Draft

SIDA's support to family planning programmes

Thirty-five years of Swedish experience
of development cooperation
A desk study

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Contents

Summary conclusions

The *rationale* for support to family planning programmes has always been twofold; it has been based both on a macro- and a micro perspective, and SIDA's view of the support has continously been influenced by the *potential* conflict between the two perspectives.

SIDA has expressed the following *value premises;*
* The right to health care of good quality
* The right to choose between different contraceptives
* Equality between men and women
* No coercion

Lately also the right to sexuality, sexual and reproductive health has been brought up.

The SIDA-support to family planning programmes has rested on the following *assumptions;*
* By improving the primary health care, particularly MCH, more children will survive, and fewer children will be born
* By encouraging breast-feeding the time between births will be prolonged (spacing)
* There exists a great - unexpressed or unconscious - demand for modern contraceptives and sterilizations.

It is not possible to make an overall assessment of the *impact* of SIDA's support to family planning activities. If changes of fertility patterns is used as an indicator, one could probably conclude that many programmes have not been very efficient, considering the relatively few beneficiaries. On the other hand, there may be more fruitful and realistic indicators to assess the support.

The most important role SIDA has played in the "family planning field" seems to have been as advocator of the rights of couples to choose themselves if and when they want children, as advocator for men and women not to be forced to use contraceptives or being sterilized, and as implementor of a high quality of health service for mothers and children.

Since the very beginning of the commitment in the "population area", SIDA has continously advocated the ethical dimension of fertility control programmes; the user should have good information of alternative contraceptives and nobody should be forced to use any family planning method.

The abuse of incentives has continously been criticized by SIDA. That SIDA decreased its *direct* involvement in programmes in the 1970'ies was at least partly a consequence of the fact that unethic approaches were used in some of the SIDA-supported programmes.

SIDA has emphasized the importance of integrating family planning service in maternal and child health care, and has strived for an acceptable quality of the service. This has certainly had a positive effect, but the strategy has also implied that issues about fertility control have become gender-biased and limited to married women with (many) children.

Officially, SIDA has always stressed that family planning programmes *per se* are efficient only under certain circumstances. The importance of raising women's status, of considering cultural values and of changing material circumstances, have continously been stressed. However, there has been a gap between theory and practice, and many SIDA supported family planning programmes have not developed in a context of a societal development giving the programmes a necessary backing.

For the future, it is considered important that

* the social, economic, and cultural contexts of each programme are thoroughly analysed,
* concepts like population issues, and family planning are critically analysed and complemented by other more fruitful concepts,
* each programme is designed in close cooperation with the potential beneficiaries and in relation to different contexts,
* the programmes primarily meet the needs of women and girls but also include men and boys,
* the special needs of adolescents as well as adult singles are met,
* unsafe abortions are avoided, and safe abortions provided when needed,
* family planning programmes are not limited to fertility control, health and diseases in relation to reproduction, but also embrace sexual health, sexual abuse and violence, as well as sexually transmitted diseases, including HIV/AIDS.

Experiences since 1958

A controversial subject

Birth control has always been and will continue to be a controversial subject. It is in the nature of the issue.

Firstly, the number of children born has implications both for local and national institutions and for the individual members of the society. When needed, all societies therefore try to influence their citizens in the desired direction, by positive respectively negative sanctions. Certain countries have used sanctions that can be considered as violations against the human rights.

Secondly, in certain religions, the number of children has been, and still is, looked upon as a gift by God. All kinds of unnatural contraceptives is forbidden. This view is however more and more questioned by the young generation and by religious women's groups.

Thirdly, the man and the women who form a couple do not always embrace the same values and wishes as to use of contraceptives. Whose wishes should be given priority? As sexuality has been a tabooed subject, such questions have rarely been taken up but have now become very relevant considering the danger of HIV/AIDS.

The subject evokes interesting and lively discussions all over. As this report is mainly based on official documents such discussions have got a limited coverage. However, this does not mean that there have been no such discussions at SIDA. On the contrary, strong arguments both for and against support to family planning programmes have continously been brought up. According to programme officers interviewed it is also obvious that these debates have influenced the official SIDA policies very much.

A pioneer role

The international involvement in the population issue started in Sweden during the 1950ies. The *rationale* for the commitment was twofold; On one hand the population growth worried politicians, on the other hand there was a movement within Sweden advocating sexual education and contraceptives from the viewpoint of working-class Swedish women. This movement was lead by Elise Ottesen-Jensen who felt a strong symphathy with women who continously were worried about unwanted pregnancies.

At this time sex, contraceptives and family planning were taboo subjects and controversial issues in most countries, not only in the Third World. Governments found the question too sensitive, and Swedish representatives therefore primarily turned to non-governmental organisations for co-operation. Elise Ottesen-Jensen became for example a member of the Indian Family Planning Association in 1952.

The first governmental bilateral agreement about a family planning programme was signed in 1958 between Sweden and Sri Lanka (Ceylon at this time). Similar agreements were later made with Pakistan and Tunisia.

Sweden also took an active role when IPPF was founded (in 1965), brought up the question in UN and was one of the supporters to establish a special organisation for population issues. These efforts resulted in the foundation of UNFPA in 1969.

The support to Ceylon

The Ceylonese Minister of Health had taken up the question of *"Birth Control"* already in 1949, but had got no response. In 1953 a private organisation was created which assisted *"Pregnancy ridden mothers"*, thus paving the way for a national programme.

At the beginning Sweden took on a very active role in the programme, encouraging a number of studies, monitoring and evaluation. The view was that the programme should be based on the welfare of the families and the couples' perceived needs. Cultural values and social norms should be taken into consideration.

The programme in Ceylon was a response to the threat of the rapid growth of the population, but it was stressed that the problem was not solved by control. Even though the demographic targets were of highest priority, the quality of the service was emphasized, and a number of different kinds of contraceptives were offered. It is a common view that Sweden had a positive influence keeping the quality at a high level.

The first years were considered a pilot period. As both Swedish representatives and Ceylon found that the cooperation was developing positively the agreements were extended a number of times.(From Evaluation Report, 1984).

Gradually, Sweden's role decreased in the programme. At the same time the approach of the programme was changed, stressing the demographic targets more and more. When this development was criticized on ethnic grounds the programme turned back to the

original form for some time. But when it turned out that the programme did not reach expected effects incentives were introduced for sterilizations, and the programme was developed in an aggressive way.

SIDA's policies 1965-1974

In 1965, SIDA was created, and the commitment to population issues and family planning programmes became central. A section for family planning and research was formed, and the disbursements increased considerably. In the late sixties, about 25 countries had got assistance within the population field. SIDA's family planning section was up-graded to a department with a section of health and nutrition questions.

SIDAs official policy was to promote the welfare of the families, by providing them with knowledge and means required to space childbirths in accordance with the wish of the parents. When trying to transform the policy into concrete projects it turned out that the issue was much more complicated than expected. Neither SIDA nor local representatives in the countries had experience in such an intimate and culturally rooted issue as birth control.

IPPF was established in 1965, and during the last years of the sixties, SIDA intensified the stress on UN to bring up population issues. At the same time SIDA expressed intention to decrease the bilateral commitment. The consciousness about the complexity being directly involved in the programmes may have been one reason for this changed attitude.

When UNFPA was created in 1969 Sweden was the first nation to support the agency. Also other UN-organisations, like WHO, UNICEF and ILO started to deal with questions about fertility control during this time, and an increasing part of the Swedish support was given to these organizations.

In 1973, SIDA developed *"Guidelines for population issues, including family planning"*. In the document it is stated that family planning should be seen as one component of social development. The people in the Third World have been denied improved living conditions so far. Consequently, there has been no change to a "modern" fertility pattern with small families.

It was argued that family planning should embrace nutrition, women's situation, maternal and child health and sex education, and it was stressed that people's living conditions must be improved, as this is a necessary precondition for persons to plan for a certain family size.

The Bucharest Conference reinforced SIDAs view

In 1974 the Bucharest Conference on Population Issues was held. At the conference, SIDA expressed a certain suspicion towards some of the family planning programmes claiming that the *rationale* behind the programmes was unclear, and that individual, humanitarian goals were mixed with demographic targets.

The conference resulted in an action plan with a strong support from all the participating countries except for the Vatican State. The conclusions from the Conference were very much in line with SIDA's policy. The plan stated that development was the best contraceptive, and that the population issue could not be isolated from other vital components in a development towards equity. It advocated an integrated view; family planning must be seen in a context of a general social policy that reinforces women's status. Furthermore, family planning was defined as a human right, provided it did not come into conflict with existing or future generations - a formulation that brought to light the potential conflict between the individual and the society.

Integration in MCH programmes stressed

In the guidelines elaborted in1973, SIDA had stressed a number of necessary preconditions for a change in fertility patterns. The Bucharest declaration, that family planning should be one integrated part of MCH-programmes, resulted in health aspects coming more into focus than before. This view was also reflected in SIDAs organization. In 1976, the Population Division changed its name to the Population and Health Division.

However, the importance of other factors in family planning programme was also stressed. In an article (1976), written by the Head of the Population Department at SIDA, "men, male chauvinism and women's subordinate position" were mentioned as the most pertinant obstacles in family planning programmes. In the same article the question was raised whether the best way to decrease fertility would be to support education among girls, to give women employment outside the family, to bring down the infant mortality rate further, or to support a general development in the countryside? The conclusion became that there was no simple answer, and that more knowledge on the microlevel was needed before making priorities.

Studies were however not carried out, but the health aspect was strengthened further during the following years. This was in line with the international development; in the declaration *"Health for all by*

2000" made at Alma Ata Conference in 1978 it was agreed that family planning was one of the eight basic components in primary health care, and that it should be subordinated to MCH.

Policy and reality out of balance

When the international community brought up family planning on the agenda, the Swedish support shifted accordingly. In the middle of the seventies about 70% of the support was channeled through international organisations both within and outside UN. The bilateral government support was largely concentrated to six countries; Ceylon (Sri Lanka), India, Malaysia, Pakistan, South Corea, and Tunisia.

In theory, SIDA continued to advocate for avoiding vertical family planning programmes, and gave priority to integrated rural programmes. The aspiration to integrate family planning into health activities was also reflected in the SIDA budget. The title "population issues" was substituted for "health- and population issues" in the vote "Special programmes" (1979/80). Three years later the title disappeared completely.

In practice, some supported programmes became more and more vertical. One example was the programme in Sri Lanka, which changed drastically from the middle of the seventies when incentives and sterilizations were introduced.

Another example was the Indian programme that had turned more and more aggressive. In the late seventies (1979) this programme was criticized both by researchers and programme officers. The criticism was multi-facetted; The ethic about giving incentives for sterilizations was questioned as was the quality of the health care. Researchers proposed that the socio-economic conditions should be identified and that the need for contraceptives should be related to such conditions. They doubted that contraceptives and sterilizations really promoted welfare and thought that the programme took a short-cut neglecting health needs.

These observations caused a lively debate in SIDA, who finally decided not to support the second phase of the Indian (IPP1) programme, carried out by the World Bank. A couple of years later (Memo May, 1981) a parallell discussion arouse when SIDA was about to expand its support to the family programme in Bangladesh. SIDA's Women Council (KIB) visited the project and recommended SIDA to break the cooperation. Shortly afterwards SIDA withdrew the support.

Integrated approach and ethical values important

SIDAs Health and Population Division changed its name to the Health Division in 1981. The responsibility of population issues continued to be at the Health Division. The consequence of such a solution was not discussed but in reality it implied a focus on family planning within health care programmes.

In 1982, SIDA developed a new health sector policy. In this it was stressed that a major goal for Swedish development assistance was to raise the standard of living for the poorest people, especially those living in the rural areas. An increasing proportion of SIDA's budget was allocated to *integrated rural development.* It was also stated that a primary health care strategy had to be the basis for a concerted attack on the health problems, and that primary health care should be given a self-evident place within any integrated rural development plan. Cooperation over sector bounderies was of utmost importance. (Health Sector Policy, October 1982, p 4-5)

Family planning was one component of the primary health care. The *rationale* for family planning was also in this policy twofold; a. the health risks associated with too closely spaced pregnancies and b. the anxiety over a rapid growth in population and the pressure on resources. It is however stressed that the first argument is the only valid for support through the Health Division. If the goal is to limit the population a number of other measures have to be taken like education, opportunity to work and legislation concerning age of marriage, abortions and land reforms, as the effects of family planning service alone are small. (ibid)

How to cooperate over sector-boundaries was a question not taken up in the policy, which concentrates on the very service. It referred to the Bucharest Declaration (1974) arguing that the family planning should serve *"the right of persons to determine the number and spacing of their children in a free, informed and responsible manner".*

SIDA considered it of particular importance to design the service accordingly. Firstly, by contributing to the extension of mother and child health care, of which family planning is a part. Secondly, by providing a varied selection of contraceptive methods and not make any method more attractive than another by offering incentives.

Lessons learnt

In the preparation for the population conference in Mexico City in 1984, evaluations of the two bilateral SIDA-programmes in Sri Lanka

and in Kenya were carried out. These were the only two countries - out of the 12 receiving bilateral health care support - that got support to family planning programmes.

The evaluation of the programme in Sri Lanka was made first, and the evaluators came up with a number of questions rather than answers about the programme. One such question was the consequences of the strong integration of the family planning programme in the health system. The evaluators thought this prevented the implementation of SIDAs policy to bring the issue of family planning into other types of programmes like water, education, and rural development programmes. (Holmberg et al. Main report, 1984, p 15)

Furthermore, the evaluators criticized the lack of attention given to men in relation to mothers and children, and that adolescents were neglected. (ibid. 1984, p 12-15). Another important issue that was taken up was the conflict between the SIDA policy emphasizing family health and voluntary use of contraceptives on one hand, and the Sri Lanka Government's targets to reduce the population on the other hand. The evaluators concluded that SIDAs credibility was in danger if the support was to continue under such conditions.

The evaluation of the support to Kenya (Holmberg et al, 1983/84, page 34) concluded that

* the family planning activities in Kenya had no significant impact on fertility or spacing

* SIDA's activities within the family planning field were limited to financing and purchasing of contraceptives

* health care resources were limited, which had a negative effect on family planning activities.

A general conclusion was that the Kenyan programme in no way was adapted to the cultural contexts, and that there was very little, if any, popular participation.

A couple of years later, the national health programme for mothers and children (PMI) in Cape Verde was evaluated. (Andersson-Brolin L., 1987). This programme included education and provision of contraceptives, i e a family planning component (PF). The Swedish Non-governmental organization *Save the Children* had supported the programme since 1977, and SIDA had contributed financially.

When the programme started, social, economic and cultural preconditions were analyzed as well as the views of the national leaders and politicians. Around one hundred women one one of the

Cape Verdian islands, São Vicente, were interviewed. This base-line study was used as framework for the evaluation made in 1987.

One evaluation was made from a societal aspect (ibid), another one from the perspective of the very health care programme (Wenngren, Björn, 1988). Both showed that the use of modern contraceptives had increased from around 20% to approximately 60%. The health programme had a vital role as one necessary precondition.

The contraceptive service had early been introduced in a small scale and in secrecy by some Cape Verdian midwives. When the women's movement gradually developed, the right to contraceptives was one important issue on their agenda. The family planning component of the health programme was therefore given credibility from the very beginning. Also the authorities stressed the importance of family planning for gender equality. At the same time they stated that nobody should be persuaded; changes of attitudes and behaviours must come "from within" the individuals.

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Furthermore, the social development in the country had been positive; a family law had been developed, there were more job opportunities, particularly for women, more girls and adult women now go to school than in the middle of the seventies. The women's organization has been very active in this development, advocating the right to education as well as to sexual and reproductive health.

All these circumstances, together with an openness to novelties and ambitions to improve living conditions have had a strong impact. Almost all (94%) São Vicente women who live in stable relations, and with a salaried job, use modern contraceptives. A weakness in the programme is that adolescents and men have been left outside. As expected, also many of the most needed women, the poor, the single and illiterate women, have been out of reach.

The Mexico Conference

During the Mexico Conference in 1984 many of the questions raised by SIDA were taken up and discussed, showing that SIDA was still in

the forefront as to population issues. Some of the recommendations from the Conference had been brought up by SIDA during the last two decades.

One such example was that the basis for an effective solution of population problems must be a socio-economic transformation and that population policies must never substitute for them; "High priority should be given to the eradication of mass hunger and the achievement of adequate health and nutrition levels, to eradication of mass illiteracy, the improvement of the status of women, the elimination of mass unemployment and underemployment and the elimination of inequality in international economic relations".

Six special recommendations took into account the need for actions to ensure that women can effectively exercise rights equal to those of men in all spheres of economic, social, cultural and political life, and in particlar those rights which pertain most directly to population concerns. It was stated that it is equally necessary for men to share fully with women responsibilities in the areas of family planning, child-rearing and all other aspects fo family life. Also these views had been expressed by SIDA during many years.

During the Conference also questions emerged that had been given less attention by SIDA. One example was that population programmes should be responsive to local values and needs, and that those directly affected should be involved in the decision-making process at all levels. Another one was that the participation of the community and concerned non-governmental organizations, in particular women's organizations, should be encouraged.

The concept of family planning questioned

In 1985, SIDA's Strategy for Support to Women was published. In this, family planning was seen as one of several means to improve women's situation. At the same time the very concept was questioned, on the basis of its limitation; it implies that planned procreation is a matter of concern only to married couples or to people living in stable relations.

The fact that family planning consultations are usually conducted through the mother and child care programmes, reinforces the view that questions around birth control are (married) women's concern. It is most often taken for granted. that young girls are left outside. In the strategy it is argued that this is unacceptable as adolescent pregnancies are increasing, with illegal abortions and abandoned children as severe consequences.

The strategy stated that new ideas and new approaches are needed for reaching young girls, boys, men and unmarried women, and that the

methods must be adopted to the culture in question. The importance of SIDA consistently to disassociate itself from every form of coercion was also stressed; *"It is self-evident from an ethical point of view that it is the users themselves who must choose the method they prefer. In order to make this choice possible, the advantages and disadvantages of the various methods available must be presented lucidly and must be made readily accessible".*

From the point of view of women the guiding principles for SIDA's work with family planning were summarized in the strategy as follows;

* Assistance activities should be directed towards changing the life conditions that motivate people to have many children

* Family planning programmes should help men and women to choose when they want to have children

* In its family planning programmes SIDA must give more serious consideration to the sexual vulnerability of adolescents and work towards improving their situation

* SIDA should also work towards making birth control information and sexual counselling available through the schools

* Another important aid activity is to work towards involving men in family planning

* The principle of free choice in family planning must not be subject to compromise

(From The Strategy for Support to Women, 1984, page 20)

It was further emphasized that family planning can not replace social and economic development.

New ideas for programmes

SIDA made efforts to change the support in line with the recommendations from general discussions and the evaluations carried out in 1984 . Researchers from Population Council were engaged to carry out studies in Bangladesh and Kenya, and the results were supposed to function as a basis for future SIDA-support. (Decision 1984-08-28; 810.000 SEK for 1984/85)

SIDA employed an advisor for population issues (1985)[1)], who paid a visit to Kenya in order to identify a number of projects suitable for Swedish support through UNFPA. Five projects were chosen.

One of the projects was carried out at the Kenya Institute of Administration (KIA). The aim was to establish a specialised short-term course in population management and administration and to adapt curricula to population and socio-cultural aspects of rural development. (The project time was set to 5 years.)

The aim of another supported project was to reinforce institutional an analytical capacity for integrating populaton and related socio-economic and health factors in the planning process at District level.

Three of the supported projects contained education in population and family life. One of these projects addressed schools and Teachers' Colleges and had adolescents as the main target group. Another project had the objective to integrate population education and communication throughout the extension network. An emphasis was placed on the training of trainers in Farmer Training Centers at the District level. The third project aimed at community-based programmes, with messages particularly for men, but also women and youth in rural areas.

These projects supported by SIDA via UNFPA were quite different from the bilateral support given, which consisted in purchase of contraceptives. The outcome of the projects has not yet been assessed.

SIDAs Guidelines 1990

In 1990, new guidelines for population issues were adopted[2]. The document comprises the following subjects; *"the world's population today and tomorrow"*, *"population and environment"*, *"the situation of the woman" and "family planning"*. Also this document reflects two different perspectives on population issues; *a.* The global view and the relationship between population growth and its effects on the environment and *b.* the micro-perspective, in which the women's status is focussed.

It was concluded that there is no simple relationship between population growth and use of resources, and that SIDA's role should be to disperse knowledge about the complexity.

From a micro-perspective view SIDAs role should be to improve the women's situation and it is argued that family planning programmes should be supplemented with other measures. Specific measures mentioned as important are; education for girls, including reproduction issues in education and training, supporting programmes for preventing urbanisation etc.The guidelines are therefore directed also to divisions other than the health division.

According to the guidelines SIDA should support four areas;

1. Primary health care, PHC, in which MCH is an integrated part

2. Health care for safe motherhood, including measures to decrease negative consequences of abortions,

3. Family planning programmes allowing a voluntary choice of methods, information, advice, and contraceptives. The programmes should be directed to men and women, and include training of health personnel. Monitoring and evaluation of the programmes is stressed,

4. Activities aiming at improving the quality of information and service.

Different channels are suggested; Swedish non-governmental organisations (NGOs) should be encouraged to consider the population issues in their programmes. The multilateral co-operation and support should continue. Furthermore, both local NGOs and international NGOs with concern for population issues should be supported.

A new strategy

On the basis of earlier experiences SIDA is now (1993) elaborating a new strategy that is to replace the guidelines of 1990. This strategy has three main lines. The SIDA support to population issues should contribute to

* increase the well-being and quality of life of the beneficiaries

* improve the sexual and reproductive health care and advocate for such rights

* review demographic changes, analyze these from environmental perspectives, and forward knowledge about complex relationships.

According to the new strategy, all international cooperation is to have a gender perspective. This implies support to an improvement of women'ssituation in general and to women's sexual and reproductive halth and rights in particular. The goal of meeting women's needs and wishes is to carry great weight.

The correlation between health care programmes and other measures to improve people's well-being is also more emphasized in the new strategy than it used to be. Cooperation between different sector divisions within SIDA is presumed.

Furthermore, the area of health care support has been broadened with less stress laid on traditional family planning programmes. This part of the strategy has been elaborated in a special policy document on SIDAs future support to fight sexual and reproductive ill-health.

Action Plan

~~The policy~~ for sexual and reproductive health

The policy for sexual and reproductive health introduces a new aproach, broadening both target groups and types of activities to be supported.

Health care programmes for women have mainly focussed on women in their reproductive roles, seldom taking sexual and social relations into consideration. It has often been taboo to speak about the severe consequences of unwanted pregnancies and of sexually transmited diseases. The main rationale for SIDAs Health Division to elaborate a new policy was that such issues should be given special attention. This also means that young persons and males will be beneficiaries.

Six areas have been identified as suitable for SIDA-support. These are;

* Adolescents' and other young unmarried pwrsons' rights to sexual health

* The rights to contraceptives and safe abortions

* Maternal health

* AIDS and other sexually transmitted diseases (STDs)

* Competence development among staff and voluntary workers within the field of sexual and reproductive health

* Legal rights to sexual and reproductive health

During the coming year specific situation analyses are to be carried out in SIDAs recipient countries, seminars and courses are to be held and the Swedish competence is to be reinforced in different ways.

Overall conclusions

Population issues and family planning

The concept of *Population issues* refers to changes in the population in a country, region or globally. It includes decreases or increases in size, fertility, mortality, and age composition in a population, different kinds of international and national migration, and urbanization. Knowledge about patterns of such changes is important for planners of health care, day care centres, schools, care for elderly people, residential areas, infrastructure etc.

In the international cooperation, the question about *the growth of a population* has received particular attention. Sometimes the growth has worried both governments and planners in the South and donors in the North, other times just the donors. What kind of measures societal planners have suggested "to solve the problem" is related to how they define "the problem", and what knowledge there is about different phenomena.

The demographic patterns are created by individuals and households, who give birth to a number of children, who move, unite, separate and migrate. In order to make adequate plans, it is necessary to know why people behave like they do. Who are moving, where and why do they move? How many children does a man get during his life-time? And how many does a woman get? Why that many or why that few?

The measures suggested are also connected to underlying *value premises*. There is always a *certain* tension between a society and its individual members, men and women, different generations, poor and rich. Therefore there are relevant questions like; Whose voice is to be listened to? Who to be empowered? What should be considered a right and what are the duties?

Usually, *family planning programmes* have not only been seen as a necessary precondition for but as *the* solution to the population growth. The concept *population issues* has therefore almost always become equal to *family planning* when used in connection with international cooperation. Such a terminology has also been used by SIDA, and has created confusion. A more strict conceptual framework is therfore suggested below.

A twofold rationale for support

When *population issues* came up on the international agenda in the 1950s, Sweden belonged to the pioneer countries. The *rationale* for the commitment was twofold. Firstly, there was a worry about the population growth, i e a definition of the problem on a macro-level. Sweden stressed, however, that the growth could not be solved by control and coercion. Secondly, the problem was regarded from the perspective of women. This view was based on the ideas of a Swedish movement, advocating sexual education and contraceptives.

The two perspectives have ever since formed the general motives for the Swedish support in the population area, but surprisingly enough, there have been few analyses dealing with the potential conflict between the two views.

From participant to a donor role

In the beginning, most governments were reluctant to bring up population issues, and Sweden worked through non-governmental organizations. The first bilateral agreement on governmental level was signed in 1958, and was followed by several more. Sweden took on *a very active role* in the support. When SIDA was established in 1965, a section for family planning and research was formed, and the commitment in the population field became still stronger.

The commitment kept increasing and in the late sixties about 25 countries received assistance. Parallelly, a number of international agencies were just about to be established, and SIDA strongly supported these organizations, particularly UNFPA, that was created in 1969. This development implied that SIDA took on a new role, that of a donor rather than an active participant.

Increased welfare taken for granted

During the 1960s, the view was that family planning programmes should be based on the *welfare of the families and the perceived needs* of couples. SIDA's *rationale* was to promote welfare by providing families with knowledge and means required to space childbirths.

When SIDA's first guidelines were formulated in 1973 it was stressed that family planning should be viewed as *one component of the social development.* It should embrace nutrition, women's situation, MCH and sex education, a view that was reinforced during the Bucharest Conference. Furthermore, family planning was defined as a human right.

The guidelines did not advocate for different programmes in different social contexts. The support was given to countries, irrespective of indicators of a social development, all in line with the general SIDA cooperation policy at this time. It was assumed that SIDA-support would be adequate, provided that the family planning activities were embedded in maternal and health care.

These ideas were based on an optimism about a general social development in the Third World, and that the fertility was going to decrease, provided contraceptives were at hand. However, when these ideas were transformed into concrete activities, a number of constraints appeared. It turned out that the positive development was put off, and that the issue of fertility control was more complicated than expected.

Many constraints

In the middle of the seventies, the complexity of family planning programmes was analyzed in an article. Men, male chauvinism and women's subordinate position were mentioned as the most pertinent obstacles, again showing that SIDA's contribution was very much dependent on the social context of the programmes. At the same time, SIDA's possibility (and wish) to influence these contexts was limited, and the gap between theory and reality continued to be wide.

Critical views

The difference between policy and actual programmes became evident in India and Bangladesh, and in the late seventies SIDAs involvement was very much criticized both by researchers and by its own staff. The criticism made SIDA withdraw from the programmes.

During the seventies there was also an international debate going on about the negative effects of contraceptives and of using some means in the Third World that were prohibited in most of the northern countries. All these negative experiences had an impact on how family planning programmes were viewed in the new health policy, formulated in 1982.

Service of high quality

In the policy of 1982 it is referred to the Bucharest Declaration (1974). The family planning should serve *"the right of persons to determine the number and spacing of their children in a free, informed and responsible manner"*. SIDA considered it of particular importance to design the service accordingly. Firstly, by contributing to the

extension of mother and child health care, of which family planning is a part. Secondly, by offering a selection of contraceptive methods, and not making any method more attractive than others by offering incentives.

Like earlier, the family planning was seen from two angles; a. health risks associated with too closely spaced pregnancies and b. anxiety over a rapid growth in population and the pressure on resources.

It was argued that the effects of family planning service alone are small if the target is demographic; if the goal is to decrease the population growth, the countries must improve education and opportunities to work and elaborate a legislation concerning age of marriage, abortions and land reforms.

If SIDA should contribute to an integration of the different types of measures to decrease fertility *was however not taken up* in the policy. SIDA's main role was defined as *focussing health aspects of pregnancies* and guarding a high service quality. This implicitely meant that the beneficiaries were women using the offered MCH-service. One reason for choosing this approach was the negative experiences from earlier family planning programmes.

Relatively few beneficiaries

SIDA's bilateral family planning programmes in Sri Lanka and Kenya were evaluated in 1984. Some conclusions from these studies were that the programmes had little effect on fertility or spacing, that SIDA's role was limited, that men were left out and that the programmes were not adapted to the cultural context. For the first time, also negative consequences of the programme being integrated in MCH were taken up.

When SIDA's strategy for support to women was published in 1985 similar opinions were expressed. The very concept of *family planning* was questioned, as this limited the beneficiaries to married couples or persons with stable relationships. It was also argued that the integration of family planning programmes in MCH reinforced this tendency, thus leaving many young girls, boys and men outside. Also in the strategy it was emphasized that family planning is but one part of a general development.

Like in most of the SIDA-documents, the importance of the ethical dimension was stressed; *the users themselves must be allowed to choose the method of fertility control that they prefer.* Furthermore, it was again stated that the activities should be directed towards better living conditions, and that contraceptives should be seen as *one* of many components of the social development.

Both the evaluations and the strategy gave rise to important questions how to approach issues relating to fertility, reproductive rights, health and sexuality. The reports contained ideas of new approaches, but it would last a number of years before these ideas were discussed seriously. It would also take some time before SIDA took up questions like who the beneficiaries are, and how to empower categories with different needs and problems.

A changed approach

The Guidelines for Population Activities, written in 1990 took the same two approaches to population issues as in earlier documents, i e a global view and a micro-perspective. For the first time the correlation between population growth and its effects on the environment was taken up. It is concluded that there is no simple relationship between population growth and use of resources, and that SIDA's role should be clarify this complexity.

Again, it was stated that even though family planning programmes are important, they have to be supplemented with other measures if the fertility rate is to decrease. Job opportunities and education for girls, including reproduction issues in education, were some examples mentioned. The responsibility for "population issues" was supposed to be shared between many SIDA divisions, even if the health division would continue to have a key role.

SIDA has always guarded the quality of different types of health care programmes. It has also emphasized that the design of the programmes should reflect the needs of the people and rest on the value premises of women's empowerment and of the right to adequate reproductive health care. Up to now such statements have been generally formulated. However, in the new *policy for sexual and reproductive health* the words have been given concrete contents. The traditional view of family planning has made room for a wider perspective, and the beneficiary group will comprise both men and women in different situations and stages in the life cycle.

An important aspect taken up in the new policy documents is the question about what channels to be used for the support. NGOs, particularly women's groups and organizations, are mentioned. *Considering earlier experiences, this seems adequate as contacts with local communities and using women's lense is a necessity.*

New conceptual framework needed

The use of the concept of *population issues* creates some confusion, particularly when it is used as a synonymous to *family planning*. Why is only family planning programmes called *population programmes* and

not activities like education, income generating activities, and integrated rural programmes? Is it because the family planning programmes are supposed to be directly linked to changes in population size? We know however that the picture is much more complex, and that the use of the concept is not very adequate.

Also the concept of *family planning* has to be discussed. Concretely, family planning has meant information about and provision of modern contraceptives and sterilizations. Access to contraceptives may contribute to better control of one's life situation, to freedom from unwanted pregnancies, to more children being wished for - provided there is no coercion or persuation from outside. However, when campaigns of persuation start, or when incentives are introduced, the access to contraceptives or sterilization is no longer a potential resource for the individuals. To regulate one's fertility is no longer a right, but has been transformed to a "societal duty".

Some programmes have been responses to women's demand for birth control. However, the majority have been carried out without taking socio-economic and cultural contexts, and women's and men's actual needs into consideration.

Even though it is difficult to draw any exact line dividing types of situations, it would be fruitful to distinguish different programmes conceptually. So far, this has not been done. The result is that the concept of family planning often evokes negative associations and that almost all family planning programmes have a bad reputation.

In the new approach for *Sexual and reproductive health care* the *family planning* concept will be less relevant. Taking *all* people's needs and sexual behaviour as a starting-point, teenagers, single women and men will have the right to contraceptive service even though they have other motives than family planning. Such a point of departure calls for *a variety* of programmes and approaches, adopted to the specific local needs of different categories of beneficiaries. Programmes are therefore best described in concrete terms.

Notes

1) SIDA's increased interest was also reflected in the fact that the title "Population issues" returned within the vote of "Special Programmes", and that the disbursements to the multilateral organisations, particularly UNFPA, increased considerably.

2) As a summary, three main goals for the support were identified; 1. A balance between population and resources, 2. improved status and situation for women, and 3. increased awareness about causes of population growth and its consequences for development, nature, and life quality

REFERENCES

Andersson-Brolin, L. *O direito de ser desejado.* (The right to be longed-for). A study of a family planning project in Cape Verde, SIDA and Rädda Barnen, 1987.

Andersson-Brolin, L. and Wallroth, C. *Some perspectives on IPPF - International Planned Parenthood Federation,* SIDA 1984

Befolkningsfrågorna inför 90-talet. En artikelsamling från PROP (Programmet för befolkningsfrågor i u-land), Lund, Maj 1992

Bergstöm, S. *Bistånd för bättre mödrahälsa och reproduktiv hälsa,* Oktober 1991

Bergström, S. *The second India population project.* A consultant report, June 1979

Egerö, B. *Några centrala frågor om befolkning och utveckling i världen i dag,* PROP, Lund 1992

Ferguson, A. *Family planning adoption, change and discontinuation.* A study from two rural areas of Kenya, GTZ/ MOH, Kenya, July 1991

Goppers, K. and Bruszt, G. *United Nation's Fund for Population Activities, UNFPA - an evaluation of its operation and goals,* SIDA 1984

Hammarskjöld, M. *Kort historik över befolkningsfrågornas hantering i det svenska biståndet,* PROP, Lund, Maj 1992

Hannan-Andersson, Carolyn. *Gender aspects in population issues,* Seminar Paper, April 1991

Holmberg, I., Liljeström, R., Murelius,O., Ohlsson, B. *Evaluation of Swedish Assistance for Family Planning in Kenya,* SIDA, 1984

Holmberg, I., Liljeström, R., Murelius, O., Ohlsson, B. and Wallroth, C. *Evaluation of Swedish assistance for family planning in Sri Lanka,* SIDA 1984

Hyrenius, H. and Åhs, U. *The Sweden-Ceylon Family Planning Pilot Project,* Demographic Institute, Report 6, Gothenburg, 1968

Landry, E. et al. *An Information and Education Strategy to Increase Knowledge and Improve Attitudes Towards Vasectomy in Chogoria, Kenya.* Community Health Dept, Chogoria Hospital, Kenya, December 1990

Nu. Nytt om U-landshälsovård. Temanummer: Population trends and family planning, Nr 2. 1991

Peterson, P O. *Child health care in Sweden.* Paper, Gothenburg Health Care Services, November 1992

Shepherd, G. *Options for SIDA in the population field in Kenya.* Overseas Development Institute, London, May-June 1986

Silberschmidt, M. *Studies on the local context of birth control in Kisii District, Kenya,* SIDA, 1986

Wahren, C. *Familjeplanering i ett internationellt perspektiv* i "Sexualitet och födelsekontroll". Socialstyrelsen, 1976

Wenngren, Björn. Mödra- och barnavaårdsprojekt inkl familjeplanering, Kap Verde 1977-1987. En retrospektiv utvärdering. Rädda Barnen, April 1988

Abortförebyggande program. Att samordna insatser som rör sexualitet, Socialstyrelsen SOS 1990:39

Barn? Författare, forskare och skolungdomar diskuterar varför det föds så få barn. Liber, 1983

Colóqio nacional sobre educacâo sexual e familiar (22-26 de Abril 1985). Relatório, Praia, UNESCO/FNUAP, 1985

Newletters from Women's Global Network for Reproductive Rights

Population Perspectives. Statements by world leaders. 1984

Review of the national family planning programme in Ceylon 1965-1975. Undated paper

Rum för miljarder. SIDAs TEMA SERIE

SIDA policies, sector reports and memos:

Reflektioner kring Sveriges framtida roll. Memo, Olof Murelius, Verksledningen, SIDA, 1985

Rapport från besök i Kenya. Memo, Stiernborg, M. Hälsobyrång, SIDA, December 1986

Population and Family Welfare Project in Bangladesh, Memo, Health Division, SIDA, March 25, 1981

Miljö och fattigdom. Handlingslinjer för SIDAs bistånd, 1991

Bistånd i en föränderlig värld. SIDAs verksamhet 1992-95

Guidelines for Activities within the Area of Population, SIDA 1973, and 1990

SIDAs Handlingsprogram för ett kvinnoinriktat bistånd, 1985

SIDA's Health Sector Policy, 1982

SIDAs insatser på befolkningsområdet, Februari 1991

SIDAs insatser för mödrahälsovård. Maj 1991

SIDA's Health Sector Report, 1992

SIDAs handlingsplan för sexuell och reproduktiv hälsa, Draft 1993

ABBREVIATIONS

ILO	Internatinal Labour Office
IPPF	International Planned Parenthood Federation
MCH	Maternal and Child Health
MOH	Ministry of Health
NGO	Non-Governmental Organization
PHC	Primary Health Care
STD	Sexually Transmitted Disease
UNFPA	United Natins Fund for Population Activities
UNICEF	United Nations Children's Fund
WHO	World Health Organization