on the main road eight kilometres away because of widespread dissatisfaction with both the frequent absence of the government 'doctors' (paramedics) and the inefficacy of the prescribed drugs. One private clinic is open all day and staffed by a nurse retired from the provincial hospital, the other five are only open in the evenings and weekends when the doctors that run them come from their work at hospitals in Khon Kaen. Doctors do not generally charge a consultation fee but make their money from selling medication. *Mor* Thin at one of these clinics says they are more popular than the government facilities because the drugs they sell are better although more expensive. Conversely, in Baan Khem, the district hospital five kilometres away exerts far more attraction. The majority of households go here for any medical assistance, primarily because so many have health cards encouraged as part of a hospital assistance scheme. The hospital also sends regular teams to conduct village health inspections.

Whether they go to the health station or private clinics, most villagers in Don Han constantly change whom they visit with no particular relationship developed between doctor and patient. The medical officials are considered simply an administering service and judged solely on the efficacy of their cures. Different doctors administer various brands of the same drugs but because of the different appearance villagers are not aware they are receiving the same medication. Many villagers told me that the doctors never provide any information about the illness or the type of medicine being prescribed and they are rebuked if they ask.

Dr Nonglak at the health station commented:

> Villagers change clinics so much because of impatience. For example, if a child has a fever the parents will take it to one doctor one day and another the next if the fever has not abated, even though the first doctor has indicated that it will take several days. The doctor they go to on the last day is credited with being the successful practitioner.

Diviners and spirit healers

A notable difference between the more modernized Baan Khem[15] and more traditional Don Han was the degree to which villagers used the services of faith healers. Amongst the older villagers in Don Han, many still believe that spirits (*phii*) are responsible for illness. These spirits are usually of someone known to the person suffering who has died in the recent past, although occasionally a more general spirit associated with specific locations may be regarded as responsible. Some of the villagers will ask a spirit healer (*mor lam song*) to perform divining rites so the spirit's dissatisfaction may be assuaged and the afflicting ailment thus removed. By contrast, in Baan Khem the villagers no longer seek treatment in this manner, for two reasons. On the one hand, modernization has lessened the extent to which spirits are considered a threat and Western medicine is felt to be the more appropriate strategy for curing illness.[16] At the same time, in Baan Khem spirit healers are not considered appropriate recourse for traditionally ideological reasons. When the nearby factories were built 18 years ago there was great concern that they had been built on the site where the village dead had traditionally been cremated. In order to avoid any misfortune this might incur, the village as a whole was exorcized by a holy man from a nearby town. In this case, the practitioner (*mor tham*) was one who gained his power from the path of virtue, from the

[15]Baan Khem lies in the middle of a minor-industrial sector near the main highway north to Laos.

[16]Electricity, for instance, is regarded as having effectively banished the dreaded *phii porp*, a spirit or ghost that possesses its victims, devours their entrails and causes delirium.

Buddhist scriptures, from *dharma* or the path of righteousness, not from the ability to communicate with the animist spirits directly. While not a monk or strictly religious practitioner, this 'doctor' is considered to use the powers for 'good' (*pen phra pen tham*) associated with godhood, in direct contrast to those spirit healers (*mor lam song*) that effect cures by speaking with and for the many spirits that also influence people's lives. While he is occasionally sought to remedy specific illnesses, villagers consult him for more general advice as to how misfortune may be remedied. Thus, the villagers in Baan Khem say they now reside in the 'field of virtue' (*yuu nai tham*) and to seek spirit healers would be to directly contravene the identification and belonging associated with this condition.[17]

During the time I stayed in Don Han, a spirit healer (*mor lam song*) was asked to come on various occasions from a distant district in Khon Kaen to oversee healing rites. A spirit healer's reputation in particular villages spreads by word of mouth and depends on previous success in the general neighbourhood. The ostensible illness varied from malaria and rheumatism to more general chronic fatigue, dizziness and malaise with no overt symptoms. In the majority of cases the spirit healer was invited because no improvement in health followed consultation with official doctors. In the case of the young man with malaria, the *mor lam song* was required by the man's mother to determine the cause of his affliction rather than make a specific diagnosis. Recognition that he had malaria required in this case a more specific personalized understanding of why he had been infected. While not all villagers believe illness is visited on the sufferer, many still hold that malevolent spirits are responsible for sickness. Some are clear in their minds what illnesses are best treated by which means. Villagers were generally unanimous that spirit healers were unable to cure advanced stages of fatal diseases such as the prevalent liver cancer or, as some surmised, AIDS. Phor Phan repeats a sentiment echoed by many villagers:

> Usually villagers will only seek treatment from a *mor lam song* when the doctors cannot cure the illness. The old people know which symptoms don't require a trip to the clinic but are better treated by a *mor lam song*. For instance, lack of appetite, insomnia, edgy and nervous conditions can all be cured by the *mor lam song* but for appendicitis you have to go to the clinic.

The spirit healer was on occasion joined by a local village woman who, while not considered a diviner, was known to be possessed by a powerful holy spirit (*tehp*) whose presence could be used to coerce lesser malevolent spirits (*phii*). Mae Phim had for years been considered intermittently mad and she spent a period in a psychiatric hospital, during which time she was attributed with mythic powers by the villagers when, in her retelling, she was treated like royalty by both the other patients and the doctors. Only recently has she felt the possessing spirit willing to be harnessed for specific beneficial purposes. She was told by this spirit that she should not attempt any healing ceremonies until she was 40 years old. The *mor lam song* was asked to find out which spirit was causing the affliction and what it required to be placated; Mae Phim was credited with the power to cure: to actually exorcize the possessing spirit.

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[17]The one case I was able to discover of a Baan Khem villager seeking a spirit doctor for treatment said that she was specifically directed to do so by the *mor tham* with his blessing saying this was how she would be cured of the repeated headaches she was suffering. When she went to a spirit healer she learned that her headaches were caused by the spirit of another very powerful healer of whom her mother had been a disciple. This spirit was angered at her switch to worshipping the path of righteousness, *dharma*, without due ceremony signalling the transfer. Once she made amends and offered four trays of sweets to the offended spirit she was cured of her headaches.

The sessions vary in length and complexity. The basic components of the healing session with the *mor lam song* begin with an initial offering and entreaty to the spirit as her assistant beats a drum in accompaniment.[18] The diviner stands and rocks slowly back and forth, eyes closed and after five or six minutes makes contact with the spirit whom we hear replying in a different voice from that with which she questions. At this point, those attending, family and friends of the sick person and often neighbours who have come to watch, also converse with the *phii* to ascertain why it is tormenting the particular person and what it requires to leave. This exchange can sometimes contain both witty banter and confrontation. At various stages of the dialogue, the diviner reverts to a prolonged chanting to encourage the spirit to make more information available. Occasionally, the patient will get up and dance seemingly without volition. In some ceremonies the *mor lam song* recalled the *khwan*, or soul, that is considered to have departed the body of the person at times of ill fortune, in this context, accidents or sickness.

During the course of the dialogue and chanting it will be determined, first what was the inappropriate behaviour that caused the spirit to afflict the person, and then the particular recompense that must be made. In the case of the young man with malaria, it was learned that the inauspicious event was the day that he and his friends stopped near a shrine to ask the way to the sugar-cane plantation where they were to work. They went into the woods to shoot some birds on the way. The spirit of a widow, living nearby, immediately swooped on Boonmii as the most attractive of the young men to claim as her own. The required offerings can be quite elaborate. For example, to appease the spirit who had caused the malaria infection, the following collection was placed at the gate to the village (for most items models or fake examples were suitable): Chinese and Thai money: 300,000 baht and 20,000 baht; three pigs' heads, two kilograms of grapes, three grilled chickens, one house, two swords, a motorcycle, a ten-wheel truck, gold, elephants, horses, whisky, flowers, flags, candles, bananas, coconuts, Vietnamese hats, a comb, a mirror and silk cloth. If these offerings are not correct the exorcism will be unsuccessful and subsequent rites will be required.

Occasionally official doctors will recommend that the villagers see a *mor lam song* for a chronic illness that they feel is psychosomatic in origin. The prevailing perception is that such rites have a beneficial influence in psychological reassurance. In nearly all of the cases I observed the reason the *phii* had caused the suffering was deemed to be related to domestic dislocations. For example, Mae Phaap's son had taken her *khwan* when he had gone to live elsewhere: he needed to come back before it could return. Boonmii got malaria not only because he had encroached on the spirit's dwelling place but because his grandmother was of such consistently bad temper that until she went away the family would never live happily; this disharmony, it was determined, had been the underlying cause behind the young man's transgression in the woods. The woman with the insufferable rheumatism not only learned she had stolen the spirit's timber when she built her house but also was addressed by her dead husband who spoke through the medium expressing his concern that she might remarry.

When speaking with the voices of various spirits, both Mae Phim and the *mor lam song* also addressed social issues on a larger scale. In one exchange, the two advised the gathered audience:

> We are selected by spirits to help mankind - everywhere things are getting worse with people becoming more and more sinful, neglecting the five precepts of the Buddha. Soon

[18]In her session Mae Phim was accompanied by a *kaen*, the local wind instrument. Mae Phim's rites required a more elaborate calling of her spirit and various ritual actions to assure the ceremony's success. In both cases, the incessant rhythmic accompaniment is conducive to trance-like states either for the diviner, or in the case of Mae Phim's healing ceremonies, the person who is ill.

> there will be no more temples, monks and nuns. This is why there are frequent droughts but people refuse to listen. Nowadays, people are just concerned with making money, not with making merit. Just dressing up and putting on airs. We are gods and we are supposed to help them, that is the way it is supposed to be.

Explanations for illness

While the inroads made by public health and Western styles of treatment have reduced consultations with folk-practitioners of all types, a recent outbreak of unaccountable deaths has reaffirmed that Western knowledge has not the answer for everything. Since the late 1980s, Sudden Unexplained Nocturnal Death Syndrome (SUNDS) has claimed a substantial number of deaths. Kunstadter (1991:20) has suggested that SUNDS is one of the ten most serious diseases in Thailand, but notes that 'Epidemiological knowledge is still too limited to intervene'. Reports show that Isan has the highest number of deaths from SUNDS in Thailand: for men 20 - 59 years of age, death rates of 35 per 1000 per year have been calculated (Biyothat 1991:110). The villagers are aware of the high incidence. In 1989 and 1990, a number of people died in their sleep in neighbouring villages to Baan Khem and Don Han; throughout the area reasons and explanations for the unexplained deaths were circulated. It was widely believed the men died in their sleep at the hands of the spirits of widows who required male companionship. Thus, it became common to enter villages and see men wearing sarongs, with their fingernails painted, hoping to fool the spirits into believing they were women. Some men wore large phallic objects at their belts to scare the spirits away.

The village next to Don Han had a sudden spate of deaths: six men died in fairly rapid succession. It was said that the guardian spirit (*jao thii*) of the village was remiss in his duties because he was a flirt and a Casanova. He became entranced by the beauty of the seven widow spirits who approached the village in red skirts and white blouses, and he allowed them into the village. The guardian of Don Han is not thought to be so easily tempted and the widows can only sneak into the village occasionally at night. For a period of time different village men, dressed as women, took turns to sleep at intersections of the roads in the village to confuse the spirits as to which way to go to find the houses of the sleeping men. Some of the men claimed to have seen the spirits approaching. For three to four months the men wore sarongs and insisted on going to sleep before the women in the house as a means of avoiding being taken. Then it was felt the widows had given up and gone to another village. In both villages, some of the men still wore phallic objects and painted one fingernail.

There is little doubt that as AIDS deaths become more frequent, causality along these traditional lines will be invoked.[19] Sharper profile can also usefully be added to a description of village reactions to illness by considering one further disease.

Leprosy is now virtually non-existent but in some respects it reflects important aspects of AIDS aetiology and is a possible indication of village reactions to the presence of people with AIDS. In Isan, leprosy is not officially considered an infectious disease any longer: the remaining cases are supposed to have been treated and to be under control; but people who have had leprosy are treated as though the disease is still contagious and interpersonal relations are inevitably governed by the villagers' avoidance of physical deformity. One

[19]The villages I am familiar with in Isan still have no local experience with people acknowledging HIV seropositivity or becoming ill as a result of infection. This is in marked contrast to many villages in North Thailand which, having been at the vanguard of HIV infection, are now commonly experiencing illness and death of community members.

villager explained that he disdained people with leprosy because it was a disease that 'society loathed' (*rok sangkhom rangiat*). Leprosy is often described with this catch-phrase depicting the social outcome of infection. I also heard this phrase used in both urban and rural contexts to describe AIDS.

In Don Han there are three cases of men who have had leprosy: all three live in varying degrees of isolation. One of these denies to this day he had leprosy; he attributes his loss of fingers and toes to untended and misdiagnosed venereal disease. Other villagers mock his dissembling and say they know it is leprosy. Social ostracism is aggravated by the custom of removing shoes to enter households or the temple. The men have lost toes and wear custom-made shoes to hide their leprosy; they do not go to social gatherings where they might have to remove their shoes.

One man in his sixties departed to live in a grove of trees near a large pond about a mile from the village. Here he built a house where his young nephews have also come to live. The atmosphere is one of great tranquillity and solitude; many animals graze freely around the house. Phor Sii said he contracted the disease 30 years ago and he was treated by both Western and Thai doctors. He felt he was not treated with any overt contempt by villagers but it soon evolved that the only people he saw were other men with leprosy, of whom there were many at that time. Even though he was invited to ceremonies and meals with other villagers he never attended and soon after he was diagnosed he decided to live alone. He never married and has lived in virtual isolation for many years. He has stopped taking medicine for more than ten years but his skin still gets very itchy; his back, he says, is the worst affected. Other villagers asked me if he was still infectious.

Phor Thonginn has had leprosy for ten years and continues to take medicine because he believes he is still infectious. He amputated his toe himself because it was causing him so much discomfort. Phor Thonginn said he is not disdained overtly by most villagers because they do not want to offend him, but he is aware that they pity him and stare at him as if he were a monster. Some actively avoid him. He commented that he is never invited to people's houses. More cynically he added: ‘Development has brought material progress but not improvement in the human heart’.

Conclusion

Villagers are being incorporated into health schemes through the establishment of local networks that link village volunteers with bureaucratic or development agencies. Official programs are presented as being adequate and necessary to solve health problems, such as they are defined by the organizing agency, most commonly in health matters the Ministry of Public Health. But at the same time, local belief systems do not always credit the official doctors with exclusive understanding of the cause of illness: villagers also look for alternative explanations. Local reactions to the presence of Sudden Unexplained Nocturnal Death Syndrome and leprosy highlight important aspects of response to the perceived threat of physical illness. The issues of contagion and the extent to which forces outside the individual are at play are major components of the perceptions being established about the threat AIDS represents (see Fordham 1993). In this context, Buddhist ideology remains a powerful underpinning of attitudes to sickness and healing. Concepts of merit and karmic attribution to explain affliction are constant components of understanding illness. As Terweil notes in his discussion of historic responses to Thai cholera epidemics,

> Precepts of virtuous behaviour have always formed an integral part of the Buddhist religion, and in Siam it may be regarded as axiomatic that proper moral action would inevitably lead to happiness, well-being and good health (Terweil 1987:152).

This attitude is still pervasive. The extent to which an individual feels personally able to control his or her well-being determines how much individual responsibility that person will take in health-promoting behaviour. Ford and Suporn have suggested that, in Thailand, risk behaviour is often associated with the concept of accepting one's fate into one's own hands (*siang duang*), taking one's chance with destiny (Ford and Suporn 1991:407). They cite this as the reason that the major cause of death in Thailand is road accidents. To my mind, such an explanation is over-simplistic; the number of road accidents is the product of numerous factors, not simply a putative national character trait. But the idea that fate or *karma* plays a role in attitudes to health or sickness cannot be dismissed.

It is more useful in this context to understand the extent to which *karma* is used as a prior rather than *post-facto* explanation, but it remains difficult to accurately assess the subjective sense of responsibility villagers feel about personal health. While Western medical knowledge and diagnoses are accorded prestige and potency because of their association with scientific knowledge and bureaucratic links to higher spirituality, villagers do not necessarily see such knowledge as excluding other coterminous explanations for illness. In particular, because doctors practising Western medicine never take the time to explain causes of sickness nor prognoses for improvement, a vacuum is created into which traditional practitioners provide crucial contextualization of the illness experience. Thus, while Western medicine and the germ theory of disease are widely understood and accepted as explanatory factors mitigating personal blame, there remain many avenues for additional contingencies.

On the distributed questionnaire, I asked about attitudes to personal health (Table 8).

Table 8
Local attitudes to personal health

	Baan Khem			Don Han		
Do you agree.... (%)	**Yes**	**No**	**Unsure**	**Yes**	**No**	**Unsure**
If you take care of your health, you won't get sick	89	4	7	86	4	10
Everyone has to die sometime so getting sick is something normal	76	17	7	87	8	5
When you get sick it is because you haven't taken care of your health	68	17	15	69	17	14
It is because of fate that you are healthy	24	54	22	29	45	26
Sometimes the doctor is wrong in his diagnosis	49	23	28	49	23	28
If someone contacts HIV/AIDS it is because of *karma*	13	73	14	12	77	11

These questionnaire responses depict general attitudes to individual control of sickness. We can see that the notion of personal responsibility ranks much higher than that accorded to fate in incidents of sickness (questions 1 and 4). However, there is also recognition that getting sick is not always under the control of individual behaviour. Most agreed that by taking care of health one can avoid sickness, but if one does get sick villagers are less sure that this is a result of individual behaviour (question 3). Very few villagers (before the fact) felt that AIDS was the direct result of *karma*. A sense of karmic causality appears to influence more powerfully the framework of understanding and subsequent interpretation rather than prediction.

What is remarkable about the responses to these questions is the extent to which both villages answered similarly. The virtually identical statistics lead me to believe that the sentiments tapped above are generalizable beyond just the particular village communities. Despite the much higher profile of medical doctors in Baan Khem than in Don Han, there is still the pervasive acknowledgement that clinical diagnosis is not always correct. This recognition provides the space for alternative explanations of sickness and for alternative therapies. Of particular relevance is the implication that the knowledge of HIV/AIDS forwarded under the guise of medical authority will not necessarily be accorded automatic acceptance. Against this background of structured programs and multiple health strategies which take place in a context of varied and fluid conceptions of cause and effect, villagers construct individual strategies to distance themselves from the threat of HIV infection.

The reproduction of knowledge is invariably related to local praxis (Bibeau 1988:414). While top-down education programs perform the valuable role of alerting the Thai populace of the present and potential threat HIV poses, history has shown that it is unreasonable to expect direct translation of this information into desired behaviour change. In any context of programmatic information transfer laden with regulatory intent, resistance to imposed ideologies is inevitable. Local participation in community-based projects is crucial to complement national initiatives both to personalize their relevance and to temper the inevitable although unintended counterproductive reactions.

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Informal care for illness in rural southwest Uganda: the central role that women play*

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Abstract

In rural Uganda care for those who are ill tends to be home based because of inadequate and expensive health care facilities, lack of medication and poor staffing levels in health units. Research findings suggest that women are responsible for the bulk of caring activities. This paper questions the assumption that female informal carers are in a position to cope with illness episodes in the home. Data were collected from 54 female informants in a rural population in southwest Uganda. Supplementary data from in-depth interviews with survey participants and counsellors were also collected. Findings suggest that women are the main providers of informal care within the home. Many women, particularly in female-headed households, did not own or have direct access to the necessary finances to meet the family's health care needs as expected of them. Although relatives and friends were seen as a valuable resource, because of poor household proximity and financial constraints they were not always in a position to offer or provide assistance. The women also identified themselves as responsible for a variety of home and agricultural tasks; such activities were frequently disrupted by illness episodes. As women take on the additional burden of care for those with HIV/AIDS an inevitable conclusion is that their resources, both social and economic, will not be adequate. These data indicate the need for additional research and stress the importance of appropriate support and relief programs for those responsible for informal care.

In Africa, as in many parts of the world, illness often contributes to economic and social disruption and accentuates poverty. Historically the African extended family is regarded as the main source of social, economic and practical support for individuals. McGrath et al. (1993:57) state that in 'Uganda, as in much of Africa, the family is responsible for much of the nursing and health care, both in and out of the hospital'. Caldwell et al. (1993:8) cite research in Uganda and Ghana, showing that 'most families anticipate little help from the state or their neighbours, and in most cases the sick turn immediately to their families'. As many patients cannot afford hospital fees, home based care is often the only viable option.

Research findings suggest that it is women within the family unit who are responsible for the bulk of caring activities:

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> In practically every country, whatever its level of economic and social development, the majority of health workers are women. If the non-formal sector is also taken into account, women's contribution to health care is overwhelmingly greater than that of men (Panos 1990:59).

De Bruyn (1992:255) acknowledges that the psychological and social burden of AIDS is greater for women than men as 'women are generally entrusted with the care of family members, especially regarding health care. This pattern holds for the care of AIDS patients'. Such findings have been widely documented (Beer, Rose and Tout 1988; Bor 1990; McCann 1990; Seeley et al. 1993; Ankrah 1993). The rural Ugandan woman's situation is essentially no different; the burden of child care, household chores, a disproportionate share of farm labour and caring activities are often their responsibility (UNICEF 1989). Care for sick household members tends to be home based because of Uganda's turbulent history in which the health and social service infrastructures were severely damaged. Even though the current Ugandan government is committed to health issues it is at present unable to provide adequate drugs, equipment, health facilities and properly paid health care personnel.

This situation is exacerbated by the increasing numbers of those suffering with HIV/AIDS. There is evidence that 30 per cent of medical admissions to Kitovu, Mulago and Rubaga hospitals in Uganda are AIDS patients (WHO/GPA/IDS/HCS 1991). Consequently in 1987 the government began to endorse and promote home-based care for HIV-infected and AIDS patients and their families.

In the light of the HIV/AIDS pandemic it is important to understand how women cope with illness episodes within the home. Using data from rural Uganda we aim to provide a descriptive analysis of women's coping strategies when caring for someone who is ill within the home; to establish whether common strategies and resources are used at the local level and how successful they are at mitigating the effects of sickness. In turn this may help us begin to ascertain the implications for informal carers of having to care for someone with AIDS.

Background

This paper describes research carried out in collaboration with the Medical Research Council/Overseas Development Administration (MRC/ODA) Research Programme on AIDS in Uganda. The primary aims of the program are to study the dynamics of HIV-1 transmission, the natural history of HIV-associated disease, and strategies for AIDS control in a rural population. The main study population is made up of the inhabitants of a cluster of 15 neighbouring villages with a total population of approximately 9,950, about half of whom are over 13 years of age; the overall prevalence of HIV-1 infection in the adult population (over 12 years) is 8.2 per cent.

The study area is a rural subcounty in Masaka district, two hours drive southwest of Kampala. The majority of the population are Baganda living in dispersed settlements and small trading centres; the inhabitants are largely subsistence farmers who produce small amounts of cash crops such as bananas and coffee. Among the Baganda descent is patrilineal with virilocal marriage, where the woman moves to the man's home: it is not uncommon for the women to move some distance from their natal home for the purpose of marriage, thus the extended family group is often dispersed over a number of villages or a wider area.

This paper reports the findings of a small study carried out at the beginning of 1993 to look at women's coping strategies when faced with illness in the home.

Method

From the 15 MRC study villages 12 were considered for inclusion in the survey; three were excluded because it was felt they had been overexposed to a similar study; of these 12 villages three were then randomly chosen. For each village a list of all households was obtained and 83 households were selected by systematic random sampling. In each selected household a female above the age of 16 years was chosen for inclusion in the survey. In male-headed households the eldest female was selected: this was usually the wife of the household head; in female-headed households the female head was selected. In one household where two co-wives were resident, one of these wives was randomly selected.

Content analysis of four women's focus-group discussions was used to determine the survey questions. The survey respondents were asked questions about illness episodes within the home; they were not asked directly about caring for HIV/AIDS-related illness. No pre-definition of illness episodes was offered by the researchers, in acknowledgement that this term was open to interpretation by the women interviewed. Survey data were collected by structured interviews conducted in Luganda, which were transcribed and translated at a later date.

The household is a social unit defined by the sharing of the same abode or cooking facilities, members may be temporarily resident elsewhere. For the purpose of this study 'carer' was defined as the person providing the physical care and emotional comfort for someone who is ill within the home.

In the findings, reference is made to supplementary data from further in-depth interviews with selected survey respondents. Descriptive narratives of 'closed' client cases (clients who have died or moved from the area) and their families' endeavours to cope with HIV/AIDS, provided by three MRC counsellors, are also referenced in the findings and discussion section.

Findings

Out of the 83 identified households 54 women participated in the survey. Thirteen of the identified women refused to participate and five women were not found at home on three separate occasions when the interviewer visited. Four of the identified informants had recently moved, three had died and two houses were empty or demolished. One woman was very deaf and unable to hear the questions and one woman had not experienced any illness episodes within the last year and therefore did not see the point in answering the questions. One of the three selected villages had a high refusal rate, with eight women refusing to participate; refusals in the other villages numbered three and two. The interviewers commented that people in the first village often refused to participate in research activities because the MRC had not provided them with food during a period of drought.

Thirty-four respondents described themselves as married, seven widowed, 12 separated or divorced and one classified herself as single. Thirty-seven per cent of households were female-headed and the average number of household members was 5.6: both figures are representative of the study population. The survey participants were also representative of the study population as a whole in terms of religion, tribe and land ownership.

Of the 54 respondents, 46 stated that household members participated in activities which earn money. The main source of household income was selling the produce of cultivation or engaging in casual labour; often household income was supplemented by the selling of surplus crops, mats and baskets, pancakes or beer. Eight respondents stated that no one within the home earned an income: of these, seven were female-headed households.

The majority (n=27) of the 34 married respondents stated that their husbands were responsible for financial affairs within the home; of the remaining married respondents five

were jointly responsible with their husbands. Only two married women were responsible for finances; one of them received minimal support from her husband, because of the existence of a co-wife; and the other woman felt financial control was hers because she was responsible for all household purchasing. The remaining respondents (n=20) were either divorced or separated, widowed or single and all controlled household finances.

All except three women had experienced ill-health of one or more household members; in total 100 illness episodes were identified by the 54 women within the last year. In the majority of illness instances (n=73) the respondent said that she was the principal carer, in a few cases (n=8) the respondents identified the husband as the primary carer; care was also provided jointly by the husband and wife (n=8). In the remaining illness episodes (n=11) care was provided in the majority of instances by female rather than male relatives.

For the majority of the 100 illness episodes assistance was not offered by co-resident family members (n=53), relatives (n=62) or friends (n=69), primarily because the illness was considered not to be serious enough to warrant asking for assistance. When asked if males in the home were specifically involved in caring activities the majority (n=37) of the 54 respondents said 'yes'; this can be divided into adult male (n=27) and child (n=10) participation. Nine respondents said that no co-resident males participated in caring activities; they felt that the men were involved with other ventures, did not have the time, were not interested or did not want to participate. Seven respondents were not able to answer this question because there were no males present in the household.

When assistance was provided there tended to be a marked sexual division in the activities undertaken by co-resident family members, relatives, friends and co-resident males. Male involvement centred around the purchasing of tablets and food supplies, provision of water, transport for the sick person to the clinic and paying for any medical expenses incurred. Only seven of the resident 27 adult males assisted with some form of direct nursing care; female assistance tended to be the provision of local herbs, money and food, help with cooking, child care and other household duties together with physical care.

In order to obtain money for medical expenses the respondents often used money derived from their main source of income or if necessary would ask friends and relatives for assistance. However, it was evident that financial constraints and household proximity influenced relatives' ability and willingness to care for a sick person. For example, one informant, and subsequent in-depth interview participant, Florence, stressed that she was responsible for all child care, household duties and medical expenses. Although she is married, her husband, who lives with his second wife, would not offer her financial help. If money was required for medical expenses, Florence would ask for assistance from her adult children, but her requests were not always answered because of the distance involved.

Another married informant, Rose, commented that she was responsible for all household duties, payment of school fees and medical expenses because her husband was seldom in the home, as he worked in Kampala, but he paid for medical expenses when he was there. In such cases women were often left to their own devices to get funds, through sale of reserved crops, handicrafts or brewing beer.

Of the 54 respondents, 32 stated that they were in a position to plan for eventualities such as illness; by saving money, storing crops to sell, keeping animals such as chickens and goats, which can be sold when needed; and by setting aside cups, plates etc. for the patient. The remaining households (n=22) were not able to plan for such eventualities primarily because they were already struggling to provide essentials for day-to-day living.

Female-headed or single-adult households were particularly vulnerable in times of crisis. Not only were they more likely to be unable to generate an income, frequently they were not even in a position to plan for eventualities such as illness. Only half of the 20 female-headed households were in a position to plan, whereas 22 of the 34 married women could do so.

Evidence from the in-depth interviews further illustrates the difficulties encountered by female-headed households compared to homes with resident adult males:

Grace was 27, separated, and lived with her ten-year-old brother and her three children. She owned a small piece of land on which she was only able to produce subsistence crops. Grace worked locally as a casual labourer to pay for clothing, food, medical expenses and school fees. Many of her relatives were dead and her mother who lived nearby was ill. She looked after her mother, her children and her brother. No financial assistance was offered by the children's fathers. Grace commented that if she were to be unwell and unable to work, or if there was no work available, there would be no other source of household income.

However, as Florence's and Rose's situations illustrate, members of polygamous families or households where the main income earner works away from the family home may be just as vulnerable in times of sickness. Financial assistance is not always to hand, limited resources may be distributed between numerous sub-households or, as in Florence's case, the husband favours another of his households.

In addition to their caring activities the women were also responsible for a myriad household and cultivation based activities; food collection and preparation, digging the *kibanja* (plot of land), crop tending and picking, child care, animal husbandry, washing clothes, collection of firewood and water, mat and basket making and cleaning the compound area.

The majority of informants felt that household and cultivation activities were frequently disrupted by illness episodes. Eighteen of the 54 respondents felt that all household duties were affected and 29 respondents agreed that only activities such as digging, crop harvesting, animal husbandry (if applicable: not all the woman owned animals), and mat or basket weaving, if undertaken, were affected. Activities such as firewood and water collection, cooking and cleaning were essential and often assistance would have to be given by friends or relatives.

Only seven respondents felt that none of their household duties or responsibilities would be affected by an illness episode within the home. One woman worked as a school headmistress, another as a tailor, one ran a small shop within the home, another made pancakes to sell and others worked as casual labourers. However, these women all commented that their work activities were greatly affected when someone was ill: invariably illness episodes entailed a loss of income.

Discussion

Our findings reiterate those of other studies which suggest that African women are principally responsible for the bulk of care provision for ill health within the home (Panos 1990; McGrath et al. 1993; Caldwell et al. 1993). Furthermore, while medical care generally has to be purchased in the developing world, most of the women interviewed did not necessarily have direct access to finances to cope with the expenses incurred. This is corroborated by Welbourn's (1990) research in Uganda which found that while health issues are the prime responsibility of women and men are rarely involved, health care is becoming largely an issue of money, to which most women do not have immediate access.

Respondents tended to focus on the physical and financial rather than the emotional ramifications of ill health despite being provided with a ‘carer’ definition (p.3) which encompassed both the physical and emotional aspects of care provision. This does not necesssarily mean that the women did not provide or experience emotional support, rather, this may have been an expression of their primary experiences and concerns.

Although all the respondents mentioned some way of obtaining money for medical expenses it is important to consider that households may not always be able to generate the

required finances. Crops are seasonal and in periods of drought this resource base may be diminished. Cultivation and other work activities are frequently affected when it is necessary to care for a sick household member; thus a means of supplementing income in times of illness can be affected by merely having to divert time to caring. Even though most respondents felt that financial assistance would not be refused by family and friends it is important to consider that inter-household and intra-household loans, which may be part of a community-wide or kinship-insurance mechanism, may come under threat in times of severe and prolonged illness. While animals or land could be sold, the disposal of valuable productive assets may diminish the households' long-term income-generating activities and thus their ability to cope in the future, for many assets can only be sold once.

It is not possible to gauge accurately how successful the women were at mitigating the effects of illness, or to produce a list of strategies commonly used by all the women. Households are not homogeneous units, and the composition may vary over time given the transient nature of some household members. Resource allocations are complex issues: not all women have access to relatives and friends who could offer assistance, nor do all the women have equal access or equitable inter-household or intra-household resource allocation. Ultimately such variability will influence the coping strategies used in caring for someone who is ill within the home, and their success criteria. We are, however, able to suggest a rudimentary framework of resource management which is similar to that identified by Corbet (1988).

Primary policies. Short-term coping mechanisms: sale of crops; reduction of current consumption levels; use of inter-household loans; increased petty commodity production, e.g. beer; casual labour; changes in cropping and planting practices; and sale of non-productive possessions.

Secondary policies. Disposal of productive assets: sale of livestock, agricultural tools; sale or mortgaging of land.

Tertiary policies. Distress migration; either the patient returns to the family home or relatives move in to the patient's home to provide care.

Household composition, the proximity or existence of friends and relatives and the severity of the illness episodes determined the action taken and the resources used. Female-headed or single-adult households appeared to be particularly vulnerable when someone was ill within the home. Often they were not in a position to plan for eventualities such as illness episodes, and had limited income and access to a family resource base: in most instances a married couple will have access to both their families in times of need whereas a single parent may only have access to her or his own family for support.

For short-term illness episodes the women were likely to engage in primary policies; for the more prolonged or serious episodes secondary and tertiary policies would be undertaken. An in-depth interview and a 'closed' client case history provided by the MRC counsellor exemplify the sequence of coping strategies employed by women for both short-term and more prolonged illness episodes:

Eva was a divorced woman of 27 years who lived with her 12-year-old sister and two children. Eva owned a plot of land and was able to produce enough crops for subsistence and to save some for unexpected events. To supplement her income she fried pancakes and made table-cloths and mats. When someone was ill in the home, Eva would attempt to sell her reserved crops or handicrafts. If needed she would ask friends and relatives for financial assistance.

Agnes was married with four children. Agnes, her husband and their two younger children were HIV-positive. Initially Agnes was able to care for her husband and children and provide money for medical expenses by selling crops and beer. Following her husband's death her own health began to deteriorate so that she was no longer able to earn a regular

income. Eventually her mother arrived and provided care and financial support until Agnes's death.

Interviews with the MRC counsellors further illustrate the resource management undertaken by adult patients and their extended families in order to cope with the effects of HIV/AIDS. As the disease progresses patients may return to their family home to be cared for by their relatives and the coping cycle will commence again:

Jennifer, a middle-aged woman, was HIV-positive; when she became ill she had no local friends or relatives to provide assistance. A counsellor managed to contact her relatives in a neighbouring district; a female relative arrived to provide nursing care. This relative gradually had to sell various household items and then land to pay medical expenses. When the finances and resources finally ran out Jennifer was taken to her carer's home.

Paul was 28 and HIV-positive; he used to earn his income from trading work in Kampala but as his health declined he separated from his wife and moved back to his parents' village with his three children. For a while Paul earned money by selling crops he produced on a small piece of land he owned. As his health deteriorated further and Paul was unable to work on his land he sold his radio. Once this money had run out he was dependent on his mother and father for his financial support and care.

It is evident that relatives and friends are valuable resources in times of need. Research has, however, questioned the notion that the extended family is a resource to be relied upon at all times and has suggested that families may not be able to deal with AIDS as they have with other health problems (Eberstein, Serow and Ahmad 1988; Panos 1990; Hunter 1990; Seeley et al. 1993; Ankrah 1993).

As Armstrong (1993:5-6) emphasizes,

> Today, the continent's [Africa's] age-old social security system is buckling under the unprecedented strain of AIDS... Many families are brought to their knees even before the death of the breadwinner by the long, costly months of nursing them through AIDS.

In the face of the growing HIV/AIDS pandemic it is probable that disruption to general household duties and income earning activities will intensify. Demand for valuable resources will also increase as members of a kinship group or community are affected by the same event. In turn this may precipitate the breakdown of the traditional household and community reciprocal relations on which Africa has relied for so long. We must therefore question whether the traditional reliance on extended kin systems will address the needs of HIV/AIDS patients and their informal carers.

Conclusions

This research has shown that illness episodes are problematical for many households in the study population, in particular single-adult households. The findings suggest that women are the main providers of informal care, and that many of these women struggle to provide the necessary time, resources and finances to cope with the effects of illness episodes in the home. In particular, many women do not own or have direct access to the necessary finances to meet the health care needs of their families.

These findings are dispiriting when families affected by HIV/AIDS are considered. As women take on the additional burden of care for those with HIV and AIDS their resources, both social and economic, are likely to be severely constrained. An inevitable conclusion is that without adequate support and appropriate intervention women will be unable to manage the care of persons with HIV/AIDS.

It is hoped that this paper will stimulate complementary research and enhance our understanding of the many dilemmas encountered by those who provide care in the informal

setting. This and similar reports will inform and guide policy makers and development practitioners concerned with the plight of home, family and community care. In particular, it should alert policy-makers, development workers, non-governmental organizations, politicians and academics to the need to be gender-sensitive when planning intervention, support and relief programs for 'community care has fertile ground in which to grow if only the seeds of organisation and financial assistance can be sown' (Kaleeba and Kalibala 1989).

An extended version of this paper is available from the Medical Research Council, Uganda Virus Research Institute, PO Box 49, Entebbe, Uganda or Overseas Development Administration, 94 Victoria Street, London.

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Qualitative exploration of intra-household variations in treatment of child illness in polygynous Yoruba families: the use of local expressions*

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Abstract

The drastic cut in government expenditure on health with the extension of the 'user pays' principle to health care utilization in Nigeria following the adoption of the Structural Adjustment Program is probably having its greatest effect on the family. Contrary to what happened in the past, when the cost of treatment was usually borne by the mother of a sick child, the role of the father is becoming increasingly significant.

Before the introduction of the 'user pays' principle to health care, treatment in many government hospitals was free. Intra-household variations in response to and treatment of child illness, especially in polygynous Yoruba households in Nigeria, occurred for a number of other reasons. Probably because the mother and her children usually form a social unit within a polygynous union, meeting the cost of treatment and some other minor daily needs of the child has always been the responsibility of the mother, although the economic independence of most senior wives seems to have waned as a result of current economic difficulties. In the past, a woman's ability to meet the cost of treatment of her children was partly explained by her separate income from that of her husband, but with the persistent rise in cost of treatment, many mothers now have to look to their husbands or other sources for assistance in paying for treatment of their children.

This paper examines treatment behaviour under the present circumstances and explores how common expressions of the Yoruba can be used to explain differences in a polygynous husband's responses to the treatment of illness of his wives' children. Such treatment poses a great risk of child morbidity and mortality now that the role of the father has become important in meeting the current high cost of treatment in many Yoruba families.

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Polygynous unions and the Yoruba family structure

Polygyny is one of the most widely known features of African marriage (Mair 1969:1; Kayongo-Male and Onyango 1984:65); in many West African countries polygyny is a flourishing institution rather than a dying tradition (Ware 1983:16). Among the Yoruba of Southwest Nigeria, polygyny — whether private or public (Karanja 1987:257) — is socially accepted and widely practised (Fadipe 1970:65). Recent studies have shown that most Yoruba men believe that they are by nature polygynous, and in order to satisfy their sexual needs, they tend to marry many wives (Orubuloye 1994).

Among the Yoruba, the involvement of the extended family is usually very critical and noticeable when a young man marries his first wife (Fadipe 1970); but this involvement is usually minimal when he decides to take a second or a third wife. Usually there is no overt condemnation or disapproval of such acts from the relatives and the extended kinsmen. However, relatives could put pressure on a man to take a second or a third wife, if the first wife finds it difficult to have a child. Generally, the choice of the subsequent wife or wives is that of the man himself.

Men derive social, moral, economic and psychological advantages from having many wives. In the past, it brought prestige, and a man with two or more wives and many children was seen as wealthy and of high social status in the community. Having many children also brings psychological satisfaction and social respect to parents (Oni 1988). In the traditional Yoruba society, a woman is married to her husband's lineage and the lineage expects her to bear many children. The number of children a woman has for her husband often becomes a crucial factor in determining her status in the husband's house and establishing her stay and favour with the husband and his relations. A delay in her becoming pregnant in the first few years of her marriage brings a great deal of suspicion about her premarital character and sexual behaviour. The suspicion develops to hatred and in most cases rejection by her husband's relatives if she is unable to bear children, or if all her children are girls. A woman in such circumstances stands the risk of losing her husband's attention to another woman who may subsequently be brought in as a second wife either by the husband or his relatives. However, the birth of a male child consolidates the position of the senior wife in the household, and among her husband's kinsfolk. The reverse is the case if she has not given birth to a male child before the new wife is brought into the family.

In addition to the health reasons for sexual abstinence (Orubuloye 1977), the Yoruba consider it morally wrong to have sexual relations with a woman once she is pregnant, and abstinence continues until the child is weaned at the age of two to three. This period of abstinence can also last for about one year after the death of an infant. The alternative for the man to nearly three years of sexual abstinence is therefore casual relations which many consider wrong, or a second or third wife (Orubuloye 1977; Caldwell 1980).

Furthermore, among the Yoruba, it is very common for successful married men to become polygynous. These are men who are successful both economically and in terms of reproduction. Women who were monogamously married into a family but were unable to bear children for their husbands, are likely to divorce them and marry such successful men in order to try their luck. Seniority within this kind of polygynous marriage does not connote older age: a woman who is younger in years could be the senior wife to a much older woman as long as she was married into the family before her, and the relationship between them is usually based on this kind of situation. Co-wives' rivalries appear to be less intense in this case.

A man's senior wife can also decide to take a younger wife for her husband, or the man may seek the opinion of his senior wife before looking for other wives. When this happens the senior wife enjoys a privileged position: she has authority over the junior wives and leaves to them the heavy housework. As long as her own position is secure, a senior wife has

nothing to lose from this type of arrangement if she has had the opportunity to approve the girl beforehand, though her consent is influenced by the tact with which her husband introduces his new wife (Marris 1961:49).

Although in the past, all the wives, both senior and junior, lived together in the same compound, this kind of agreement between the senior wife and her husband to bring in a new wife did not always prevent such households quarrelling among themselves. If the wives agree and their husband treats them with scrupulous fairness, the household may live happily together, but such households are more vulnerable to any change in the husband's economic circumstances which may also generate more conflict and tension between the wives. Quarrels are most likely to arise from jealousy and favouritism. The senior wife may resent the new wife as a threat to her security and status in the household, especially if she had not been consulted by her husband before his decision to take another wife. A common expression to describe the situation among the Yoruba is *Orisa je n pe meji obinrin ko de'nu,* meaning *a prayer to the god to become two in a husband's house is never from the heart of a woman*.

Relationships in polygynous marriages tend to give rise to divisions among children. Women generally support their own children, with occasional help from husbands, and the most important divisions among children in the same household usually stem from their mother's status, which might include her seniority in the house, education level, her family's social and political connections, her business success or such special situations as being the favourite wife of her husband or the 'official' wife who must appear in 'civilized' contexts with the man (Bledsoe 1990). Furthermore, Castle (1992, 1993) posited that a woman's status or position in relation to other women within the marriage union dictates her degree of control and her differential access to resources. A man with many wives is more likely to allow his favourite wife access to his cash and resources than the other wives in the union.

Among the Edo-speaking people of South-western Nigeria it has been found that the existence of both co-wives and what others have called 'outside wives' (Karanja 1987; Omorodion 1993) often gives rise to jealousy and it may result in women inflicting harm on their co-wives and co-wives' children (Bradbury 1957; Omorodion 1993). Last (1992:799) writing on the Hausa of northern Nigeria observed that a situation whereby one wife has 90 per cent of her children alive while her co-wife has 90 per cent dead, usually brings a reaction to a woman whenever there is a death of a child in her family. Last's work admittedly presented a picture of child mortality experience in polygynous families in a northern Nigerian village, but among the Yoruba, similar experiences are not uncommon, for child mortality is a function of response to and treatment of child illness.

The situation in polygynous households differs from that in monogamous ones. A man with many wives usually spends very little time with each and in contrast to the situation that Steady (1987) observed in Sierra Leone, where the first (senior) wife plays the primary role in health care payment and decision-making, each Yoruba wife and her children are virtually subsidiary households on their own. The children of the same mother are drawn together by close ties of loyalty and affection. In Yoruba households the smallest social unit is the mother and her children, who then form part of a larger whole, her husband's household, to which his dependants are also attached (Marris 1961:14). The role of child rearing is closely associated with that of child bearing. Children who are not well-trained bring shame and dishonour upon their parents and most often the mother gets the blame. Such expressions as *omo ti o ba dara ni ti baba, eyi ti ko ba dara ti iya re ni,* meaning *a good child belongs to the father, while the bad one is for the mother* (Renne 1993:343) explains the Yoruba expectation of mothers in the character building of their children.

Although both husband and wife take part in household decision-making, the Yoruba conjugal family is largely open to the extent that other kin and in-laws join in making

decisions about child-rearing and even the timing of the next pregnancy (Adeokun 1983:136). As has been found in other parts of the world, the decision to seek either curative or preventive health care for a sick child among the Yoruba is also rarely taken alone. Decision-making usually involves a range of people: fathers, mothers, co-wives, relatives and friends (Friedson 1961 cited in Graham 1984:166).

Although some studies have found little difference between the health outcomes of children of polygynous and monogamous women (Desai 1992:15-16), others have found that women's household status in relation to other women in the household appears to be an important factor affecting their opportunity to exploit resources controlled by their husbands (Castle 1992,1993). Except for a few studies on the role of infertility, the effects of women's status in polygynous marriage and the relationships with their husbands in the treatment of their child illness, particularly among the Yoruba, have received little attention.

Yoruba proverbs which usually appear in the form of a plain statement of fact, of a warning, or an apt expression, are capable of bringing out more sharply than ordinary statements the required point (Oni 1995). The importance of these Yoruba proverbs is summarized in another proverb which says *owe l'esin oro, bi oro ba sonu, owe ni a fi n wa a,* meaning *a proverb is a horse which can carry one swiftly to the idea sought* (Delano 1973:77). Some relevant Yoruba expressions in form of proverbs are discussed in this paper. The discussion is based on responses during a qualitative survey conducted in six Ekiti communities in Southwest Nigeria. The qualitative survey included in-depth interviews and focus group discussions, which revealed a great deal about how husbands respond to illnesses in the children of individual wives. The discussions also show how a mother's position among her husband's wives and her relationship with the husband affects the treatment received by her children when they are sick.

Method

The data used in this paper came largely from a qualitative study conducted in six communities in Ondo State, Nigeria, between April 1993 and February 1994. The study consisted of seven focus-group discussions, six for all mothers with at least one surviving child, and one for fathers. Perceptions of child illness, the origin and cause of illness, income management between husband and wives, the role of co-wives, and their relationships in child illness, were among the issues discussed in the focus-group sessions. Several common expressions and day-to-day proverbs were discussed and explored to explain how fathers respond in different ways to illness in the children of their various wives. Thus the discussions shed more light on how the position of a woman among many wives, and her relationship with the husband vis-ˆ-vis the other wives, affect the treatment and the amount of the husband's attention she receives when her children are ill.

Design and organization of the focus-group discussions

A total of seven focus-group sessions were held in the survey communities: six sessions for women of childbearing age (15-49 years), and one for men, some of whom were the husbands of the women who had been interviewed before or participated in the focus group discussions. Each of the discussion meetings lasted for about one hour. An average of eight to ten people participated in each focus group, and all the discussions were tape recorded.

A typical focus-group discussion meeting started with the singing of songs related to children's health and well-being to arouse the interest of the discussants; this was followed by a short introduction about the purpose of the discussion. The moderator, recorder and discussants were then asked to introduce themselves. Each discussant was asked to state his or her name, age, religion, occupation, marital status, number of husband's wives (number of

wives ever had for men discussants), wife's order of seniority, and the number of children ever born. The issues already prepared for discussion were then raised. A typical meeting ended with songs and refreshments.

As part of the qualitative survey, a number of in-depth interviews were conducted with married women of different ages selected randomly from the quantitative survey. Issues covered in the in-depth interviews include those related to intra-household relationships, income management, treatment decision-making and other treatment-related issues between wife and husband, with particular reference to the comparison of monogamous and polygynous unions.

In addition to the qualitative survey, a quantitative survey was conducted covering a total sample of 1538 Yoruba households. This survey generated information on child illness and how parents and other family members respond to child illness. In each of the six communities, four clusters were randomly selected, from which dwelling units were selected on a systematic basis until the quota for each cluster was reached. The first available household in each dwelling unit was selected for interview; from this household, one currently married woman of childbearing age (15-49 years) with at least one surviving child under 15 years of age was interviewed. In order to extend the survey to many households, only one respondent was interviewed from each household.

Respondents were asked questions on the most recent illness experienced by each of the children living in their households. The questions covered type of illness, symptoms noticed, the person who first noticed the symptoms, the person who decided where to seek medical help, and the person or persons who paid for the treatment. A comparison of these variables on treatment of child illness was made between the children of senior wives and those of junior wives. The quantitative analysis was used to illuminate the qualitative findings on which this paper is based.

Findings

In its various forms and dimensions, polygyny, as a form of marriage, continues to flourish among the Yoruba. At the time of the survey, 31 per cent of the women covered in the survey were in polygynous unions: 38 per cent in rural and 22 per cent in urban areas were in polygynous families. In both the rural and urban areas, there is evidence that those who are currently in monogamous unions may end up in polygynous unions, and almost all women have to see this as possible throughout their lifetimes (Caldwell 1994b:7).

A total of 2016 illnesses to non-fostered children were reported in the 1,538 households covered in the quantitative survey; of these, 636 were in 469 polygynous households. One way to understand the differences in husbands' responses to their wives' children’s illness is to examine the issue of who decides and who pays for the treatment. The wife's status in a polygynous union is classified into two in this paper: 'senior' and 'junior'. This classification is not based on the age of the women at marriage but on their position at the time they enter the union. Senior wives are those women who have one or more other women taken into the union after them, that is, they do not occupy the latest position. Junior wives however, are women who were taken last into an existing marriage. This classification stems from the experience of the author and evidence from qualitative data that most recent wives are likely to be treated differently from the preceding ones. At the end of the classification, 53 per cent of the polygynously married women covered in the study were of junior status and 47 per cent were senior.

The quantitative data on person who met the cost of treatment of child illness within the polygynous unions show that husbands paid more for treatment of illnesses to children of the junior wives than to those of the senior wives. The implication of this is that senior wives

were more likely than junior wives to pay for treatment of their own children's illness, also that younger or junior wives have a better chance of getting support from their husbands, while often the only option for a senior wife is to seek assistance from her grown-up children working and earning incomes. This traditional source of support from grown-up children has now become an unrealistic expectation for most mothers because of the increasing rate of youth unemployment due to the economic adjustment programs.

Since senior wives, as a result of their economic activities, are more likely to be economically independent of their husbands than the junior wives, they should be more able to afford treatment for their children than junior wives. It might be argued that most senior wives have stopped child-bearing, so they can concentrate more on economic activities, while junior wives are still in their active reproductive years and so are less able to afford treatment: it is therefore to be expected that junior wives receive more financial support from husbands, especially in paying for treatment of their children.

However, the data in this study seem to suggest that the economic independence enjoyed by Yoruba women is waning, mainly as a result of the difficulties caused by the Structural Adjustment Program, which is affecting the family income as well as individual incomes. Also, among the Yoruba, the expected role of the husband, regardless of the economic status of the wife, is to take responsibility for the health and education of his children. Although women do assist their husbands, it is the responsibility of the man to meet the basic needs of his children and of course of his wives as well. If senior wives therefore were able to pay for treatment in the past with the proceeds from their economic activities, it was generally regarded as a form of support for the husband, not perceived as the woman's responsibility.

In this paper much reliance is placed on qualitative data. Statistical analysis and significance often derived from quantitative analysis do not always tell us as much as we wish about the issues such as are discussed in this paper. The point has been made by Caldwell that

> Many demographers fail to appreciate that the quantified part of some phenomenon is merely one aspect of it, and often one that has been pushed into a certain configuration to make the measurement possible. And they do not often appreciate just how artificial it is to break up continuous variables into quantifiable segments (Caldwell 1994a:9-10).

Nevertheless, quantitative data sometimes point to issues which are later explored and discussed with qualitative evidence. Intra-household relationships in polygynous unions appear to be complex beyond what we can easily explain in statistical terms, and consequently a more in-depth qualitative approach seems appropriate. The findings presented here were collected from qualitative research conducted among some Yoruba communities in Nigeria.

Discussion

> One of the most important distinctions among children is that stemming from polygynous unions. . . . The most important divisions among children in the same household usually stem from their mother's characteristics: their seniority in the house, education level, families' social and political connections, business success, or special designations such as the favourite wife or the 'official' wife of an important urban man who must appear in 'civilized' contexts with only one wife (Bledsoe 1990:563).

> We need to know more about the structure of the family . . . . In terms of the husband's payment for the treatment of wives, does the situation differ between monogamous and polygynous marriages or senior and junior wives ? (Orubuloye, Caldwell and Caldwell 1991:207-208).

Iyawo ti a ba feran ni omo re n'wuni: It is the wife one loves whose children are admired.

For a long time there has been different or preferential treatment by husbands of their wives of different status in polygynous unions, in almost all cultures where two or more women are married to the same man.

The limitation of the quantitative findings briefly presented in the preceding section raises a number of questions. Which of the wives in a polygynous marriage usually gets more of the husband's attention, love and support than the others ? Do the husband's responses to illness in his polygynous family vary with different types of child illness ? How much do the husband's job and presence at home affect his responses to the illness of children of different wives ? There are more questions, which may be answered by future research. My intention in this paper is to explore common expressions among the Yoruba, and see if they explain some of the preferential and different treatments of child illness in polygynous unions.

One of the Yoruba expressions is: *iyawo ti a ba feran ni omo re n'wuni,* meaning *it is the wife one loves whose children are admired*. The corollary to this statement is the common belief among the Yoruba that good children can only come from a good wife, although the concept of 'being good' is always from the husband's point of view. If a woman is considered bad by the husband, her children invariably will be seen as bad. A thorough examination of this expression will probably elucidate the differences in husbands' responses to each of their wives and involvement in treatment of their children's illnesses.

The eleven men who took part in the male focus-group discussion all agreed that it is not possible for a man to love all his wives equally. There was a consensus among them that the polygynous family is common and one of its certain characteristics is that a man cannot love all his wives the same. However, they differed on the reasons for this. While some of the discussants thought that the senior wife usually enjoys the favour and support of her husband, others maintained that the junior wife stands a better chance.

Similarly, some of the men considered this situation as common and natural in polygynous families, while some argued that the character of the individual wife is a crucial factor in determining the husband's disposition and relationships with the wife. For example, one of the discussants said:

> It depends on the character of the wives, I have seen a man with two wives, the younger one was so kind, good, hardworking and as a result the man loved her more than the first one who was hostile and had no respect for the husband and his relations.

Another man's opinion was:

> A man may have a wife at home and she may not be useful in taking good care of the husband or she may not be the responsible type. As a result the husband may decide to go out and look for another wife. For example, my father first married my mother, and later, because of circumstances, he took another wife. As soon as my father brought in the second woman, there were repercussions. My mother started going to herbalists for one reason or the other. My father thus decided to shift his love and interest from my mother to the new wife and because of that my mother had to leave my father's house.

The reports above suggest a number of issues. Apart from the belief of Yoruba men that by nature they are polygynous (Orubuloye 1994), and that polygyny itself tends to bring social benefit to men, the second quotation suggests that men often take other wives as a result of the behaviour of their first one. This may be seen as a way men tend to rationalize or justify their action in taking another woman. Women would have a different explanation for the decision of a man to take a new wife. For example, no woman will agree that her bad behaviour has motivated her husband to take another woman, she would rather argue that the presence of a new 'stranger' in the marriage has led to her bad behaviour.

The viewpoint of Mr. Agbelere seems to support the first line of explanation usually given by men whenever they take an additional wife:

> The issue is that the Yoruba used to say obinrin so iwa nu, O l' Oun ko lori oko, meaning a woman who has lost good virtue considered herself to be ill-lucked in finding a suitable husband. My father has two wives, and it was not his will to marry two wives, for my mother was the first one and she was wise, clever, clean with good behaviour and virtues and she came from a good family. Nevertheless, as you all know, there is no way women will not misbehave. When this happened to my mother, some other people pushed my father to take the second wife. But, unfortunately, the new wife was so dirty that it was easier to continue to love my mother than her. She was not even allowed to prepare food for my father. It is not possible for a man to love a woman like that, who is also troublesome, quarrelling and fighting with all people most of the time. That is the situation.

Women's opinions are quite contrary to men's explanations. In a situation where the husband has taken an additional wife, most women will rationalize their behaviour in a way that will justify them and shift the blame onto their husbands. For example, findings from the female focus group meetings show that whenever a man decides to take an additional wife, his former wife will always blame him, especially when there is a misunderstanding between the co-wives, or when the man is failing in his duty of sharing his love equally between them.

One comprehensive and interesting opinion from the discussion meetings was given by Mrs Iyaalelagba, the first wife of a man who is currently married to three wives:

> You see you men, no one can trust you, when a woman is married to you, she leaves everything she has before, her own paternal house, her father's name, and she becomes your wife. At this point, you will promise heaven and earth for her, some women even abandon their education for their husbands, no matter the education we've had before, we end it up in the kitchen for the men. Although, at the beginning, the man will pretend to love and he tries to do everything for the wife, suddenly, one day for some flimsy reasons, he starts to look for other women, and this often happens after the wife has given birth to two or three children. Before you know in some cases, the new woman has come into your matrimonial home. It is at this point that the first woman no longer knows how to do things in the right way, she does not know how to cook good food again, she is not good any more, and all those useless excuses will start to come from the man, and sometimes the man is driven into such action by the type of friends he has. Tell me, *ha !* which woman is good or which one is bad ? Which woman will not appreciate love from the husband? But when frustration has arrived, because of the *iyawo soyoyo*, then the attitude of the first woman will change. After all, our father used to say *'omo eni ni oko eni*' [meaning 'her children are her husband', that is, a woman's status is only consolidated in her husband's house by the number of children she has]. But one thing that is sure is that *opa ti a fi na*

> *iyaale ni, o mbe l'aja fun iyawo* [the whip with which the first wife was beaten is kept inside the ceiling for the new wife]. That is the whole truth of the matter.

The two viewpoints presented above shows the divergence of husband-wife relationships in most polygynous unions. But whatever the direction of the argument, the character, attitudes and relationship between a man and his wife largely determine the type of treatment she receives from her husband. The variations in the disposition of the husband to each of his wives may be a product of the wife's attitude and behaviour, and at the same time it could be the other way round. If a man takes another wife as a result of dissatisfaction with the character and behaviour of the first one, obviously, the new wife will enjoy more of the husband's care than the first one. She also has a better chance of access to his resources than the first one with whom he has become dissatisfied.

Further findings seem to suggest who among the senior and junior wives is likely to have the greater chance of access to the husband's resources and support, especially when it comes to the question of paying for medical treatment. The opinion of Mr. Ikulelebe is stated below.

> My own understanding of the discussion is that the second or younger wife more often gets the favour of the husband than the first wife. The reason is that if you look at it from all sides, she is younger and more beautiful than the first one, and as a result the husband would prefer her to the older one. Furthermore, historically I can say that the majority of Africans are polygynists. For example, as a farmer a man would need many hands on his farm, and from my experience my father married many wives for this reason. However, he used to love the junior ones most because they were young, attractive and active in all aspects of life.

It is evident from this statement that junior or younger wives tend to have a better chance of support and love from husbands than senior wives, and it repeats the view that African men are by nature polygynists. However, Mr. Igba-kolo-bi-orere expressed his view on what might make a man love one of his wives more than others:

> My own explanation is that the character of the woman is important. Truly, a new wife might use her beauty and some other qualities to win the favour and interest of the husband at the expense of those married into the union before her. However, this is just an initial advantage, and very soon the illusion will fade away gradually. If she has no good manners her character will soon become clear to the man and his love might shift back to the elder wife. However if she has good manners, she might enjoy the husband's favour and care more than her senior counterparts in the union. Nevertheless, I agree that, naturally, husbands love one wife more than the others but their character will determine which one. Beauty may determine whom to marry, but character determines the longer-term affection, love and concern for a woman and her children.

It seems to be rare for a polygynous man to love and support all his wives equally, and junior or younger wives stand a better chance of getting the husband's affection and support. Does this also happen during the time of treatment of children's illness? Can a man transfer the love he has for a woman to her children in times of sickness and be less supportive to wives he seems not to love also whenever her children fall sick ?

The opinions of both Mr. Gbeborun and Mr. Moriyiri addressed the issue of how a husband's love toward a particular wife extends to her children.

> Gbeborun: It appears to me that if a man is sick and there is a woman who cares for him and who is closer to him than other wives, he will love her more than the others . . .

> However, when a woman or any of her children is sick, the way her husband responds to her and assists her in seeking treatment is usually a clear manifestation of the love he has towards her. Furthermore, to my mind it also depends on the attitude of the man. To be sincere, the majority of those that hate one or some of their wives normally transfer the hatred to the children of the wives, to the extent that the kind of treatment he gives to the mother, he will also give to the children. Invariably, when the children of the loved wife have received ten naira from the father, the children of the hated wife have received only one-tenth of that amount. We see this kind of example very well and it is very common around here. This should not surprise you, after all, our father used to say the proverb, *iyawo ti a ba feran ni omo re n'wuni.*

> Moriyiri: There is no controversy in it. It is clear, and we all know it that a man will concentrate more of his effort and support on the wife he loves most and spend more on her children. From past experiences, I found out that the husband helps and spends more money on the wife he loved most. However, if a man tries to divide his love into equal portions between his wives by using his education and knowledge of books, and he puts them in different houses as is being practised nowadays, he may try to love them equally, and then there would be no serious jealousy among the wives. However, this is difficult for a man to do.

Mr. Otitokoro shared his own experience on this subject:

> My experience in a polygamous house where I now live shows that men always transfer the love they have for a woman to her children, even when they are sick. My landlord took his second wife a few years ago. Each time I noticed that when anything happens to the senior one [*iyaale*], that man always felt unconcerned about her. However, if anything happens to the junior wife [*iyawo*], he will go to any length to make sure he satisfies her and cares for her. As a result of this, it has been fighting today and quarrelling tomorrow, and there has been no peace in the household since. The man now has a kind of predominant love for the younger one and the same love has been transferred to her children. He can now spend thousands of naira on the children of the younger wife, while the older wife has to look for assistance from her own relations if she cannot meet the cost of the treatment herself.

The contribution of Mr. Agbateru also throws more light on the discussion:

> We should not be surprised at what Mr. Otitokoro has just said, for we all know that the proverb says *iyawo ti a ba feran ni omo re n'wuni*. Experience has shown that, even if the child is not good at all, and even if he behaves like an idiot, the father will carry him and kiss him, because he loves the mother. It is quite likely that a man will love the children of his favourite wife more than all other children. In my case, my first wife had two children for me, and so did the second wife, but since I loved one more than the other, I cannot tell a lie, I love my junior wife more than the first wife, although I cannot tell you all the reasons. It is natural and it may be inevitable that I must love her children more than all other children, certainly, that is how it used to be.

Finally, Mr. Ape-jeun-ma-je-baje revealed how he thought that the mother's position and relationship with the father affects the treatment received by her children:

> Thank you, the Yoruba often say ohun a ba fe ni iwu'ni, ohun a ba feran ni'po lola eni meaning it is what we want that is admired, and what we admire forms a greater part of our wealth. In Yorubaland, as Mr. Agbateru has said, it is true that the love the husband has for any of his wives extends to her children. I came from a family of many wives — my father had about seven wives — and I observed that, among them, my father loved my mother most, and I discovered that, because of this love, many family matters were revealed to us by my father, even things not revealed to the children of other wives. He used to call us and tell us certain matters in confidence. Furthermore, when children are sick, truly, the love of the father to the child's mother is a crucial determinant of whether there will be proper care from the husband for the sick child or not. It is not that this man will not try to help all his children, but more would be spent on children of the favourite wife. For example, if he spent five naira on the children of the wife he does not love very well, he would spend one hundred naira or more on any of the children of his favourite. There is care for all children in the family, but it is more for some than others.

All the discussants agreed that education does not have any effect on the differing behaviour of a man to his wives. Although one of them maintained that religion might make a man love all his wives equally, this also is a controversial issue. The polygynous nature of man and the different dispositions towards wives in polygynous unions among the Yoruba were clearly demonstrated. The in-depth interviews with women in polygynous unions were also quite revealing. Most of the women interviewed who were senior wives reported that their husbands had abandoned them and their children for new or junior wives. None of the women who were junior wives complained of lack of support from their husband, which also suggests that first wives are at a greater risk of being put aside by their husbands. Two case studies of senior wives are presented.

Mrs. Kojumaribi, 20 years old, had been married for five years without any problems. According to her, her husband used to perform all the responsibilities expected of him as a good husband. Suddenly the man decided to take another wife about six months ago, and, as a result, the reverse is the case with her now. She now suffers total neglect and lack of attention from the husband, and quite often he beats her up and gives her no money. The man does not even bother to care for the only baby girl she has for him. At the time of the survey, she had separated and now lives with her own parents, while the husband lives with the new wife, who now has his whole affection and care. She said that she was now prepared to divorce him very soon.

Mrs. Iyayipo is in a situation quite similar to the one above. She is about 35 years old. She complained that her husband does not pay attention to her any more, because he now has many wives. She was the first wife, but the husband now prefers the most junior wife. According to her, the husband now treats the junior one with more love and care than any of the senior ones, and the children of the favourite junior wife receive better treatment and attention from the husband when they are sick than her own children. She complained bitterly about this and how she had lost four children already, although she did not attribute their deaths to the attitude of the husband, two of the children died of measles, and the other two died mysteriously. The latter two deaths were said to have happened around midday.

It was very difficult to reach the husbands of these women for interview, but their situation elucidates the results of misunderstanding and differential love and support of husbands in polygynous unions.

Conclusion

Regardless of the character of a man, is he likely to behave differently to his wives? Is this likely to affect his responses to his children's illness and how they are treated? Unfortunately that is the case. Although we cannot conclusively say which of the wives in polygynous marriages will be more favoured by the husband than others, the qualitative evidence suggests that junior wives and their children have a greater chance of enjoying both the moral and financial support of husbands than senior wives, and this is also true for the treatment of illness.

One important aspect of treatment of child illness that could be greatly affected by the differing husband-wife relationships in polygynous unions is that of meeting the cost of treatment. The favoured wife and her children are more likely to enjoy both moral and financial support from the husband in paying health costs within the family. On the other hand, the neglected senior wife is now obliged to pay for treatment alone or seek for support from her grown-up children or from her own relations. This is an important issue, especially during this period of the Structural Adjustment Program, when the cost of treatment has gone up drastically and government health care support has almost completely collapsed. The SAP policy has also negatively affected the economic power of most women, who used to have economic independence from their husbands in the past. Most women then paid for treatment for their children more often, because they were able to do so; however, it seems they are now obliged to do so if their husband is not responding.

An implication of the differential responses from fathers to the treatment of child illness on the basis of the mother's position in the household, is that some children are at great risk of morbidity and mortality.

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Forum: Health Transition Review 6, 1996, 71 - 122

The International Conference on Population and Development, Cairo, 1994. Is its *Plan of Action* important, desirable and feasible?

The nature of the forum

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The *Review's* editors identified ICPD, Cairo as being one of the most important events of our time in the field of reproductive health, population and development. From their different viewpoints, all our forum contributors concur. Accordingly, we felt that this forum was the place to debate the reality behind the rhetoric and the wishful hopes. We invited a range of persons to contribute, from those most identified with women's reproductive health to those whose background is mostly population and development, and this spectrum approximately determines the order in which the contributions have been assembled (with the exception of Minister Haryono Suyono's piece which is placed last so as to provide at that stage a view from the apex of one of the world's largest population programs). The original design has been modified by events: many fewer persons working in reproductive health either accepted our invitation to contribute or ultimately wrote a paper than did those with a greater family planning orientation.

The contributors are more cast from one mould than their disagreements might at first give appearance. None have placed themselves beyond participating in the dialogue which Margaret Hempel regards as now necessary. All believe in more technical aid for Third World countries, an improved situation for women in those countries, and higher quality family planning services. None identify with those First World politicians and sectors of their electorates who believe in reducing development assistance budgets. There is even near agreement with Hempel's statement that 'reproductive health is, fundamentally, a different agenda with different goals from the traditional approach to population programs', although division remains as to the priority that should be allocated to it.

Perhaps, after nearly 40 years of association with Third World family planning programs, I might be allowed to differ from one strand of thought which was evident in the corridors and meeting rooms of ICPD and to some extent in this forum. That view held that the proponents of Third World family planning during most of that period, especially the foreign advisers and their institutions in the First World, were so fixated by global population numbers and so patriarchal in outlook that they decided that women should be the sole vehicle for curtailing population growth, and gave little thought to their comfort, desires or safety. I knew few people of this type. Nearly all worried that most forms of fertility control related to women, although some worked in societies where women clearly preferred the degree of control over their reproduction that this gave them. All believed that providing the option to control family numbers and to space births further apart raised the position of women and their future chances in life as well as limiting the reproductive ill-health that threatened them.

We had hoped that more of the forum would focus on the extent to which the identification of reproductive ill-health is possible in remote rural areas and urban slums of very poor countries; the possibility of effective treatment; whether the costs would cripple or

limit family planning programs; and whether family planning programs should proceed in areas where full reproductive health cannot be guaranteed. The first papers do address these issues but the treatment is limited, clearly because the answers are not yet in. Margaret Hempel argues that we can only find out from experience in trying to improve women's reproductive health. Huda Zurayk is somewhat reassuring with her evidence that 'Experience in ... Egypt has shown that a clinical strategy with minimal laboratory services is workable in taking care of reproductive health problems of women provided there is proper follow-up and referral'. Nevertheless, this evidence raises the question as to whether family planning programs should venture beyond the reach of clinics manned by physicians.

There is agreement that NGOs transformed the ICPD, thus making it an unusual United Nations meeting in that its *Plan of Action* has very considerable potential for changing the world. There is disagreement whether the priorities were correctly assigned. There is less worry about whether 'precoms', held in New York City and dominated by *avant-garde* Western groups, should be able to largely determine a plan before most of the world's governments have seriously considered it. It is not very worrying when you largely agree with the outcome, but may some day be less agreeable when different forces learn these tactics. The whole process supports the view I have expressed that the United Nations is one of the world's most powerful Westernizing mechanisms and that much of the advocacy of the UN is for aims supported totally only by Western progressive minorities. Again, I usually agree with their aims.

Most of the other papers have three main complaints. The first is that, by attacking past family planning programs and by making it sound as if all were coercive and uncaring, many individuals and NGOs involved with ICPD undermined the conviction of donor governments that they should exert themselves to contribute to such programs. The second is that the emphasis on the individual, the attack on concern with numbers, and the extraordinary lack of concern about the long-term implications of rapid global population growth gave much less emphasis to social, community and national issues than was warranted and thereby eroded the will of donor governments to strain themselves to support foreign family planning programs or the will of Third World governments to give them high priority. The third complaint is that the Cairo agenda appeared to be making population programs and their budgets support huge health, educational and employment objectives which really were the responsibility of the full range of government.

The truth is that most concerned persons, certainly those represented in this forum, do hope for Third World family planning programs that reach everyone; that do their best to improve the reproductive health of the women they contact and to ensure that the acceptance of contraception does not reduce their level of health; and that make it possible for women to bear fewer children and the world lesser population than threatens to be the case. Those of us supporting the ICPD Plan of Action should realize that First World electorates and their representatives are increasingly unlikely to believe these objectives to be so important that their incomes should be taxed to achieve them; and accordingly, we should put a convincing case for continued support . If money for Third World family planning programs declines, then the chance that more can be done for the reproductive health of women in those countries will also be diminished. Finally, it might be noted that a major aspect of the Asian national family planning programs, which have made the major contribution to the decline in world population growth, has been, as is noted by Haryono Suyono, an emphasis on government leadership in convincing the population that they will be better off with smaller families. Hardly anyone at Cairo or in this forum has dared to mention this.

Reproductive health and rights: origins of and challenges to the ICPD Agenda

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In September 1994, at the International Conference on Population and Development, 184 governments met in Cairo to discuss, debate and, in the end, come to consensus on a new approach to population and development issues (UN 1994). The final Programme of Action represents a critical shift of focus in the population field from a concern with achieving demographic targets, largely through the provision of family planning services, to an emphasis on improving individuals' quality of life. Central to this analysis is the role of women, not just as beneficiaries of services but as active agents of change. The document emphasizes the importance of human rights and the links between population and development concerns. In terms of services, the document not only stresses the need for quality family planning services but also includes, as integral to reproductive health, attention to safe pregnancy, sexually transmitted diseases and HIV/AIDS. It addresses the problem of unsafe abortion and calls for programs for adolescents and men. In addition to specific recommendations for expanding existing services (Alcala 1994; Germain and Kyte 1995), the ICPD also challenges those working in this field to think beyond providing services for policy. It calls for multisectoral approaches to the fundamental determinants, economic, cultural, legal and social, of sexual and reproductive health. This ambitious agenda should not, however, be read as a list of requirements. Rather it is a vision of where the field is headed, assigning new roles and responsibilities to the advocacy, service, research and government sectors.

This broadened approach is mainly due to the fact that feminist health and women's non-governmental organizations (NGOs) from developing and developed countries played an active role in all phases of the conference preparations, from national-level working groups to international UN preparatory meetings. These dynamic, broad-based coalitions of women's NGOs were joined by progressive voices within the family planning, health, environment, development, human rights and research communities who were challenging their respective sectors' approaches to and analysis of these issues. Together, they provided much of the vision and the data on which the final Programme for Action is grounded. The challenge now is to build on this process and maintain the collaboration between NGOs, policymakers and the research community to continue to advance our understanding of reproductive health and to develop services and policies that reflect this new approach.

The emergence of a reproductive health agenda

The concept, or at least the language, of reproductive health has been adopted in international policy and many national settings with remarkable speed. Though critics have argued that these concepts were imposed by a small group of Western feminists organized around the ICPD, a brief review of their history reveals that the concept of reproductive health had already taken root not just in the feminist health community but also in the service and research sectors of both developing and developed countries. Indeed, the ICPD is best understood as part of a broader process that began more than a decade ago and will continue to transform the scope and structure of population programs in the years ahead.

Developments in the women's health and advocacy sectors

In the early 1980s, searching for alternatives to the narrowly focused government and private family planning programs, women's health advocates in developing and developed countries started some of the early models of comprehensive care, providing women with access to a greater range of choices in contraceptives and other services, including abortion and menstrual regulation. In contrast to the often target-driven, sometimes coercive national family planning programs, these services emphasized counselling and attention to interpersonal dynamics, including empowering women to make informed decisions about their health. Such models were grounded in the understanding that reproductive health needs are related to a wider set of economic, social and familial circumstances in which women live. For example, the Bangladesh Women's Health Coalition, founded in 1980, and the Feminist Health Collective, founded in 1984 in Brazil, provide not only a wide range of health care and counselling but also legal aid, social and advocacy services (Kay, Germain and Bangser 1991; Diaz and Rogow 1994). In the United States, the National Black Women's Health Project has been providing preventive health care information and services to poor women through its network of self-help groups since 1983. Building on these experiences of direct service provision, many providers and women's health advocates also began to push for greater attention to the range and quality of services provided by national health and family planning programs (Mueller and Germain 1993).

In the early 1990s, there was intensified discussion on population policies among feminist health groups from developing and developed countries. For example, at the International Women and Health Meeting in Manila, in 1990, some participants argued that population policies were inherently coercive and could not be reconciled with women's rights. Others felt it was important to persuade the existing power structures — donors, national governments and the UN system — to change their priorities and expand the scope of their programs.[1] One example of a subsequent effort to describe feminist population policies was the 'Women's Declaration on Population Policies' produced by an international network of women's health advocates. This declaration outlined minimum program requirements and set out some basic principles including respect for women as responsible decision makers in their families and in society, and principles of equity, non-coercion and inclusion of women at all levels of policy making. It also began to define in more depth the increasingly used concept of male responsibility, stating that 'men have personal and social responsibility for their own sexual behavior and fertility and for the effects of that behavior on their partner's and children's health and well-being.'[2] In January 1994, over 200 women's health advocates from 80 countries met in Brazil at the Reproductive Health and Justice: International Women and Health Conference for Cairo '94, where population policies were discussed from diverse perspectives. While not a consensus document, the final report highlighted several areas of unanimity among the participants, emphasizing the need for greater human development efforts aimed at the empowerment of women and respect for and protection of women's rights. It also noted the need for high-quality health services for women that provide more than contraceptives, and recognized safe abortion as an intrinsic part of health and human rights (Hartman 1994). While these debates contributed to a synthesis view that placed reproductive health in the broader social and economic frameworks that affect women's and men's lives, discussions within the feminist health groups continue on the relative importance

[1] Examples of these different perspectives can be found in Mueller (1993); ISIS (1993); Berer (1993); Hartman (1987); *Reproductive Health and Justice* (1994).

[2] 'Women's Declaration on Population Policies' (ISIS 1993).

given by governments and NGOs to population programs versus broader social and economic development goals, and whether these are inherently contradictory approaches.[3]

These different meetings and organizing efforts challenged the prevailing view that considered women only in terms of their reproductive capacity; instead they argued that women's health and well-being were important goals in their own right and not merely for improving the effectiveness of population programs.

Developments in the international agencies and family planning sectors

The idea that family planning and health programs needed to address the full range of women's health needs throughout their life-cycle was also promoted by progressive staff within international agencies and the family planning sectors. Rosenfield and Maine's 'Where is the M in MCH?' article in 1985 criticized traditional maternal and child health programs for their focus on the health of the foetus and newborn (Rosenfield and Maine 1985). The global Safe Motherhood conference, held in Nairobi in 1987, helped focus attention on the problems of maternal mortality and morbidity. Subsequent national and regional Safe Motherhood workshops were held in countries around the world, bringing together NGOs, service providers, policy-makers and media representatives to address these concerns in their particular country contexts.[4] A similar cross-section of constituencies, including physicians, feminists, lawyers, public health professionals, social science researchers, and policy-makers participated in an international meeting on women's health in Brazil in 1989.[5] In addition to focusing on unwanted pregnancy and abortion, the papers presented at this symposium represent some of the earlier thinking on what a broader reproductive health approach would entail in services and policies (Rosenfield et al. 1989). Several papers, for example, discussed reproductive tract infections as a serious health burden for women.

Some of the major international family planning organizations such as the International Planned Parenthood Federation (IPPF) and the Population Council also began efforts to improve service design and delivery. IPPF's 'Vision 2000' put forward in 1992 a broad approach to reproductive health that includes gender relations and sexuality and promotes attention to these issues throughout a woman's life cycle (IPPF 1992). Staff at the Population Council in the late 1980s and early 1990s defined and advanced a 'quality of care' framework. This approach focused on improving the quality of family planning services from the client's perspective. Later adaptations have incorporated other reproductive health services and greater attention to gender dynamics involved in service provision (Bruce 1990).

By the late 1980s, family planning programs that were experimenting with ways to improve the quality and scope of services could be found in most countries, from the Indonesian Planned Parenthood Association to Profamilia in Colombia. At the same time, funding agencies such as the Ford Foundation and the MacArthur Foundation began programs that emphasized a broader reproductive health approach (Barzelatto and Hempel 1991).

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[3] For a discussion of how the ICPD advanced a progressive reproductive health framework but failed to push a similarly progressive economic agenda, see Petchesky (1995).

[4] From 1988 to 1995, over 100 countries participated in national or regional Safe Motherhood meetings. A full listing and copies of conference reports (or referrals to correct source) are available from Family Care International, New York, NY.

[5] Organized by the International Women's Health Coalition, the Christopher Tietze International Symposium on Women's Health in the Third World: The Impact of Unwanted Pregnancy (see Rosenfield et al. 1989).

Developments in the research sector

Researchers in the 1980s gave increased attention to the social, economic and political factors in fertility. Population research began to investigate how gender roles and economic forces, among other factors, shape demographic outcomes. By the 1990s, the effect of the HIV/AIDS epidemic also began to influence research. With no cure for AIDS and no vaccine to prevent the spread of HIV likely in the foreseeable future, researchers and policy-makers began to realize that effective prevention required better information on what motivated sexual behaviour and attitudes and how to change them. The resulting research, while still limited by its disease orientation, engaged a broader cross-section of social scientists from the fields of anthropology, sociology, and political science. This, coupled with work under way in feminist scholarship examining the social construction of gender roles, created the base from which to explore the interface of social and cultural roles with reproductive health issues and sexuality.

These emerging academic lines of work were also taken up by several key research organizations and networks. WHO's Special Programme of Research, Development and Research Training in Human Reproduction (HRP), traditionally a biomedically oriented program, expanded its work on social sciences during the 1980s. HRP materials from the mid-1980s defined reproductive health to include maternity care, infant and child health, prevention and control of sexually transmitted diseases (STDs) and attention to infertility. HRP also recognized the importance of social issues:

Improving reproductive health will not be achieved with machines, devices or drugs without taking into consideration the human element. Changes in behavior and social attitudes are often needed to achieve lasting improvements in health (WHO 1987)[6].

The Council for International Organizations of Medical Sciences, together with HRP, organized an international meeting on Ethics and Human Values in Family Planning. A multidisciplinary audience of biomedical and social science researchers, lawyers, ethicists and theologians considered the underlying cultural, religious and ethical concerns raised not just in family planning service provision but also as related to infertility and prenatal care (Bankowski, Barzelatto and Capron 1989). In the early 1990s, the International Union for the Scientific Study of Population established committees on gender, anthropological demography and HIV/AIDS. Social science associations, such as the International Federation of Institutes for Advanced Studies, also began to address issues of women's health.

Aiming to make these findings more accessible to broader audiences, organizations and individuals also began to develop more popular versions of academic articles and participated in efforts to educate policy-makers. This proliferation of outreach efforts and publications, many of them designed to provide an overview of the substantive questions that would be debated in Cairo, greatly enriched the policy debates. Publications focused on the role of religions and of ethics in shaping a reproductive health agenda (Development Law and Policy Program 1994), elucidated women's diverse perspectives on reproductive rights,[7] provided gender-based analyses of population and development issues (Correa 1994) and highlighted the widespread but neglected problem of STDs (Germain, Nowrojee and Payne 1994; Zurayk, Younis and Kattab 1994).

By the early 1990s, the concept of reproductive heath was widespread in feminist health groups and increasingly used in the service and research sectors. The willingness and ability of these NGOs to then interact across fields and to engage more systematically in the policy

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6 See introduction by Jose Barzelatto and concluding chapter by Mahmoud Fathalla.

7 See reports from International Reproductive Rights Research Action Group, Hunter College, New York, NY; Steve Isaacs and Lynn Freedman, Columbia University.

process created a synergy that was critical to developing the consensus framework achieved in the conference process.

NGOs transform the ICDP

With these changes already under way, the ICPD preparations provided an important opportunity for health advocates, service providers and researchers to discuss with each other reproductive health issues. In this process, women's health and rights groups played a leading role not only in articulating a new paradigm for population programs but also in challenging the traditional ways of running such conferences. Previous UN conferences on population in Bucharest in 1974 and Mexico City in 1984 had been largely the domain of male government delegations, with input from a few key demographers and population organizations. In contrast, the ICPD process had broad NGO involvement, with strong leadership provided by people in the feminist and social-justice movements of the developing world. Many of the leaders had participated in the 1992 UN Conference on Environment and Development (UNCED) and the 1993 UN Conference on Human Rights. As a result of their efforts, women's concerns were incorporated in UNCED's 'Agenda 21' and women's rights were recognized for the first time as human rights in the Vienna Declaration.

Such success encouraged NGOs to participate more fully in the preparations for the ICPD. In Brazil, China, Colombia, Egypt, India, Mexico, Nigeria, and the Philippines, NGOs formed national networks to influence their government's positions at the preparatory meetings and at the conference itself. While these networks and their strategies varied from country to country, they shared an emphasis on collaboration among the service, advocacy and research groups and a focus on publicity and public education.

As a result of the activities described above, the level of NGO involvement in the conference preparations was unprecedented. Over 4,000 individuals from 1,700 organizations participated in the ICPD and the NGO activities that ran parallel to the government negotiations. Some NGOs lobbied as outside pressure groups, others participated as official representatives on government delegations, still others acted as resource persons providing technical advice and research data for the governmental discussions. For many organizations, these roles were fluid, with staff participating in different capacities. Forums such as the Women's Caucus provided opportunities for exchange of ideas and strategies among NGOs and between NGOs and government representatives.[8] The increasingly hostile attacks on the conference agenda by the Vatican and conservative Catholic and Islamic delegations also encouraged increased collaboration among the diverse sectors working towards an expanded reproductive health agenda.

Thus NGOs transformed the ICPD, not only by helping advance a new reproductive health framework but also by establishing effective ways of working with governments. Such collaboration, that built on UNCED and the Human Rights Conference, has remained integral to subsequent UN conferences on Social Development in Copenhagen, the Fourth World Conference on Women held in Beijing 1995 and the Habitat Conference scheduled for June 1996. NGOs have helped government delegations (whose representatives were, for the most part, different for each conference) make the connections between different documents and hold firm to commitments made at previous conferences. For example, at the Beijing Conference, rather than giving ground on reproductive health concepts as many had feared,

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[8] At the preparatory meetings and in Cairo, the Women's Environment and Development Organization (WEDO), a worldwide network of women's groups, organized the 'Women's Caucus', a daily briefing session open to all NGOs and government representatives to share information and develop common gender-based analyses of the documents being negotiated.

governments accepted an even broader understanding of sexual and reproductive health, emphasizing a woman's right to control her own sexuality (UN 1995:paragraph 96).

The series of UN conferences following so closely on each other has given NGOs and governments an opportunity to link the issues of environment, human rights, population and development, social development and the status of women. Moreover, by engaging in these meetings, many NGOs have improved their advocacy skills and developed contacts they are now using at the national level to ensure that the words in the conference documents are translated into action.

ICPD Follow-up: the challenges ahead

Political will and NGO involvement

For many NGOs that participated in the UN conference processes, developing continuing mechanisms and relationships that will help hold their governments accountable to these international agreements and guide national programs is a logical and critical next phase of work. In fact, the ICPD document encourages the growth of this collaboration between NGOs and governments as crucial to implementing the Programme of Action. It recognizes that NGOs have provided much of the expertise on the development of policies that are more responsive to women's needs. Since they have also provided models for improved service delivery, it is important that they be involved in broader efforts to scale up these innovations and integrate components of reproductive health into larger programs.

In several countries, the ICPD commitments have already provided a framework for NGO-government collaboration that could greatly advance the reproductive health agenda. Of the 56 countries responding to a one-year follow-up report, two-thirds make explicit mention of involving NGOs, through increased consultation, formal participation in government projects or, in the case of five country reports, increased funding for NGOs (Hamilton 1995). Materials prepared for the UN Commission on Population and Development noted that the trend among the 78 countries that submitted reports was towards greater NGO involvement in national reproductive health activities (UN 1996). It is also encouraging that some of the leading population donors, including the United Nations Population Fund (UNFPA), the World Bank and USAID are supporting women's NGOs to implement new approaches for reproductive health care. For example, the USAID office in Peru made a shared award of $19 million over five years to three leading NGOs with extensive experience in reproductive health, gender and community development: Movimiento Manuela Ramos, Flora Tristan, and the Centro de Investigacion Social y Educacion Popular Alternativa. The project will work with community-based organizations and use participatory methods to identify and then respond to the reproductive health needs of the communities involved. Included are finance for micro-enterprise loan funds and other measures to respond to the social and economic needs of the women concerned.

It is important to ensure, however, that governments and donors see NGOs as innovative collaborators and not as a means to relieve government responsibility for the Cairo agenda. The NGO sector has neither the funds nor the reach in most countries to provide reproductive health care to all those in need. Furthermore, while NGOs can raise questions and assist in connecting different policy sectors — education, health, family planning, finance — such collaborations will require, in the end, the commitment of governments to reassess their approach to population and development issues at the national level. The reports mentioned above do not show much progress in this regard. In the Commission document, it is clear that NGOs are viewed more as filling gaps in the service sector than as colleagues in developing national policies. The Earth Summit Report's reviewers, working with developing-country

colleagues, found that in many cases it was not clear who or which departments within national governments had responsibility for following up the ICPD.

The lack of significant state action on ICPD implementation in many countries raises questions about the level of government commitment to this new agenda. Given competing demands for limited resources, reproductive heath issues are often not made a priority by many governments. In some countries, governments and NGOs face domestic political pressures that make championing a broader reproductive agenda more difficult than in the international context of a UN conference. Indeed, many NGOs are finding that without the international attention surrounding the ICPD and the other UN conferences, open and participatory relationships with their governments are difficult to maintain. In some cases, governments resist collaboration because NGOs are seen as anti-government. And in many countries, there is little precedent and few effective models for NGO-government collaboration.

For NGOs, there are also tensions regarding whether and how to engage with government agencies. Some prefer to retain their role as 'outside' critics. Also, many providers focused on the day-to-day delivery of services are less concerned with engaging actively in larger-scale policy formulation. Some NGOs are also concerned that governments' positions may be largely rhetorical and that closer collaboration will lead to very limited advances. They thus fear that their participation may lend legitimacy to a process in which they would have little power. For NGOs that include advocacy as part of their mandate, accepting government funds can create a conflict of interest or limit their ability to act and speak independently of the government priorities. At the same time, with the majority of funds for family planning and health provided by governments and international agencies, NGOs need to find ways of access to these resources.

Clearly each NGO will need to decide where on this continuum they can be most effective: working from outside to keep pressure on governments and donors or working in some degree of partnership to help develop new program and policy models. Both approaches are needed to advance the goals of the ICPD.

In addition to national efforts, the cross-national networking among NGOs that proved so effective in shaping the agenda of these conferences will also be critical in developing mechanisms to hold both individual governments and bilateral and multilateral agencies accountable to the commitments made in Cairo. Such coalitions will need to build on the ICPD process that gave greater voice and priority to the perspective of women in developing countries. This will require developing modes of communication that allow for shared agenda-setting as well as a division of labour and sharing of expertise among groups working at the national, regional and international levels. Some beginning examples in this regard are WEDO's Women Watching ICPD that links with their efforts to monitor UN and World Bank activities and the network, HERA 2000, an alliance of women from developing and developed countries who were closely involved in the Cairo conference.

Multisectoral approaches

Implementing this broad agenda that recognizes the relationships between issues such as girls' education or improved employment opportunities for women and reproductive health services will require the involvement of other sectors beyond the family planning or population divisions of government. Some have argued that this broadened mandate may dilute what population programs do well : provide contraceptive services. Others fear that it will cause funds allocated for family planning services to be diverted to education and development. In fact, the ICPD document specifies that implementation of this agenda is not the sole responsibility of the population sector but requires the technical and financial involvement of the health, education, planning and finance ministries. This broader approach has the

potential to strengthen national-level responses by calling on a wider array of participants in these issues.

One example of a multisectoral approach is found in the Philippines. The Population Commission established a program in 1994 to better integrate attention to gender and reproductive health within all levels of the Commission and its programs, including information to previously ignored groups such as adolescents and men. An advisory committee was established that includes representatives of the Departments of Health; Education, Culture and Sports; Social Welfare and Development; Labor and Employment; Interior and Local Government and the National Economic Development Authority, as well as NGO representatives from universities and gender, reproductive health and women's rights advocates. A complementary effort at the provincial level is seeking to develop models of community engagement in policy dialogue and in the agenda setting process.

Reproductive health indicators

Also necessary for genuine advancement in this area is the development of new indicators for services and programs that measure more than numbers of contraceptives delivered or couple-years of protection. A new framework would incorporate concepts related to quality of care and client satisfaction and would look at outcomes beyond numbers of births to include women's health and morbidity. Some work has been initiated in this regard, including Jain's Helping Individuals Achieve their Reproductive Intentions (HARI) index to measure program success by whether each individual client was able to achieve her desired fertility in a healthful manner.[9] Central to this approach is the concept of following the individual woman to assess how services meet her needs. Others have been exploring more effective management techniques that would address the quality of care clients receive at the service site.[10]

Most of these still focus, however, on contraceptive delivery. Much less has been done to develop indicators for the broader reproductive health services and policies recommended in the ICPD. Initial efforts include work by IPPF Western Hemisphere Region and the USAID funded EVALUATION project. The latter is developing indicators for six key reproductive health interventions, including safe pregnancy, post-abortion care, breastfeeding, STDs and HIV and adolescents. Some potential markers include the percentage of adolescents receiving reproductive health education and services, and percentage of women admitted to hospitals with obstructed labour or ruptured uterus not delivered within two hours (Bertrand and Steward 1995).

Also needed, however, are indicators that can be used to assess progress in promoting sexual and reproductive health at the national level, using measures that go beyond service indicators to capture elements of broader social change. For example, how would we assess the impact of multisectoral programs' effect on women's empowerment and improved reproductive health? How would a community assess the effectiveness of an integrated program to address women's economic, educational and health needs? What indicators would one use to determine if particular programs or policies were facilitating or hindering improved sexual health? Little has been done to date to show what these broader indicators might be and, even less on how these would be monitored. One example is work by Schuler

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[9] See Jain and Bruce (1994). In this model, clients are classified by those who want and those who do not want another child for 24 months. The program would then follow each woman to see if she met this goal and, if not, why not, including attention to method failure, information failure, a related morbidity, etc.

[10] See Association for Voluntary Contraception's (AVSC) COPE model.

and Hashemi (1994) looking at the links between credit programs, empowerment and contraceptive use in Bangladesh. Additional insights might be gained from looking at work under way in other sectors including gender and development to identify and develop monitoring systems for broader social indicators.

Resource requirements

A discussion of the challenges facing implementation of the ICPD would not be complete without mention of the resources needed to support this agenda. Certainly more funds are required. However, reproductive health cannot be seen as an addition to existing services that will happen only if and when additional funds are provided. Rather reproductive health is an agenda and a commitment to transform provision of services and implementation of policies. In times of scarce resources for social services, it is important to think creatively about what to do with the funds already available.

Many reproductive health services can be implemented within existing structures and budgets (Germain, Nowrojee and Pyne 1994). In many cases, at least in the first phase of moving towards a reproductive health approach, efforts to change attitudes, improve interpersonal skills, and design service hours and content to better meet the needs of a diverse clientele, may be as helpful as additional funds. In some cases reorganizing or better integration of services may even result in savings. The ICPD document notes that while improving quality of care in family planning programs may, in some cases, increase expenses, these are likely to be offset by declining costs per user as contraceptive prevalence increases. In this changed context, additional resources would then be more efficiently used and would contribute more directly to improved reproductive health.

The ICPD document includes some general estimates of the level of funding required for this expanded reproductive health agenda, breaking out costs for family planning, reproductive health, HIV/AIDS and research. Such efforts to document the financial requirements, however, have done as much to show the inadequacy of our estimates as to give hard figures of what is needed. First, international statistics may give us broad goals for international development but in aggregate do little to help nations plan for their particular reproductive health needs. As pointed out by Zeitlin, Govindaraj and Chen (1994), analyses of current population and health expenditures are severely deficient because of poor data. Furthermore, understanding the full range of reproductive health costs requires considering not just population budgets that tend to be largely spent on contraceptive services, but also current expenditure on HIV/AIDS, Safe Motherhood, Maternal and Child Health and Child Survival. Similarly, policy-makers should estimate the level of social expenditures allocated to education or development programs that also incorporate elements of reproductive health. Some countries have begun to identify the content and financial requirements for essential reproductive health services, but these are still very preliminary (cf. World Bank 1995). Once governments better understand what they already allocate towards an expanded reproductive health agenda, they can make effective decisions to reorganize their priorities. Though it is important to encourage international agencies to support expanded programs, national-level re-ordering of priorities is perhaps more important, since most funds for reproductive health are provided by national governments and the users.

At the service level, such financial analyses are also needed. As opponents of an expanded reproductive-health agenda are likely to use cost excuses for not expanding services, those committed to reproductive health must begin to document the real costs of such programs. Some preliminary efforts in this regard indicate that reproductive health services are indeed cost-effective (Diaz and Rogow 1994; Aitken and Reichenback 1994). These estimates need to consider direct service costs and also those associated with poor services, women switching methods and leaving the health system through dissatisfaction

with the services provided, etc. Only with such figures can we see what reproductive health will cost, and the social and economic costs of not providing such services.

Questions of resources are hard to separate from the fact that new reproductive health is a different agenda with different goals from the traditional approach to population programs. Thus comparisons between them are difficult as most cost-benefit analysis is intended to compare progress towards a common goal. Nonetheless, estimates of cost effectiveness of the broader approach would also help inform the debate about whether the two world views can be reconciled.

Conclusion: contested concepts

For those working intensively on the ICPD, the preparations provided an opportunity for a shared understanding of a reproductive health agenda and for expanding the network of people and organizations conversant with this. Outside the organizations closely involved with the ICPD, the concept of reproductive health is still relatively new. In some languages there is no word for it, and where there are common terms, the concepts still mean very different things to different people. The lack of clarity on the concepts among those now responsible for implementing the ICPD agenda, from service providers to ministerial personnel, may prove to be one of the biggest challenges to the reproductive health agenda. Thus high priority should be given to training staff and to communication at the national level and within each sector concerned to better understand the concepts of sexual and reproductive health. There should be national and local efforts to experiment with and publicize policy and program models that incorporate elements of this expanded agenda. Such efforts may help clarify areas of the ICPD that remain contentious or unclear.

In addition to the many areas where broad consensus was fairly easily reached, the ICPD was also marked by intense debate over several core issues that are critical to its comprehensive approach. These include access to safe abortion, services and education for adolescents, sexuality, recognition of changing and diverse family norms and structures, and women's unequal positions in family and society. While consensus was reached on these topics, it was achieved less through a change in perspective than through finding language that was general enough to allow for diverse interpretations. For example, the recognition of unsafe abortion as a major public health problem is followed by a statement that any changes related to abortion must be determined according to the legislative process of each country. In practice, this could be interpreted to mean that it is the responsibility of governments to ensure women have access to safe abortion services, or to mean that the way to eradicate unsafe abortion is to impose stricter legislative sanctions against it. The links between reproductive health and rights, including sexual rights, also need discussion to further clarify what they mean and who is responsible for ensuring these rights.

The intensity of these debates, and the fact that reproductive health concerns often challenge deeply held cultural beliefs and stereotypes, show the need to continue discussion at national levels where the political and cultural challenges may be even more acute than in the halls of the UN. Indeed, the post-ICPD and certainly post-Beijing climate has seen some vocal opposition to the ICPD agreements from conservative groups in a number of countries. A reasoned and constructive response to these differences can only be advanced by discussion of the diverse ethical and religious values involved. Most religions affirm principles of compassion and social justice which may provide a common ground for further debate on a range of reproductive health concerns. Ethics too provides such an opportunity. For example, discussion of basic principles such as ‘do no harm’ has proved to be effective points of departure for reproductive health policy and program discussions across a wide range of cultural contexts.

In the post-conference era, it is important that advocates, researchers and practitioners continue to push the frontiers of our analysis, to explore the concepts that are less well understood or are still contested. Such analyses must be grounded in the realities of the countries and communities concerned and the findings integrated into evolving program and policy agendas. As these dialogues take place at the national level and involve a wider circle of people and disciplines in the discussions, it is likely that the concepts advanced at the international level will be further refined and adapted.

The ICPD process and the resulting document were based on the reality of women's lives, the experiences of service providers and the findings of those researchers exploring the conventional boundaries of their disciplines. Yet the document itself is ultimately the product of a political process, shaped by events of the time, the constraints and priorities of participating governments' domestic agendas and the active lobbying and engagement of diverse groups of NGOs. Indeed the ICPD's importance and potential strength lie precisely in the advocacy process that led up to it and the fact that it is a statement of political will on the part of governments. It sets an international standard against which population and development programs and policies can now be assessed. Like all such international agreements that are non-binding under the law, its implementation will depend on whether governments maintain it as a priority. Ultimately, this will be determined largely by the extent to which NGOs and others affected by the policies and programs hold their governments and the international agencies accountable to such commitments.

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Population Policy Revisited: Examining ICPD

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The International Conference on Population and Development, held in Cairo in 1994, marked the first time that women's movements had been able to help define the parameters of the discourse on population. Women from the North and the South had a distinct and important role in changing the focus of the conference and the resulting document away from population control to reproductive health. The focus on women is a crucial and long awaited change to the analysis of population and development. Though the Cairo document mostly reflects the crucial role that women's movements had on ICPD, a particularly important issue that needs further analysis is the connection between population and development.

The most significant contribution from women's movements both in developed and developing countries is the placement of women at the centre of the population debate. Gender equity and gender equality were addressed in the preamble, as well as in the set of principles that set the tone for the entire document. Two separate chapters were devoted to addressing gender equality, equity, empowerment, and reproductive rights and reproductive health. This clearly marked a victory for the women's movement.

The document recognized that women's empowerment and improvement in status are important ends in themselves and essential to the achievement of sustainable development. This is in direct opposition to the prevailing notion in the population field that women are merely a means to reach a preordained target of population growth. The importance of male responsibility and the need to pay particular attention to the girl child are crucial to a long-term change in the way population and family planning policies are carried out (ICPD *Plan of Action*). The target-driven population policies guided by demographers have finally been replaced by the considerations of the rights of women and men to make informed and responsible decisions about the number and frequency of childbirths.

Human sexuality and gender relations, the definition of the family, connecting HIV/AIDS to family planning issues, and the inclusion of adolescents are a shift towards a reproductive health approach. Along with the change in the field, the reproductive health approach also brings about a clearly demedicalized notion of health that examines its social, economic and psychological components. The ICPD is the first UN population conference with a particularly feminist agenda. It has reversed at least the rhetoric in the population field, giving women a central role.

The document very early in the preamble expanded the focus to recognize the connection between population, poverty, patterns of consumption and production. The need to understand population growth in a wider context was another important principle initiated at UNCED in Rio. The development agenda, however, is narrow, and does not reflect the progressive rhetoric of the rest of the document in that economic growth, though in the context of sustainable development, becomes the overriding principle.

Some have argued that the focus on reproductive health was responsible for the neglect of the more important issue of development, inequity between North and South, and the unequal and exploitative transfer of resources. The placement of reproductive health and rights in the centre has been seen, especially by some in the South, as a way to limit women to a primarily reproductive role which does not include the more important need to understand women's economic and social dimensions.

The focus on reproductive rights, the empowerment of women and reproductive health is a step toward changing the direction of the population control policies that have been carried out for the last few decades, especially on women in the South and poor women in the North. Woman's unequal position in society is linked in many ways to her reproductive role, and attaining control of our reproductive lives should be part of a progressive agenda either in the North or the South. The need for women to force the re-articulation of the field is of crucial importance in determining the way in which population policies will be carried out.

What concerns me is not reproductive health versus development but to understand when, how, and why population as such became an important public policy issue. We have yet to challenge the prevailing paradigm that poverty is caused by population growth and, more recently, that the sustainability of the environment is primarily threatened by worldwide population growth.

Though ICPD claims to understand the connections between population, development, poverty, patterns of consumption and production, it does not explain what the connections are or should be. It assumes that population growth is inherently opposed to the economic well-being of people and/or the sustainability of the earth. What is lacking in the challenge to the dominant paradigm is the questioning of assumptions which link population and development.

The ICPD document fails to address the cause of environmental degradation. The document promotes the idea that economic growth can be carried out in the context of sustainable development. However, we are actively promoting an economic system globally that cannot survive without the constant consumption of new products at the expense of sustainable development. The only people who have little concern for the large population of the South are the transnational corporations who are actively searching the world for populations where they can create a need that they can then fulfil. Both in the North and increasingly in the South a very small percentage of the people are consuming most of the world's resources.

The ICPD is a step forward insofar as it has shifted the discourse on population to emphasize women and gender issues. Petchesky argues that

> the Cairo document begins to approach a conceptual framework of interdependence and non-linear causation that departs significantly from Malthusian thinking...Population growth, according to the document, is only one variable in a complex array of interconnected problems, including women's low status, widespread poverty, resource depletion, 'social and economic inequality' and unsustainable patterns of production and consumption (Petchesky 1995:157).

The next step for the feminist challenge is to question further assumptions, to clarify the appropriate significance of the variable of population growth in addressing inequality and environmental degradation. We need to be attentive to a global economic system that is in its structure of production removed from the interests of its members, and can only survive with a never-ending growth of consumption, regardless of justifiable social needs. We need to be able to demand women's reproductive freedom, gender equality, equity and empowerment for their own sake, even if it means that women will then have more children.

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The Cairo consensus and women's reproductive health in less developed countries

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The recommendations agreed upon at the International Conference on Population and Development in Cairo have been celebrated as a 'quantum leap to a higher state of energy' (Sadik 1994). Not everybody agrees, however, on the immediate consequences of the Cairo consensus over the access to fertility regulation by women and men in less developed countries.

The difference between previous conferences on population and development and the Cairo Conference, is that while the previous international agreements had set demographic targets for world population with family planning being the instrument to achieve those goals, in Cairo, women's reproductive and sexual rights were recognized, for the first time, independent of their role as mothers.

The Cairo consensus also placed great emphasis on development, education and employment, but its greatest effect derived from the priority given to gender equality and the new perspective of family planning. The latter was no longer seen as just a means to achieve demographic objectives; the emphasis moved from quantity to quality, with contraception becoming part of reproductive health services.

The influence of the Cairo Consensus on women's capacity to control their fertility goes beyond the recommendations directly related to reproductive health. There is no doubt that expanded access to education and employment and a reduction in the gender power imbalance are equally important in helping women control their own fertility. However, in this paper, discussion is limited to the effect of the recent reproductive health approach on family planning activities in developing countries.

This 'new' approach was seen as a threat to the success of family planning programs by many population agencies, governments and donors, who believe population growth should have the highest priority. They are concerned about the problem of limited resources and are confused about how to restructure health care facilities to provide comprehensive reproductive health care.

The argument by those who are unhappy with the idea of a full range of reproductive health services, rather than vertical family planning programs, is that existing facilities and human resources for health and family planning are already insufficient to respond to the demand. Consequently, the adoption of a broader reproductive health approach would not be feasible or would reduce the access to fertility regulation and increase unmet needs, with disastrous consequences.

Some of the premises on which the above concern is based are that there is no chance of increasing resources allocated to primary health care; primary health care facilities are already providing services at their maximum capacity; improvements in quality of services will create a much greater demand on human and other resources; and other reproductive health services that are currently available should not be taken into consideration.

From my personal experience in several Latin American countries, I believe that these four premises are not necessarily correct, and that the reproductive health approach not only is fair for women's health and well-being, and a human right, but has the potential to improve access to contraception and reduce unmet need for fertility regulation. In order to be systematic, the four premises listed above are discussed one by one, in the same order, although there is some overlapping between them.

No chance of increasing resources for primary health care

In most Latin American countries, with few exceptions, the percentage of the government's budget allocated to health is shamefully small, almost always in single digits. This is in sharp contrast to the political platform on which almost every candidate to executive office, at the central or local level, runs, invariably promising to give higher priority to the health needs of the people.

Once the candidate is in office, many of these promises are not fulfilled, but there is almost universal awareness that greater investment in health is needed. The chances are relatively good for increased investment in women's reproductive health through two possible mechanisms, not mutually exclusive. One is by increasing the health budget, which is easier, the lower the current proportion of the total budget and the better the economic perspectives of the country. The other is a redistribution with emphasis on reproductive health within the current health budget. This will strongly depend on the political leverage of the women's movement in each country. At the present time, the political power of organized women's groups is increasing in most, if not all, Latin American countries.

Primary health care facilities already at their maximum capacity

This argument is frequently raised on the basis of anecdotal examples, and by physicians complaining that they are overwhelmed by the demand. It is undoubtedly true that the primary health care system in most Latin American countries lacks sufficient equipment, supplies and human resources, and that those deficiencies limit its capacity to respond to the health needs of the population. Basic equipment is either missing or not functioning, with no system available for repairing or replacing parts. Supplies are often discontinued and there is rarely a good logistics system. Physicians' salaries are usually unacceptably low and paramedical personnel are scarce, and frequently include staff with little or no formal training. This depressing general picture of the primary health care system appears to justify the idea that the right solution is to implement specially funded and separate, vertical family planning programs.

But looking more carefully at the basic elements of the system, the clinic or health post, one almost invariably finds that the facilities are underused, human resources are improperly used, and there is ample possibility of delivering more services through better organization, planning, supervision and management. If elementary health planning principles are applied, the system is frequently found to use only two-thirds or less of its total capacity to provide health care. Consequently, there is often ample space for expanding the services offered and the population covered.

This will not happen automatically: improvements in management, service statistics, logistics and supervision are required, but this would not be difficult to achieve with the appropriate support from government and donors. This does not necessarily mean increased funding, but reallocation of resources to improve efficiency.

Improvements in quality of services will create greater demand

The argument that improved quality will increase to unbearable limits the work-load of primary health care staff also appears reasonable if one applies Bruce's (1989) definition of quality of care in family planning. It is true that it is easier to simply prescribe a contraceptive method than to provide complete information on all available contraceptives and let the women choose the one they prefer. But that is more an issue of organization than of increasing work-load. Good counselling can be provided in small groups, which offers more advantages than individual counselling. The latter is boring for the counsellor and the quality drops during the course of the day. Also, not all women feel comfortable asking questions when they do not understand and are intimidated by the provider. On the whole, counsellors need a lot less time for small-group counselling than for individual counselling and have more time to explain each method clearly and in greater detail. Also, clients who are more timid will benefit from the questions raised by other women who are more outspoken.

The question of confidentiality and privacy is part of another element of quality of care: client-provider interaction. After counselling, each woman has to be seen individually for history taking and examination, and at this time more intimate details can be discussed. Good interaction means being gentle, listening to what the clients have to say, and responding to their questions. It can be argued that this takes longer than just providing a method, inserting an IUD, or prescribing a hormonal or barrier method. If the mean time spent attending one client is 15 minutes, appropriate interaction requires only goodwill on the part of the providers.

The fact that many physicians spend much less time consulting with each patient, and neither listen to nor answer their questions, is due not to limited resources, but to the lack of proper training, absence of good supervision, and the community's limited or non-existent capacity to exert social control over the service providers.

Providing reproductive health services together with family planning was also part of the original six elements of quality of care proposed by Bruce. Those concerned that it would be detrimental to the provision of contraception are not aware that the additional effort is, in fact, minimal, and does not necessarily mean doubling the duration of each client visit.

Some of the ‘new’ reproductive health care activities, such as measurement of blood pressure, a properly taken personal history, and a basic pelvic examination, are required for proper provision of contraception. To extend services beyond family planning to respond to women's other health needs means placing more emphasis on women’s reproductive history and the observation of the vagina and cervix; the identification and treatment of reproductive tract infections; and an increase in the examination time by a few seconds in order to take a Pap smear before inserting an IUD. Providing good quality of care and broadening services' scope to include other health needs of women does increase the duration of each visit, but that the increase in time and effort is relatively small and is compensated by the benefits and time saved in the medium and long term.

The benefits are obvious and the medium or long-term time savings derive from a decrease in the frequency of follow-up and emergency visits, when the quality of services provided at each visit improves. If women are well informed, allowed to freely choose and use methods they really like, they will have fewer complaints, will use the methods longer and will demand follow-up care less frequently, and ultimately reduce the demand on clinics. If other reproductive health needs are attended in a timely manner, more severe complications will be avoided, again reducing the demand on the services. Thus, the initial investment in time and care will be compensated without overwhelming the clinics' capacity.

It is also well known that satisfied users are excellent advocates of family planning for other clients, and thereby contribute to reducing unmet needs. On the other hand, clinics with better services promote trust in their clients and consequently, increase the chance of them

requesting other methods when they are no longer satisfied with their current method. The providers themselves will gain the appreciation and respect of their communities, to which they are always sensitive.

This may appear to be an artificially rosy picture, but it has worked well in places where it has been tried.

Other reproductive health services currently available

What is frequently ignored is that at the primary health care level other reproductive health services are more often offered than family planning. The traditional primary health care centre provides antenatal, postnatal, infant and child care. Family planning, cervical cancer prevention and treatment of reproductive tract infections are rarely part of the activities at this level. Thus, broadening the scope of services and viewing each woman as a whole person with multiple needs, not only as a pregnant uterus or as the mother of a child, will increase the access to fertility regulation of many women who at present are seen by the system only as mothers.

Those who argue that the reproductive health approach will reduce the resources allocated to family planning appear to envisage only clinics currently exclusively dedicated to providing contraceptive services, where the provision of other services would divert part of their existing resources. They do not take into account that integration means that contraceptives would be offered in all the health posts that now provide only antenatal and postnatal care. It would mean multiplying the service delivery points offering contraceptive services at a fraction of the cost of installing new clinics which offer only family planning. A health post that already exists, with its infrastructure and staff, can support the addition of family planning and other reproductive health activities with minimal investments in training and supplies. In the medium and long term, the unwanted and unintended pregnancies averted by the availability of contraception will reduce the demand for antenatal visits, liberating resources for cancer prevention, treatment of reproductive tract infections and contraception.

Having considered the four premises that are the basis for the concern about the 'new' reproductive health approach, readers may wonder whether all the arguments above are not theoretical nonsense which never would be put into practice. Fortunately, there are practical experiences that show that, given the political support, these concepts can be applied with excellent results.

The UNFPA-funded national family planning program for 1974-75 in the Dominican Republic originally allocated resources to increase the number of family planning clinics from the existing 58 to about 80, adding 20 additional clinics in the country in two years. The project followed the vertical approach applied up to that time; the 58 family planning clinics functioned within public hospitals or outpatient clinics, only during certain hours of the day and not every day of the week. The clinic usually consisted of a well-equipped outpatient room that remained locked and unused more than half the time, while the rest of the centre was poorly equipped and a lot busier, providing mostly antenatal and infant care.

The Dominican authorities and the donors accepted the idea of switching from that original proposal to an alternative one, using the same resources to add contraceptive services to all existing service delivery points providing women's health care, previously limited to antenatal care. The result was that, with the same resources, the number of service delivery points providing family planning increased from 58 to 204 (instead of only 80), the number of new acceptors more than doubled in two years, and the prevalence of contraceptive use rose from 2.8 to 8.0 per cent between December 1973 and December 1975 . Although these data seem too good to be true, they were confirmed by comparison of the results of the National Demographic Surveys carried out in 1970 and in late 1975 (Faundes and Hardy 1977).

At the same time, the supervision and logistic structure created and funded to serve family planning activities exclusively was used to also cover antenatal care and cervical cancer prevention. One measurable consequence was a steady increase in the number of Pap smears taken and reported, although not at the same pace as contraceptive use.

All that was achieved without increasing the original budget, which had been allocated for a less ambitious target in terms of new acceptors and contraceptive prevalence. This is a well-documented example of how the use of resources originally allocated to contraception for other reproductive health care activities does not necessarily jeopardize the family planning program and can be more than made up for by the use of the existing structure, originally intended for antenatal care, also for other reproductive health needs, of which contraception is usually in greater demand.

The benefit of the approach integrating family planning and reproductive health was crystal clear. It was not greater because at the central level, the separation of family planning and MCH remained, in spite of the integration at the provincial and primary health care level. The problem was that this experience was ahead of its time; it did not receive the attention that is now given to the integrated reproductive health approach.

Nevertheless, there are possible negative effects of the Cairo consensus on the availability of contraception for women and men in less developed countries. These consequences are not related to the capacity of the primary health care system but to the interpretation and political reaction of governments in developed countries, international organizations and other donors, whose main objectives are demographic; they may believe that the new approach means that their money will not produce the expected results, they will not maintain their support at the same level, and all services will suffer the effects of reduced funding.

On the positive side, family planning will receive the full support of women's groups, which were previously against vertical programs or ambiguous about them. The Cairo consensus will also provide them with strong arguments to obtain local and central government support for reproductive health, including family planning. This new approach will also gain the support of public health professionals, who previously were suspicious that family planning was not being offered to improve women's health and well-being, but to reduce population growth, which foreign countries considered the only determinant of poverty and underdevelopment.

The comprehensive reproductive health approach not only is a fair response to women's legitimate demands but will improve access to fertility regulation, if existing funding is not cut. If funding in fact increases, as the conference recommended, the reduction of fertility and improvement in women's health and well-being may be dramatic.

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A holistic reproductive health approach in developing countries: necessity and feasibility

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One of the most important contributions of the International Conference on Population and Development, held in Cairo in September 1994, is its adoption of a reproductive health approach in the Plan of Action. As an interdisciplinary group of researchers including medical and social science specializations, women and men, we have been undertaking research in Egypt since 1989 within a reproductive health framework, as part of a larger regional Reproductive Health Working Group. The Group sees the reproductive health approach as advancing a holistic and integrated perspective of reproduction and its health consequences for women, from adolescence to the reproductive years and beyond, and including also men and other relevant family members. This is how women perceive the process of reproduction, and herein lies an element of strength of this approach, that it is consistent with the reality of the outlook of women whom it aims to serve. A reproductive health approach is also sensitive to the social context of women's lives and is aware of the existence of local systems of knowledge and practice, all of which have to be taken into account in planning for working with women and communities towards the goal of improving reproductive health.

In ideal terms reproductive health is defined to include reproductive choice, healthy reproduction, avoidance of gynaecological and associated problems, and dignity. This is far from the reality of the situation of women in the developing world. We believe that working towards this ideal requires more than a medical approach, focused on the supply side of service delivery. Attention is required, in addition, to the demand side including as active agents women, men, families and communities. Yet this multidimensional and holistic approach to reproductive health has unfortunately created a concern for some over the cost of service programs, in view of limited resources, and of competition with more narrowly defined goals that have received priority in the past, paramount among them being control of fertility through family planning programs in the developing world.

Perhaps this concern over cost has been influenced by recent writings that present comprehensive frameworks for reproductive health care, including detailed service elements within an integrated perspective (Pachauri 1995; Hardee and Yount 1995). These frameworks are valuable attempts to delimit what is involved in a reproductive health approach. However, they must be taken as providing a topography of service elements which developing countries must view selectively, carefully choosing what to adopt, and at different rates and forms, depending on the reproductive health situation each country faces and on available resources.

This concern over the cost of adopting a reproductive health approach is probably also influenced by an over-technological perspective. Many of the pressing reproductive health problems in developing countries, such as reproductive tract infections, require what are as yet relatively expensive laboratory procedures to diagnose. However, it is possible to avoid

[*] The Reproductive Health Working Group was established in 1988 by the Population Council Regional Office in Cairo for West Asia and North Africa (WANA). Its co-ordinator is a staff member of the Population Council. It is composed of an independent network of regional scholars from medical and social science disciplines undertaking research individually and in groups on priority topics in women's reproductive health as defined by the Group.

such procedures by adopting a strategy that relies first on a preventive approach. Such an approach would address health services and providers to ensure, for example, that sterile procedures are adopted in all services including family planning. It would also address women through health education and counselling on topics such as hygienic behaviour and recognition of symptoms for early treatment.

A strategy involving a simplified perspective of care would also rely on clinical services to the extent possible providing adequate training to health care providers. This training will have to include sensitization to women's perspectives and social realities so that a provider can draw the needed information for a diagnosis well-informed by a woman's complaint, when there is no recourse to advanced technology. A strategy relying on clinical diagnosis would have to be complemented by a proper system of follow-up and by implementation of adequate referral procedures to take care of persistent and serious cases.

Our own research in the two Giza villages of Egypt has shown a discrepancy between women's reporting of symptoms of reproductive tract infections and diagnosis based on laboratory examinations (Zurayk et al. 1993). However, the collection of information on women's reports was undertaken through survey research using an interview questionnaire in the woman's home. What we are considering here is a clinic situation with a physician giving careful attention to case history taking and follow-up. Experience in a clinic situation in Damietta, another rural area of Egypt, following the Giza Morbidity Study, has shown us that a clinical strategy with minimal laboratory services is workable in taking care of reproductive health problems of women provided there is proper follow-up and referral (Delta Consultants 1996).

The reproductive health approach represents a holistic perspective on women's health care and not a system of services. Services within a reproductive health approach can vary in scope and in level of technology used, and can thus be kept within available resources. In addition, more attention should be given to the possible cost-saving implications of this approach. A holistic reproductive health approach involves a framework of health care which is attractive to women. It would succeed in bringing more women to health services and would thus reduce the cost of recruitment of clients to vertical services such as those of family planning programs. It would also avoid the costly complications of some of these services when they do not give due attention to health implications and side-effects, such as infections due to non-aseptic insertion of IUDs, and such as bleeding much feared by women.

There is a great need currently for projects in various settings of the developing world that involve design and implementation of interventions, within a reproductive health approach, to establish evidence that this approach is tenable within available resources and effective in improving the reproductive health of women in the developing world, We are currently undertaking such a project in the Giza villages in Egypt that were the scene of the Giza Morbidity Study we undertook in 1989-90. The Giza Morbidity Study gave unique evidence of the heavy burden of gynaecological and related conditions that women bear in silence. It also highlighted constraints within the social context, low awareness level of women and quality of care considerations, as affecting women's health and health-seeking behaviour (Khattab 1992; Zurayk et al. 1993; Younis et al. 1993; Zurayk, Younis and Khattab 1994).

On the basis of these findings we are currently undertaking a project, with UNFPA funding, to develop and test an intervention framework that takes a holistic approach to women's reproductive health involving a three-dimensional intervention. The intervention includes:

1. A health services component that involves selective upgrading of the current Family Planning and Maternal Child Health services being provided at the health centres, as well as introduction of elements of gynaecological services that address gynaecological and related

morbidity conditions revealed as prevalent by the Giza Morbidity Study. The physical set-up at the clinic will also be upgraded in necessary medical equipment and supplies, and in cleanliness and privacy concerns.

2. A provider component that involves training to enhance providers' awareness and technical skills to enable them to better address reproductive health problems in prevention and treatment. Providers will also be sensitized to women's perceptions of health and illness and to the socio-economic constraints imposed on them, in order to make communication with women and treatment regimes more suitable for the realities of women's lives.

3. A health education component which is aimed at raising awareness in women and men of how to prevent reproductive health problems, of symptoms of these problems and of when to seek medical help for their treatment and management.

This project has a more general concern with learning how to improve reproductive health care nationally in Egypt. The project is therefore conducted in collaboration with the Ministry of Health in Egypt and involves contribution from key personnel in the Ministry in the design, implementation, monitoring and evaluation of the project with a view to scaling-up the intervention for gradual integration within the Ministry's Primary Health Care Program. The project gives priority concern to effect, as well as to cost, feasibility and sustainability of the intervention. It is developing indicators to monitor and evaluate the progress and performance of the intervention. It will involve dissemination to professionals and organizations interested in similar efforts in Egypt, in the region and in the developing world.

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ICPD and Family Planning Associations

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The International Conference on Population and Development (ICPD) in Cairo in September 1994 and the Fourth World Conference on Women (FWCW) in Beijing in September 1995 were important milestones not only for the International Planned Parenthood Federation (IPPF) but for the world as a whole.

ICPD was critically important because it moved the debate from the demographic way of thinking about population programs towards the broader concept of sexual and reproductive health, including family planning, and emphasized the importance of women's interests, needs and rights as essential components of development. The Beijing Conference focused on how to achieve equality and empowerment for women in all areas of life.

The ICPD gave an important impetus to the reproductive and sexual health agenda. This conference was a decisive one in that it firmly moved the focus of family planning away from fertility targets and national demographic goals towards meeting the needs of individuals for family planning and reproductive and sexual health care. It made it a goal for the world's governments to make available universal access to a full range of high-quality reproductive health services by the year 2015. It emphasized people's rights to reproductive health and most important, quality services: services should be accessible, acceptable and convenient to all users. This reflected IPPF's own endeavour to introduce a client-centred approach that stressed the rights of those being provided with services for quality care.

Family planning services, including counselling, information, education, communication and contraceptive supplies, remain at the core of sexual and reproductive health care. The difference lies in taking a lifetime view of people's sexuality, so additional elements are also considered important. These include gender-sensitive education and counselling on sexuality; providing care during pregnancy, delivery and postpartum; monitoring infant growth and development with particular attention to the girl-child and her nutrition to ensure that she grows up in an environment conducive to the development of her sexuality; taking care of people's concerns over sexually transmitted diseases and infertility; HIV/AIDS prevention; and the prevention and management of unsafe abortion and the provision of safe abortion services where legal.

Since all these different elements of sexual and reproductive health are connected, gains in one area will more than probably have beneficial repercussions in other areas. People are much more likely to take advantage of family planning services when they find their other sexual and reproductive health needs are being recognized as well.

As the ICPD Programme of Action records, surveys suggest that if more accurate information and affordable services were easily available, as many as 120 million more women would be using a modern family planning method than do so currently. The growth in demand for services and the continuity of contraceptive use are often directly related to the quality of family planning programs. The quality of services has been lessened by lack of adequate management skills, particularly in the least developed countries. Governments in Cairo noted their responsibility for creating a climate favourable to high-quality reproductive and sexual health care, but also acknowledged the important role of non-government organizations which are closer to their constituent groups and often better able to represent their voices.

The Conference stressed that the full involvement of client groups is an essential element in ensuring the acceptability and appropriateness of information and services to their users and to an assessment of quality. Women are often not treated with respect, or guaranteed privacy or confidentiality, nor do they always receive full information about the options and services available. These basic rights are elements of quality of care highlighted in the Cairo document.

The sad reality is that sex is still a potentially dangerous business for women: pregnancy and unsafe abortion are still the leading causes of death among women of reproductive age in many countries. Regrettably, decrease in public health spending and structural adjustment programs in many countries have adversely affected access to health services, including those for reproductive health services. Too many governments have been slow to provide the information, education and services women require. Establishing sexual and reproductive health service costs money. Frequently, it costs political capital too. In many parts of the world, both kinds of currency have been in short supply.

It is intrinsic to the new approach that Family Planning Associations should look at priority needs and this may require them to move resources away from thriving, successful clinical programs to concentrate on reaching the poor and under-served through more difficult and expensive outreach services. This not only creates a dilemma about the existing program, but raises concerns about how these actions are to be justified to donors.

However, a number of Family Planning Associations in different regions have been successful in making programs sustainable through cost recovery or alternative sources of funding, allowing them to shift resources to areas of greater need. Some Family Planning Associations have found that adopting the sexual and reproductive health dimension increases their popularity, allowing additional costs to be recovered from clients.

Many Family Planning Associations have collaborated at the regional level to take forward the messages from Cairo through innovative initiatives to increase women's empowerment and ultimately control over their own reproductive health.

In the South Asia Region, there is a shortage of basic information about sex and reproductive health, especially since these subjects are not widely or openly discussed. A major sex and reproductive health education project, known as 'Sexwise', has been undertaken with the BBC World Service Radio to broadcast programs on different aspects of sexual health in eight regional languages.

The Cairo document refers specifically to the active discouragement of harmful practices such as female genital mutilation. Several Family Planning Associations in Africa have intensified their efforts and emphasis in their programs to campaign with community leaders for the eradication of this practice. The Kenyan Family Planning Association's program against female genital mutilation is particularly effective in its approach and results.

Other initiatives have sought to raise the profile of the Cairo Programme of Action. A conference organized by the IPPF Arab World Region on operationalizing ICPD was held earlier this year. The need to translate the enthusiasm generated at the ICPD into effective action in the region was stressed at the Conference, in addition to the duty of non-government organizations to remind governments of the commitments they have made. At Cairo, there was a clear acknowledgement of the important part these organizations have to play in mobilizing community and family support for reproductive health programs and in co-operating with governments to ensure promises are followed by action. Programs are much more likely to succeed if they are owned by those who will be affected by them, starting at the grassroots. The involvement at Cairo of religious leaders in the population debate also represented a crucial step in raising awareness of reproductive health as an issue of human development.

Under the Federation's newly appointed Secretary-General, Mrs Ingar Brueggemann, IPPF itself convened an expert group meeting in London in October 1995 on Operationalizing Sexual and Reproductive Health. Under the chairmanship of Professor Mahmoud Fathalla, senior international and regional staff and representatives of national family planning associations discussed and clarified the concepts and contents of sexual and reproductive health programmes, and provided guidance to family planning associations on the kind of options available and the criteria for choosing among them. A report on the meeting is available from IPPF (1995).[11]

Many donors are aware of the risk-taking role played by Family Planning Associations and it is generally acknowledged that a transitional period is necessary when benefits may be limited or difficult to show. Efforts to make donors partners in the sexual and reproductive health approach might lead to a middle ground, where donors' concerns to address the needs of individuals are met and in the process development and demographic considerations are also satisfied.

The Cairo Conference called for spending on family planning and broader reproductive health programs to rise to US $17 billion by the year 2000, of which about a third, or US $5.7 billion, would come from the international donors, the remaining two-thirds continuing to be found by the developing countries. So far, there are few signs that international donors are willing to provide these additional resources. Family planning associations and other non-government organizations therefore face problems on how far they should undertake the full range of sexual and reproductive health services.

Whether or not extra funding is forthcoming on the necessary scale, progress can still be made by multilateral organizations and all development assistance agencies intensifying their collaboration and seeking ways of achieving complementarity in providing services. Without the infusion of funds from international donors and the realization of a common purpose to accommodate the needs identified in the Cairo Programme of Action, ICPD will, in the words of Dr Nafis Sadik, 'remain a paper promise'.

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Implementing the ICPD's message

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Progressive elements of the population establishment and of women's groups managed to achieve a consensus at the International Conference on Population and Development (ICPD) in Cairo on how to stabilize the world's growing population and, at the same time, improve women's health and well-being. While the academic community will continue the sterile debate on the relative importance of development versus family planning programs for fertility reduction, the issue was put to rest, at least in the international policy arena, for the first time at the conference. Both the need for providing the means to reduce unwanted fertility and the importance of creating conditions favourable to promoting the desire for smaller families have been recognized. The main message constitutes two elements: provide contraceptive methods within broader reproductive health services, and enhance women's equality in education, health, and economic opportunity. These are tall orders for any government.

The implementation of the ICPD's main message would require an ideological transformation both for the population and for the development establishments, and a realignment of turfs in the national and international bureaucracies, which are used to working with sectoral mandates.

Implementation of a broadened population policy

Traditionally, population policies, concerned with the reduction of population growth and fertility, have been implemented by means of organized family planning programs. A broadened population policy, concerned with improvements in gender equality, would, therefore, present a major challenge to existing institutional mechanisms.

To bring about a reduction in gender disparities with regard to education, health, and economic opportunity would require implementation of gender-sensitive social and economic policies. Implementation of such policies, however, falls outside the purview of a country's family planning program (designed for the population sector), but this is exactly what the entire development sector is supposed to do. About 98 per cent of the funds allocated for all development activities are spent on sectors other than that of population. The efficiency of these expenditures must, therefore, be improved in order to promote women's equality and to create conditions conducive to lower family-size preference. In brief, the mainstream development process must incorporate the reduction of gender disparities as its primary goal.

Not only do population and women's groups have no leverage concerning the way funds for development are spent but also no bureaucratic mechanism exists to implement such an agenda. Within the United Nations system, for example, the United Nations Population Fund has no influence over the resources allocated for improving child health, female education, or economic opportunities for women. These funds are controlled by other UN agencies. Similarly, the Office of Population within the United States Agency for International Development and the departments of family planning in other national governments have no leverage over the funds required to empower women so as to create conditions favourable to a preference for smaller families. Some mechanism, therefore, must be created to make expenditures for development consistent with the objective of reducing gender disparities.

Reproductive health and family planning programs

Whether to provide reproductive health services is not an issue. The issues are: who should provide and pay for these services and why?

Since the ICPD, much discussion has centred around the question of how to integrate reproductive health and family planning. At one level, the solution is simple: because the spread of contraceptive use is expected to reduce the risk of pregnancy and, therefore, maternal mortality (and consequently can be viewed as a part of reproductive health), a simple computer program could be used to search for and replace the phrase 'family planning' with 'reproductive health and family planning' in all official documents. This change, however, would not affect the scope of the services provided.

It can be argued that contraceptive services should be subsumed within reproductive health programs, which, in turn, would be subsumed within broader health services. The problem here is that reproductive health may not receive as high a priority among all health issues as its advocates wish. Moreover, both contraceptive and health services have their own separate constituencies and budgets; by contrast, reproductive health has some constituency but no independent budget. Thus, reproductive health advocates would have to work both with family planning programs and with health programs to ensure the delivery of all reproductive health services.

In order to design family planning programs that provide reproductive health services beyond those required to distribute contraceptive methods, we need to understand why these programs have not paid attention to health issues related to reproduction.

While the establishment of family planning programs has been guided by multiple rationales, the overriding intent of governments and donors has been to reduce fertility and population growth. By contrast, the reproductive health approach focuses on individual rights and well-being. Because of the demands made by reproductive health advocates, family planning programs are now being pulled in two directions: they are expected to improve individual well-being and to reduce a society's overall fertility. A focus on individual well-being would contribute to the achievement of the social objective by reducing unwanted fertility. In this respect, the two objectives are consistent. However, a focus on the reduction of population growth and total (wanted and unwanted) fertility has led some programs to use undesirable means, such as monetary incentives to clients and providers, method-specific quotas, and coercion. In this fashion, the two objectives, under certain circumstances, can be inconsistent.

Some managers and donors (internal as well as external) of family planning programs are likely to be concerned that a focus on only individual well-being may reduce funds for these programs. Moreover, a reproductive health approach would divert funds from contraceptive to reproductive health services. Under these circumstances, managers are likely to implement the reproductive health approach only if they think it is a cost-effective way to reduce total fertility or if the primary objective of family planning programs is redefined. A convergence of the interests of reproductive health advocates and family planning program managers is easy to envisage in terms of the provision of services for safe abortions, because the availability of these services would reduce fertility, expand choice, and reduce maternal morbidity and mortality. However, no empirical evidence supports the idea that adding other reproductive health services, such as treatment for reproductive tract infections or sexually transmitted diseases, is a cost-effective way of lowering fertility. Furthermore, efforts to gather such evidence are unlikely to be productive. What if empirical research shows that the addition of services to diagnose and treat such conditions is not as cost-effective in reducing fertility as are incentives to providers and clients? Moreover, since the objective of offering reproductive health services is to improve the health of individuals, provision of these

services for the purpose of reducing fertility and evaluating their effectiveness based on their ability to attain that goal would not be justified.

In order to include reproductive health services within family planning programs, the primary objective of these programs should be defined in terms of empowering individuals to achieve their own reproductive intentions in a healthful manner. The first part of this objective maintains the link with fertility reduction by focusing on unwanted childbearing, and the second part extends the link with reproductive health services. A practical strategy could be designed so that those reproductive health services that interact directly to reduce unwanted childbearing safely are paid for and delivered by family planning programs, whereas other issues of reproductive health become the responsibility of health programs.

Acceptance of the proposed objective for family planning programs will have profound implications for the design of services, their costs, and the evaluation of their performance. One way to redesign contraceptive services from a reproductive health perspective is to deal with the contra-indications of each method, by developing standards for screening, and focusing as well on diagnosis and treatment (including referral for treatment) of these conditions. Monitoring compliance and incorporating the occurrence and treatment of reproductive morbidities should also be part of the evaluation of these programs. The cost estimates of offering a method through a program with such an approach should include not only commodity costs but also the costs of screening for and diagnosis of contra-indications, and treatment of such conditions, and the costs of diagnosis and treatment of adverse reactions to that contraceptive method. The effect of family planning programs could then be assessed in terms of their combined outcome, reflecting both the avoidance of unwanted and unplanned childbearing and associated reproductive morbidity. Such an assessment could be facilitated by an index called HARI, an acronym for Helping Individuals Achieve their Reproductive Intentions (Jain and Bruce 1994).

Suggested role of the population sector

Implementation of the ICPD's main message would require that we go about the tasks of development and family planning differently. What can the population sector do to facilitate the entire process? While the temptation may be strong for it to focus only on the scope of services, to neglect completely the development and implementation of a broadened population policy would be a mistake.

First, the population sector can promote the elements of the main message to a wider audience so that they may be endorsed at various national and international forums. Second, it must accept that the achievement of replacement fertility sooner rather than later will require more than organized family planning programs. Third, it should revise the primary objective of and the main evaluation criteria for family planning programs in such a way that serious attention is paid to reproductive health issues. Fourth, it should forge alliances with like-minded development professionals so that other development sectors increase their efforts to reduce gender and other kinds of inequalities in education, health, and economic opportunity. Fifth, the population sector must mobilize and devote the resources required to delineate these roles and responsibilities and to identify institutional mechanisms to implement the population and women's agendas.

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A view from Turkey: men as well as women

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The Programme of Action says (4.24),

> ... in most societies men exercise preponderant power in nearly every sphere of life, ranging from personal decisions regarding the size of families to the policy and programme decisions taken at all levels of Government. It is essential to improve communication between men and women on issues of sexuality and reproductive health, and the understanding of their joint responsibilities, so that men and women are equal partners in public and private life.

Then the objective is stated (4.25): 'to encourage and enable men to take responsibility for their sexual and reproductive behaviour and their social and family roles'.

The Programme of Action mainly focuses on empowering women so that they can make their own reproductive decisions (independently from men?), using contraception and health care provided by the health system. To be even handed, male reproductive health ought also to be considered, which would require attention to urology and infertility as well as gynaecology in the reproductive health services. However, in the Programme the place of men is mostly not considered, except for the quotations above, which ask that men support women; the theme is 'responsibility', which translates roughly into 'give support, but do not interfere', consistent with the North American feminist demand that women have total control.

In this view from Turkey, we try to ground these generalities about men's and women's roles and relationships by showing what they are in fact. These notes present the views of people themselves about one of the important issues in reproductive health: choice of methods of birth control and considerations of reproductive health that are part of the choice process. They are based on ethnographic field research among working-class people in Istanbul during 1994 and 1995 (Angin and Shorter 1995).

In Turkey, during the decline of fertility which has reached near-replacement levels today, the principal method of birth control has been, and still is, male methods, mostly withdrawal, but also condoms. The family planners have achieved only limited success in persuading couples to use female-controlled medical methods. These facts about method choice are usually interpreted as showing that men are all-powerful and that they determine both the level of fertility and the way it is achieved. As Santow (1993) writes, referring to populations in the Ottoman region, inclusive of Turkey:

> While the care of small children is a matter for women, the actual begetting of children or, rather, not begetting them, is a matter for men: just as husbands are expected to be the ones to initiate sexual activity, so are they expected to take charge of contraception (Santow 1993:779, 782).

The narratives collected in our ethnographic research warn us against thinking that the association of methods of birth control with the male or female body is enough information to know who decided when to control fertility and how to do so. Such associations are not able to explain the relative power positions and gender responsibilities for the choice of method. Thus, by observation of the method alone, one would not know how it came to be selected. One cannot say that the use of male methods engenders absolute power in male hands for the

management of fertility control and the effects this may have on reproductive health, even though in particular cases where men do have absolute power in matters of reproduction they choose the male method.

Furthermore, female power and negotiation with the spouse is often part of the 'equation' that results in the choice of male method. Both women and men in our study claim that choosing male methods and practising male responsibility are ways to escape from the risks of medicine. In many cases, men are persuaded to practise either withdrawal or condoms by women and by the cultural beliefs which say that male methods are natural, secure, and uncomplicated solutions for preventing pregnancies. We interviewed men who use condoms and withdrawal but who complained at the same time about reduced pleasure and that this was known by their wives as well, who nevertheless insisted upon it. The choice is 'reasonable' for them if they and their wives are concerned at the same time about the health and beauty of the wife, who they think would be adversely affected by one of the 'modern' contraceptives. From one of the narratives:

> During the delivery you have to go to a doctor. They 'scratch' inside of you (she means that while doing something necessary, they create additional problems and pain). I do not want to go there for any other reason (except deliveries). I am really afraid ... still I use condoms. In fact, my husband does not want to use them. He wants me to have an IUD inserted. I heard that it is not useful for everybody. It can move to the stomach. My skin is very sensitive, it takes two years to heal. We will continue using condoms as long as he will use them—as long as I can 'deceive' him. In fact, they are *temiz* (no complications) in a way. You do not intervene in any way. That is, it is good.

Individuals culturally construct their own knowledge about reproduction and contraceptive methods, different from medical knowledge. As with other kinds of knowledge, the knowledge of reproduction and birth control is uncertain, unstable, constructed and imposed through relations of power (see Foucault 1976). Cultural beliefs about the methods of birth control and their degrees of pleasure, efficiency, healthiness and protection against infection circulate in the same way as 'natural truths' do throughout the society. As Kleinman (1988:10) puts it:

> what is natural depends on shared understandings in particular cultures and not infrequently diverges among social groups. The meanings ... are standardized 'truths' in a local cultural system inasmuch as the groups' categories are projected onto the world, then called natural because they are found there.

Many women in the study want to keep their bodies in their natural harmony by staying away from doctors and medicine concerning the issues of choosing and obtaining a method of birth control and follow-up controls of the methods. Men and women believe that pills cause weight gain, headaches, and cancer. One should take a break while using them to prevent side effects.

When an IUD is used, this does not signify that the woman has obtained absolute power to manage her fertility. The IUD is sometimes a male choice and a means by which he can pass the action of contraception to his wife and monitor her behaviour at the same time. He may oversee her access to a health centre where she would have to go to have it removed. As explained in this man's narrative:

> The best is an IUD. Others are harmful for one's health. In birth control, what fits my mind is an IUD ... On some issues one must think logically. Pills are harmful for a women's health. Those pills cause some women to gain weight. She has to take them regularly on

> time. It is highly risky. The best is an IUD. It is guaranteed with respect to the others. 1500% ... IUDs are very good for some women. It is a matter of getting used to it. It is a device like a colander. You have it placed in the woman. She needs only a few days to become used to it. It may cause an allergy. It may cause injury. It may cause nothing. If you see there is something wrong with your wife, it means you cannot use it. You have to have it taken out. It may even cause cancer. Of course, it does if there is a problem with the adaptation, but if it is okay ... Anyway when we had it inserted, the doctor said: 'you will come to me for a check-up one week later'. When you go for the check-up after one week or fifteen days, if you feel OK, the IUD is the best. Those pills and others are a tale. I mean they are a bit of a primitive method. There is a problem if you do not take them on time.

As these notes show, men are implicated in matters of women's reproductive health, they do take 'responsibility' in the ways that this culture understands, and women are often partners in persuading them to do so. Limits on the number of children are as much a male as female concern. The principle of the Programme of Action that these matters should be the exclusive concern of women is simply not accepted. Public policy and services must address both parties and find a way of accepting male as well as female determination of the courses of action that affect reproductive health—of both parties.

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Family planning reproductive health: the neglected factor

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A fundamental theme in the discussions surrounding ICPD and at the Cairo conference itself was that institutional population programs are too often concerned with demographic targets at the expense of women's needs and women's dignity and autonomy. Family planning, in such a context, had become simply the means to an end, that of lowering fertility, rather than 'a legitimate end in itself' (Cohen 1993).

The Programme of Action adopted at ICPD attempted to respond to these criticisms by redefining the role of family planning. The document (UN 1995:30) states that the reproductive health, within the WHO context of complete physical, mental and social well-being, implies 'that people are able to have a satisfying and safe sex life and that they have the capacity to reproduce and the freedom to decide if, when and how often to do so'. Implicit in this last condition, the Plan continues, is the right of information about, and a choice of methods for, family planning.

Thus the right to choose, first enunciated at international level in the 1968 Teheran Declaration of Human Rights but still an unfulfilled goal emblazoned upon feminist lapel

buttons, has moved from being an underlying principle to a 'legitimate end in itself'. Indeed, the sole aim of family planning programs, as described in the document,

> must be to enable couples and individuals to decide freely and responsibly the number and spacing of their children and have the information and means to do so and to ensure informed choices and make available a full range of safe and effective methods (UN 1995:30).

Family planning, then, is unequivocally a reproductive right; what is its relationship with reproductive health? This is not easy to establish, in part because the chapter 'Reproductive rights and reproductive health' is remarkably unspecific about reproductive health issues. Sexually transmitted disease and HIV/AIDS do get considerable attention, but otherwise there are only scattered references to such items as female genital mutilation, or adolescent pregnancies. If one turns to the chapter on 'Health, morbidity and mortality' in search of further clues, it is to discover that here women's health means maternal, rather than more generally reproductive, health. Nevertheless, within that context, the chapter does at least identify complications relating to pregnancy and childbirth, unsafe abortions, and nutritional deficiencies, and suggests that family planning programs have a role to play in reducing morbidity and mortality from these conditions.

By contrast, while the Programme's chapter on 'Reproductive rights and reproductive health' does have, as one of the six Objectives described under the section on family planning, 'the prevention of unwanted pregnancies and morbidity and mortality' (UN 1995:30) the detailed recommendations for action make no reference to any possible role of family planning programs in such an objective, except through helping to prevent the spread of sexually transmitted diseases and HIV/AIDS. The sole mention of birth-spacing, better maternal and child health and child survival comes in the context of breastfeeding, which family planning programs are urged to promote because breastfeeding contributes to such health gains.

In short, one chapter talks a great deal about (undefined) reproductive health, in which reproductive choice is simply a free-standing ingredient and an end in itself; the other concentrates on maternal health and includes family planning among the means to improve health outcomes. Contradictions between the two viewpoints are compounded when the latter chapter, apparently reaffirming the Alma Ata Declaration on primary health care, changes the original. Where 'maternal and child health care, including family planning' was among the primary health care components, countries are now asked to provide 'reproductive health care'.

Neither position is entirely satisfactory as a blueprint for future programs, but the first is perhaps the most dangerous. Family planning is not just an end in itself, but an essential component of primary health care which provides a major contribution to reproductive health. In terms of reductions in mortality, the direct benefits to women and their children of postponing early childbearing and spacing pregnancies are well-established, and surely do not need repeating here (see, e.g. WHO 1992; UN 1994).

In addition, however, contraception offers the possibility of considerable reductions in reproductive morbidity amongst women which, as with all morbidity, is less well documented, but is nevertheless recognized. A reduction in the number of pregnancies itself reduces the frequency of risk of childbirth-related ill-health, including for example genital prolapse, which appears to be common amongst women in the Third World (Younis et al. 1994). Nutritional deficiencies including anaemia, the prevalence of which amongst pregnant women rises from 40 per cent in Africa to 88 per cent in India (World Bank 1993), are exacerbated by frequent pregnancies and breastfeeding. Menstrual problems, especially dysmenorrhoea, which are widely-reported reproductive complaints (Omran and Standley

1976) can be considerably reduced by use of the oral contraceptive. The most common cause of female infertility, infections leading to disease of the Fallopian tubes, may be reduced by the use of condoms. Other consequences of pelvic infections (which condoms could help women to avoid) include increased risk of ectopic pregnancy and cervical cancer, as well as continuing pain and discomfort. Pelvic infections may also affect the survivors of unsafe abortions, the incidence of which could be reduced by access to contraceptives.

If contraception is good preventive medicine, it is also a significant ingredient in the broader agenda for women which was outlined at ICPD and spelled out more fully at the Beijing International Conference on Women, 1995. The ability of women to complete schooling and further training is all too often thwarted by pregnancy, whether outside or within marriage: so too is the chance of employment. More subtly but fundamentally, a woman's empowerment is dependent to a considerable extent on her ability to make her own fertility decisions. If reproductive health is indeed a matter of mental and social, as well as physical, well-being then these attributes of family planning are also health benefits.

Reproductive health programs which fail to take into account this primary health care function of family planning are likely to concentrate disproportionate effort and resource on curative interventions. Those interventions in themselves create the kind of expanding spiral all too familiar in the history of medicine, in which, as the scale of the immediate 'problem' is better recognized, resources are diverted increasingly to its containment. The resources are not simply financial. Staff, too, whether doctors or health workers, are more likely to respond to the challenge of alleviating or curing pain and sickness than to handing out the condoms or pills which might prevent its occurrence. Family planning 'integrated' into maternal and child health programs has too often become a residual: how much less will it weigh in the scales against the whole gamut of reproductive ill-health?

Furthermore, if family planning is seen solely as a question of providing choice, the issue of appropriate methods for particular circumstances may, paradoxically, receive as little attention as it has under the most demographically-driven programs. Offering a comprehensive method mix together with comprehensive information may not be enough if a woman is not aware of whether she has a reproductive tract infection, and if the service has neither the skills nor the resource to help her establish that fact. As a recent thoughtful study (Zurayk, Younis and Khatlab 1994) noted:

> At a minimum, disease conditions that are contraindicated for methods of contraception should be of concern to a family planning policy, particularly those conditions prevalent in communities covered by family planning programmes.

Naturally, it can be argued that reproductive health programs would indeed concern themselves with such issues: my point is that even basic family planning programs already have, or should have, a broader mandate than facilitating fertility decisions.

The question is how far should they go? Clearly, further than merely being a component in maternal and child health programs. That alternative, classical, focus ignores the very real needs of young people and those not currently married; in a number of countries such people are specifically excluded from family planning programs. That focus gives little emphasis to the role of family planning as a change-agent in women's empowerment and status, for it concentrates upon women in the context of their most traditional role. In addition, an apparent focus on maternal and child health has, almost invariably, resulted in the real attention being given to the health of children, with a mother's health problems relevant primarily insofar as they affected child survival.

But if family planning is more than an end in itself, and more than an ingredient of maternal and child health, it does not necessarily follow that family planning programs can,

or should, attempt to shoulder the whole burden of reproductive health. Many have urged their involvement, claiming, for instance, that

> Family Planning programmes can provide the appropriate contexts for the prevention activities required to stop HIV transmission. These include STD prevention and control programmes, condom promotion and IEC programmes directed at changing behaviour which facilitates HIV transmission (Oppong 1995:21).

However, as Setel (1995) notes, testing and counselling HIV-positive women in Africa have failed to induce significant changes in reproductive action, and even if counselling had a demonstrated effect, 'there are numerous practical and contextual limitations on the role that intervention can play' (Setel 1995:1). Thus, while family planning programs may have a limited role in HIV prevention (in public education and condom distribution, for example) unrealistic expectations of their scope can lead only to disillusion.

Indeed, in many countries the crucial issue is not the development of broader reproductive health programs but developing reasonable family planning programs as an intrinsic part of primary health care. In too many instances programs cannot meet even the basic conditions assessed by the Population Council (Mensch et al. 1994) under its Situation Analysis inventory: is there running water? A dustbin? An actual supply of the contraceptives theoretically offered?

The World Bank (1993) estimated that, in order to implement its minimal Essential Public Health and Essential Clinical Health Packages—both of which concentrate heavily on the health of women and children, and include family planning and safe abortion—government health spending in the poorest countries would have to be doubled. With stagnant economies across much of Africa, for instance, and serious declines in international assistance by the donor countries, such a prospect appears increasingly Utopian. But an obvious priority is to build on what already exists to ensure good family planning programs which are recognized not only as a reproductive right, but as major contributions to improving women's reproductive health.

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ICPD and the feminization of population and development issues

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The ICPD's program of action is remarkable for the extent to which so many of the central issues are viewed from a feminist perspective. Of course problems of gender inequity and inequality are an important component of the population debate and need to be addressed. Most commentators would agree without hesitation to the opening statement of Chapter IV that 'the improvement of [women's] political, social, economic and health status is a highly important end in itself'. But the dominance of this theme at Cairo has some unfortunate consequences and is all the more regrettable because the 1995 Beijing Conference on women offered a more appropriate forum for detailed considerations of gender issues. In this note, I shall ignore the many admirable features of the ICPD and focus on these unfortunate_consequences. They include dubious premises, biased priorities, and confusing prescriptions.

Dubious premises: the position of women and fertility decline

The opening paragraph of Chapter IV provides the key intellectual link between gender and population. Specifically, the assertion is made that 'improving the status of women.... is essential for the long term success of population programmes'. This proposition provides one of the main rationales for much of the ICPD rhetoric. It also carries huge implications for social and demographic policies of nations. But is it valid?

It has long been argued that the low status of women—including limited access to resources and income-generating opportunities and subordination to the control of males—is an important obstacle to demographic modernization. Improvements in the position of women are often portrayed as a precondition for the achievement of low mortality and fertility, a view endorsed at the ICPD.

There are several plausible pathways of influence. The most obvious one rests on an assumption that men are inherently more pronatalist than women, because they reap the benefits of fatherhood without bearing the burdens of pregnancy, birth and childrearing. To the extent that women lack decision-making power, they may be reproductive prisoners of male-dominated systems. The validity of this argument rests on whether men indeed do want larger families than women. Contrary to popular belief, a rapidly increasing body of survey evidence suggests that the reproductive aspirations of men and women are broadly similar in all major developing regions (Mason and Taj 1987). While incongruence between individual couples in childbearing desires may be common, at the aggregate level it appears that men

and women have an equal interest in family size limitation. This diagnosis is consistent with the fact that, despite the paucity of male methods of contraception, approximately one-third of contracepting couples in the world rely on such methods or on techniques that demand the co-operation of men.

A second obvious link concerns lack of alternatives to childbearing. In societies where girls receive less formal schooling than boys and where non-domestic employment opportunities for females are limited, women have little incentive to curtail childbearing. This argument has played a central role in demographic theories and is both familiar and persuasive. The creation of better employment prospects for women, it is claimed, increases the opportunity costs of childbearing and fertility itself responds to the new situation.

A huge amount of research has been devoted to assessments of these and similar propositions that appear to be self-evidently true. Yet the results have been largely negative. Neither at the societal level nor at the household level, has a decisive effect of employment on reproductive behaviour or fertility aspirations been demonstrated (e.g. UN 1987). In the post-Second World War era, fertility has declined sharply in societies where the participation of women in public life, including paid employment, was, at that time, minimal: Japan in the 1950s, South Korea in the 1960s and Bangladesh in the 1980s to cite but three examples. Moreover, fertility remains extremely high in West Africa where women have long enjoyed an unusual degree of economic and financial autonomy from their husbands.

The assertion that improvement in women's status is a prerequisite for sustained fertility decline thus rests on a very fragile empirical base. Much more consistent with the evidence is the view that the advent of reproductive choice, mass use of contraception and smaller family sizes represents a giant step on the pathway towards female emancipation and equality. This sense of liberation has always been one of the forces behind the international family planning movement. It is surprising and regrettable that it was not echoed at Cairo.

Biased priorities

The ICPD plan of action has a real urgency when discussing women's issues that is largely absent when discussing problems of population growth and structure. Chapter III, on interrelationships between population, economic growth and development, is disappointingly bland. And in Chapter VI devoted to population growth and structure, the topic of fertility, mortality and population growth rates is dispatched in little more than one page; it generates a miserable two paragraphs of recommended actions. For a conference ostensibly devoted to population and development, there is a perverse sense of priorities.

This criticism is not an endorsement of the apocalyptic vision of some pressure groups. No doubt the planet will survive despite the probable doubling of population by the middle of the next century. Yet this continued increase, much of it an inevitable consequence of age structure, has huge implications that should have been at the heart of the ICPD document. Instead they were virtually ignored.

One such implication concerns the steep increases in the size of the potential labour force that will occur in many developing countries. Many of these countries already face severe problems of unemployment and underemployment. While prospects for educated and skilled Žlites in South Asia, Latin America and Africa may be bright as more labour-intensive activities relocate to low-income economies, it is much more difficult to be sanguine about the prospects of the much larger numbers of ill-educated and unskilled persons. Even in Europe, the problem of high unemployment among less skilled workers seems intractable. But the situation in many developing countries is far worse in terms of absolute numbers, future increases in job seekers and current levels of unemployment. What development strategies are most appropriate for those countries that will see a doubling of their adult populations in the next few decades? Will further globalization of the world's economy help

or hinder the massive task of job creation? There are no easy answers but this is no excuse to ignore the issue.

While some countries face problems associated with rapid population growth, others are more concerned about impending decline accompanied by acute population ageing. Population ageing attracts five paragraphs in the ICPD report. The topic of below-replacement fertility is totally ignored. The ICPD represented an ideal forum for discussion of the role of the State in attempting to influence the reproductive decisions of its citizens, whether in pronatalist or antinatalist directions. The report, with its emphasis on the reproductive rights of individuals, appears to deny State action any legitimacy in the reproductive domain. This stance is unrealistic and mistaken. Coercion in all its forms is rightly condemned but surely governments have a right, perhaps even a duty, to advocacy.

Confusing prescriptions: integrated reproductive health services

A constant refrain in the Cairo report is that family planning provision should no longer be seen as a separate service but as a component of a wider package of reproductive health services. Much of the relevant text is contained in Chapter VII but the same sentiment recurs in many other places. The tenor of the discussion is captured in paragraph 7.13 which states that 'family planning programmes work best when they are part of, or linked to, broader reproductive health programmes' and paragraph 7.16 which asks that 'all countries should... assess the extent of national unmet need for good-quality family planning services and its integration in the reproductive health context'. The text stops short of demanding total integration of family planning and related health services but clearly represents a significant move in that direction. Is this the best way forward?

There is much to recommend this stance. Clinical examinations at family planning centres offer valuable opportunities for health screening, just as postnatal checks offer opportunities for family planning counselling. In countries where sexually transmitted diseases, including HIV, are common, it is a public health scandal that family planning services have done so little to promote methods that offer dual protection against conception and disease.

At the same time, the evolution of family planning programs over the past 50 years has often taken the opposite pathway: away from clinics and medical control and towards the community and the marketplace. The contribution of the private sector, of social marketing schemes, and of community based distribution towards overall contraceptive provision is already appreciable and is growing. These distribution strategies represent greater choice for clients, better access, greater convenience and often greater confidentiality. None of them, however, is very amenable to the concept of integrated reproductive health services, with their stress on clinical skills and diagnostic procedures.

The net result of these tensions is likely to be confusion, both at national level and among donors. Optimal solutions are likely to be context-specific. They will depend on the disease environment, and strength and nature of existing public sector services. Badly needed also is applied research to assess whether more integrated services, particularly the linking of family planning with STD services, are acceptable to clients and cost-effective. The answer is unpredictable. Historically, these two types of service have not dovetailed well. However, past failures should not thwart fresh attempts.

Conclusions

The ultimate question to be asked of the ICPD is whether it matters much, outside the UN family for whom it constitutes a blueprint for action. Past political conferences on population left no decisive imprint. At Bucharest, much of the rhetoric was hostile to family planning

programs but these were pursued with even more vigour after the conference than before. The Mexico conference, hijacked by a maverick United States delegation, is perhaps best forgotten. It remains to be seen whether the Cairo conference will have a lasting effect. Much depends on the actions of the World Bank and the larger bilateral donors who command much greater resources and influence than the UN system.

Cairo revisited: some thoughts on the implications of the ICPD

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The United Nations International Conference on Population and Development (ICPD), held at Cairo in September 1994, was an important landmark in the modern history, not of population, but of the women's movement. More than any earlier intergovernmental population meeting, Cairo squarely faced many delicate issues involving the most profound interests of women. The meeting addressed the question of the education of girls and women; it took a position on the responsibilities of government to provide gainful employment of women; and it committed the world to a policy aimed at the empowerment of women. In an important sense, Cairo marked a turning point in the globalization of the women's movement. It was not, however, a step forward for the population movement, which for many years has given primacy to efforts to limit population growth.

In the aftermath of Cairo, the population movement finds itself in a quandary. Stated in the simplest terms, governments, intergovernmental bodies and non-governmental organizations have been committed to a greatly expanded mandate without assurances of increased resources. Even before the conference itself, participants in the ICPD process were aware that the proposed programs would be expensive. New ground was broken by the inclusion of rough estimates of the additional costs needed to provide a broader array of reproductive health services. Since the conference, however, efforts to extract additional financial commitments from governments, especially the rich donor governments of the West, have proved difficult. While the United Nations Secretary-General's first report on fund-raising for reproductive health, including family planning, attempts to put a good face on it, the truth is that few significant commitments have been made (United Nations, Commission on Population and Development 1995). The question of resources for the broader 'development' recommendations in the Cairo Programme of Action was not seriously addressed at Cairo but was referred to the Social Summit held in Copenhagen in 1995, where attempts to obtain commitments from governments were also only modestly successful.

To understand what happened in Cairo, and to comprehend what might be its effect on family planning programs around the world, it is not sufficient to approach the conference and its Programme of Action with the eye of a financial manager or accountant; rather, it demands a perspective that is both historical and philosophical. Cairo was not just another United Nations population conference. In the view of most participants and observers, it was a breakthrough for women's groups, which played an unprecedented role in shaping the agenda and de-emphasizing its demographic and population aims. Cairo added a critical impetus to the women's revolution that has been unfolding for many years in the West and, more recently, diffusing through cultural links to developing countries, where it is now becoming established in such diverse places as India, Brazil and Nigeria. That Cairo was co-opted by women's groups was made clear both by the ubiquitous presence of women in the preparatory process, and by their numbers and influence on national delegations at the ICPD. The power they wielded is most evident, however, in the predominance of women's concerns

among the 'new issues, new approaches and new actions' that appeared in the Programme of Action (United Nations Population Division 1995:2).

Our choice of the word 'revolution' in the context of Cairo was made advisedly to mean that we are witnessing a radical change in the role and status of women throughout the world. Changes of this sort are neither easy nor simple, nor do they happen overnight. History tells us that revolutionary forces are not monolithic but contain within them many factions that come to the fore, recede, form coalitions and split asunder in response to events that take place, often over decades. The women's movement that came together at Cairo in 1994 is no exception. Its ranks comprise many distinct entities that focus on women's health, or rights, or empowerment, or social and economic development, or other concerns that are less easily categorized. Fissiparous tendencies are also present, not only among the main categories but also within them, as national or regional factions may form around specific local interests. At Cairo, one of the strongest unifying forces was the outright rejection of 'traditional' family planning that less than a generation ago was regarded as a liberating program of social change, vital to the advancement of women. At Cairo, also, the underlying threat of cleavage was reduced by a strong tendency to close ranks against the Vatican's resolute attack on abortion liberalization, the legitimation of the 'non-traditional' family, and some aspects of reproductive health.

These considerations go some way toward explaining the difference in tone and substance between the ICPD and the two previous population conferences. In the years since Mexico City, Western feminists, together with their developing-country counterparts, had elaborated a broad agenda for action on women's issues; they had also developed a strategy for taking it to each of the major intergovernmental conferences that were planned around the United Nations' 50th anniversary in 1995. The product of the Cairo meeting, the Programme of Action, with its array of recommendations, is perhaps best viewed as a manifesto for a vision of an ideal world, rather than as a serious plan intended for full implementation.

It is a tribute to the organizational capabilities of women's groups, no less than the power of their message, that they were able to enlist and maintain the support of foundations, NGOs, and even normally intransigent government delegations. Indeed, the momentum generated by the preparatory process may have blinded participants to some of the political and economic realities that are now making their presence felt. Delegates seem to have forgotten that governments do not commonly make national policies in the glare of international meetings, but rather, in the dimmer light of home, where binding decisions are made by political leaders sensitive to budgetary constraints and aware of other proposals competing for funds. Secondly, the euphoria generated by near-universal support for the Cairo agenda obscured the mismatch between the costly budgetary requirements of the Programme of Action and the serious economic problems being experienced by virtually all of the main donor countries. A third unrealistic expectation stemmed from the failure to appreciate that while government delegates to population conferences tend to support liberal social policies, the reins of power in many donor countries are currently held by fiscal and social conservatives who are opposed to many of the Cairo provisions. Despite the leading role played by the Clinton administration in developing the Cairo agenda, for example, the fiscal year 1996 Congressional appropriation for population and family planning has been delayed, cut by 35 per cent, and required to last for 15 rather than 12 months (*Congressional Record* 25 Jan. 1996:886).

What does all this mean for the quality of family planning programs in developing countries? This is a complex question, the answers to which will not be known with any certainty for several years. Yet there are a number of points that can be made now. First, if broader, more comprehensive programs are attempted without additional funds either coverage will be reduced or quality will decline, the most likely prospect being that both

elements will suffer. Secondly, in the enthusiasm over their growing success in the Cairo preparations, the drafters of the Programme of Action have stated as established fact some critical relationships between development variables and population change that should be seen as hypothetical. For example, the Programme of Action states that 'Improving the status of women also enhances their decision-making capacity ... especially in the area of sexuality and reproduction. This ... is essential for the long term success of population programmes' (United Nations 1994, Para. 4.1). This assumption oversimplifies the relationship between women's status and fertility.

Moreover, even the relationship between women's education and fertility, which is identified as the main programmatic link between status, empowerment and fertility, appears to be somewhat complicated. While it has long been established that educated women have fewer children than uneducated women, there is growing evidence that this is not a simple relationship but one which interacts with the level of development, culture, and a number of other variables (Jejeebhoy 1992; Martin 1995). None of this is to suggest that women's education, status and empowerment are not highly desirable objectives that should be pursued in their own right; it does mean, however, that their value as instruments of population policy is yet to be established.

In considering the effect of the Programme of Action on the quality of programs, it is no longer sufficient to lump all developing countries together. In countries such as those in Southeast Asia, where family planning has become institutionalized and there has been economic and social development, it is likely that some broadening of reproductive health services could take place without loss of quality and with benefits to individuals and the community. Many of these countries, however, have lowered their birth rates and have already 'graduated' from population assistance. The present remarks address the poor countries, in which quality is uniformly low.

The Cairo document carries a pervasive sense that the quality of family planning programs should be largely defined by the breadth of the reproductive health services within which family planning services are embedded. This implicit hypothesis does not accord with the realists of the poorest countries such as many of those in sub-Saharan Africa, and in parts of Latin America and South Asia. In these countries, where fertility has barely started to decline and little socio-economic development has taken place, the quality of services is primarily conditioned by poverty. The problems facing virtually all government programs in such countries are those of limited financial and human resources, fragile organizational structures, poor education, training and supervision, coupled with growing demand derived simply from rapid population growth. Under these conditions, family planning commonly suffers from weak public demand and also, though less often than in the past, from a lack of commitment by the leadership.

In this context, it is necessary to remember that ministries of health generally lack the political muscle to be a major influence in the inter-ministerial struggle for funding. Although ministries of health routinely integrate related services, a practice in which they are encouraged by WHO, this does not mean that they have the organizational and resource capacity to include an expanded range of reproductive health services without a loss of quality.

The Cairo Programme of Action is not the first United Nations document to include family planning in an integrated combination of services. Something similar was attempted in the primary health care initiative that grew out of the World Health Organization's Alma Ata conference in 1978 (WHO 1978). Although the services subsumed under the rubric of primary health care differed from the reproductive health services of the ICPD document, it is instructive to consider the fate of the family planning component of this program. While the purely health components of primary care that were given specialized attention—oral

rehydration therapy and the expanded program of immunization, for example—family planning was most commonly allowed to languish. Although this is not the place to analyse how this neglect occurred, the sensitivity of the subject, the lack of push from the top, and the orientation of the medical profession all contributed.

Thirty years ago, the appearance on the market of safe, effective and easy-to-use contraceptives revived the Western movement for women's liberation, which had lain dormant since before the Second World War. The freedom to choose the number and timing of their children was seen by women as an essential first step in their march towards full equality with men. In 1968, the Teheran Conference on Human Rights affirmed the basic human right of couples to decide on the number and spacing of their children (International Conference on Human Rights, 1968. Resolution XVIII). Since then, the international population movement has succeeded in making that abstract right a reality in many poor countries; in doing so, it has lowered population growth, fostered social and economic development, and laid a foundation for achieving a rise in status and greater empowerment for women. The contraceptive revolution is not yet completed, however, and there remain many countries in which it has barely started.

It is still too early to measure the effect of Cairo on family planning as newly designed integrated programs have not yet gone through the bureaucratic, policy, and budgetary process to reach the field. However, without significant new resources neither family planning nor reproductive health programs will prosper. While both women's groups and family planners can find support for their positions within the several chapters of the Programme of Action, the Cairo process exposed and intensified the differences between them. The real need is to re-establish family planning as an important component of the women's revolution, not only for the benefit of the individual but also for the community and society.

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The crisis in international family planning

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International family planning faces an unexpected crisis. The number of women of fertile age is rising and desired family size is falling, but many of those who want to limit the size of their families cannot afford the full cost of modern contraception. At this moment of exploding demand, the resources available to assist those who want to control their fertility are undergoing a sudden decline. This crisis is deepened by the imperative of AIDS, which can be slowed only by using some of the same technologies, logistics, service and informational systems that family planning also uses.

With increasing numbers of women of fertile age and rising contraceptive prevalence, the number of couples using family planning in developing countries (excluding China) could increase from 200 million in 1990 to between 330 and 385 million in 2000. The International Conference on Population and Development (ICPD) at Cairo in 1994 set a target of US $17 billion annually by the year 2000 to pay for reproductive health (family planning, STD control, safe motherhood and demographic analysis) in developing countries and in the former Eastern Bloc. The family planning component was costed at US $10.2 billion in 2000, of which an estimated US $5.7 billion would come from the donor governments, with the remainder coming from the countries themselves.

There is no evidence that budgets set at Cairo will be reached: indeed the trend is downwards. The US Agency for International Development provided 46 per cent of the US $774 million given by Western governments to international family planning in 1991 (PRISM 1995). As part of a continuing resolution designed to keep the US government functioning, the obligation for fiscal year 1996 was cut from $546 to $72 million (Potts 1996). This is an unprecedented and catastrophic cut and will not be made up by other donors. The total British foreign aid budget for 1996 has been cut by 5.4 per cent and it is expected to fall by 18.8 per cent in 1997/98. Japan and Germany have proposed increases in support of international family planning. The Wellcome Trust in the UK is giving £ 50 million over five years, but a few committed donors cannot conceal the fact that budgets are far below the ambitious trajectory set at Cairo. Despite the excellent publicity associated with the ICPD, many international donors remain wary of anything to do with family planning. France and Italy give only a few cents per capita per year. Many of the countries with greatest need of help are themselves getting poorer. For example, in 1981 the government of Kenya spent US $9.5 per capita per annum on all aspects of health care, while it could afford only $4.5 in 1991.

The collision between rising demands and falling resources for international family planning is immediate and real. Fortunately, the demand for family planning is so strong and so much is known about effective delivery systems that a great deal can still be achieved if clear policies are set and appropriate priorities are followed.

An unfocused document

The ICPD set a series of broad goals concerning reproductive health and the status of women. Much attention was paid to definitions and philosophical objectives but numerical targets and costs were dealt with superficially. Estimated costs were calculated on the simple basis of multiplying the number of couples using family planning under the medium UN projection for global population by a constant $16 per couple-year of protection (CYP). Some people,

however, use non-clinical methods, while others pay for their contraceptives on the open market. The estimates for the cost of safe motherhood and STD control were even more vague.

Only a little over one per cent of foreign aid flowing from OECD countries goes to family planning; and much of that small sum is not focused directly on meeting the unmet demand for family planning.

Incontestably, women in developing countries suffer many social injustices and their reproductive health is often gravely compromised. A compelling case can be made for increasing investment in all aspects of women's development. The '20/20' formula where nations and international agencies each commit 20 per cent of their budgets to the social sector deserves support. The ICPD confuses development sectors: female education, for example, must be financed from the 98 or 99 per cent of foreign aid that goes to sectors other than family planning and population. To take money out of declining family planning budgets for anything except basic family planning access would undermine already inadequate support for family planning and tragically short-change broader aspects of women's development, which deserve investments much in excess of the one or two per cent of overseas aid dedicated to family planning.

Setting priorities

Those committed to health and population have an ethical obligation to ensure that limited resources are used to the maximum advantage of the most underprivileged groups: we must not only cut our coat according to the cloth, but we must ensure the coat is used to cover those in greatest need.

Much can be learnt from the successes (and mistakes) of the past 30 years of organized family planning. In Bangladesh the total fertility rate has plummeted from 7.0 to 3.4 in 20 years. These changes are not the result of socio-economic improvement (Bangladesh is amongst the poorest countries in the world), but they are the result of governmental and non-governmental systems making a range of family planning choices available through a variety of channels and of a concerted effort to deal with the public health consequences of unsafe abortion.

On the road to comprehensive reproductive health care, family planning is the first step; and for many women it is a giant leap forward. Without access to family planning choices, including safe abortion, no woman can be free in a social or political sense. In a poor country with a weak health infrastructure, such as Nigeria, child spacing and limitation as the result of family planning is one of the most practical steps that can be taken to reduce maternal mortality.

The ICPD set a goal of achieving increased access to reproductive health services 'no later than 2015'. Given trends in funding that have emerged since Cairo, it may be impossible to meet this target, but the international community can still set a priority of making basic family planning choices universally available over the next five years. Such a policy would include widespread distribution of condoms, which are also essential for STD control and HIV prevention. The next step on the road to comprehensive reproductive health care should be improved STD diagnosis and treatment. STDs are significant in their own right and important risk factors for HIV acquisition and transmission.

These goals could be achieved, even assuming reduced levels of international assistance, if the following eight points are observed.

International donors must secure an adequate supply of contraceptives

There is a large and noble literature on the need to improve the quality of family planning services, but if contraceptives run out then every other aspect of reproductive health is futile. Even today, social marketing programs in Vietnam, Tanzania and several other places are forced to ration supplies because of shortages.

In the case of pills and condoms, competition between international manufacturers keeps prices for bulk purchase low. Local production in a country solves nothing if people are too poor to buy contraceptives when they come out of the factory. For the foreseeable future, the international community will have to meet many of the contraceptive supply needs of poor countries, such as Bangladesh, Ethiopia and Nigeria. It has been suggested that the UNFPA should set up an international group to purchase contraceptives in bulk for governments, IPPF affiliates and significant NGO programs. It is an urgently needed initiative.

Unfortunately, donor governments fear the controversy and the recurrent costs of supplying commodities. But in the real world, yet another conference or another training course is less likely to prevent unintended pregnancy, or pre-empt a case of HIV infection, than an adequate supply of condoms, pills, IUDs and injectables accompanied by clear, appropriate information about their use. All serious donor agencies should have an unambiguous commitment to supply sufficient commodities to reduce fertility and fight the spread of HIV. Tokenism can frustrate genuine progress.

Donor agencies should support large-scale, cost-effective family planning programs

Empirical observation suggests people will spend about one per cent of their annual per capita income on family planning (Ciszewski and Harvey 1995). In situations where modern contraception costs more than that, then the difference must be made up from the country's tax base or the donor community. It may sound obvious that attention to costs is imperative at a time of rising demand and declining resources, but it is a rule more often broken than followed. For example, Japan rated a family planning program costing over US $100 per CYP a 'success'. The same dollar, yen or Deutschmark cannot be spent twice and failure to choose the most cost-effective programs inevitably ends up denying even basic family planning access to some in order to provide more complex and costly services for a few.

In many situations, social marketing has proved the most cost-effective and easy to manage way of distributing condoms and oral contraceptives. Prices are subsidized in order to maximize sales, rather than profits. A program selling pills and condoms in Vietnam cost US $6.9 per CYP in the second year and it is estimated it will be below US $5.0 in the third year, including the cost of commodities. Social marketing of condoms helps meet the imperative to slow the spread of HIV.

Unscientific medical barriers to family planning must be eliminated

The Tanzanian Ministry of Health policies still require a clinical examination before prescription of oral contraceptives; in one central Asian republic women are subjected to uterine curettage (without anaesthesia) when an IUD is removed and most doctors are convinced both IUDs and pills cause breast cancer; in Vietnam women have been told to stop the pill after 6 to 12 months 'to rest their bodies'; and in parts of Francophone Africa women beginning oral contraceptives were supposed to have tests that cost the equivalent of more than one month's per capita income. Such over-engineered programs do little or nothing to enhance women's heath, but end up denying family planning choices to many people. Policies must be updated

Safe abortion must be made available

A large part of the literature, and the policies of many countries and international agencies, imply family planning can be limited to contraception. Abortion is sometimes mentioned only to be condemned or as something to be 'eliminated' by 'better family planning'. As women all over the world recognize, reality is very different. No society has even achieved replacement levels of fertility without a significant number of abortions, and none will in the foreseeable future. It is impossible to achieve a low maternal mortality without access to safe abortion. In many countries, providing this access is the single most effective step that can be taken towards improving women's health.

Fortunately, the technology for performing early abortion is cheap, safe and effective. Vacuum aspiration abortion, where necessary using a manually operated syringe, can be made available at the primary health care level, and it is an appropriate technology to teach to non-physicians. While many communities, for example in Bangladesh or Zaire, cannot even afford the full cost of purchasing, distributing and promoting something as simple as a condom, practically everyone can find the money to pay the full cost of providing manual vacuum aspiration.

If Western donors are too mean, and developing country governments too poor, to provide the resources needed to meet the ICPD goals, then there will be even more abortions in the world than there would have been otherwise: policy makers should recognize this fact and make safe abortion available.

There needs to be much greater involvement of the private sector in many aspects of family planning

The emphasis given to quality in the family planning at the ICPD is often best met by giving the consumer some direct leverage on the services. Two and three decades ago, South Korea and Taiwan evolved programs where the government subsidized selected and qualified private doctors to insert IUDs or offer voluntary sterilization: the consumer, paying part of the cost, had a choice as to which private doctor to approach and the government achieved an increasing level of cost-recovery. It was a 'win-win' situation and deserves to be copied.

In an increasing number of countries, responsible non-government organizations can offer safe abortion. The fees generated can subsidize other reproductive health services. There may be limitations to advertising, and euphemisms and legally contrived explanations may be required, but in the end women get safe abortions. Government hospitals are relieved of the cost of treating botched abortions and politicians are relieved of having to deal with a topic they perceive as controversial. Responsible religious leaders recognize the need for humane solutions to a ubiquitous problem, while those who might oppose such a strategy are often so out of touch with reality that they do not see what is happening.

Realistic policies must be adopted to deal with adolescent sexuality

The ICPD rightly and forcefully highlights the many problems besetting young people in the contemporary developing world. With increasing modernization and urbanization, the age of marriage is going up, but the age of first intercourse is going down: the exposure to premarital sexual relations is increasing. Most STDs and exposure to HIV occur before age 25 or 30. What might have been a mistimed pregnancy for a young married couple becomes a social disaster for the unmarried, solvable only by abortion. AIDS cannot be contained without paying particular attention to the needs of adolescents.

Young people demand a high degree of confidentiality and often present genuinely complex social and clinical problems. It is essential to focus more of the limited personnel

available for counselling and the diagnosis of STDs on the needs of adolescents. Happily, there is a corresponding opportunity in many family planning programs to simplify the services for older couples in stable unions.

As the birth rate falls voluntary sterilization becomes more important

Voluntary sterilization is the single most important method of family planning in countries as different as the USA and China. Wherever male and female sterilization have been made available, numbers have climbed. As surgical sterilization usually provides many years of protection against pregnancy it is cost-effective, although the costs of surgery usually exceed the ability of a poor couple to pay for the operation.

Health professionals must be motivated to provide a repetitive operation. Item-of-service payments are part of the Western practice of medicine: doctors usually charge fees. But the same payment to a doctor working in difficult circumstances in a developing country has sometimes been misinterpreted as 'coercive'. One effective policy would be to set a modest charge to the client and top it up with a subsidy from the government, UNFPA or other donor. Coercion cannot exist where people pay.

Unfortunately, female sterilization is the technically most difficult item in the family planning repertoire to provide as part of a high-quality service. The trans-cervical placement of quinacrine is a woman-friendly way of offering sterilization that could be made available in any primary health care setting and the method deserves objective evaluation (Pies, Potts and Young 1994).

The need for direct technical assistance to family planning programs from Western donors will decline

This is a message not everyone wants to hear, but the pilot phase of family planning is long past and the major elements of HIV prevention have been clear for some time. Big, simple programs providing billions of condoms or offering millions of people the choice of sterilization may seem boring to design and administer, but they are what the world needs. Fortunately the bureaucratic work involved in setting up a US $5 million program is often little more than that involved in a pilot project costing US $50,000. Expatriate advisers should be used only in well defined situations: the cost of such a person, together with a housing allowance and airfares for his or her family can be equivalent to 2-4 million condoms or half a million cycles of pills a year.

Genuine choices

Donors have key choices to make about the allocation of funds. They can focus on small, selected populations and try to meet the full range of reproductive health needs identified in the ICPD, or they can set their sights on all those who need access to family planning. The work needs to be broken into a series of achievable steps. By any measure of impact, the starting place must be to secure universal access to family planning. With limited resources costs must be watched carefully. Unfortunately, it has become fashionable in some quarters to use the word 'targets' in a pejorative sense, although it is difficult to see how human suffering can be ameliorated unless the scale of that suffering is appreciated.

One key to providing acceptable services within a tight budget is to remember that 'integration' is not a policy to be orchestrated by a ministry of health, but it is a process that takes place at the doorstep of an individual home. It is no more difficult for an adult to 'integrate' condoms from the local kiosk, IUDs from the primary health care centre, STD treatment from an informed pharmacist and sterilization from the provincial hospital, than it

is for a household to 'integrate' their diet by buying food from the butcher, baker and grocer in different streets.

The strategy that worked best in countries as diverse as Colombia, South Korea and Thailand was to begin by setting up simple vertical programs, focusing on delivering basic family planning choices. With the passage of time, and as countries became richer, vertical programs grew naturally into more comprehensive services. Thirty years ago, for example, South Korea launched a vertical, highly focused family planning program, but today Korean women have better access to more equitable and comprehensive reproductive health services than many women in the USA.

The ICPD must not be allowed to become a mirage promising unachievable ends. The goals set are valid and inspirational. The several essential steps on the road to comprehensive reproductive heath care, however, need to be taken in sequence, beginning with access to basic family planning choices. Some will have to be deferred until the current financial constraints are lifted. The alternative of improving services for a few, who would receive comprehensive reproductive health care, at the expense of the many, who would receive little or nothing, should be rejected as an unethical use of resources.

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Quality of care and service: some notes from the Indonesian family planning and family development movements

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The Indonesian Population and Family Planning movement has gone through consistent evolutionary stages. When the National Family Planning Coordinating Board (BKKBN) was established in 1970, services and care were provided from the **clinical** approach. This was gradually expanded to include the active role of local communities, and ultimately from the beginning of the 1980s became the **community** approach. In the 1990s the emphasis changed to the more tangible **family** approach.

Throughout all these developments, BKKBN and all the implementing units, both in the private and public sectors and in the non-government organizations, have been committed to providing the best services and care to the clientele. Since its early years BKKBN's management has been constantly reminded that inadequate services and care would only result in method discontinuation, and hence failure to lower the fertility rates.

The following is a brief account of Indonesia's deep commitment to constantly improving the quality of services and care, all within the context of Indonesian society.

The Indonesian Family Planning and Family Development movements

Through all stages since its inception to the most recent features of its development, the Indonesian program has closely adhered to the ultimate objective of the 'small, happy and prosperous family' norm, acceptable to all facets of Indonesian society and thus involving all sections of the population. This norm confirms five principles, as follows.

1. Spacing: eligible couples within the age bracket 20-30 years are motivated to have no more than two children.
2. Family health and welfare: eligible couples who are over 30 years of age are motivated not to have additional children.
3. The involvement of the youth is strongly encouraged as they will ultimately become responsible parents.
4. All parts of the society, particularly parents, are strongly motivated to support and to take an active role in the program.
5. All appropriate societal norms and values are geared towards family welfare and family development.

The apex of family development was in 1992 when Legislative Act no. 10/1992 on *Population Development and the Development of Prosperous Families* was passed. The striking feature of this Act is that it does not carry any threats of penalties for non-compliance; on the contrary, it is prescriptive and motivational. The Act does not dictate the number of children couples should have, rather it states that the number of children should be in accordance with the future secure upbringing of these children and the present welfare of the whole family.

The Act also prescribes the duties and the rights of the population, families, and each member thereof in the process of development. It defines the rights of the vulnerable segments of society, including the handicapped, the children and the women, and motivates families to take care of the underprivileged and the old, instead of committing them to institutions. It also states explicitly that all members of society, even those who seem to be incapable of participating, have significant roles in development.

This Act is the basis for the principle that population and family planning care and services are to be provided at the highest standard in accordance with prevailing needs and values.

With regard to the development of prosperous families, the Indonesian approach to societal development is founded upon the strength and potential of families, the sum of whose qualities makes up the nation. For that reason Indonesia is committed to developing the quality of all members of the family without exception.

Family planning care and service

The Indonesian concept of family planning care and service is that the public has the absolute right to the best quality of service that the government can provide. Hence, the quality of care and service for family planning is determined not by the service providers, but by what the people desire. As the people's needs and aspirations progress with time and with increasing educational attainment, quality of service and care also is a dynamic concept. The following are basic considerations for quality of care and service in a family planning program.

Quality should not be a static concept, but should be related to a program's condition over time. Quality should consider not only the individual's or couple's needs, but also those of society. Quality should entail acceptance by the community based upon their cultural norms and their religion. The ultimate goal of family planning programs should be the improvement of family well-being. Programs that empower local communities and women are more sustainable than those that do not. Quality should be related to a program's

efficiency in using its resources. Quality of a program at any time and place should involve consideration of the client's perception of needs and their satisfaction. Quality of a program should also incorporate the extent to which the program actively addresses its own improvement.

Determining standards

Quality assurance and quality of services and of care are to adhere to standards of the providers' institutions; standards of the clientele's satisfaction; and standards of the society's satisfaction, including the prevailing religious, social and cultural canons.

By 'providers' institutions' it is meant that individual providers and service installations have their code of conduct and their standards with which to measure compliance, based on the prevailing technology and values. Anything imposed from outside these circles is bound to be redundant as, perhaps, the technology is not applicable or the values are not acceptable. For example, when the 'vaginal sheath' was introduced, Indonesia expressly rejected this as contrary to accepted local reproductive practices. Conversely, Implant-Norplant was introduced with the utmost care, by conducting an acceptability investigation first. Western and advanced medical standards may not be readily applicable to the Indonesian setting.

Within the context of clientele satisfaction the concern is in maintaining the clients' participation in the program, thus enabling them to materialize their needs in family planning and the welfare of their families. The Indonesian Demographic and Health Surveys (IDHS) of 1978, 1991 and 1994 have indicated significant lowering of the rates of unmet need in the program. Still, Indonesia is trying hard to meet the needs of the public, both in increased coverage of the program and in improving the quality of service. This is corroborated by the relatively high continuation rates across all contraceptive methods and the significant reduction in fertility rates.

Client satisfaction is assured by segmenting the public. For those who can afford to pay more for better service and care, the private sector is geared to cater to their needs; for those who need free or nominal-fee service the public health centres and hospitals are readily accessible. The concept of self-sufficiency in family planning care and service is elaborated in a separate section of this paper.

In Indonesia, society's satisfaction is synonymous with social acceptability, which includes religious and cultural acceptability. Imposing the government's will on the public without due consideration would only bring resistance. With regard to the religious values of the society, the majority of the Indonesian people are devout, as is apparent from the abundant attendance of Muslims during Friday prayers at the mosques, of Christians at the Sunday Mass, and of other denominations at religious ceremonies. Going against religious values could be disastrous for the program. One example of this is that because of religious considerations sterilization—better known as 'secure contraception'—is not a family planning method. Religious circles are willing to allow this only when it is done for medical reasons. Although this method is fast gaining popularity, particularly among those above 35 years of age, BKKBN has not adopted it as an official family planning method.

Community development

As community development is a popular movement involving all the people, and as quality of care deals with the satisfaction of the community, quality of care and services becomes the concern of the whole community as well. In this context the components of quality of care are determined by the community's interests: institutional commitment; dynamic attitudinal and behavioural change; education and training; economic considerations; resources and technology; marketing aspects; referrals, and management.

Institutional commitment becomes much more important than simple individual or group commitment. Whereas individual or group commitment is time-constrained, institutional commitment can be sustained for as long as the institution prevails. Conversely, establishing and maintaining institutional commitment becomes more strategic.

Attitudinal and behavioural change is the basis of any family planning program. Almost all family planning programs begin by trying to get the idea of the small family accepted by the population. The success or failure of a family planning program is reflected in the extent to which it has achieved attitudinal and behavioural change.

Education and training is a constant element of any successful attempt at improving the quality of service and care. This is not only for the providers but also for the clientele with the aim of making them fully aware of what they deserve to know.

The **economic considerations** of quality improvement should be readily obvious. However, as family planning services deal with human beings, caution is necessary so that cost considerations should not hinder improvements.

The availability of **resources and technology** should also be apparent, particularly that of technology. Again, Indonesia is careful to use only the most appropriate of available technology. The major consideration is not how to master the technology; it is more important to apply what is acceptable to the community and the most suitable by local and national ethical standards.

Marketing aspects begin to be important when it comes to persuading the clientele to pay for service and supplies. Here the principle of self-sufficiency is important, and Indonesia seizes this opportunity to boost the self-esteem of certain sections of the population.

Referrals and the referral system are always important in Indonesia where providers with their expertise in care and services closely adhere to established standards. Lacks and discrepancies will have the referral system to fall back on.

Management is perhaps one of the stronger points in the Indonesian program; without this Indonesia could not have had the successes of high prevalence and continuation rates and ultimately fertility reduction. Management of quality improvement involves quality control of contraceptive supplies and also of service delivery standards. Supervision can perhaps be used as an example in the Indonesian program, where it is not performed only by BKKBN or by other concerned agencies, rather it is the clientele on which BKKBN relies for managing quality of care and of service.

Quality assurance and control is dependent on strong and committed leadership. Indonesian experience has indicated that compliance with established and agreed-upon standards can only be achieved with this element. Leadership in this respect encompasses three major factors: leadership to effectively manage people; leadership in shaping program policy and implementation strategy; and leadership to mobilize and use all the required resources.

Notes from experience

Twenty-five years of experience result in the following checklist for quality assurance and improvement in population and family planning care and service in Indonesia.

The Indonesian concept of quality of service and care is based on what the community and the clientele dictate, and far less on what the providers prescribe. Standard indicators are needed. This, Indonesia has shown, is not a simple task. The standards of the clientele and the providers may compete, and the two parties are not always compatible. Indonesia has also shown that convergence can be sought through consensus. Satisfaction of the clientele, religious authorities and the community must be assured. The next point is internal and external auditing procedures. Internal audits may be simply done as this falls within the purview of organizations. External audits, however, are for the most part beyond the control

of management, and can be even more complicated when one considers the public opinion poll as one of the procedures for obtaining audit information. Procurement reviews, mostly of contraceptive supplies for the public and the private and commercial sectors, ensure that procurement has been done on a timely basis, with the right quality, and in the right locations.

Process control: production and distribution are done according to established methods. Drug and Material Certification is one of the requirements in Indonesia. Inspection and testing procedures can be viewed as part of Drug and Material Certification, but can also be considered as part of production process control. These are closely monitored by BKKBN not only at the manufacturer's level, but all the way to the villages.

Indonesia is putting great emphasis on feedback from the users. From time to time, top management of BKKBN go to the villages to interview families and acceptors on their opinion about the methods they are using. Supplier and distribution rating: in a competitive diversified market such as for contraceptives, Indonesia attaches great value to the rating of all manufacturers, to ensure that they will strive for better quality. The same applies to the service providers: the best clinics will ultimately attract the most acceptors.

Editor's Note: An invitation to join us in Volume 6(2), October, 1996

We intend to run a follow-up forum in the next issue. This time it will not be by prior selection but by allowing the readers to chose themselves.

If you have evidence on the neglected matters I identified in the first paper of this forum, we would especially like to hear from you: To what extent can reproductive ill health be identified and treated among poor, remote populations? What impact will this have on family planning programs? Should family planning be offered to populations where good quality treatment for reproductive ill health cannot be guaranteed?

If you have evidence on other related matters or believe we have ignored or misinterpreted relevant parts of ICPD or its *Plan of Action*, we would also like your contribution.

These contributions should reach Jeff Marck, *HTR*'s Production Officer, by the end of July and should generally be confined to 1,000 words or less.

J.C.C.

Book reviews: Health Transition Review 6, 1996, 125–130

Book reviews

Health and Disease: A Reader. Second Edition. Edited by Basiro Davey, Alastair Gray and Clive Seale. Buckingham: Open University Press, 1995. xii + 436 pp. Paperback. A$42.95.

Q: What do you get when you take sixty-two reasonably high-quality articles and condense them into a little over 400 pages?
A: An edited collection that isn't as good as it could be.

That pretty well sums up my feelings about the book under review. It is the revised edition of what has apparently been a successful Open University set text, first published in 1984. Two-thirds of the articles are new to this edition which spans the 'health studies' disciplines and represents diverse personal experiences, political commitments and national locations. Several contributions are 'classics' in my pantheon: Dubos, Navaro, Illich, Goffman, McKeown, Engels and Cochrane to name a few. Even among the lesser lights, I found myself interested in most of the chapters, glad to be made aware of them for the first time or to be reminded of insightful arguments I had encountered but subsequently forgotten.

Edited collections are fickle beasts: they can be immensely helpful to teachers and students, and in a world of exploding information, they can help researchers get their bearings. But collections are inevitably composed according to somebody else's criteria which means one rarely finds all the chapters equally valuable. For use as a textbook, then, most collections suffer from a standard drawback: it contains a number of pieces one would not have included while it omits several one regards as vital. I thought that would be my main complaint, but surprisingly, that is not the problem with this collection. The selection is intelligent, diverse and coherent, with helpful introductions. It covers mainly the UK and USA but includes a few articles considering other locations (Latin America, India). Medicine is discussed but the book is not medico-centric. It opens with ten chapters on concepts of health, disease and healing, and the book considers the experience of health and illness as well as health services. There are also several essays each on influences on health and disease, and the social context of health care. The concluding part contains several provocative 'prospects and speculations', including one on the health impact of environmental change by the eponymous Leaf, a 'challenge to the purchasing orthodoxy' by Whitty and Jones, and a thoughtful essay on 'The last well person' by Meador.

With such an array, the book looks promising. Reading the table of contents and the intelligent introductions, I thought it might be just the text for a unit I teach to students in our Graduate Diploma in Public Health. It would save the students and me endless photocopying and would present them with a range of perspectives and insights on the health field, combining golden oldies with newer material.

Too good to be true. On closer inspection of individual articles, I found that in many cases, the editing has gone too far. Simple arithmetic shows that, with introductions and a shortish index, few chapters can be much over five pages long, and with some the condensing process has—not surprisingly—deleted vital information, leaving the article far less compelling or coherent than the original. So valuable elements of the collection become less useful because often, the guts have been removed in an effort to include a bit of everything. It

is always difficult to weigh the depth-breadth dilemma, and strongly as I advocate for diversity, I think the editors have erred too far on the side of breadth in this book.

There are also some strange bedfellows here: articles on public health appear in the section titled 'The role of medicine'. On the other hand, the section on health work wisely groups items on health services together with unpaid health care. It also contains a surprising chapter by Paterson on kitchen maids in a hospital whose main relevance is, I suppose, that it supplies a sociological explanation of the work practices that produce such poor-quality food. Perhaps a bit more selectivity in the choice of such peripheral articles would have left more room to retain more of the significant deletions from other articles. Finally, while it is not the job of the editors to expunge verbal blunders already committed to print, I found it grating to come upon use of masculine pronouns as generic ('the doctor... he') in the editors' own introduction!

Despite these quibbles, the collection could be useful for undergraduates having their first exposure to health studies. Researchers and more advanced students will have to look elsewhere.

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Rethinking AIDS Prevention. Cultural Approaches. Edited by Ralph Bolton and Merrill Singer. Yverdon, Switzerland and Langhorne PA: Gordon and Breach Science Publishers 1992. Reprinted 1993. 225pp. Paperback.

AIDS and STDs in Africa: Bridging the Gap between Traditional Healing and Modern Medicine. By Edward C. Green. Boulder: Westview Press, and Pietermaritzburg: University of Natal Press. 1994. xi + 276pp. Paperback.

AIDS and HIV in Perspective: A Guide to Understanding the Virus and its Consequences. By Barry D. Schoub. Cambridge: Cambridge University Press. 1994. xx + 268pp. Paperback. Australian $29.95.

Sexuality Research in the United States: An Assessment of the Social and Behavioral Sciences. By Diane di Mauro. New York: Social Science Research Council 1995. iv + 100pp. Paperback. No charge.

Executive Summary of Sexuality Research in the United States: An Assessment of the Social and Behavioral Sciences. By Diane di Mauro. New York: Social Science Research Council 1995. iii + 19pp. Paperback. No charge.

New books on AIDS are now flowing in for review in such numbers that they must be dealt with in batches. The justification in this case is that, with one exception, they relate to each other in that they place a major emphasis on culture and behaviour.

Rethinking AIDS Prevention is a reprint of seven papers which constituted a special issue of *Medical Anthropology* in 1992. With the exception of the paper on Zaire by Brooke

Grundfest Schoepf, all the contributions are focused on the United States. Nevertheless, their relevance for AIDS prevention programs in the Third World is striking. It is encapsulated in the long paper by Ralph Bolton on 'AIDS and Promiscuity' where he argues, with relation to homosexuals in the United States, that prevention programs have no right to make an assault on cultures, even sexual cultures. He believes that much of the determination to change multi-partnered sexual relations and the mores of the sexual revolution are really based on attitudes and moralities which are anti-sex and certainly opposed to sexual freedom. He believes that the proper moral stance of the campaign against disease — and the most efficient one — is to offer technological help. The campaign against AIDS shoud have been focused almost entirely on risk-free sex, and in our present state of knowledge, should have had as its centrepiece the use of condoms.

Most of the contributors take the same view of the importance of promoting condoms and making them available. This message obviously has its greatest relevance for the world's major AIDS epidemic, that in the main AIDS belt of East and Southern Africa. It is becoming increasingly clear there that governments are reluctant to attack what they regard as the private behaviour of their citizens and the greatest current success against AIDS appears to be the rapidly increasing use of condoms. Schoepf advocates the use of traditional doctors to promote condoms, but the demand in East Africa for them is now growing so rapidly that small retailers are keen to sell them in a situation where fear of the disease is rapidly overcoming the older fear and dislike of condoms.

Edward Green's book on *AIDS and STDs in Africa* reports on studies of the possible role of traditional healers in six sub-Saharan African countries. He reinforces previous evidence that they are regarded as experts on reproductive and sexual disease and problems. Thus, he believes that traditional healers should be used in campaigns for safer sex, condom use and the avoidance and treatment of other sexually transmitted diseases (STDs). His recommendations have not been taken up: one reason is undoubtedly the one he feared, the opposition of the modern medical profession. Nor has his advocacy of a major campaign against STDs received much support, possibly because some medical opinion is that STDs are so infectious as to render an attack on them even less likely to suceed than a direct attack on AIDS. Green, too, believes that condoms will play a critically important role in containing both AIDS and STDs.

Barry Schoub's *AIDS and HIV in Perspective* is encyclopaedic, but global and very general. Although the author is located at the University of Witwatersrand, Johannesburg, there is very little discussion of the situation in Africa.

The AIDS epidemic has presented an opportunity to increase vastly the research on human sexuality which many social scientists favoured either in its own right or to pursue other agendas than AIDS. Diane di Mauro's work for the Social Science Research Council, assessing *Sexuality Research in the United States*, takes as a starting point the challenge of the AIDS epidemic, but soon gives greater emphasis to the 'many problems associated with sexuality', especially among adolescents. Bolton would certainly be suspicious. The report also emphasizes the need to study abusive and coercive sexual behaviour, and to advance all research on sexuality by promoting it as an important area for university teaching and research.

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Australia and the ICPD: Australia's Position against the Program of Action of the United Nations International Conference on Population and Development

1994. Department of Immigration and Ethnic Affairs. Canberra: Australian Government Publishing Service, 1995. Paperback 204pp.

The (presumably unintentionally) ambiguous subtitle of this report does less than justice to its ambitious purpose. That purpose is, as the then Minister for Immigration and Ethnic Affairs Senator Nick Bolkus stated in the Foreword, to 'assess the extent to which Australia meets the goals and objectives of the ICPD Program of Action' and to provide 'a platform from which further action may be considered'. In addition, the Report is to provide a model for the world: 'I am hopeful that Australia's initiative will stimulate similar action by other national governments....'.

Organized by chapters, the book sets out the undertakings made at the ICPD, referenced by their paragraph numbers, and places below each a summary of government policies and initiatives. It also claims to record 'outstanding challenges and proposed future action', but its compilers seldom seem to have identified either. Thus, the chapter on requirements for basic data collection, analysis and dissemination, for example, is largely a description of what data are already collected by which government departments. One challenge is suggested: that of obtaining reliable data on violence against women; but that, we are assured, is already being addressed through a survey. Other possible challenges are eliminated more comprehensively. The ICPD recommendation for national and regional training programs in statistics, demography and population and development studies is countered by the statement:

> The government does not dictate the type of postgraduate or undergraduate courses which are developed and offered at Australian higher education institutions, or the student load attached to any given course. The range of courses offered and the number of students in any given course are at the discretion of each institution. A number of Australian universities engage in population and demographic studies.

Any need for data on, or research into women's health is apparently being met by the current longitudinal study, which is the sole subject of the paragraph under that heading. There is no mention of any need for additional data on reproductive health. This is despite the fact that the Australian Bureau of Statistics publication *Women's Health* (1994) had an appendix listing major data gaps and deficiencies: two-thirds of the items on the list related to national data deficiencies in reproductive health. The ICPD recommendation of *increased* support for reproductive health research is unaddressed; instead, the response lists a few small research projects funded by the government, a couple of workshops and the 'objective' that organizations funded under the Family Planning Program undertake research.

ICPD called for developed countries to assist contraceptive research programs in developing countries and promote technology transfer to them, as well as facilitating their contraceptive manufacturing abilities. For a response the reader is referred to the chapter on international co-ordination, where one learns that Australia is assisting with climate monitoring and combating desertification in Africa.

Of most interest to the readers of *Health Transition Review*, perhaps, is the chapter on health, morbidity and mortality. This does admit that 'the health situation of Aboriginal and Torres Strait Islander people requires further attention ... the National Aboriginal Health Strategy responds to these issues'. The single paragraph on indigenous infant mortality refers us to another chapter, on vulnerable population groups, in which the National Aboriginal Health Strategy is mentioned: there we learn simply that 'particular emphasis is required on maternal and child care services' and that 'The government is strongly committed to improving the unacceptable health situation of indigenous people ...'. Maternal mortality too, the report notes, is disproportionately concentrated amongst indigenous women, but apart from a reference to the provision of culturally appropriate birthing centres, their specific

needs are not identified in the two and a half pages which deal with ICPD's safe motherhood recommendations.

During the Cairo conference, much hot air was generated over the issue of the health impact of unsafe abortion. That heat seems to have wilted the official response here into four paragraphs of defensive obfuscation. It is just possible to infer that abortion services exist—because Family Planning Associations (for which the government provides funding and which the government hopes 'will encourage a more responsible attitude to parenthood and result in a decrease in the number of unplanned pregnancies, thus reducing the demand for abortion') do offer abortion counselling and referral. Also,

> the Health Insurance Act provides that Medicare benefits are payable where medical expenses are incurred in respect of a professional service listed in the schedule to the Act. The Medicare Benefits Schedule includes medical services which may be used for the termination of pregnancy .... It is important to emphasise, however, that the legal and ethical responsibility for determining medical need for any service rests ultimately with the individual medical practitioner and patient, operating within the framework of the relevant State or Territory law. These laws are the responsibility of State and Territory governments.

Thank Providence—or our founders—for a Federal constitution.

A similar mixture of complacency and evasiveness pervades every chapter of this depressing document. Far from providing genuine assessment of where Australia is in relation to ICPD, or a basis for determining future action, it is quite simply an oversized glossy PR promotion. One can only hope that—despite Senator Bolkus's best endeavours—no other government will be tempted to replicate it.

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The AIDS Epidemic. Social Dimensions of an Infectious Disease. By William A. Rushing. Boulder, Colorado: Westview Press, 1995. xv + 288 pp. Hardcover $US59.00, Paperback $US16.95.

William Rushing's ambitious treatise on the social dimensions of the global AIDS pandemic adopts a novel approach to the task of demonstrating 'how HIV-AIDS is more complex and socially embedded than many have assumed' (p. xii); in each chapter, he adopts a different sociological paradigm for the analysis of the social causes of and responses to HIV/AIDS. The volume is divided into two main sections. Part One, entitled 'Social Aetiology', examines the nature of 'high risk' groups in the United States, controversies surrounding theories of the origin of HIV, AIDS in Africa, and trends in preventive behaviour in America and Africa. Part Two, 'Societal Reactions,' covers topics such as fear, moralizing and 'scapegoating', medicine as social control, and AIDS and the sick role. The book is based nearly entirely on secondary sources, is densely referenced, has many tables and graphs, and a useful index.

Any attempt from within the social sciences to demystify the AIDS epidemic and to convey its social and cultural underpinnings in clear and concise language is welcome. To this end, Rushing's technique of using a different approach for each chapter has yielded a surprisingly successful discussion of arguably the most complex and multifaceted health issue to emerge in the twentieth century. The book, however, is uneven and has several

shortcomings, many of which derive from what makes it interesting—the narrative technique of using one theoretical perspective per chapter to analyse each topic. An over-reliance on single paradigms leads to serious oversimplification and a lack of theoretical sophistication where it is called for. These problems are most apparent in the use of dubious typologies such as 'sex-positive' and 'sex-negative' cultures, the sections on 'cross-cultural' approaches to AIDS in Africa, and the discussion of trends in preventive behaviour.

The chapter entitled 'The Cross-cultural Perspective: AIDS in Africa' is sure to raise the hackles of anyone concerned with cultural context. While Rushing raises several important themes, such as gender power, mobility, and cultural relativism in sexual morality, he engages in gross generalizations about Africa and Africans on the basis of scattered case studies and limited, outdated ethnographies. More problematically, in the following chapter, he blunders into a hornets' nest of issues by asserting in several passages (e.g. pp. 120–123) that Africans are too mired in non-rational, culture-bound notions of health and illness to accommodate scientifically-based AIDS prevention messages.

The obverse problem emerges in his attempts to prove that over time, scientific knowledge will conquer all in 'rationalized societies such as the United States' (p. 123), and that health-related behaviour will be predominantly informed by rational, personal assessments of risk and reward based upon a medically-informed reasoning process. Not only does he fail to raise obvious counter-examples from the United States such as persistent levels of cigarette smoking and alcohol abuse, but he weakly explains away data about race and class which contradict his theory by glibly suggesting that African Americans and members of economically marginalized groups have internalized their oppression and so have a lower sense of self worth (e.g. p. 106), which leads to higher-risk behaviour.

There are a few straightforward and less controversial themes that run through the entire book. Rushing is on more stable ground with his statements that both the manifestations of and reactions to HIV/AIDS are rooted in social institutions and cultural values, and that norms and values about sex combine with social and economic disadvantage in various ways to increase both sexual risk and obstacles for preventive behaviour in certain populations. His most convincing argument about the relationship between knowledge and action is demonstrated in his explanation of why the 'doomsday' projections of a rampant HIV epidemic among American heterosexuals (e.g. pp. 148–150) failed to come true. With the exception of noted subgroups, Rushing argues, the capacity of the population of the United States to inform itself and to respond to the epidemic was grossly underestimated by 'experts,' while the potential for an AIDS Holocaust was overstated from the outset. Other strong chapters deal with high-risk groups in the United States, the debate over the origins of HIV, and fears of contagion.

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