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INTEGRATION

International Review of Population and Reproductive Health

Supporting the Private Sector

Kazakhstan and Kyrgyzstan pay closer attention to promoting reproductive health care and family planning

Johns Hopkins University School of Public Health Center for Communication Program

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INTEGRATION

International Review of Population and Reproductive Health

Kyrgyzstan, one of the former Soviet Republics in Central Asia, is working hard to lower maternal and infant mortality rates. A series of reform it has develolped for the health system is obtaining good results. But more rapid improvements are required through innovation of services that will not require additional government cost. First Deputy Minister of Health of Kyrgyzstan Dr. Beyshekan Kalieva said: "In my opinion we have to support the private sector that promotes the well-being of families including provision of contraceptive services."

First Deputy Minister of Health of Kyrgyzstan Dr. Beyshekan Kalieva

Indonesia is challenging for improvement in the quality of the population by promoting the family welfare movement. Prof. Dr. Haryono Suyono, minister of State for Population and chairman of the National Family Planning Coordination Board, writes: "The community should be encouraged to pay more attention to improve the qualtiy of population by enhancing the well-being of families of low welfare.

State Minister for Population Haryono Suyono

COVER

Karligash Rahimova photographed in Almaty, Kazakhstan by Hiroshi Taniguchi

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KYRGYZSTAN & KAZAKHSTAN

Supporting the Private Sector

The need for the structural reform is clearly recognized for effective promotion of family planning

By Hiroshi Taniguchi

Mr. Yasar Yaser, executive director of the Turkish Family Health and Planning Foundation and I visited Kyrgyzstan (pop: 4.4 million) and Kazakhstan (pop: 16.9 million) from May 25 to 31, 1996 to observe the reproductive health and family planning situation, learning from high-ranking officials and specialists there.

The reproductive health situation appears unsatisfactory in the two Asian Central republics, which broke away from the Union of Soviet Socialist Republics (USSR) at the end of 1991, as represented by the high maternal and infant mortality rates. The maternal mortality rate is 67.4 per 100,000 live births in Kyrgyzstan[1] and 77.3 per 100,000 live births in Kazakhstan[2], respectively (in 1995). The infant mortality rate is 27.5 per 1,000 live births in Kyrgyzstan[3] and 26.8 per 1,000 live births in Kazakhstan (in 1995).[4]

We were often told that the undesirable level of reproductive health in the two countries had been greatly attributable to serious economic problems. Since the economies of Kyrgyzstan and Kazakhstan had been interwoven with the other republics of the USSR before independence, the two countries have been unfavorably affected by the consequent loss of economic ties with the other former member countries of the USSR after their breakup with it. (Remarks: The per capita gross national product is $830 in Kyrgyzstan and $1,540 in Kazakhstan (in 1993).[5]

The process of privatization is also reported to be causing many state companies and factories to be closed. For example, industrial production has dropped by 35 to 50 percent in Kazakhstan since the breakup.[6]

The environmental destruction is said to also have been badly affecting the health conditions of the population. In Kazakhstan, for example, healthy women account for only 30 percent[7] due to salinization of the soils and draining of the Aral Sea (once the world's fourth largest inland sea) caused by extensive irrigation.[8] More than 500 nuclear tests conducted at Semipalatinks in the country are said to have created long-term environmental health problems.[9]

One of the deplorable issues we have identified is the frequent use of abortion as the major method for regulating the number of births or for spacing, reflecting the strong desire to regulate the number of births or spacing of births against the limited supply of modern contraceptives.

The abortion ratio (the number of abortions per 1,000 live births) is quite high. In Kyrgyzstan the abortion ratio is 610 in 1990/93. In Kazakhstan it is 980 in 1990/93.[10]

The contraceptive prevalence rate (percent of married women using modern contraceptives) is 25 percent in Kyrgyzstan and 22 percent in Kazakhstan.[11], far lower than the level of knowledge of modern contraceptive methods: 91 percent in Kazakhstan and 87 percent in Kyrgyzstan.[12]

The hardships including couples' dwindling income brought on by the economic and political chaos started around 1989 seem to be greatly increasing couples' desire not to have as many children as before against the uncertain future perspective. In Kyrgyzstan, the total fertility rate (TFR) that peaked at 5. 39 during 1960-1965 and still stood at 4.10 in 1985 declined to 3.3 in

Minister of Health of Kyrgyzstan Naken Kasiev: We are eager to get support of other countries including Turkey in IEC including publication, training and contraceptives

The special report of this issue was planned in cooperation with Mr. Yaser Yaser, executive director of the Turkish Family Health and Planning Foundation. Authors, including the editor, heavily used the POPLINE, an international population database available on compact disc, provided by the Johns Hopkins University Center for Communication Programs, when writing their articles for the special report.

1995. In Kazakhstan, the TFR that peaked at 4.54 during 1955-1960 and dropped to 3.1 in 1985 fell down to 2.3 in 1995.[13, 14 & 15]

The Ministry of Health of Kyrgyzstan began to work on the reproductive health program since 1989 when it knew that about 60 percent of infant deaths were the infants of mothers who very often gave birth to and/or the infants who were born at very short intervals.[16]

Kyrgyzstan health officials lament that they suffer from lack of adequate scientific research and deep analysis of the prevailing reproductive health situation. They are trying to improve gynecologists' knowledge and technique which have fallen behind developed countries. It is reported that due to shortage of adequate medicine, equipment, etc., babies die even in the maternity hospital in the capital, Bishkek.[17]

The Ministry of Health of Kyrgyzstan has focused its reproductive health and family planning program in the southern part of the country where the infant health condition is very bad.

"Communist Party bureaucrats - the apparatchiks - decided what factories produced, what farmers planted, how much people were paid, the price of every item in the economy...The list is endless. The system failed because: 1) it was too complex; 2) it took away basic incentives for individuals to excel; 3) it punished individual initiatives and innovation; and 4) it was run by a non-caring cadre of privileged bureaucrats who were not subject to the will or even the goodwill of the public."[18]

We thought that it was true of the health system including reproductive health and family planning in Kyrgyzstan and Kazakhstan where we were visiting. A simple question is that why and how the rigid old health system can continue to survive amid privatization of economic actitvities. Dr. Beyshekan Kalieva, first deputy minister of Health of Kyrgyzstan, said that a lot of resources were still invested in the aged health system of the country.

Apparently the results of a series of reform for the health system are not unsatisfactory. The need for structural reform, in other words, privatization of health services, is recognized as necessary. "In my opinion we have to support the private sector that promotes the well-being of families including provision of contraceptive services," said Dr. Kalieva. "We have already created some NGOs and we are in the process of helping establish the private sector.[19]

The Ministry of Health of Kyrgyzstan is working for the improvement in the reproductive health and family planning in collaboration with the United Nations Development Program (UNDP), United States Agency for International Aid (USAID), United Nations Children's Fund (UNICEF), etc., so that a great number of people will have free access to quality services. It is also constructing a children's hospital with 300 beds using the fund of six million dollars provided by the Japanese government. Dr. Kalieva said that the Islamic bank of reconstruction and development had recently decided to assist the republican maternity hospital with the budget of two million dollars.

How will two Central Asian Republics be successful in improving reproductive health (a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes)? The answer to this question will depend on the determined development and implementation, especially on the services to be provided by NGOs and the private sector in these countries. The key is how to meet with the changing reproductive health and family planning needs that greatly vary according to the gender, age, area, time, etc. In this respect, both traditional bilateral donors, and new donors such as Turkey and member countries of "Partnership in Population and Development" established in September 1994, will greatly help the two Central Asian Republics timely develop and implement quality services for women and men. We are anxious to see the fruits within a decade. ■

First Deputy Minister of Health Dr. Beyshekan Kalieva: We are in the process of helping establish the private sector

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KYRGYZSTAN

Program for Change

Women should not be dying because of diseases entailing pregnancy and childbirth

By Mairam D. Akayeva

The demographic characteristics of any country are closely linked to the size of women in fertile age, the state of their health, peculiarities of their reproductive behaviors, as well as the socio-economic conditions in the country. It is these factors that determine the health of the children.

In the Kyrgyz Republic (pop: 4.6 million) women in the childbearing years consists 22.3 percent of the population (in 1994). The total fertility rate is 3.1: about 19 percent of women give birth almost every other year and 22.3 percent of mothers give birth every two years. The birth rate is 25 per 1,000 population.

Women-mothers of large families in the Republic constitutes 35 percent. In rural areas this figure rises up to 52-55 percent.

Due to various reasons, only 9-12 percent of women are healthy. 20-36 percent of all teenage girls suffer retardment of physical development. The figure goes to 40-60 percent among girls from families engaged in cultivation of tobacco and cotton, and stock raising. Moreover, the reproductive organs of about 15 percent of all girls aged 11-17 are functionally disordered.

Mortality is higher among the women-mothers of large families (more than 5 children): they make up one-third of all women dying annually.

The reproductive behaviors of women of different age groups have their own peculiarities. The age-specific fertility rate for women aged 40-44 in Kyrgyzstan exceeds four times that in the Commonwealth of Independent States (CIS), and the age-specific fertility rate for women aged 45-49 is more than 9 times.

Unwed teenagers' pregnancy is also posing a big problem: the extramarital birth rate of adolescent mothers aged 15-18 increased to 34 percent in recent years.

Mairam D. Akayeva, the First Lady of the Kyrgyz Republic, has a dream of world where every child to be bron is a planned one

In the mountainous areas of the country, with 93 percent of the territory being located at a height of 500 to 7,000 meters above sea level, about 32 percent of pregnant women suffer from complications. Moreover, about 11 percent of women have premature births.

The majority of children are born with a low-body weight which is one of the causes

Mairam D. Akayeva, the First Lady of the Kyrgyz Republic, is the president of the International Charitable Foundation "Meerim." This paper is adapted from the English translation of her presentation at the "Family Health and Family Planning in Islam" Conference held in Ankara, Turkey from Nov. 16-17, 1995.

for high morbidity and mortality rates.

The level of contraceptive use is low: only 21.3 percent of the fertile women use contraceptives with the intrauterine device (IUD) being the most popular.

The absence of proper attention to the promotion of family planning, which is of particular importance within the medical and social issues related to the protection of maternity and childhood, has made abortion the main birth control method.

Reflecting the low use of contraceptives accompanied by the high abortion rate (40.7 was the estimated number of abortions per 1,000 women aged 15-44 years in 1995), many women are dying because of pregnancy and childbirth complications: there are 80.1 maternal deaths per 100,000 live births, which is 4-5.3 times higher than in industrialized countries. The main causes of maternal mortality are attributable to the extra-genetic pathology, obstetrical hemorrhage, and puerperal septicemia.

The major causes of child mortality are also prenatal diseases including intrauterine infection and those related to the sexual organs.

The child morbidity and mortality rates increased for the past several years due to the spread of a high level of hypo-agalactia in the country. The pathology results from the incomplete diet and unbalanced nutrition of the pregnant women and feeding mothers who suffer from extremely low level of financial security. It implies that mothers' poor health and nutritious conditions are exerting an extremely negative impact on the health development of the upcoming generation.

We have, however, a hope for the improvement of this far-reaching problem. The child mortality rate decreased to 29.1 per 1,000 live births in 1994, down 8.8 percent from the previous year's level. This decrease, however small, has given us strong encouragement for continuous efforts.

It is generally known that women's health is a key factor to development of a healthy society. We should spearhead the movement for their health protection. To our regret the deteriorating economic conditions have been unfavorably affecting women's health and reproductive behaviors, for very often mothers are obliged to engage in highly paid but health-damaging work, in order to help family finances.

One of the special problems confronting the Kyrgyz Republic is the poor state of reproductive health of teenage girls. Teenage mothers account for one percent of all dying mothers with abortion being the main cause of mortality.

According to recent statistics, abortions performed on girls of 15-19 have reached 7,986 (with 229 cases performed on 15-year-old girls), which accounts for 14 percent of all abortions performed in the Republic.

The reduction of the maternal morbidity and mortality rates is the major objective of the reproductive health and family planning programs in the country.

One of the promising programs is the "Kyz-Bala (Girl)" program with prime attention paid to the protection of reproductive health of teenage girls, which has been developed and promoted by the International Charitable Foundation "Meerim." As the worldwide experience shows, the most efficient way of promoting family planning is to start at an early age.

Another is the Family Planning and Social Nursing Service that was established in 1989. The Service provides family planning services, promotes a higher sanitary behavior of the people through the information campaign for a healthy life style. The Service also carries out activities that aim at preventing "risk" families from developing into maternal and child mortality.

The Social Nursing Service has accom-

Kyrgyzstan is a country of high mountain ranges. The highest altitude is 7,439 meters, the lowest is 401 meters above sea level

A mother with three children in Bishkek

A boy taking care of his sister

plished good results, according to a study. Targeted "risk" families generally improved their health thanks to care and advice provided by the Service's specialists. Moreover, no mother died in 1994. The death toll of children aged 0- 5 decreased 40 percent from the previous year's level and the infant mortality rate was reduced by half. The number of premature births and abortions also diminished. The contraceptive prevalence rate increased to 18 percent which resulted in the 34 percent decrease in the number of children born in two successive years.

Enactment of legislation for the reproductive rights in the Kyrgyz Republic corresponds to the provision of the United Nations European Convention and the World Health Organization (WHO). The new law is aimed at the liquidation of all forms of discrimination concerning safe maternity that has been incorporated in our Constitution. The idea of removal of various types of discrimination is also evident in the law on "public health protection" adopted by the Kyrgyz Parliament.

The government program "Healthier Nation" developed on the basis of a clearly defined policy has adopted the reproductive health strategy.

The following tasks by objective should be developed in the long-term perspective of the reproductive and family planning policy and they should be immediately implemented:

1. For promotion of spacing of births: how to educate the target women on the damage which frequent childbirth will cause to their health and their children's, and the effectiveness and advantages of using different methods of contraception and their access to them. In this connection, the provision of free and reliable contraceptives to "risk" women such as women of low-income and large families is of great importance.

2. For prevention of abortion: how to inform the target women of the harm to their health which abortion (especially in the later period of pregnancy) will cause.

3. For quick and wide dissemination of information: how to develop a special information system for information dissemination on the importance of family planning and protection of reproductive health.

4. For hygienic education and social adaptation of the young: how to conduct a study of the medical and social aspects of a healthier way of life, reproductive behavior and the problem of socialization. Remarks: Many diseases are connected to or result from the way of life and they are preventable and/or manageable through the positive change in the lifestyle.

5. For raising the qualification standards and skills of the medical personnel and staff: how to develop a special government training program for the Social Nursing Services, and how to strengthen educational infrastructure with educational materials such as guidebooks and textbooks being developed.

6. For provision of a wide selection of safe and effective contraceptives and improvement in the public access to them: how to conduct training for medical personnel and staff of the Social Nursing Service.

7. For development of quality standards of the medical service and its costs: how to enact a legislation for helping expand the involvement of doctors of non-governmental organizations (NGOs) and the private sector.

8. For improvement in the reproductive health: how to develop a national strategic plan for promotion of the reproductive health.

9. For resource development: how to identify financial sources for the reproductive health program.

We are adherent of the program for change, that makes it possible for mothers and children of the Kyrgyz Republic to enter the 21st century with the aspiration to a better future, a future free from disease that is crippling and ruining our society, the future free from abortion, poly--melus, goiter and blindness resulting from lack of vitamin A. It is against these diseases that we have to struggle both at home and on the international stage. Mosque and Church should also jointly struggle against them in collaboration with the government and NGOs. It is on the result of this struggle that history and people will be judged.

To conclude I would like to state that I have a dream, a dream of world where every child to be born is a planned one; children are well-educated, loved and secured; and women are not dying because of complications of pregnancy and childbirth.

Let us come to an agreement and start working for the sake of mankind. ■

Young women in Bishkek

KYRGYZSTAN

Increased Use of Pills

The number of abortions started to decrease in Bishkek in 1995

By Anara Doolotova & Javed S. Ahmad

The extensive reliance on abortion as a means to avoid unwanted births is a matter of grave concern for the governments and health agencies in the newly independent states of Central Asia including Kyrgyzstan. Historically, the incidence of abortion had been high because many women wanted to control the number of births in a situation where appropriate contraceptive services were limited.

Central Asian Republics were short of modern contraceptives, even the IUD that used to be the sole contraceptive offered by the health systems in the Central Asian Republics (that include Kazakstan and Azerbaijan). Shortage of IUDs began to take place in 1991, when these countries became independent. With the breakup of the Soviet Union, supply of IUDs from Russia, the exclusive supplier of IUDs to these countries, stopped. The countries' stock had quickly dried up.

In 1993 UNFPA sent several missions to the region to meet with the crisis of contraceptive shortage. Based on their recommendations, UNFPA sent bulks of IUDs (Copper-T), oral pills, injectables (Depo Provera) and condoms to these countries as an emergency measure. UNFPA also expressed its intention to provide support for training in contraceptive technology and information, education and communication (IEC) in reproductive health.

The Kyrgyzstan Ministry of Health started to provide birth control services with the use of contraceptives supplied by UNFPA late in 1994 soon after it received the shipment. (Condoms arrived toward the end of 1995.)

In 1995, the UNFPA-funded Safe Sex Education Campaign was decided to be launched in Bishkek, the capital of Kyrgyzstan. At the request of the Mayor of Bishkek, the campaign to be developed was aimed at reducing the high incidence of abortion in the city.

Dr. Anara Doolotova says that the number of abortions will further decline when contracpetives can be offered accompanied by appropriate IEC activities and friendly counseling

Prior to developing the IEC messages, it was felt necessary to study a profile of the abortion clients. For this purpose, it was decided to analyze the abortion client record cards of the Marriage and Family Guidance Consultation (M&FGC) Clinic, the main government health facility in Bishkek.

The M&FGC clinic, an organ of the National Research Institute of the Ministry of Health, is conveniently located, and within walking distance from the city's main railway station.

The majority of the clients come from

Dr. Anara Doolotova is the chief of Marriage and Family Guidance Consultation, Kyrgyz Institute of Obstetrics and Gynecology, Ministry of Health, Government of Kyrgyzstan. Mr. Javed S. Ahmad is the adviser on Labor & Population (IEC), UNFPA Country Support Team for South and West Asia, Kathmandu, Nepal.

urban areas (basically Bishkek).

The M&FGC clinic, headed by an obstetrician and gynecologist, and staffed by several specialists and nurses, provides reproductive health services to roughly 300 outpatients, both men and women, every working day. The services include diagnostic test and referral, treatment of related diseases, infertility and both mini- and maxi-abortions.

Under the government policy, all services are charged except for a few qualifying clients. Current fees for a mini abortion is 51 soms (about $4.60) and 76.4 soms(about $6.89) for a maxi abortion. Clients, who need extra services such as diagnostic test, pay an additional 8.4 soms (about $0.75) .

Clinic staff have received training organized by the Futures' Group (SOMARC), the Association for Voluntary Surgical Contraception (AVSC) and the Family Health International (FHI).

Nearly 80 percent of the women undergoing an operation for abortion are counseled on contraception. A big problem is that there are no appropriate IEC materials on contraception that can be given to these women who ask for counseling. Also there is no video program or audio-visual aids for use during training or counseling.

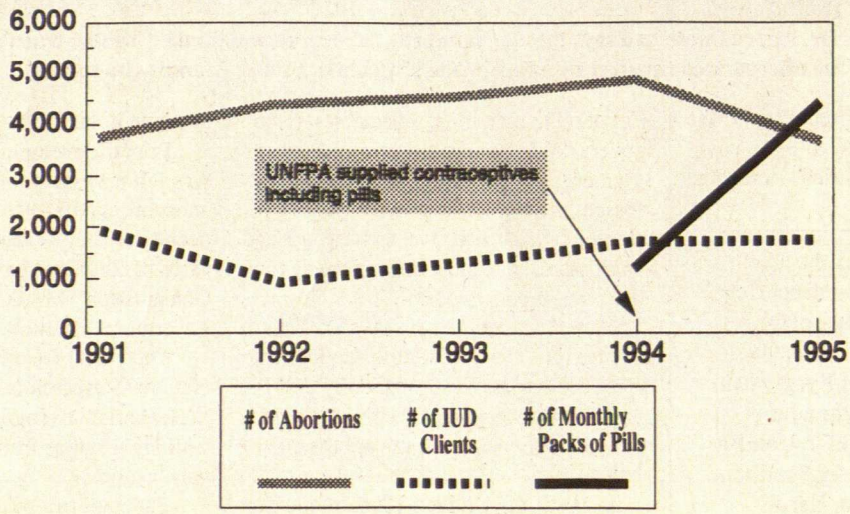
A mother and her two children in Bishkek

Methodology

Among the items in the client record card used by the M&FGC clinic, 15 items were selected necessary for analysis of abortion seekers. On October 23, 1995, input was started with the use of an Excel spreadsheet program. By February 26, 1996, the work finished: data of a total of 743 abortion clients (representing 100 per cent of abortion clients during the four months from Oct. 23, 1995) were input.

After making necessary conversions from the data maintained in Russian to numerical code, spreadsheet data were saved in Lotus 123 worksheet format and further translated in the SPSS PC + (Version 5) format. Using SPSS analysis tools, frequency

Figure 1 Number of Abortions Performed, IUDs Inserted and Monthly Packs of Oral Pills Dispensed at the Marriage and Family Guidance Consultation Clinic, 1991 -1995



Shopping of necessities of life at shops that came into existence along the market economy policy

Table 1 Number of Abortions Performed and IUDs Inserted in the Six City Clinics, 1994-1995

Year	Abortions	IUDs
1994	11,103	6,738
1995	10,232	6,633

Table 2 Percentage Distribution of Clients by Type of Service

Type of Service	Percent
Abortion (any type)	2.4
Mini Abortion	82.5
Abortion up to 12 weeks	15.1
Total	100.0
Number	743

Table 3 Percentage Distribution of Clients by Frequency of Visit

Frequency of Visit	Percent
First	24.0
Second	75.5
Other	0.5
Total	100.0

and cross tables were produced, albeit for limited items.

Findings and analysis

The number of abortions performed at the M&FGC Clinic began to drop sharply in 1995 (Figure 1). Being queried for its perception of the rapid fall in the number of abortions, the clinic management referred to the increased use of oral pills among those who wanted to control the number of births. The number of monthly packs of oral pills dispensed more than trebled in 1995 compared to the previous year. The clinic could meet the larger demand for pills because a bulk of pills supplied by UNFPA had reached the clinic late in 1994. Meanwhile the number of IUD users plateaued. The management added that there were no changes in the procedures and fee of abortion and clinic staff that may have affected clients' decision to have an abortion.

The decline in the number of abortions at the M&FGC seems typical or indicative of the city-wide trend. Six other government clinics in the city also reported a decline in the number of abortions. The numer of abortions showed a 7.8 percent decrease in 1995 from the previous year. Meanwhile there was a 1.5 percent drop in the number of IUDs inserted at these six clinics (Table 1).

Unfortunately, data for pill and condom users, that could have helped understand the whole contraceptive situation, were not available at the six clinics.

Profile of the abortion clients at M&FGC

The following is a profile of the 743 clients who underwent an operation for abortion at the M&FGC Clinic during the four months starting from Oct. 23, 1995.

Nearly 83 per cent received mini-abortions, while only 15 per cent had maxi-abortions (Table 2). (Remarks: Those cases who required maxi-abortion were often referred to the hospital where facilities for administering anesthesia and urgent medical care were available. Such cases are not included in the table.)

The majority visited the clinic for the secondary time. Only about one-fourth of the clients went there for the first time (Table 3).

Over 90 per cent belong to the age group 15 - 39 years. The age group 25-29 accounts for the largest share of 25.8 percent and the age group 45-49 the lowest of 0.5 percent. It is noted, however, that there is little difference in percentage distribution among the age groups 20-24, 25-29 and 30-34 (Table 4). This may indicate that women of sexually-active age use abortion as a method of fertility regulation regardless of age.

The majority is urban residents, most likely living in Bishkek. Only about 18 per

cent come from rural districts (Table 5).

A great majority are married. Only about 18 percent were single (Table 6). This may show that women are using abortion as a method to interrupt unplanned pregnancy regardless of the marriage status.

Most (almost 90 percent) had had at least one previous pregnancy prior to the current one which they planned to terminate with abortion. Over 10 percent had 7-10 previous pregnancies. A small proportion (less than 2 per cent) had 11-22 previous pregnancies. Meanwhile only 11.7 percent did not have a previous pregnancy (Table 7).

Generally there is no noticeable difference in percentage distribution of abortion clients by the number of previous pregnancies between urban and rural clients. The percentage of "No previous pregnancy" and "2 previous pregnancies" among urban clients is, however, relatively higher compared to their rural counterparts. Meanwhile the percentage of "more than 6 previous pregnancies" among rural clients is relatively higher compared to their urban counterparts (Table 7).

A young couple with one child in Bishkek

Table 4 Percentage Distribution of Clients by Age Group

Age Group	Percent	Cumulative Percent
15-19	4.3	4.3
20-24	21.3	26.2
25-29	25.8	52.0
30-34	22.1	74.1
35-39	18.4	92.5
40-44	6.9	99.4
45-49	0.5	100.0
Total	100.0	

Table 5 Percentage Distribution of Clients by Place of Residence

Place of Residence	Percent
Urban	81.6
Rural	18.4
Total	100.0

Table 6 Percentage Distribution of Clients by Marital Status

Marital Status	Percent
Single	18.8
Married	81.2
Total	100.0

The number of deliveries is smaller than the number of pregnancies. For example, only 12.7 percent had more than three deliveries (Table 8) while about 60 percent had more than three previous pregnancies (Table 7). A large majority (87.2 percent) had less than two deliveries (Table 8). This indicates their intense desire to keep a small family and/or their strong demand for interruption of unplanned pregnancy.

Only one out of five women had no previous abortion. Nearly half of the women had one or two previous abortions. More than 30 percent had three or more previous abortions (Table 9).

Less than 7 percent visited the clinic 15 days after the expected date of their menstrual period. More than 28 percent visited the clinic after 20 days. Over 12 percent waited more than 22 days before the visit (Table 10).

More than 97 percent underwent an operation for abortion before the 6th week of pregnancy, when it is easier and safer to perform a mini-abortion (Table 11).

Not surprisingly, nearly one-half had

Adolescents in Bishkek

A street car in Bishkek

Table 7 Percent Distribution of Clients by Number of Pregnancies Prior to the Current One According to the Area of Residence

Number of Pregnancies	Percent	Percent Urban	Percent Rural
None	11.7	12.4	8.8
1	12.1	12.2	11.7
2	16.0	16.8	12.4
3	17.4	17.3	17.5
4	12.7	12.5	13.1
5	9.6	9.7	8.8
6	7.3	6.6	10.2
7-10	10.4	10.9	13.9
11-22	1.8	1.5	3.6
Total	100.0	100.0	100.0
Number	743	606	137

Table 9 Percentage Distribution of Clients by Number of Abortions Prior to the Current One

Number of Abortions	Percent
None	20.9
1	25.4
2	21.7
3	12.1
4	6.7
5	5.0
6	3.5
7-20	4.5
No information	0.1
Total	100.0

never used any method of family planning. Among those who reported having used any method, 11.4 percent used IUD, 8.2 percent pills, and 4.4 percent condoms (Table 12).

Table 8 Percent Distribution of Clients by Number of Deliveries

Number of Deliveries	Percent
None	19.9
1	36.2
2	31.1
3	9.2
4	2.8
5+	0.6
No information	0.1
Total	100.0

Conclusion and Recommendations

According to the findings, the demand for abortion has begun to decline. There are some competent reasons. First, people's awareness of the high risks of abortion has been heightened. Second, there is increased availability of alternatives in the form of modern contraceptives, especially pills. Third, more women are willing to plan the number and timing of births than before.

Apparently most women do not want to have more than two children. 19.9 percent of women who had an abortion at the M&FGC clinic had had had no delivery; 36.2 percent of women had had only one delivery; 31.1 percent had had only two

A mother with two children

A family enjoy chatting over drink at an open-air cafe in Bishkek

deliveries. They resorted to abortion because they could not have practiced family planning due to their poor knowledge of effective contraceptive services and/or the limited availability of counseling and services. Thus it is most likely that when contraceptives can be offered accompaied by appropriate IEC activities and friendly counseling, the number of abortions (and the abortion rate) will further decline.

Women who had an abortion to terminate their unplanned pregnancy expressed their desire to use long-term contraceptives or permanent methods when they were counseled on contraception. The practical choice is, however, limited to IUD today because other methods including sterilization are not yet fully provided. Thus, IUD which is the most commonly used modern method is projected to remain the most popular method for the time being.

To make a better comparative study of abortion clients at the M&FGC clinic by year, it is recommended that data input should continue on the same 15 items of the abortion client records from 1996 onwards. Such data input also should be made on the abortion clients for 1994.

It is also recommended to add a few more items to the client card so that it will be easier to make the comparison of the findings with those of the standard research study carried out elsewhere. The suggested new items include the reason for seeking abortion, the reason for not using contraception, the type of contraceptive offered after the operation, the occupation or indicators of social and economic status of the clients, and the number and sex of the clients' living children. ■

Table 10 Percentage Distribution of Clients by the Number of Days After Their Expected Menstrual Period

Number of Days	Percent
15 or under	6.2
16	14.5
17	11.4
18	14.5
19	7.8
20	28.4
21	4.6
22 or more	12.3
Total	100.0

Table 11 Percentage Distribution of Clients by Reported Number of Weeks of Pregnancy at the Time of Abortion

Number of Weeks	Percent
2- 2.5	5.1
3- 3.5	13.8
4 - 4.5	38.8
5 - 5.5	39.4
6 - 6.5	2.7
7	0.1
Total	100.0

Table 12 Percentage Distribution of Clients Who Were Ever Users of Contraceptives by Method

Method	Percent
None	47.5
Barrier methods	0.5
IUD	11.4
Oral pill	8.2
Condom	4.4
Jelly	0.4
Combination	1.3
Post-coital pill	0.7
Safe period, breastfeeding	2.4
Others	0.3
No information	22.7
Total	100.0

KYRGYZSTAN

Strengthening Family Planning

Most registered families do not want to have many children any more

Keita Hata

The total fertility rate (TFR) has been dropping in Kyrgyzstan, a country composed of several ethnic groups. Kyrghyz account for 52.4 percent of the population; Russian 21.5 percent, Uzek 12.9 percent, Ukrainian 2.5 percent, Tatar 0.9 percent, Kazakh 0.9 percent, German 0.9 percent, Dungan 0.9 percent and Uigur 0.9 percent. The smaller percentage constitute the Tadjik, Turk-Meskhitin, Korean, Azerbaidjan, Kurd, Byelorussian, etc.[1] TFR dropped from 4.9 during 1975-1976 to 4.1 in 1985, and 3.3 in 1993.[2]

The fertility levels by ethnic group is not, however, uniform. TFR is the lowest among Russian. Indigenous Kyrghyz families are said to have as many as 10 to 12 children. While Kyrgyzstan was part of the Union of Soviet Socialist Republics (USSR), tens of thousands of mothers with many children were awarded the "Hero-Mother" order.[3] The awardee was given the right to certain privileges and grants from the state. These privileges included exemption from income taxation, and receipt of social pension worth at least 100 percent of a pension proportionate to one's age in the case of not receiving the labor pension.[4]

"Before the breakup of the USSR in 1991, each of the big stores had a special section to take care of families with a large number of children," said Erke A. Bayaly, vice-president of presidium of the board, The Large Family Fund based in Bishkek, the capital. In 1989, families with more than five children accounted for 18.9 percent of families in Kolkhoz, a collective farm, and 8.1 percent of blue collar and white collar families.[5] "When the Russians left, this practice was stopped." The more serious damage was brought about when the state stopped giving special privileges and grants to families with many children.

Bayaly, who is a mother of five children herself, felt the difficulty in bringing up many children in the country when its economy began to be severely hit after "the breakup and the consequent loss of economic ties with the former USSR member countries."[6] Being unable to let it pass unnoticed that many families with many children had to live in a miserable condition, Bayaly started to call to her friends, policy makers, etc., for assistance to those families. She was convincing. Mothers with more than five children got together to hold meetings to consider how to cope with the situation. They decided to establish The Large Family Foundation to help those families who cannot afford to bring up their children.

A problem surfaced sometime after the establishment of the Fund in 1991. Few came to the Fund to ask for help as most families did not know of the existence of the newly established Fund, much less, availability of its assistance. Thus, while, the Fund's staff went out to poor families with many children to assist them, its board members went on TV, speaking on the radio to inform people of the Fund's establishment and services.

Whoever will come to the Fund for help will be properly helped. The Fund tries not to overlook any of those who are really poor. All the families who are judged to qualify as recipient are registered in the Family Registration Book. Names of the family, children and their schools, family's address, dates of birth of each family member, etc., are written down. On the basis of the registered information, the Fund tries to assist each family as much as it can. Once a month each family comes here to get some assistance. The Fund tries to help poor families with all the resources that it can collect. It gives money, foods including bread, and clothes.

A Large Family Fund Vice President Erke A. Bayaly says that many mothers are at loss what to do with unplanned and unwanted pregnancies

Keita Hta is a staff writer of INTEGRATION.

The Fund also helps poor families get to hospital.

The Fund has its own commission that will visit each registered family to check whether what the family reported is correct or not, including the information on the number of the children. Bayaly emphasizes, "We try our best to reach our hands to those who really need our help." The fund collaborates with the United Nations Children's Fund (UNICEF) to carry out its relief activities.

Children in an area where big families live

Vice-President Bayaly recalls that the Fund received a large donation called humanitarian donation from abroad several years ago. The donation contained a big quantity of cereal such as rice, and many kinds of food including dry milk, sugar, etc. Then the fund's commission got together to decide to distribute them to about 400 registered families. Each family received ten kilograms of food. The Fund carried the food to the homes of families who did not have even the money for transportation to come into the fund's office to get the supply. Bayaly says that the humanitarian assistance came from the United States, Turkey, etc.

Unfortunately the Fund can not start the regular assistance program yet because it does not have the steady source of income. What the Fund does is send board members to potential donors including various institutes and ask for their contributions. Whatever they can collect is provided to regis-

A Family with 11 children

Ayhan Toichieva got married to her husband Ziabiden Najieva in 1963 when she was 22 years old. He was then working as a welder in a factory. They have 11 children: 7 daughters and 4 sons. The eldest is 20 years old. Her husband was the sole breadwinner because she was so busy taking care of children, having no time to go out to work.

They live in a house with four rooms. The husband has been jobless since the factory was closed three years ago due to lack of business. The family is living on the government's allowance provided by the mayor's office: 75 soms (about 10 dollars) per child. Their life is hard and the wife is trying to get a job through the mayor's office.

Ayhan says that she likes to have many children. She always wanted to have more children after giving birth to a child. That is why she has gotten 11 children. She has never tried contraceptives. Now she does not want to have a child any more because she can not provide her children with sufficient bread.

Ayhas has never tried to use contraceptives

One of the daughters goes to a Turkish school near her home. She is in the 8th grade now. She goes to school thanks to a scholarship provided by The Large Family Foundation. The brilliant girl says that she wants to be a lawyer. ■

A Family with 8 Children

Airie, 49, got married in 1965 with her husband Battlebeck Sessary when she was working in a bread factory. The husband was working as a driver in the same factory. Now she is just a housewife.

They have eight children. Their ages are 28, 27, 26, 21, 18, 13, 9, and 8. The wife says that previously things were very cheap . Apparently she did not think of the cost of raising many children when she was pregnant. She gave birth to one child after another. It should have been easier to raise children then, but now things have changed. Everything costs.

Airie says, "Nobody knew what to do about prevention of pregnancy, except abortion"

The oldest is married with only child. The second oldest one is working. The third oldest is working in a police academy as a driver. The fourth oldest is jobless now. The rest are in school.

Since the bread factory was closed two years ago, the husband earns some money by looking after cattle. The family is not getting an allowance from the government. Asked why they are not receiving livelihood protection from the government, Airie says that she does not feel that they need such assistance, because the three children who are working are covering household expenses. (Remarks: because of much red tape, it takes a long time to get government relief, so many people have decided not to apply for it.) But The Large Family Foundation is helping the family.

The wife confesses that she aborted the unplanned pregnancy after giving birth to the third child. She wanted to have several years before having another baby. Thus she had several abortions until she decided to have the fourth child. "There was no family planning," she lamented, "Nobody knew what to do about prevention of pregnancy, except abortion." She had the last child delivered by Caesarean section. After that she had two more abortions. ■

tered families.

Since the number of the registered recipients alone is larger, compared to whatever the Fund can support, relief goods are distributed to families according to the list of recipient families by priority, which the Fund's special commission regularly reviews. There are over 3,000 famiies with more than five children in Bishkek but the Fund is helping only 1,500 families.

The Office of President has also helped a lot in the fund's activities. Sometimes it gave the fund the means of transportation, even money at one point.

The number 4 clinic in Bishkek provides medical services to families with many children in collaboration with the Fund. The director of the clinic is committed to assisting the impoverished family's medical needs including family planning. Whenever the Fund's staff goes out to give donations to needy families, clinic staff accompany them to provide medical services on the spot.

The fund has recently received an award from the president for all the activities it has organized to support deprived families with many children.

Many mothers come to the Fund, saying that they can not take care of another child. They are at loss what to do with unplanned and unwanted pregnancies. When their pleas are found appropriate, the Fund sends them to hospital for free abortion. Ohterwise, abortion costs 350 soms (30 dollars).

Bayaly is thinking of strengthening the family planning promotional activities as she is convinced that most registered families do not want to have many children any more in the market-oriented economy. ■

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KAZAKHSTAN

An Encouraging Effect

In 1995 the abortion rate dropped 40 percent from 1989

By Saoule Nukusheva

Kazakstan that got independent in 1991 is in the hard transitional process to a market economy. Fifty-one percent of women are in working positions.

Compared with other Central Asian Republics, Kazakstan's birth rate is lower.

Starting from 1978, the total fertility rate (the average number of children to a woman during her lifetime) has been dropping. It went down to 2.7 in 1995.

According to an evaluation of women's health condition, most women are not healthy: healthy women account about 30 percent in the counry; only 20 percent in some regions.

The incidence of anemia among pregnant women increased two times during the last 5 years; kidney diseases 1.5 times; cardio-vascular pathology 1.1 times.

Women's reproductive health is one of the serious problems that Kazakhstan faces in the last few years of the 20th century.

Family planning, one of the components of reproductive health, should be directed so that all the children to be born are desired children. Such thesis is the base for promoting maternal and child health. Family planning is an essential element of primary care, necessary to provide family health protection (Almaty Declaration 1978).

As is known, family planning includes the principle of voluntary birth control. Unfortunately, abortion that negatively affect women's health is the main method for birth control in the country. Researches on epidemiology, causes of maternal deaths, and structure of gynecological disease clearly showed that abortion is the most frequently used method to terminate unplanned pregnancy. 9.2 percent of pregnant women had "artificial" abortions.

Dr. Saoule Nukusheva is the chief gynecologist of the Ministry of Health, Kazakstan.

Abortion is a leading cause of maternal mortality, accounting for 20-22 percent of maternal deaths. Annually 40-45 women of young age die due to abortion. Abortion also gives a hard psychological shock, especially to teenagers.

Chief Gynecologist Saoule Nukusheva

About 43 percent of maternal deaths are due to womb rupture during abortion and 39.9 percent due to bleeding at childbirth. 33 percent had abortions in anamnesis.

An early start of sexual life (17 percent of woman who had abortions had had early start of sexual life), poor knowledge of contraceptives, ineffective use of contraceptives —all have increased the risk of unplanned pregnancy that leads to a high rate of "artificial" abortion in the prematurely biological, psychological and social conditions.

A countermeasure has been taken. A special program called "Program of Reproductive Health Improvement in Kazakstan" has been promoted to help decrease the number of abortions in the Republic.

One million women of reproductive age need family planning information and services for spacing of births and prevention of abortion. Modern contraceptive methods are not always available to those whoe need ones in the Republic because of insufficient level of supply or shortage of contraceptives. Only 31 percent of women are supplied with contraceptives. If 45 percent of them have access to and use effective contraceptive methods, maternal death is projected to decline 25 percent. Meanwhile such promotion of contraceptives will not have an effect on the increase or decrease of the birth rate.

As for the family planning program which the Ministry of Health has been promoting, administrative, methodical and research work is conducted by the Republic Research Center for Maternal and Child Health Care. The organizational and management responsibility for family planning information and services in Almaty, the capital of the country, is placed on the Human Reproduction Center of Almaty. In the Oblasts (regions) and rural areas, "Marriage and Family," which is a prenatal care dispensary, provides counseling on sexual problems, family planning services including the supply of contraceptives, treats infertility, etc. Moreover, a family planning center whose activities are directed for reduction of abortions, has been established in all Oblasts during the last three years.

The family planning program has been having an encouraging effect on prevention of abotion. Abortion has been slowly but steadily declining. The number of abortions has dropped to 224,000 in 1995, down 37 percent from 1989. The decline is also evident in the abortion rate (the estimated number of abortions per 1,000 women aged 15-49 years) and the abortion ratio (the estimated number of abortions per 1,000 live births). The former went down 40 percent to 54.9 and the latter dropped 11 percent to 828.

To support such a decreasing trend, we are working hard to further improve the quality of reproductive health care provided to women, trying to extend reproductive health care services including family planning to all those who need them. ■

KAZAKHSTAN

Ensuring Safe Motherhood

Investments in the protection of women's health has gained importance

By Nina A. Kaupova

The Kazahkstan delegation fully supports the International Conference on Population and Development (ICPD) Program of Action (Cairo, 1994) which aims at ensuring sustainable development and economic growth, enhancing the status of women in society, empowering women in decision-making, strengthening the family as an institution fostering parents' and children's responsibility, providing social support to every member of society, protecting their rights to education, promotion of cooperation and research.

Under Kazakhstan's Constitution, all citizens enjoy the freedom of speech, belief and their expression; freedom of creating volunteer associations to exercise their rights and the benefits of expert legal assistance and defense.

The government guarantees all citizens the right to housing, work, health protection, education, social welfare, and an environment favorable to human life and health.

The new Constitution says: "The family, motherhood, fatherhood and childhood shall be protected by society and the state."

One of the government's priorities is to protect the health of mother and child. President Nursultan Nazarbaev and UNICEF Executive Director James Grant signed the Convention on the Rights of the Children in New York in February, 1993.

The primary goals of the Council on Women, Family and Demographic Policy Problems set up under the President of the Republic of Kazakstan are to define priorities; give recommendations for formulating family and demographic policies and to assist in preparing an integrated system to provide social, economic, legal and psychological support to families, women and children.

The council is composed of Cabinet ministers, representatives of non-governmental women's organizations, prominent researchers and workers of arts, etc.

Being guided by the International Convention on the Elimination of All Forms of Discrimination against Women and the Nairobi long-term strategies for the improvement of women's legal status, the council places emphasis on the development of such programs that will enhance women's social status, which is defined as an objective of society's social, economic and political development.

Being brought together and united by their interests, trades and occupations, various non-governmental women's organizations have been set up. These organizations have consolidated their activities to improve the social status and well-being of women while identifying new approaches to and means of promoting social develoment. Women's problems are raised in the monthly magazine *Kazakstan Eielderi*. The national paper *Kazakstanskaya Pravda* started a weekly supplement called *Zhuma* in March 1995. The national television broadcasts the program *Women, Family and Society*.

Dr. Nina A. Kaupova says, "Improving a maternal and child health strengthens the family family's health, leading to development of a healthy society as a whole"

Dr. Nina A. Kaupova is the chairperson of the Council on Women, Family and Demographic Policy Problems under the President of the Republic of Kazakhstan. She is also the director of the Republican Scientific Research Center for Maternal and Child Health of Kazakhstan. This paper is adapted from the Kazakstan Country Report presented at the ECO/UNFPA Conference on the International Conference on Population and Development Program of Action in the ECO Region held in Almaty, Kazahstan from April 18-20, 1996.

Declining fertility level

A demographic situation analysis indicates the need to formulate a population policy.

Because of the substantial drop in the birth rate accompanied by the slower decrease in the death rate, the rate of natural increase declined from 1.66 percent to 1.23 percent during the past decade: the birth rate declined from 24.9 per 1,000 population during 1980-1985 to 19.8 per 1,000 population during 1990-1995, while the death rate decreased from 8.3 to 7.5.[1]

Decline in fertility level is clear: the total fertility rate (the average number of children per woman during her lifetime) dropped from 2.95 during 1980-1985 to 2.50 during 1990-1995.[2]

Women's average life expectancy is 73.9 years, which is 8. 9 years longer than that of men.[3]

A silent but significant change is taking place: our society is quickly aging. The percentage of people aged 60 years of age or over, which was 9.9 percent in 1995, is projected to increase to 15.4 percent in 2020 and 23.6 percent in 2050.[4]

Growing percentage of single mothers

Families are instable in the transitional economy. The marriage rate (the number of marriages per 1,000 population in a given year) dropped to 7.6 percent in 1994 from 10.0 percent in 1985. On the other hand the divorce rate has increased from 2.6 percent in 1985[5] to 3.2 percent in 1994.[6] Moreover, single mothers increased 20% during the last three years to reach 155,000.

Deteriorating environmental situation

Children's mortality remains high: the infant mortality rate was 26.8 per 1,000 live births in 1995 (Table 1).

Infant mortality has its specific features. About one in three infants dies from inborn anomalies and conditions arising in the perinatal stage (from 28 weeks of pregnancy to under 7 days of age).

The root cause of high infant mortality is the unfavorable ecological situation, posing a serious threat to people's health and life. The Aral region stands out in the overall grim environmental picture, proclaimed "areas of ecological disaster." The situation is similar around the Semipalatinsk nuclear testing grounds. Industrialized areas also have been and remain considerably polluted and ecologically unsafe.

The deteriorating environmental situation is also basically responsible for high maternal mortality rate (the number of deaths to women due to pregnancy and childbirth complications per 100,000 live births in a given year). It increased from 67.2 per 100,000 live births in 1991 to 77.3 per 100,000 live births in 1995 (Table 3).

Given an extremely hazardous environmental situation, the government has been making efforts to prevent adverse man-made impacts on the natural environment, maintaining a natural equilibrium, and organizing rational conservation.

Cutting the number of abortions

Abortion ranks first in the cause of maternal deaths. One out of five maternal deaths is attributable to induced abortion conducted to terminate unwanted pregnancies. Therefore, family planning, the use of birth control to avoid unplanned pregnancy, has been energetically promoted to decrease the number of abortions.

Family planning, a component of the reproductive health program, is instrumental in protecting women's health. The Alma-Ata Declaration (1978) focuses on the protection of mothers' and children's health, including family planning, as an essential element of primary care.

Mr. Yasar Yaser, executive director of the Turkish Family Health and Planning Foundation, visits Dr. Nina Kaupova

It is encouraging that the determined promotion of family planning for abortion prevention, accompanied by development of effective contraceptives, sharply decreased the number of abortions: it went down from 274,896 in 1989 to 224,084 in 1995 (Table 3).

Protection of motherhood and childhood

The right to health is guaranteed by Article 23 of the Constitution and the Law on the Protection of Health of the Nation. The right is exercised in state-run medical establishments where free medical care is available. The expenses are covered by national medical insurance, premium on which is paid from the national budget during this period of transition.

In order to further improve the women's health situation, a health program reform has been formulated with enactment of a package of laws to provide better health care. For example, a National Program of State Support to Health Care is being developed, with special emphasis placed on

the protection of motherhood and childhood. Thus, investments in the protection of women's health with a view to ensuring safe motherhood has gained in importance.

Under the new health program, we have made constant efforts to give all the population access to relevant information on family planning; encouraging healthy life styles; developing a consistent system of sex education for adolescents; and ensuring development of reliable contraceptive technologies.

Curative and preventive care is provided to mothers and children by a network of medical establishments such as children's polyclinics, women's and children's clinics, children's hospitals, maternity clinics, children's sanitariums, etc.

Special programs for reduction of maternal, perinatal and infant mortality rates are being set in motion.

Provision of the latest curative-preventive care is given to mothers and children by such research centers as the Republican Research Center for Maternal and Child Health Care and the Research Center of Pediatrics and Children' s Surgery.

Perinatal centers, medical-genetic centers, family planning centers, motherhood and childhood centers have been opened in major cities and oblast (provincial) centers.

A children's rehabilitation center has recently been inaugurated in Almaty.

For resource-saving in health care, outpatient hospitals, polyclinics and day hospitals are being developed.

Women in transition to a market economy

Changes that started in Kazakstan since its independence in 1990 are continuous with economic reform being carried out for a socially-oriented market economy.

Strides have been made in modernizing the system of economic relations. The new law cherishes the right of property ownership and its protection. The initial privatization is being completed and the massive privatization of state-run property has begun.

The government's program of action to enhance the economic reform and get the country out of the economic crisis has begun to bear fruit. Inflation has successfully slowed down by the reduction of expenditure on the national government's programs combined with an austerity monetary policy. It is estimated that by the end of 1996 inflation will drop to 2-3%, bringing about macro-economic stabilization.

We are, however, still in transition. Expansion and securing of employment is an uphill problem in a transitional economy, where the labor market has been increasingly glutted. Life is hard. Women who account for 51.3 percent of the population have felt the greater necessity to work for a living in the difficult economic situation.

Thus, the State Employment Agency has been set up to promote employment among citizens seeking work and social protection of the unemployed in the difficult economic situation. But the number of the jobless people, which the State Employment Agency began to officially register in 1992 when the Law on Employment was enacted, increased from a little more than 4,000 to 90,000 in 1995. According to the State Employment Agency, women account for two-thirds (65%) of the accumulative number of the unemployed (323,000).

Learning useful lessons for enhancement of women's status

Article 25 of the Constitution grants the right to education regardless of race, nationality and sex. The right is backed up by the availability of free secondary, secondary specialized and higher education in state-run educational establishments.

Ten percent of the population has higher or incomplete higher education, with 11.6 percent of women having this type of education. Although women prevail among persons with higher and secondary specialized education in this country, they account for few places in government, including decision-making positions. What is worse, they concentrate at the lower tiers of state administration. Women are also few among parliamentarians of all levels.

Therefore, we are planning, with the help of international organizations, to organise the study of relevant experiences of coutries where women have higher social status, so that we will be learning useful lessons for our country's programs for enhancement of women's status.

Supporting women's entrepreneurial activity

Women's work outside the home is a promising alternative to unemployment, working as a housewife doing household chores that do not pay and poorly remunerated work in the public sector.

In this connection, development of business opportunities for women has been attracting attention as a promising strategy to help women earn a substantial income.

More and more women will be able to go into business in our society supported by their sufficiently high level of education. Women's active participation in entrepreneurship is also growingly demanded in our emerging market economy. There is a clearer need to develop the service industry and cottage industry including manufacturing of handicrafts, where women have experience and expertise and higher potential capacities. It is also an historic opportunity to apply women's capabilities to gainful occupation and strengthen women's social partnership with men.

The time is ripe for development of a nationwide social program for the promotion of small-to-medium-sized enterprises.

Kazakhstan women returning from shopping

The government's program of action calls for cultivating of entrepreneurship, vocational training and provision of a small soft loan to support women's entrepreneurial activity.

We are learning from other countries' experience. In this respect, we rely on the Technical Assistance for Community of Independent States by European Community (TACIS) to provide training in the basis of business and creation of small business models, provisioning of small credits as seed capital.

Occupational training for the unemployed has been conducted by contracted vocational schools, training courses (UKK), training centers (UPK), and other training facilities. There are also centers

for occupational training and vocational guidance, attached to employment agencies, throughout the republic, including Almaty and Baikonur.

Training of the unemployed in the basics of entrepreneurship has been quite popular with business courses for unemployed women conducted under the Australian Government Program and the agricultural courses under the Winrock International Institute (USA) having been regarded to be successful.

Development of entrepreneurship may be said to have produced visible results: more than 32,000 small businesses came into operation by early in 1995. To support the management of these small businesses, the Ministry of Labor and the International Labor Organization (ILO) is jointly running the project "Restructuring of Local Economy and Employment Regulation." Being watched with keen interest is the development of a consultative group as part of the project, which is to be set up within the Ministry of Labor. The expert group will render technical assistance to fresh entrepreneurs, counseling on tax and monetary policies, accounting, marketing, management and the legal regulation regarding entrepreneurship as well as evaluation of business plans.

Kazakhstan children and their mother at a park

Developing favorable conditions for working women

Article 19 of the Constitution entitles citizens to safe and healthy working conditions. Labor laws specifically define women's rights to labor safety and health, paying proper regard to women's physical and psychophysiological features, and women's role in childrearing. In spite of such legal protection, relevant regulations are often not complied with, leading to insignificant improvement in working conditions over the last decade.

Taking into consideration such disadvantageous working conditions, the republic has begun to formulate a national program for labor safety, with special emphasis placed on developing favorable working conditions for maintenance of and improvement in health, especially maternal health.

Welfare for socially vulnerable groups

Government continues to support health and welfare of women and families, though its national budget is lacking. It provides six types of family allowances: (1) a lump-sum allowance to a family at the time of the birth of a child; (2) a lump-sum allowance to families with children; (3) benefits to single mothers; (4) benefits to unemployed mothers with four or more children under age 7, (5) benefits to children of personnel in active military service; and (6) benefits to children with HIV and AIDS. Each allowance is granted regardless of whether other allowances are paid.

Besides, the Law on State Awards stipulates that to enhance the authority of mothers with many children, mothers with six or more children should be presented such awards as the Altyn Alka and Kumis Alka. They are entitled to preferential pensions and other benefits. Rural women with five or more children also enjoy benefits and pensions.

In addition to measures to raise living standards of socially vulnerable groups, social protection is also extended to families affected by nuclear tests at the Semipalatinsk nuclear testing grounds and environmental disasters in the Aral Sea area.

Stipulated by law, the national program for social protection of the disabled provide social assistance to families with disabled children, disabled persons since childhood, and disabled women with children. Yet the disabled continue to face a lot of problems, with social rehabilitation being the greatest challenge. Thus a national program for state support to socially vulnerable sections of the population is being formulated.

State support to socially vulnerable sections of the population is supplemented by assistance from local governments and work collectives.

Pensions hold a special place in social welfare measures. Old-age pension, pension for the handicapped, and pension for a spouse whose breadwinner is dead are granted in accordance with such laws as Law on Pensions for Citizens; Law on Pensions for Servicemen, Officers and Men of the Internal Affairs Bodies and Their Families; and Law on Social Protection for the Handicapped. Substantial benefits are enjoyed by handicapped mothers or mothers with handicapped children. There are 2.9 million pensioners and handicapped (in addition to retired servicemen), including 2.6 million who do not hold jobs.

Social protection of the elderly and disabled

The loneliness of the elderly and disabled has become a major problem in our society. To support those single elderly persons, 72 homes for old people and the disabled have been established. These homes accommodate about 18,200 war and labor veterans who live alone in the twilight of their lives. Small homes for single veterans, often funded by state and collective farms, also have been opened in some oblasts (provinces) and in rural areas.

Women constitute the largest percentage of the single elderly persons. In many cases, this is a result of war. Single elderly women (40,000) who live in their own houses are assisted by a network of social workers.

Table 1. Vital Statistics of Kazakhstan, 1989-1995

	1989	1990	1991	1992	1993	1994	1995
Population (million)	16.5	16.8	16.9	16.9	16.9	16.8	16.5
Birth rate (per 1,000 population)	23.0	21.7	21.0	19.9	18.7	18.3	16.8
Death rate (per 1,000 population)	7.6	7.7	8.0	8.1	9.2	9.5	10.2
Rate of natural increase (percent)	15.4	14.0	13.0	11.8	9.5	8.7	6.6
Infant mortality rate (per 1,000 live births)	25.9	26.4	27.4	26.2	28.0	27.2	26.8
Maternal mortality rate (per 100,000 live births)	76.4	75.8	67.2	76.8	62.8	69.3	77.3

Source: *The Official Statistical Data: Health of Population of Kazakstan and Activity of Health Care Organization in 1990, 1991, 1992,1993, 1994,* and *1995*

Table 2. Contraceptive Prevalence Rate in Kazakhstan, 1989-1995

Percent distribution of women aged 15-49 by contraceptive method currently used

	1989	1990	1991	1992	1993	1994	1995
Oral pill	1.0	1.2	1.2	1.3	1.4	1.9	3.3
IUD	29.9	30.3	30.8	31.7	32.3	34.4	38.1
Condom	Statistical data not available						
Injectable	Statistical data not available						

Source: Unofficial Statistical Data. They were counted by using the data from the statistical form N 30-zdra as percent 15-49 aged women

Table 3. Abortions in Kazakhstan, 1989-1995

	1989	1990	1991	1992	1993	1994	1995
Abortion	274,896	254,943	264,936	346,405	290,703	261,834	224,084

Source: *The Official Statistical Data: Healthof Population of Kazakstan and Activity of Health Care Organization in 1990, 1991, 1992,1993, 1994,* and *1995*

Facilitating returnees from CIS member countries

The republic recently saw the beginning of a return of compatriots. Between 1991-1994, 120,000 settlers from Mongolia, Iran, Afghanistan, Turkey and other Commonwealth of Independent States (CIS) members countries came back to Kazakstan, their historic homeland. All possible measures have been taken to facilitate their return and settlement. Lump-sum allowances are paid to heads of households and family members. Having received citizenship, they enjoy all rights and benefits prescribed by law and regulation of the country. Virtually all returnees have received housing. Their children go to school. Most able-bodied people have got jobs.

There are, however, some problems. Returnees from Iran, Turkey and Afghanistan lack knowledge of our written language and the language of inter-ethnic communication so that their access to work is hampered with everyday life being complicated. On the other hand, they are more adapted to working under the market economy.Thus employment agencies have been assisting them in becoming self-employed or starting a small business in the emerging market economy.

Genereous assistance rendered by international organizations

After joining the international community in 1990, Kazakstan started actively learning from other countries' experience in reproductive health and family planning. In this connection, the country has enjoyed generous assistance rendered by international organisations such as United Nations Population Fund (UNFPA), United Nations Development Program (UNDP), United Nations Children's Fund (UNICEF), World Health Organization (WHO), and the United States Agency for International Development (USAID) in training and other relevant fields.

The reproductive health program for 1996-2000 was developed together with UNFPA. The five-year program aims at improving women's reproductive health; reducing maternal and perinatal mortality rates; cutting the number of infertile marriages; preventing abortions; setting up a data bank in order to identify and meet the public's need for contraceptives; and involving men in family planning.

In cooperation with UNICEF, the country also developed a project called "The Aral Sea: The Project of Environmental and Regional Assistance (ASPERA) in Support of the Children and Women of the Aral Sea Region in Kazakstan, Turkmenistan and Uzbekistan."

Health is a prerequisite condition for society's development. An individual's health begins with his or her family's health. A child owes his/her health to his/her healthy mother. Improving a maternal and child health strengthens the family's health, leading to development of a healthy society as a whole. Accordingly, Kazakstan has drafted a national program called "Women and Children of Kazakstan" for enhancement of maternal and child health. The main components of the program are: Reproductive Health with Safe Motherhood and Family Planning Being Its Main Parts; Ecology and Women's and Children's Health; and Children's Nutrition.

For further development of the health conditions and improvement in well-being of the population, we are willing to learn from and exchange our experience with other countries. ■

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KAZAKHSTAN

A Measurable Impact

The number of abortions dropped 40 percent since the family planning program started in 1993

By Tamara M. Djusubalieva

By the end of 1992, the gynecological and obstetrical problems in Almaty (pop: 1,182,400), the capital of Kazakhstan, had reached an alarming level. Many mothers had been dying due to complications of pregnancy and childbirth: the maternal mortality rate (the number of women who die as a result of childbearing in a given year per 100,000 births in that year) was high at 108.3 per 100,000 live births in 1992. The perinatal mortality rate (the number of fetal deaths after 28 weeks of pregnancy plus the number of deaths to infants under 7 days of age per 1,000 live births) was also high at 18.8 per 1,000 births in the same year (Table 1).

The general health indicator of women had been also decreasing every year. Seventy percent of all pregnant women had one kind of disease or another. The most common disease was anemia, which increased four fold from 1989 to 1993. Diseases related to the urinogenital system doubled during the same time period.

The health facilities are considered adequate. There are 5.2 gynecological beds and 7.8 midwifery beds per 10,000 population. Mothers give birth to babies in seven maternity houses in the city.

Thus the Health Care Department of Almaty made declaration in 1993 of the emergency situation of gynecological and obstetrical services, pointing out that the deep-seated cause of all of these problems was the frequent resort to abortion (an average of five abortions per woman during her life time) for termination of unplanned pregnancy.

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Dr. Tamara M. Djusubalieva: the contraceptive prevalence rate increased to 45 percent in Almaty in 1995

Fertility had shown a declining trend in the city under the serious social problems. For example, the birth rate, one indicator of fertility level, dropped from 15.8 per 1,000 population in 1990 to 13.7 per 1,000 population in 1992. Unfortunately such fertilty decline had been made with the increasing reliance on abortion, not with the wider use of modern contraceptives. Abortions of the first pregnancy accounted for 13.4 percent of all abortions in 1992, when the contraceptive prevalence was only 27% (Table 2).

Abortion had been a major method for regulating the number and spacing of births in Kazakhstan for many years when it was part of the Soviet Union. For example, in 1989, the abortion rate, the estimated number of abortions per 1,000 live births in a given year, was 933 in the country. The abortion rate was higher in Almaty.

The Health Care Department was also very much concerned about the high percentage of births of malformed infants and infants with hereditary diseases delivered by mothers of advanced age. For example, in the cases of infants born with Down's syndrome, one of the congenital anomalies, 58 percent's mothers were more than 35 years old. Approximately 20% of infants were born by mothers aged 35 and over. Many couples were not fully aware of the effect of pregnancy and childbirth at an advanced age on the health of the baby to be born.

Shorter intervals of births was also an issue to be solved as part of efforts to develop maternal and child health. Spacing of births was a well accepted concept and practice but 6 percent of births still took place within less than 1.5 years after the previous birth.

Thus, on February 12, 1993, the Almaty's Health Care Department developed the Family Planning Program, that aims at replacing abortion with modern contraceptives.

The main objectives of the Program are:

- to decrease the number of abortions by

A young mother with her baby in Almaty

half; and

- to decrease the maternal and perinatal mortality rates.

This program requires all medical institutions to provide family planning services. Twenty five family planning rooms have been established in medical institutes including all the territorial women's consultation centers and all the territorial polyclinics that serve the adult population, in the eight districts of the city. Two special family planning room exclusively for women with mental disorder, etc., also has been established: one at a mental institute; and another at a hospital for female drug addicts and alcoholics.

The main function of the family planning room is to render counseling on family planning for women of reproductive age. Each woman visiting a medical institute, whatever the purpose of her visit, is encouraged to also visit the family planning room in it.

When a client comes to the family planning room, she is counseled kindly on her desire for the number of children and timing of births, etc. If she wishes to accept modern contraceptives for either spacing or limiting the number of births, a physical and gynecological examination is conducted. As for methods, the family planning nurse recommends the most suitable one to the client on the basis of counseling and the result of the examination. Oral pills are available at all the family planning rooms.

For the systematic promotion of family planning services in each district, one family planning room was selected and designated to function as the district family planning center, which is responsible for the effective performance of family planning services in its jurisdiction.

In addition to the role of coordination and management, the district family planning center also administers several functional activities, one of which is to conduct a vacuum-aspiration (mini-abortion) for outpatient at amenorrhea for less than 18 days.

As for organizational and methodological management responsibilities for family planning in Almaty, the City Human Reproductive Center is entrusted with the task, serving as the City Family Planning Center.

Services are provided by nurses who have been trained at the City Family Planning Center. This system is modeled after the English one which a group of Kazakhstan physicians observed during their observational tour to London in 1993. The study trip was conducted with support from the International Planed Parenthood Federation (IPPF).

In order to effectively and timely extend services to a larger number of women of reproductive age, medical personnel working outside the family planning room, the District Family Planning Center and the City Family Planning Center are also designed to take part in the family planning program. To facilitate their family planning work, their duties in the family planning program are clearly defined. Today many obstetricians and gynecologists, general practitioners, pediatricians, and other specialists are providing family planning counseling and services in their own working places. For example, pediatricians work as counseler to teenagers on sexual education. They also counsel breast-feeding women on appropriate methods of contraception.

All gynecological departments are emphatically counseling abortion-seeking clients to use modern contraceptives, especially IUD, soon after having an abortion. The result is significant: 18 percent of abortion-seekers had IUD inserted immediately after abortion in 1993; 30 percent in 1994 and 20 percent in 1995 (Table 2 & 3).

If a general practitioner identifies a woman who has difficulty in getting pregnant during his/her medical examination, he/she offers counseling on treatment of infertility to the client or refers her to a nearby family planning room where she will be provided with special counseling and treatment.

Along with the Program's strategy to give easy accesss to family planning, contraceptives including pills are selling at phar-

Table 1. Maternal and Perinatal Mortality Rates, in Almaty, 1991-1995

	1991	1992	1993*	1994	1995
Maternal mortality per 100,000 live births	77.8	108.3	48.9	80.3	85.6
Perinatal mortality per 1,000 live births	21.0	18.8	15.0	13.7	12.0

Remarks: The family planning program started in 1993 in Almaty.

macies in all the medical institutions and industrial enterprises. Many large industrial enterprises provide free contraceptives to employees. Students can also obtain contraceptives free of charge.

Every month the City Family Planning Center receives a monthly family planning report from each district family planning center. The report includes the following information:

1. The total number of abortions conducted in the district with the following breakdown:
   - number of abortions by age of client
   - number of abortion by order of pregnancy
   - number of mini-abortions, and
   - number of frequent users of abortion services
2. The number of women registered as contraceptive acceptor, with the following breakdown:
   - number of inserted IUDs
   - number of women registered as IUD acceptor, and
   - number of women registered as pill acceptor
3. The number of women suffering from complications with internal organs
4. The number of sexually active teenagers
5. The number of breast-feeding women
6. The number of women with many deliveries

A woman leaving the City Human Reproduction Center of Almaty

The achievements in the family planning program in 1993, the first year of implementation, are summarized as follows:

1. The contraceptive prevalence rate increased from 27 percent in 1992 to 35 percent. As for contraceptives, 14,518 women became new acceptors of oral pills, that were introduced to the city for the first time in 1993; 17,171 new IUD acceptors (Table 2). Moreover, thirty-two surgical sterilizations were conducted using mini-laparotomy method after the USAID-funded training on surgical sterilization conducted in October 1993 by the Association on Voluntary Surgical Sterilization;
2. Friendly counseling and follow-up service proved effective: the number of abortions remarkably decreased among those women who had asked counsel at a family planning room. As a result, the number of abortions dropped 11.5 percent from 1992 (Table 3);
3. The maternal mortality rate dropped 54.8 percent from 1992 (Table 1);
4. The perinatal mortality rate declined 20.2 percent from 1992 (Table 1); and
5. The contraceptive coverage of high-risk women, including those who

Table 2. Family Planning in Almaty, 1991-1995

	1991	1992	1993*	1994	1995
1. IUD					
• Coverage	27%	28%	31%	33%	35%
• Number of Inserted IUDs	16,750	15,583	17,171	19,198	19,269
• Number of IUDs inserted immediately after abortion			2,292	2,729	1,661
• Total number of women with IUD inserted	90,000	92,000	105,683	114,298	125,140
2. Oral pill					
• Coverage			4.2%	8%	6%
• Number of oral pills users			14,518	27,124	20,235
3. Injectable					
• Coverage				1.4%	2.2%
• Number of IUD users				5,000	7,560
Contraceptive Prevalence Rate	26%	27%	35%	42%	45%

Remarks: The family planning program started in 1993 in Almaty.

had a lot of abortions, those who are mentally deranged, those who have extragynecological dieseases, and alcoholics, has significantly increased from 30 percent to 58 percent.

Encouraged by such remarkable accomplishments, the family planning program continued to be developed and strengthened with the introduction of new activities addressing special target groups. Outstanding was the counseling service to socially incapacitated families. In 1994, two-hundred fifty nurses specially trained in family planning counseling begant to work as counselors to socially incapacitated families, providing contraceptives to acceptors free of charge.

A measurable impact was brought about by the family planning program in Almaty. Compared to 1992, one year before the family planning started, the following changes were observed in 1995:

1. The contraceptive prevalence rate increased 66 percent (Table 2);
2. The number of abortions decreased 45 percent (Table 3);
3. The maternal mortality rate dropped 21 percent (Table 1); and
4. The perinatal mortality rate declined 36 percent (Table 1).

A mother and her child on their way home from shopping

We are now focusing our attention to the high incidence of pregnancy among teenagers. As the teenage pregnancy often results in abortion, prevention of teenager's unplanned pregancy is a matter of serious concern. There are 113.1 pregnancies and 93.0 abortions per 1,000 teenagers (15-18 years).

As part of the strategy to reduce the unplanned pregnancy among teenagers, the Center for Medical-Social Aid to the Young including Teenagers was recently established. The main goal is to give consultations on effective contraception. It also provides counseling on narcology, gynecology, sexology, urology, venerology, psychology and AIDs.

We are also in the process of asking the state government to start sexual education for teenagers, and provide reproductive health services to the young and future generations. ■

Table 3. Deliveries, Abortions, etc., in Almaty, 1991-1995

	1991	1992	1993*	1994	1995
1. Number of deliveries	19,230	17,600	16,074	16,407	15,130
2. Abortion					
• Number	45,320	44,425	39,327	24,489	21,238
• Abortion ratio (per 100 live births)	235.6	252.4	246.6	149.2	140.3
• Abortion rate (per 1,000 women of reproductive age)	113.6	127.8	125.3	75.3	63.70
3. Total number of induced abortions	15,655	15,575	12,686	8,986	8,252
4. Abortions of the first pregnancies					
• Number	3,061	2,710	2,812	3,119	1,595
• Percentage	14.1	13.4	16.6	23.6	13.1
5. Number of abortions per 1,000 adolescents aged 10 - 14	0.9	0.9	1.1	0.7	0.9
6. Number of abortions per 1,000 adolescents aged 15 - 18	108.7	107.0	113.0	89.1	93.0
7. Percentage of abortions among women aged 19-34 to abortions among women aged 15-49	47.8	47.0	37.0	29.7	27.0

Remarks: The family planning program started in 1993 in Almaty.

Guiding Reproductive Health Programs for the Central Asian Region

The following is the excerpts of the draft Clients' Perspectives on Contraceptive Technologies and Practices in Four Central Asian Republics by EXPERT Sociological Center, Tashkent, Uzbekistan.

In late 1993, the Ministries of Health of the Government of Kazakhstan, Kyrgyzstan, Turkmenistan and Uzbekistan initiated the Reproductive Health Services Expansion Program (RHSEP) with fundings from the United States Agency for International Development (USAID) and technical assistance from the Johns Hopkins University Center for Communication Program (JHU/CCP), The Future Group, the Association for Voluntary Surgical Contraception (AVSC), and the Johns Hopkins Program for Internaitonal Educaiton in Reproductive Health (JHPIEGO).

Each republic is unique in terms of how elements of culture, traditoin and current socieeconomic and political conditons affect reproductive health knowledge, attitudes and behaviros. However, enough commonalities exist in the Central Asian region that some gneralizations are made. These generalizations can guide reproductive health programs for the region as a whole.

Commonalties in the Region

1. *Age at first marriage:*

Throughout the region, it is customary for the husband to be three to five years older than the wife at the time of marriage. Men should marry by the age of 25 years. Men younger than 21 years of age are thought to be too emotionally immature, too wild in spirit, too inexperienced, and not financially settled enough to take on the responsibilities of supporting a family.

Women are thought to become more emotionally mature than men at an earlier age; they are mentally and physiologically prepared for marriage three to five years before men and should therefore be married by the age of 20 or 21.

2. *Fertility preferences and family size*

The traditional preference for larger families is clearly giving way to the economic reality of life in the new republics. Many people still support the idea of large families, describing them as happy bustling environments, but grudgingly acknowledge the impracticality of large families today. Large families are seen as expensive and hard to manage, but many people also recognize that the welfare of children can suffer if family resources are stretched too thinly. Even so, the norm for family size is still three to five children, although there is growing sentiment for one to two children, especially in Kazakhstan and Turkmenistan.

Preference for sons is still very strong in much of the region, especially in Uzbekistan and Kyrgyzstan where sons are thought to have more economic value than girls.

3. *Attitudes toward family planning*

Support for family planning, at least in principle, is strong throughout the region although there is still significant resistance in some areas on religious or nationalist grounds. In general, economic hardships make family planning seem practical to a great many people.

However, even though people say they favor family planning, there are many things that work against consistent and effective contraceptive practice: persistent and strong cultural values and kinship traditions, deeply held religious beliefs, family pressures, lack of reliable access to methods and services, low quality methods, indifferent and largely unresponsive health services, and - for women - the indifference of husbands toward the reproductive and psychological health of their wives. This combination of factors, common throughout the region, results in strong attitudes (both pro and con) toward contraception. While reproductive health is seen as desirable, both men and women recognize how difficult it is to achieve in an era of shortages and many people, especially women, resign themselves to survival rather than struggle for what seems to be an unattainable goal.

4. *Knowledge about family planning methods*

Condoms are widely known, but extremely unpopular as a contraceptive method, although they are widely recognized to protect against sexually transmitted disease. They are associated with homosexual and extramarital sex and, as such, have an unsavory reputation that makes many people reluctant to consider their use between husband and wife.

IUDs are widely known and most preferred, but primarily because they are the most widely available method and not because of any intrinsically desirable qualities. There are strong reservations about IUDs in all four republics, but this method is still seen as the most acceptable in spite of those reservations.

Oral pills are well-known, but suffer from a negative image because low-dose varieties have not been widely available and because physicians recommend against their use.

Traditional methods of contraception, including calendar methods and withdrawal, are appreciated mostly for their "naturalness" and are contrasted with the harsh, artificial, chemical or invasive nature of modern methods.

5. *Family planning communication between husband and wife*

Discussion of sex and reproductive health, including contraception, between spouses is rare and episodic throughout the region. Such matters are still highly embarrassing to most people, especially to men, except in the more cosmopolitan and European areas of the region. The responsibility for contraceptive decision is left to women. Men prefer not to be involved in decisions about family planning; most prefer not to think about it at all. Still a woman is expected to seek her husband's approval if she decides to use family planning, but it is rather uncommon - except in the more conservative communities - for a man to reject the preference of his wife.

6. *Sources of family planning information*

The region has historically suffered from a lack of reliable client-oriented information about contraception and contraceptives. That situation has further deteriorated with the breakup of the Soviet union and declining access to Russian media, especially print. People used to rely on science and health magazines for information about reproduction, sexuality, and contraception, but such materials have become much harder to obtain, especially in local languages.

7. *Additional perspectives*

(1) Health services and providers: Public sector physicians have a relatively poor image. Many people believe them to be callous, corrupt, greedy and incompetent. Consequently, they are not trusted to provide reliable information, although for many people physicians are the only source.

(2) Abortion: People are of two minds about abortion. There are strong and almost unanimous objections to abortion on moral and health grounds, yet there is widespread acceptance of it on practical grounds. Many people simply see no alternative. The strongest objections come from the more conservative Muslim areas of the region, although even there some people question the morality of bearing children one cannot support or endangering the life of the mother through too closely spaced pregnancies. ■

INDONESIA

Prosperous Family Development

The first family welfare registration has induced high political commetment in all segments of the population

By Haryono Suyono

On June 29, 1949, Lieutenant Colonel Soeharto[1] reported to Sri Sultan Hamengkubuwono IX[2] that all republican troops and fighters had been reunited with their families in the capital city of Yogyakarta after the Dutch had agreed to abandon and return the city to the Indonesian authorities. On that day Indonesian families began to rebuild themselves in an atmosphere of independence. They started to replace their deceased members who had died in battle with new children. The replacement took place at a high speed, resulting in a 'baby boom.' Thus, President Soeharto appealed to Indonesian families to plan and implement the development of happy and prosperous small families in order to counteract this 'boom' on June 29, 1970, when he installed the first BKKBN (National Family Planning Coordinating Board) Chairman and Family Planning Council. His appeal was received warmly by his people.

During the first long-term development period (1969-1994), the mission of the family planning movement was to lay a foundation for the acceptance of a new 'happy and prosperous small family' norm, oriented towards strengthening community institutions as the movement's supporting force at village and subvillage levels. At the time, the movement's strategy was based on a 'three dimensional approach,' i.e., program expansion, intensification, and institutionalization and internalization.

Program expansion was intended to increase concern about, and political commitment of community institutions to, the population problems. The expansion was characterized by efforts to recruit potential acceptors to become new acceptors.

Program intensification was aimed at supporting the establishement of a nation-wide program infrastructure for development of family planning and health services, and the improvement in the capabilities of community institutions.

Development of family planning and health services includes establishment of family planning clinics and family planning posts, which later developed into POSYANDU (Integrated Service Posts), training of traditional birth attendants, and establishement of UPPKA (Family Planning Acceptor Income Generating Group). Establishment of the UPPKA was initially intended to stimulate the more regular conduct of acceptor group meetings, the more frequent exchange of experience, the further improvement in relationships among members, and the strengthening of motivation to continuously practice family planning. UPPKA activities were also related to family income generating, and the provision of hybrid coconut seedlings, supersemar scholarships, etc., to long-time acceptors.

Capabilities of village institutions like acceptor groups, PKK (Family Welfare Movement), religious leaders, youth groups, etc., were strengthened so that they would be more concerned abcut, and involved in,

State Minister for Population/Chairman of BKKBN Haryono Suyono is explaining to President Soeharto about TAKESRA (Prosperous Family Saving Scheme) and KUKESRA (Small Credit for Prosperous Family Development Program)

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the promotion of family planning with more acceptors continuing to practice family planning.

BKKBN made its utmost effort to help develop various institutions, even ones at the village level, concerned about national development so that they would be playing a key role in promotion of family planning. BKKBN provided its support to PKK, Dharma Wanita, Dharma Pertiwi, involved and trained religious leaders, youth organizations like KNPI (National Committee on Indonesian Youth), Karang Taruna (Indonesian Youth Movement in Indonesian Villages), assisted various university and non-university research centers, professional organizations such as IDI (Indonesian Doctor Association), POGI (Indonesian Obstetrics and Genecology Society), IBI (Indonesian Midwife Association), ISI (Indonesian Sociology Society), IPADI (Indonesian Demographic Society), IAKMI (Indonesian Public Health Society), helped build special schools such as public health schools, developed family planning networks in the villages like Family Planning Posts, POSYANDU and acceptor groups. BKKBN also helped build a village medical service network and other extensive activities in coordination with various departments (ministries), including the Departments of Internal Affairs, Health, Religious Affairs, Education and Culture, the Armed Forces; and community organizations.

Under institutionalization and internalization, that took place at a later stage, each family was directed to develop its function as the focus for developing its members and the basic unit for nation building. Then emphasis was placed on encouraging family planning acceptors to be capable of becoming respected citizens and self-reliant in meeting their family planning needs.

The family planning movement's three stage approach were quite successful. Concerned about family planning, the community family planning movement arose in every part of the country. Religious leaders and youth became active supporters of the movement. In other words, we could bring about a small family norm for the majority of Indonesians, building a strong institutional base at the village level. As a result, the majority of Indonesian families became continuing acceptors.

Thus, various family planning activities attained good results during the first long-term development period. Symbolic of the achievement was the enactment of the civil law on Population Development and Prosperous Family Development (Public Law No. 10/1992).[3]

On June 29, 1993 President Soeharto declared in Bandar Lampung that June 29th should be established as the 'National Family Day' to commemorate the success in family planning in the first long-term development period. Then President Soeharto stressed that families should become the place for nation building.

The declaration of the National Family Day officially instituted the implementation of prosperous family development in the second long-term development period (1994-2019), when development of prosperous family will be achieved within a spirit of national unity, based on Pancasila, the Five Basic Principles of the State Ideology, and successful families will be encouraged to help other families improve their welfare. Moreover, prosperous small family development will be promoted in an atmosphere of dynamic social transformation, i.e. as part of the process of change from a traditional agrarian society to a modern, urban, informed industrial one.

As an integral part of the prosperous family development, the family planning movement - which consistently encouraged the community to build small families through mutual help during the first long-term development period - will strengthen its promotion of small families through a more family-oriented development approach supported by a stronger community support.

The main pillars of the family planning movement will continue to be village institutions such as the acceptor groups, PKK, religious leaders, village elders, religious educational centers, youth groups, senior citizens, traditional birth attendants, and so on.

Modernization of the Indonesian Community

The modern way of life, or urban characteristics, have increased at an annual rate of about 5.5 percent during the last 10 years. On the other hand, rural characteristics have almost come to a standstill. However, social change may not have been felt strongly, due to the close relationship among generations that two or three generations still live in the same house, in an atmosphere of strong Oriental values.

In the early stage of the second 25-year development period, those who will be living in urban areas or having urban characteristics is projected to account for 30 percent of the population (of no less than 189 million). Besides, mass communication will continue to reduce the urban-rural distances, exerting urban influence on even the rural population, so that the rural way of life or rural characteristics will also be loaded with a modern flavor, causing a vigorous cultural shock to rural residents. As a result, the social transformation process will, in the end, have a major influence on the welfare of families regardless of their places of living, urban or rural.

If the urban growth stays between 6-7 percent annually, the urban population or population with urban characteristics will double within only 12-10 years, accounting for 50-60 percent of the whole population of the country. This means that Indonesia will become an 'urban community' early in the 21st century when the rapid urban development will have taken place accompanied by the rural industrialization and modernization. Then, the relationship between urban communities and their rural relatives will become weaker.

Under the successful national development plan, each individual will enjoy a chance to develop himself or herself with a higher level of education. Such self-improvement will occur throughout the country. Then social change, including heightening of social mobility, will follow.

Such social change will be accompanied by a change in the family relationship, especially the rise in the woman's role in the family. Unless timely and adequate care is taken, the enhanced woman's status may shake the family's resilience and bring about instability. The failure will cause frustration. Therefore, we have to provide families with various kinds of support that will help them adapt themselves to the changing social situation.

A movement to stimulate national concern

The passage of the Law on Population Development and Prosperous Family Development in 1992 has developed a broader definition of family planning, i.e. efforts to enhance community concern about and participation in postponement of the age of the first marriage, regulation of births, family resilience building, and family welfare enhancement to create happy and prosperous small families.

Under this new definition of family planning, each family should build a prosperous family with its own strength and capabilities. Each family is highly encouraged to have their ideal number of children so that it will be possible for the family members to deepen their devotion to the One Supreme God and not to lose their balanced relationships among themselves, among families, etc., due to the disturbances

that may be caused by socio-cultural changes.

The Law on Population Development and Prosperous Family Development defines the prosperous family as:

> *A family built through legitimate wedlock, capable of fulfiling its own physical and spiritual needs, faithful to the One Supreme God, with balanced, appropriate, and harmonious relationships among its members, among families, and with the community and the environment.*

Thus the prosperous family is expected to improve its capabilities in two ways. First is to improve the capability of fulfilling its duties and responsibilities to develop all of its members. In this case the family should play the role of a seed-bed and focus to institutionalize noble values, and to improve the welfare of its members. Second is to improve the capability to maintain the balanced relationships in the changing social environment, i.e., every family should build the capability to educate its children and develop their good character so that they will be always able to socialize harmoniously in the community.

In the second long-term development period, various multi-faceted approaches to prosperous family development should be sought after, in addition to continuously promoting activities that will be conducive for the fertility decline, leading to the decrease in the natural population increase. These new approaches should be quite different from family planning approaches taken during the first long-term plan, under which kinds of 'training' in deepening one's knowledge, changing one's attitudes, giving one's commitment, and developing one's personal capabilities were conducted with the objectives of stimulating planned births, correct breastfeeding, and giving the same amount of love to one's children regardless of the gender.

Building and development of village institutions that were found very effective in the first long-term plan should be continued to be supported. During the second long-term development period, however, emphasis should be placed on supporting these institutions to make both the internal and external adjustments. The internal adjustment is the physical and mental integration of the institute that will facilitate the institute to develop a self-reliant attitude and behavior. The external adjustment is a transformation to an organization highly trusted and credited by the community.

Development of manpower capable of building and involving women in development should also be highly supported in the second long-term plan. The manpower that we help build will develop institutions with a high degree of credibility. Such credible institutions should be an expression of continuous community participation taking place in accordance with the respective community dynamics.

Eight family functions

In developing and building prosperous families, several family functions need to be refreshed and/or developed when necessary. These include:

1. The religious function: the family becomes the first and primary focus to make all family members believers in the One Supreme God;
2. The cultural function: the family becomes the focus to preserve national culture and dignity;
3. The love and affection function: the family becomes the first and primary focus to grow love and affection among its members, between spouses, between parents and their children, and among children themselves;
4. The protection function: the family becomes the primary protector in developing a sense of security and peacefulness, physically and mentally, for their children and descendants;
5. The reproduction function: the family becomes a healthy reproductive planner, to make children of this nation children of high quality;
6. The socialization and education function: the family functions as the first and primary educator in raising its children to become respectful citizens;
7. The economic function: the family prepares itself to become a self-reliant unit capable of improving family welfare; and
8. The environmental preservation function: the family becomes capable of preserving and sustaining a favorable environment for its descendants in the future.

These eight family functions have to be made living entities, refreshed, and developed in a balanced manner to produce families of high quality, full of devotion to the One Supreme God, capable of improving family welfare, having a balanced, appropriate and harmonious relationship with the social and cultural environment, and dynamic community changes.

Deployment of in-village midwives

The Indonesian government and people have worked hard for improvement in the maternal health. The result is significant and substantial with Indonesian families undergoing great socio-cultural transformations for a better life. However, much can and should done. For instance, Indonesia is far behind our neighboring countries in lowering the maternal mortality rate, a measure of maternal health. There are about 300-390 maternal deaths per 100,000 births in Indonesia, which ranks the highest among the member countries of the Association of South East Asian Nations (ASEAN). Meanwhile the maternal mortality rate is only 5-10 per 100,000 births in developed countries like the United States of America.

Thus, greater efforts should be made to support institution building at the village, subvillage, and even neighborhood levels. PUSKESMAS (community health centers) and POSYANDU need to be further improved. Stronger integration of activities conducted by BKKBN and PKK also should be developed. Information, education and communication (IEC) and services which provide greater satisfaction to the community people should be encouraged and supported with higher political commitment, and oriented towards higher coverage and protection of target groups.

One breakthrough made during the last two years is the deployment of in-village midwives. We consider the deployment as a revolution at the village. In-village midwives have proved effective in steadily improving maternal health and welfare, leading to the bigger role of women in self-reliant development, especially in the prosperous family development. Thus, deployment of midwives in the villages should be supported with higher political commitment and adequate resources. Midwives also should be deployed in the sub-villages in the future.

We should all work harder to enable each of these midwives to become self-sufficient, 'owned' by an appreciative village community as it is getting prosperous. Meanwhile we will do our best so that until such time, adequate support will continue to be provided for their sustainability.

Responsible and appropriate healthy reproductive welfare behavior

A sharp fertility decline took place throughout the country during the first long-term plan. The fertility rate reached even

replacement level in five provinces (Yogyakarta, East Java, Jakarta, Bali, and N. Sulawesi). Such achievement provides a strong motivation for us to work even harder. The high family planning practice level should be a stepping base where new efforts for futher progress should be planned and implemented.

The foundation for such fertility decline was laid by the institutionalization and internalization of the small, happy and prosperous family norm, which the family planning movement successfully promoted. Among others the highest political commitment has proved the most important factors for promoting acceptance of the small family norm as responsible and appropriate healthy reproductive behavior.

Future prospects

During the second long-term development period, the rate of natural population increase and the total fertility rate (average number of children per woman) are expected to decline further. Decrease in the rate of natural population increase accompanied by the improvement in the quality of the population is strategically important for Indonesia to develop reliable human resources for economic development.

Meanwhile Indonesia's population is projected to continue to increase. The absolute number of increase in the total population is mainly due to the high birth rates during the 1970s. Babies born in those days are now entering marriage to bear children. The total number of couples who will have babies will be much larger than before, though the average number of children which couples are going to have will be fewer. The increase is also caused by the decreasing death rate, which has led to the increase in life expectancy. The drop in the death rate is attributed to the improvement in health and welfare, especially the effective health and medical care for infants.

Community participation in the effort to plan births will continue to grow. This is due to the higher education and aspirations of the community people, and the increase in the number of couples who have acces to family planning services. In this respect, it is noteworthy that the increasing number of young low parity couples will be willing to pay for their own contraceptive needs, as many of them can earn sufficient levels of wages. For these couples prime quality services should be provided for.

More appropriate efforts will be needed to further promote acceptance of "rational" reproductive behavior so that replacement level fertility will be reached earlier, when Indonesia will be entering the era of zero population growth.

Stimulating various development changes

A big change took place in the population structure in the first long-term development plan, i.e., the gradual but substantial increase in the elderly population. The number of the total work force also increased. The trend is projected to continue during the second long-term development plan. Thus it is and will be quite important to develop and strengthen their physical and mental abilities so that they will be able to maintain their participation in development, working as reliable manpower for development of the nation.

Management of the prosperous family development should also be aware of and understand the dynamics of the national development in the second long-term development plan. The development will be more complex due to the influence of the globalization of information and rapid advance in technology. Thus, the emphasis of the prosperous family development should be placed on the enhancement of the quality of the family so that the family is expected to perform two roles, i.e., an agent to help its members to adjust themselves to the changing social and technological conditions, and to be capable manpower; and the seed bed to preserve noble national values as well as to develop the small prosperous family.

Meanwhile the national family planning movement, that supports the development of the small prosperous family, should implement those activities that will develop conditions conducive for national development: transformation of agrarian community values to industrial community values, the increase in the level of education, the improvement in the role of women, the flourishing in science and technology, the heightening of the faithfulness to the One Supreme God, and the elevation of the role of youth in development.

Eligible couples and family planning acceptors

Guided by the Broad Guidelines of State Policy and various Presidential Decisions, the registration of eligible couples and family planning acceptors by method were conducted during the first long-term development period. The result of the registration was later mapped on the community map for clear visualization.

These analyzed data were disseminated routinely to various parties including village institutions like acceptor groups and PKK so that they would be used to promote higher continuation of family planning. As a result, identification of target groups for recruitment and maintenance of acceptors at the village and sub-village levels has been much facilitated.

These data were also useful to prepare for conducts of skill training, which led to the establishment of sewing groups, cooking groups, and finally UPPKA (Family Planning Acceptor Income Generating Group) that is oriented toward development of women in economic activities. In other words groups of families in villages and sub-villages initially formed as socio-cultural groups have developed into groups for income generation. Group capital, initially very small, has increased considerably and has benefited its members.

Slowly but steadly, Indonesian families both in the urban and rural areas have realized that they can become economic forces for development of their community and the country.

Prosperous Family Registration and Mapping

The 1994 prosperous family registration will be a continuation of the registration and mapping of eligible couples and family planning acceptors carried out during the first long-term development period. The difference is that the 1994 registration will collect additional information about the family and the population.

The 1994 registration will have three objectives:

(1) to know the position of current family planning practice, including characteristics of current users and potential users, and the maternal and child welfare situation;

(2) to know the welfare situation of families based on several criteria so that they will be effectively assisted to develop into prosperous families; and

(3) to know the demographic and socio-economic characteristics of the population so that appropriate programs will be developed to help improve their capabilities as reliable development force.

The family welfare registration will yield data including information on families with pregnant mother, infant(s), child(ren) under three, child(ren) under five; eligible and non-eligible couple(s); wives below 20 years of age, between 20-30 years, and 30 years and over; number of births during the past year delivered by mothers below 20 years,

between 20-30 years, and 30 years and over; number of deaths during the past year below 1 year, between 1-5 years, and 5 years and over.

Registration and mapping workers

Volunteers who will undertake the 1994 prosperous family registration will be recruited from among potential supporters of youth development, i.e. members of the scout movement, the Karang Taruna (Youth Development Movement) and primary school teachers. Various volunteers in the village level are also encouraged to join the field work. The main reason of selecting those people as volunteers is to stimulate their interest in national development by concretely showing the usefulness of the prosperous family registration findings for future development. Workers of the registration will be selected from family planning workers, Village Family Planning Management Assistants (VFPMA), sub-VFPMAs, PKK members, etc.

Prosperous family indicators

According to the findings of the 1994 prosperous family registration, Indonesian families will be classified into the five kinds of family by the level of welfare:

1. Pre-Prosperous Family, which is not yet capable of meeting its minimum basic needs.
2. Prosperous Family Stage-I, which is capable of meeting its minimum basic needs in terms of food, clothing and housing, and very basic health needs.
3. Prosperous Family Stage-II, which is capable of meeting its minimum basic needs and socio-psychological needs, but is not yet capable of fulfilling its developmental needs.
4. Prosperous Family Stage-III, which is capable of meeting its minimum basic needs, socio-psychological needs, and developmental needs, but is not actively supporting or involved in community efforts in its village or area.
5. Prosperous Family Stage-III Plus, which is capable of meeting its minimum basic needs, socio-psychological needs, developmental needs, and is regularly supporting or involved in community activities.

The indicators of welfare level by kind of family are as follows:

• **Pre-Prosperous Family**:

A family that is living below the welfare level of the Prosperous Family Stage-I.

• **Prosperous Family Stage-I**:

1) In general, all members of the family consume two meals or more daily.
2) All members of the family use different clothing at home, at work or in school, and while traveling.
3) The largest part of the house floor is not made of soil.
4) When children are ill, they are taken to a health facility/worker, or given modern treatment.

• **Prosperous Family Stage-II**:

A family that meets not only the criteria 1) through 4) but also the following conditions:

5) The family prepares meat/fish/eggs as a side-dish at least once a week
6) All members of the family received at least one set of new clothing during the past year.
7) The average amount of house floor for each occupant is at least 8 sq. meter.
8) All family members below 60 years of age are currently able to read text with Latin letters.
9) All children aged 6-12 are currently enrolled at school.
10) At least one family member aged 15 or over has a permanent job.
11) All family members are healthy and able to perform their tasks/functions during the past month.
12) Family members conduct or attend religious services regularly in accordance with their faith.

• **Prosperous Family Stage-III**: A family that meets not only the criteria 1) through 12) but also the following conditions:

13) The maximum number of living children is two. (If the parents of reproductive age are be currently using contraceptives, the number can be more than two.)
14) Part of the family income is put aside for family savings.
15) The family usually eats one meal together at least once a day.
16) The family usually takes part in community activities in its area.
17) The family does recreation together outside the house at least once every three months.
18) The family has access to information from the newspaper/radio/television/magazine.
19) Family members are capable of using transportation facilities available in the local area.
20) The family conducts efforts to improve religious knowledge.

• **Prosperous Family Stage-III Plus**: A family that meets not only the criteria 1) through 20) but also the following conditions:

21) The family or a family member regularly provides contributions in kind to community social activities
22) The head or a member of the family is actively involved as board member of an association(s), foundation(s), or other community institutions.

These indicators have been prepared, tested and finalized by experts of the Indonesian Sociologists Association, etc.

After classification of all the families in each community into the five kinds of family, each family will be marked on the community map by different colors: the red color for the Pre-Prosperous Family; yellow color for the Prosperous Family Stage-I; brown color for the Prosperous Family Stage-II; green color for the Prosperous Family Stage-III; and blue color for the Prosperous Family Stage-III Plus.

There are three types of packages of intervention or development support to be provided for prosperous family development: support for health and family planning; support for backward families; and support for the improvement in the quality of the population.

Support for health and family planning

Support should be given to promote family planning among eligible couples; and develop the health of children, especially, under fives and under threes.

For enhancement of the community's concern about and commitment to family planning, the following activities should be developed and strengthened:

- The PKK movement and various development activities in the villages and sub-villages;
- Training of village workers, and orientation on welfare-oriented development that will help increase existing village institutions' concern about and participation in the family planning movement;
- Various competitions to build the village pride, motivation, unity, and commitment. Several competitions like Welfare Underfives' Family Competition, Continuing Family Planning Participant Competition, Successful VFPMA Competition, Immunization Competition, Rooming-in Hospital Competition, Under 30 Family Planning Participant Competition, etc.

For such communities and families with relatively low knowledge of family planning

and basic health, the following are suggested to be implemented:

- The Well-being and Healthy Mother Campaign or Movement which will make community people feel ashamed of having insufficient knowledge of family planning and basic health.
- Identification and indication on the community map of those families that need medical and/or family planning help.

  (Remarks: Such visualization of the health condition and family planning acceptance of the respective community will make it easier to understand the existence of those families that need help. Clearer understanding of the situation will also help stimulate the motivation to work harder and strengthen the mutual cooperation to help each other to build prosperous families.)
- Protection of wives aged 30 and over from high risk pregnancies.

  (Remarks: They should be educated truthfully concerning the dangers of high risk pregnancies leading to maternal deaths, which is reported to be 7 to 8 times as high as the risks to mothers aged 20-30 years. They should be counseled to practice family planning, to help them prevent such risky pregnancy, not for the sake of limiting the number of their children.)

The annual registration and mapping will reveal the progress in health and family planning coverage from year to year. It will, at the same time, help collect reliable data on the number of births, deaths, and other demographic incidences at the village and subvillage levels, as the initial effort to improve the vital statistics registration.

Support for backward families

With the good use of a community map on family welfare, mutual help activities that do not require a large fund can be developed to effectively assist families of low welfare stages so that they will enjoy the higher state of welfare. Therefore, such methods should be developed that will encourage families marked blue and green on the community map, to have concern about the conditions of families of lower levels of welfare at the village, subvillage, and neighborhood levels, which are marked red, yellow and brown.

In this respect, support from the community, community organizations, and government agencies are very useful to enhance people's concern about families under the poor welfare level. Once their concern is heightened, generation of their commitment of mutual help will be easier for necessary activities towards developing families of a higher stage of welfare. People would be willing to work together to help backward families in their respective areas, uniting their capabilities for various collective developmental activities. Various competitions among villages or neighborhoods are suggested to be conducted to stimulate community participation.

When assisting those families of low welfare conditions, priority should be given to families with a woman aged 30-35 and over as head of the household. Many of these female household heads are poor widows or those left by their husbands for economic and unsuccessful marriage reasons. Most have a low level of education and a relatively large number of children. First of all they should be helped up from below the poverty line .

As for the approach to helping increase the family income, the Family Income Generating Effort should be strengthened so that each of these families will be developed into a reliable economic unit. However, the change of the family role from a socio-cultural unit to an economic unit should not be allowed to break down its overall family functions. The economic function is merely one of the many family functions that need to be developed in balance with the others.

Improvement in the Population Quality

The community should be encouraged to pay more attention to efforts to improve the quality of the population by enhancing the well-being of families of low welfare. Specific families that need the community assistance are as follows:

- Families with children under five

  (Remarks: They should be encouraged to join the Gerakan Bina Keluarga Balita (Movement for Improving of Families with Children Under Five) to learn how to provide the best for their children.)
- Families with children aged 6-15 years

  (Remarks: The nine-year compulsory education is important to build a happy and prosperous future. Therefore, families with children aged 6-15 years should be encouraged so that their children will attend and complete the compulsory education. Since families below the poverty line often let their children work for money, timely assistance should be extended to those families so that they will be able to make up for the deficit in their living expenses.)
- Family with members aged 16-60 years

  (Remarks: Whether male or female, those aged 16-60 should be encouraged to work as reliable manpower for development, improving the family's financial situation. Also they should not be very particular about their kind of work.)
- Family with members aged 60 years and over

  (Remarks: Those aged 60 years and over should be given special attention so that they will be able to enjoy their lives in their old age. Those still capable of leading productive lives should also be given opportunities to contribute to the community.)

Inducing high political commitment

The 1994 prosperous family registration was conducted throughout the country from January 1994 to March 1994, using the 22 welfare indicators. Ninety-five percent of the villages throughout the country were covered. Working maps have been developed from the results of the registration by neighborhood, sub village, village, and subdistrict in each province.

The collected data which was used to prepare community maps on family welfare has varying strengths and weaknesses by area: areas with skillful enumerators have highly accurate data. On the other hand, data collected from areas with weak human resource support should be accepted with care and used only as a reference.

Noteworthy development has been achieved: the registration has induced high political commitment to the family welfare movement. Moreover, families belonging to the category of Prosperous Families Stage-II, Stage-III, and Stage-III Plus have begun to pay increasingly significant attention to the needs of community efforts to support the relatively backward families (who belong to the category of the Pre-Prosperous Family or the Prosperous Family Stage-I).

Supporting the second type of families

According to the findings of the 1994 family welfare registration, the characteristics of the Pre-Prosperous Family and the Prosperous Family Stage-I are as follows:

A Pre-Prosperous Family is the one who lives in a house without windows. Moreover, the toilet is unhealthy and usually located close to the source of drinking water. The family members have poor hygiene. Because the floors are made of soil, the house is generally moist and is prone to induce worm

infection, skin diseases, etc., to children under five. Moreover, they seldom have access to modern medicine or health facilities such as a community health center.

A Prosperous Family Stage-I is the one who is, in general, incapable of meeting its developmental needs, incapable of paying attention to its religious life, and have illiterate members. Efforts by family members alone are insufficient to enable them to pull the family above the poverty line.

Families belonging to the category of the Pre-Prosperous Family and the Prosperous Family Stage-I may be divided into two large types: families with low economic capabilities and few possessions, and families who are "poor" in terms of their willingness to improve their standard of living.

The families under the former category are economically poor or very poor and are unable to meet their basic needs. They have characteristics as shown by the indicators developed by the Central Bureau of Statistics and the National Development Planning Board.

The families under the latter category are, in general, apathetic or unwilling to changing their life style for the better in spite of the economic capabilities to do so. For example, many keep soil floors though they have enough money to replace them with wooden floors. Besides, they are ignorant of the merit or value of taking part in development activities including the literacy campaign in their villages. They also lack proper knowledge of health care: they are not ready to take their children to the health center in case of illness, much less to have them immunized.

As a practical viewpoint, priority should be given to the second type of family when the community tries to assist poor families. These families could improve their standard of living more easily if convincing messages could be delivered to them through various channels, accompanied by timely encouragement and motivation.

On the other hand, assistance to the first type of family will consist mainly of material support such as cement, clothing, etc. These should be arranged to be provided through the community's mutual help system.

Prosperous family development movement

Various approaches to supporting prosperous family development are being conducted throughout the country. One of them is the poverty alleviation program. There are two main schemes for supporting poor families' income-generating activities.

The first one is the IDT Program developed by the Presidential Decree No. 5/1993. It has been implemented in "poor" villages since 1994. Families who are still below the poverty line living in such selected villages are given appropriate guidance and necessary working capital.

The second one developed by the Presidential Decree No. 3/1966 is implemented in those villages which are not covered by the IDT Program. The program aims at mobilizing self-reliant family-oriented development efforts in these "non-poor" villages. The program is designed to support economic activities of those families who belong to the category of the Pre-Prosperous Family and the Prosperous Family Stage I. The President has assigned the State Minister of Population to implement the program together with various departments (ministries) and community and private institutions.

To support these target families' self-reliant initiatives, KUKESRA (Small Credit for Prosperous Family Development program) is provided to be expended in their economic activities. The credit scheme is designed to help those needy families develop their cash business by timely providing them with easier access to working capital. The family who can apply for the small credit should have the following qualifications: (1) to reside in a village which is not covered by the IDT Program, (2) to belong to the Pre-Prosperous Family or the Prosperous Family Stage-I, (3) to have already joined in an economic group, such as UPPKA (Family Planning Income Generating Group) and (4) to have already been a member of the TAKESRA (Prosperous Family Saving Scheme). (Remarks: The Jimbaran Business Group helps a target family open a family saving with a grant of Rp. 2,000.)

The BNI Bank provides the credit to the applying family. The proposal for such a credit should, however, be considered and approved by the community group of which the applicant is a member.

The procedure to get this credit is very easy; fill out a special form and then have this form approved by the PLKB and the chief of Desa (village) or PPLKB. Since the credit is extended through the Sub-Post Office in the Sub-District level, the applicant may visit the Sub-Post Office to collect the loan once sanctioned. The interest on this loan is 6 percent per year. There is no interest on arrears.

The maximum amount of the credit to be extended for the first time is Rp. 20,000, which should be reimbursed within eight months. The amount of the second credit which will be given only after the borrower has promptly repaid the first loan will be bigger. If the amount of the credit becomes Rp. 160,000, it should be reimbursed within ten months. The maximum amount of the credit under KUKESRA is Rp. 320,000, which should be reimbursed within 12 months.

It is important to know that KUKESRA is one of the investments that aim at helping families living in poverty. Borrowers are also given counseling for, and skill training in, income-generating. They are also provided with opportunities to acquire marketing experience by entering into partnership with established business groups. Thus, many poor families are able to start small business.

According to findings of a research carried out in Yogjakarta, one of the major cities in the country, a nasi guded (rice gruel) seller who started with a capital of Rp. 15,000 is making a daily profit of Rp. 5,000. It made it clear that although the amount of credit may have been very small, it was sufficient for starting a food stall. This also shows that a person who is provided with not only seed money but also skill training, can be successful in small but profitable business.

Continuing, self-reliant movement

People should develop into a reliable development force. Families should develop into prosperous families.

Briefly explained is the background appraisal of conditions expected to occur during the next twenty five years and the philosophy to be developed, to guide the people in building prosperous families through the FP movement and various other integrated development efforts.

The idea presented here is limited to the general guidelines to prepare a more comprehensive second long-term development plan. It is hoped that, with all parties' growing concern about and active participation in working out the development plan, the basic thought may be developed into a continuing, self-reliant movement and program. ■

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Muslim young girls listen attentively to issues on population and family life

Strategy

NIGERIA

Islamic Legacy for Reproductive Health

Soliciting the goodwill of men in general and Mallams in particular are the first step to be taken to improve the welfare of women

By Hajia Kindin Yolah

Putting Islam in correct perspective

From the view point of adherents of Islam, the dictum of "Give onto Caesar what belongs to Caesar and to God what belongs to God" is not acceptable; because Islam is a complete unconditional and total "submission" of the human will, individually and collectively to the will of the only Supreme Being, one true God, "Allah Subhanahu wa Ta'ala" and no one else.

Islam embraces and encompasses the whole gamut of human existence for now and the hereafter, including our moral behavior, social interaction, business dealings as well as system of legislation, taxation, family formation, commercial development, societal structure and international relations and more.

Islam considers man and woman as vice-regents of Allah. Total sovereignty, however, lies with God Himself. It is a religion of simplicity but total adherence to laid down injunctions is a pre-requisite to acceptance of the creed. The Qur'an, the ultimate miracle, the Book of God, has never undergone any review over one thousand four hundred (1,400) years because, it being the words of God, such revision is not permissible.

Muslims are expected to be guided by the Law of Shariah (path to be followed). Shariah, the Divine Law, is from Allah, the only authority and the Law Giver. Shariah is a body of institutions, rules and regulations that guide Muslims in matters of Ibadah (worship) and relationship to fellow Muslims and non-Muslims as well as society.

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While the Qur'an remains our primary and pre-requisite source of the Islamic Law that guides us, the Sunna (Ways of The Holy Prophet) and Fatwas drawn from these are our secondary source. Additionally, we have:

1. the consensus of Ijima (theologians) or analogy (qiyas), as complementary source
2. examples from Medina residents, juristic preferences (Istihsan) and public welfare and unrestricted interests (al-masali al-mursala), as supplementary source
3. rule of concomitance (istishab)
4. blockage of the way (sadd al-aharai') and
5. prevailing customs (urf)

Moreover, Islam has the following four rules:

1. The rule of permission of basic nature of things unless prohibited explicitly by text (nuss)
2. The rule of 'no harm and no harassment'
3. The rule of 'necessity permits the prohibited' (within limits), and
4. The rule of 'choosing the lesser harm'

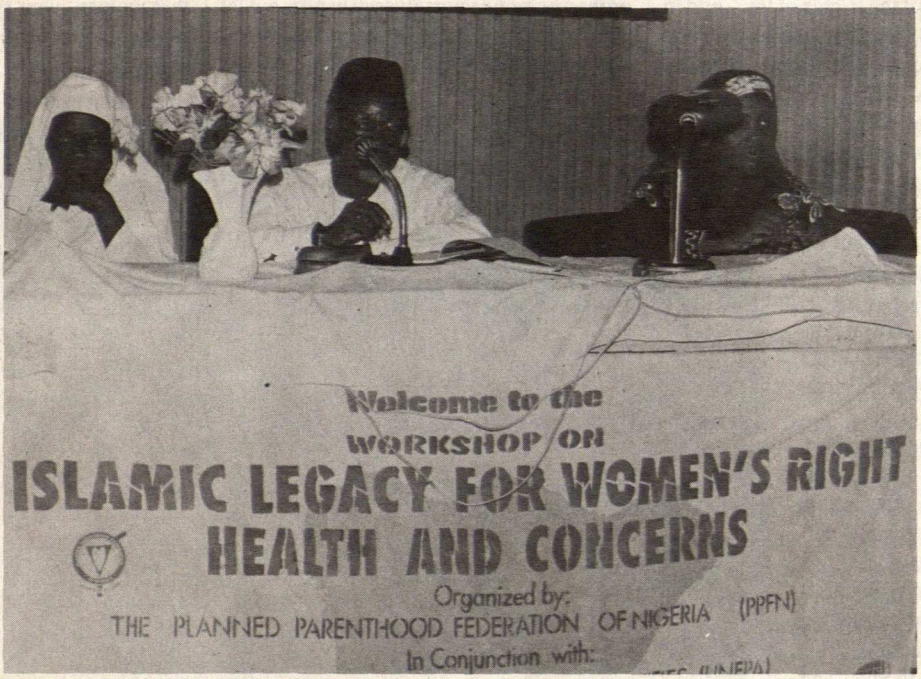
Human rights in the realm of Islam

Islam enjoins that our obligation towards God will take priority over our own rights. Whatever rights human beings have are granted by the Creator, and not legislated or recommended by human beings. Our rights are formulated in the forms of Divine Commandments and in an ideal Islamic state, we are duty bound to observe them. Muslims are permitted to secure benefits and ward off harm but without overstepping our limits - (Ijtihad).

Islam is also a very practical religion with complete codification that provides solutions to our daily problems, in the realm of education, health, development, social or family concerns. The Holy Prophet (PBU) reminded all 'Ummas' on the Mount Arafat during His last pilgrimage to Mekka, by saying that "I am leaving two things for you: The Qur'an and The Sunna. If you follow these two, there is no danger of you going off track." [1] Yet he also enjoined adherents against extremism. Rather, he opted for moderation and recommended that everything should be seen to be permissible till they proved forbidden. The Qur'an further reiterates, "And has not laid upon you in religion any hardship."[2]

Islam is a progressive and timeless religion. For example, today in the 20th century, medical experts are advising couples to cross-check blood groups before marriage for fear of acquiring inheritable diseases such as sickle-cell anemia, AIDS, etc. There is evidence in the traditions (Hadith) of the Prophet (PBU) authenticated by Ibn Maja to this effect. He is quoted to have said, "Choose where you deposit your sperm, for the line of descent id conducive."[3] And a common advice is to "Marry from outside your kith and kin, lest you beget puny children."[4]

In Islam, there is freedom and right to decide even your relationship with God, for He has declared, "Let there be no compulsion in religion. Truth stands out clear from error."[5]



Popularizing development ideas advocated by Islam: The Planned Parenthood Federation of Nigeria organizes the Workshop on Islamic Legacy for Women's Right, Health and Concerns in conjuction with UNFPA

Woman's triple roles

The status of woman, being a crucial factor in her ability to perform her role in the family and society at large, is not a matter of dispute.

Woman's triple roles as procreator, food producer and processor have also been well recognized. Her informal role of being health provider and manager within the family set-up and in the community at large is, however, less appreciated.

Unfortunately, women are rarely well equipped for their appointed roles. Unhealthy due to inadequate intake of nutrition, lack of education, overworked and overburdened with excessive daily chores and responsibilities, and weakened by improper reproductive well-being, women have contentedly accepted their low social status.

A woman of limited education often has poor management capability. It is not an easy task for an illiterate mother to groom and develop physically, mentally or spiritually healthy children. Besides, such a mother finds it difficult, if not outright impossible, to keep the family's health strong: her health and her children's health are easily impaired due to her inability to understand health and hygiene management.

Women's rights are part of human rights

The preamble to the Charter of the United Nations set as its basic goal "to reaffirm faith in fundamental human rights, in the dignity and worth of the human persons, in the equal rights of men and women."[6] Furthermore, article one of the Charter proclaims that one of the purposes of the United Nations is to achieve international cooperation in promoting and encouraging respect for human rights and fundamental freedom

for all people "without distinction as to race, sex, language or religion." Apart from this, the Convention on the Elimination of All Forms of Discrimination Against Women became necessary for adoption in 1979 to further combat continuing discrimination against women.

The Charter of the Universal Declaration of Human Rights, the Resolution of the General Assembly of the United Nations, the two draft Covenants of Human Rights, the Declaration of the Rights of the Child in 1959, the UNESCO Declaration and the Commission and the Sub- Commission on Human Rights and the Commission on the States of Women, all have called for:

1. Equality and brotherhood of man
2. Rights of people of the earth to self-determination
3. Friendly relations among nations in order to strengthen universal peace
4. Equality before the law
5. Civil and political rights and other social and economic and cultural rights.
6. Prevention of discrimination and protection of minorities
7. Rights of women and children
8. Abolition of slavery
9. Rights to work and trade union rights
10. Rights of prisoners of wars.

Furthermore, in 1993, at the World Conference on Human Rights, the international community adopted priority objectives, for full and equal treatment of women in political, civic, social and cultural life and the eradication of all forms of discrimination on grounds of sex. Narrowing down human rights to the rights of issues that are of special concern to women, the Convention on Human Rights also states that all issues pertaining to women's rights, including reproductive rights and the right to choose freely the number and spacing of children as well as having the necessary information and the means and services to do so, are also part of human rights.

To adherents of Islam, the recurring theme on human rights and women's rights, including reproductive health right, ring with certain familiarity.[7] It is like a revisit to messages that followers of Islam have been clearly enjoined to observe over 14 centuries since the revelation of the Holy Qur'an.

God Himself declared the sanctity of life and right to life when He decreed that man is "Khalifatullah," i.e. vice-regents on earth and being next to God, his status is raised above all other creatures. "We have indeed created man in the best of moulds."[8]

On the sanctity of human life God commanded in al Nisa (Sura 4: 29) of the Holy Qur'an: "O ye who believe, eat not up your property among yourselves in vanity, but let there be your traffic, to add by mutual goodwill, not kill or destroy yourselves. Verily Allah is unto you ever merciful."

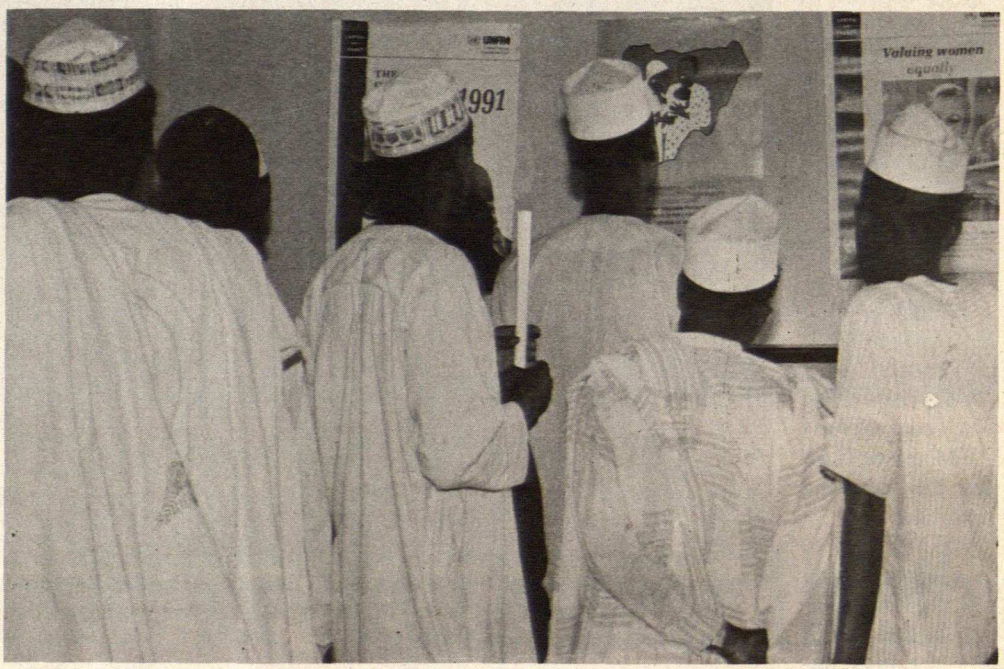
In the eyes of the Creator, all men and women are equal as He has proclaimed. "Oh mankind, we created you from a single (pair) of male and female and made you nations and tribes that you may know each other (not that you may despise each other). Verily most honored of you in the sight of Allah is (he who is) the most righteous of you. Allah has full knowledge and is well acquainted with all things."[9]

Whether man or woman, we are all equal before the eyes of God and piety is the only valid criterion tor distinction.

The Qur'an is very specific on equality of both sexes: "All the believers, men and women alike, are protectors, one of another, they enjoin the right and forbid the wrong, they observe regular prayers, pay the poor due and obey Allah and His messages. On them Allah have mercy."[10]

Women are even permitted to take up arms for defence of their religion and land since the Almighty has enjoined them to "go forth light armed or heavy armed and strive for the course of Allah."[11]

At the time of the Prophet (PBU), women accompanied men in battles and when attacked by enemies, they joined freely. Thus, be it religion, worldly affairs, work, trade or commerce, there are ample records to show that women were fully involved. They attended public functions, studied, taught and traded.



Muslim youth at the Population/Family Life Information Stand at the trade Fair Organized by the Population, Information & Communication Branc of the Federal Ministry of Information and Culture

Prior to the advent of Islam, women were mere chattels to be bought and sold at will. Their birth was heralded with shame and dishonor for the family so much that at times female infants were buried alive. But within a single generation, Islam bestowed honor, dignity and rights with enhanced status that had been unprecedented on women.

Islam does not support the suffering of man or woman, be it at the individual level as seen in street begging, child abuse, etc., or at the societal level as is the case when a nation has an economic crisis. "The upper hand is better than the lower one. The upper hand is the one which expends, and the lower is the one which asks."[12]

Allah further declares; "... Allah desires for you ease (yusr); He desires not hardship (usr) for you..."[13]

This is further confirmed by the advice to young men in the Quran: "Let those who find not the wherewithal for marriage keep themselves chaste until God gives them means out of His grace."[14]

Note that this in effect is an instruction from God that men should not get married until they are fully ready and able. For Muslims it is accepted that marriage is one of the most natural things and is desirable. Procreation to perpetuate the species through marriage is also desirable and gratifying way of Islam. But God has also decreed Islam as a religion of yusr (ease) and Muslims are enjoined by God to choose the part of less harm within the limits of the Sharia, whenever faced with a problem. Mothers too are advised to breast feed their babies for two years. "The Mothers shall give suck to their offsprings for two whole years."[15]

This is not only helpful for warding of hardship, but has also been proved by medical science to be the most beneficial for both mother and child on health grounds.

For warding off genuine hardship and health reasons, coitus interruptus was practiced during the time of the Prophet (PBU). He Himself knew of it and did not object to it.

There are many genuine traditions to support this submission. In fact it was reported that a young man intimated to the Prophet (PBU), "I have a young wife, I hate to make her pregnant, I would want what other men want; but the Jews claim coitus interruptus is a minor infanticide." The Prophet' s outright reply was, "The Jews lie. If God wishes to create the child, you will not be able to divert it."[16]

Although abortion is forbidden in Islam, it is permissible on health grounds, such as fear of the death of the mother. Incidentally, abortion in the 120 days of conception is not considered infanticide in Islam because the embryo is yet to acquire soul and shape of a human being.[17]

Muslims are often reminded of the Prophet (PBU)'s advice: "Marry the affectionate and prolific woman and I shall be proud of you among nations." However, scholars of Islam have also reminded Muslims that the Prophet (PBU) of Islam would not want to be surrounded by multitude of Muslims who are undernourished, and social misfits on the day of judgment. The Qur'an has warned: "O ye who believe! Truely, among your wives and children are (some that are) enemies to yourselves: so beware of them!..."[18] There is no doubt that if the parents have many children to think about and if the children make a big demand on them, the family may lead him to a corrupt life.

From the foregoing, Muslims need to be reminded of the requirements of Islamic multitude (Kathrah). These include:

1. a nation with high morals
2. recognized scientific and educational excellence
3. high prestige among nations
4. cooperation if not, total unification
5. ability to produce more than consuming
6. no intra-Muslim conflict
7. healthy population growth without risk to mothers or children

In conclusion, It is incumbent on all Muslims to desire for a healthful family and, by extension, a healthful society. We need both providence and planning to build up a healthy family and society. This surely cannot be contrary to the will of Allah because He Himself has declared that the whole universe rests on the plan and order of God as decreed by Him. For without planning there could be chaos as "All they have, We created after a fixed decree."[19]

Learning is very central to the Islamic faith and culture. As attested by the Prophet (PBU) of Islam, "the ink of scholar is more than the blood of the martyr."[20] He enjoined his followers, men and women to seek knowledge "even in China."[21] In fact, "to pursue education is obligatory (farida) on all Muslims, men and women."[22]

Contrary to misconception on Islam, women are equal to men in religion, social and patriotic responsibilities, although wives often defer to their husbands in family affairs.

Marriage, for example, is not supposed to be enforced. Moreover, women can keep their maiden names: the Prophet (PBU)'s wife, Safiya, daughter of Hayyi, kept her maiden name.

Wives are given financial independence while husbands are enjoined to be responsible for taking care of their wives and children, providing for the household.

A mother has a special place in a family: children cherish the deepest affection for and practice their loyalty to their mother.

Detractors of Islam at times refer to the unequal treatment of women in the law of inheritance. This is, however, usually dictated by reality of the circumstances. In reality women in Islam have the right to inheritance. Moreover, there are many occasions when a woman is more favored than a man as successor.

Women in Islam also have the right to work, earn a living, own properties and freely marry whom they want to marry. Besides, women are permitted to put into contractual form, all decisions that will be binding the husband, at the time of marriage.

A marriage can be annulled at the wish of the wife, as reported in a tradition by Abu Huraira when a young woman went to the Prophet (PBU) of Islam to protest that her father had given her away in marriage to his nephew to improve his social status without first asking her consent. The prophet gave her the choice to reject or accept it. Then she answered, "I condone what my father has done, but I just wanted to tell women that fathers have no such rights." (authenticated by Tirmidhi).[23]

Contrary to current misconception, women have the right to custody of a child in Islam, as related in a tradition - Umar Ibn Khattab had dispute over a child and the wife reported to Abubakar. "His father repudiates me." Following the tradition of our Prophet (PBU) Abubakar said, "You have a better claim to his guardianship, as long as you have not married."

It is of interest to note a man must first seek permission from his wife before performing coitus interruptus. Worthy to note further, is that neither of them is compelled to inform the other under a situation of genuine fear, that a child may inherit bad character or fall a victim of social evils.

Islam also disallows preferential treatment between boys and girls and urges equal rights for both from birth: "And when one of them receiving tidings of birth of a female child, (for him) his face darkens in sadness and disappointment. He hides himself from the folk because of the disgrace of that of which he has tidings. (He argues with himself): shall he keep it in contempt or bury it alive? Verily ! Evil is their judgement."[24]

The Prophet (PBU) too has been quoted to have said, "Do not hate daughters, for they are comforting dears."

In another tradition, it was said that, while a man was sitting with the Prophet (PBU) "His little boy came up to him and he sat on his lap. Later his daughter came and he asked her to sit in front of him. The Prophet (PBU) said, 'Why don't you treat them equally?' "[25]

It was reported that on one occasion the Prophet (PBU) refused to witness a gift of a man who singled out a child among many others. He advised, "It is incumbent upon you to maintain equality among all of them as it is due on them all to be good to you."[26]

A lot has been reported by close associates of the Prophet regarding the immense benefits that will accrue to parents who devote their resources to the care of their female children. These benefits are to be

realized in this world and in the hereafter as well.[27]

At times, however, conservatives say that women are not equal to men in Islam, referring to "men are a degree above women," a verse in al-Baqarah (Sura 2: 228). Meanwhile Ibn Abbas, the Prophet (PBU)'s cousin, has this to say by arguing that this verse is a call on husbands to treat their wives better than they are expected to be treated by their wives. Hence the degree does not necessarily connote superiority. In fact, in a tradition of the Prophet of Islam authenticated by Ahmad and Abu Dawoud, "Men and women are equal halves."[28] This has been further corroborated by what Ibn Abbas, our Prophet's cousin, is reported by Qurtubi to have declared: "I adorn myself for my wife as she adorns herself for me, and I would not like to exact all my rights that she owes me, so that she would not claim all what is due to her ... The 'degree' is a cue to invite men to pleasant cohabitation and to extend to women more money and good manners, because the one with more (al afdal) should impose more upon himself."[29]

God calls on men to be guardians and superintendents of women, in al-Nisa (Sura 4: 35). It is because of men's physical superiority and it is also based on the knowledge that many women are at a disadvantage economically. Hence, Islam has allotted responsibility for the protection of the weak (women) against the strong (men).

During the Prophet (PBU)'s lifetime, women were engaged actively in public life and community development. Shifa Binti Abdallah was appointed three times by the messengers of Allah to what could be comparable today to a Director General of Marketing .

History of Islam has many examples of women who spoke up for their rights even at the times of our Prophet (PBU). It is rightly said that, the seeds for "women's movement" were planted at the time of the Prophet (PBU) as well noted in 1959 by Sheik Shaltory who recounted the discussion between Hind Bint Utba (wife of Abu Sufyan) and the Messenger of God in connection with the rights of women to take independently the oath of fealty (loyalty).

It was reported that women took the bold steps of giving refuge to a convict of war and the Prophet (PBU) condoned it.

The Prophet (PBU) was known to have set aside a day to hold discourse with women.

The support for the independence of women and their rights is demonstrated further by women in their relationship to powerful companions of the Prophet. A man went to Umar Ibn Khattab to complain about a nagging wife only to discover that, the leader of the faithful was himself a victim of wife nagging, so he was about to run away when Umar accosted him. On hearing the man's mission, Umar had this to say: "My dear brother, I bear with her because of her rights on me. She prepares my meals, bakes my bread, washes my clothes, and nurses my child. Non of these tasks is a binding duty on her. My mind finds comfort in her to keep me away from Haram, i.e. what is forbidden. So I bear with her." Then the man said, "I shall bear with her. Life is a brief period." This is indeed a lesson for men in the 20th century.

Sayidina Umar was known for his no nonsense posture in public life, yet he was a lenient and understanding husband who recognized both the dignity and rights of women.

Hafsa, daughter of Umar, too, is known to have had tough arguments on occasion with her husband, the Holy Prophet (PBU).

The prevailing situations in many Islamic societies are far from the ideal described above. One of the fundamental reasons may be that most adherents of Islam in developing countries, including Nigeria, do not have a comprehensive and clear view of the ideals of Islam on women's rights as well as general Islamic teachings, due to their inability to read Arabic. They can not read the Qur'an (as it is written in Arabic). Their source of Islamic teachings is usually a learned "Mallam" (Ulema), who may be versatile in the recitation of the Holy Qur'an but is not necessarily fluent enough in Arabic to fully decipher the scripture.

Therefore, it is important and essential and should be promoted to translate the Qur'an and literature on Islam into vernacular languages so that a wide range of people who can not understand the Arabic language will be able to easily and correctly understand them. In this respect, we are watching, with keen interest, the translation plan of religious books in the Northern part of Nigeria. Some key Islamic literature are being translated into the Hausa or other Northern Nigerian languages using Arablic alphabets known as Ajamiin. When the vernacular versions shall have been published, a far larger number of people will have access to authentic Islamic knowledge and teachings.

A "Mallam" is quite an important person in the community. He is the focal point of community activities, serving as the role model for people in the community for both spiritual and temporal guidance. Apart from the interpretation of the Qur'an, teachings of compulsory prayers and moral training, a "Mallam" is involved in mundane affairs such as providing both preventive and protective medicines for illnesses, witchcraft, love potion and interpretation of dreams, etc. No solemnization of marriage, funeral and festival takes place without the "Mallam"'s involvement. No serious transaction can take place without the presence of the "Mallam." He is respected and at times feared. Often he is a trusted friend, a confidant, a healer and an intercessor, a social purifier and a community protector against evils.

The average Muslim woman is greatly influenced by the "Mallam."

Who is the average Muslim woman? She is highly disadvantaged with her social status being perpetually kept low, contrary to the spirit of Islam. Living in her cultural cocoon, the dividing line between culture and religion is obliterated and is hardly ever questioned.

A ordinary Muslim woman lacks basic education, health care and functional literacy. Her knowledge of the Qur'an rarely goes beyond the Five Pillars of Islam and therefore, her rights and obligations as a free human being are at most times unknown to her. Her human rights are abused: she suffers from early forced marriage, sexual harassment, physical abuse, double work without commensurate compensation, lack of custody of children, lack of accessibility to credit facilities, lack of sexual and reproduction health rights, etc.

Subjected to poverty and deprived of the basic necessities of life, a common Muslim woman also lacks the essential tools to enable her improve her status, and to play her expected role within the family and society at large. Her low social status itself is also the stumbling block in the path of propagating health development activities, including reproductive health care. From birth to death, she is under the constant dominance of male authorities to which she has resigned herself.

As inheritor of the Prophet (PBU)'s way of life, a "Mallam" is shouldered with the prophetic duty to better society. A "Mallam" should give educational opportunity to both men and women as educator, according to the Prophetic injunction. He is enjoined to process and propagate information. As communicator and teacher, he is also instrumental in forming norms and shaping of attitudes in our society. Thus, it is possible to encourge and expect a "Mallam," without hurting his integrity, to assist in popularizing developmental ideas, which are advocated by Islam. Moreover, a "Mallam" can

propagate and guide people's efforts for working out solutios of all health issues in the context of Islam if he is fully convinced of the need to do so. Islam pays serious attention to maintenance of good health. For example, the compulsory five daily prayers cannot be performed without ritual cleansing of the body.

Information, education and communication program

Thus, an appropriate information, education and communication (IEC) intervention program should be undertaken so that true Islamic teachings will be imparted to common Muslim people, including women. When such IEC program is to be developed, it is important to bear in mind the divergent socio-cultural affiliations and religious background of the audience. I said in another forum, "my position as an IEC manager has taught me that an effective communication designed for a particular group of people must be done in such a way as to be in tune with its socio-cultural beliefs, agreeable with objectives at hand."[30]

The principle goal of any IEC program is to facilitate the change in behavior and action. IEC should be seen as a tool for development and change.

Islam has been in our midst for centuries and there is a lot of cultural diffusion into our religious practice. Thus, when the IEC officer plans and implements the dissemination of information on women's rights on health and well-being, etc., he or she should pay a due respect to Islam and its culture. Luckily, Islam has more than enough practical examples from the Holy Qur'an and the tradition of the Prophet (PBU), some of which have already been referred to, that support women's rights on education and health, including reproductive health. More examples must be compiled to be presented in the IEC program.

As mentioned earlier, the "Mallam" is very influential in the community. Therefore, it will be a futile exercise to embark on any IEC program without getting the trust of "Mallams" in particular, and men in general in our male-dominated society.

All categories of "Mallams" must be brought into the fold in the IEC campaign. They must be enlightened and re-oriented through the orchestrated campaign for the Islam's true views on various issues including women's right to health. If possible, actual visits and exchange of ideas as well as showing them films of examples from other Islamic countries will go a long way in ensuring that "Mallams" identify with the ideas proposed in the IEC campaign. Parallel examples from other Islamic nations must also be made available so that learned "Mallams" will be aware that they are not alone in the new development activities.

As for the message of such IEC intervention program, the content must first and foremost be concrete. Without concrete information, the IEC program will not have great impact on people's knowledge, attitude and behavior. That is to say, the communicator must have relevant facts, data, ideas, etc., which he wants to impart. The communicator must further ensure that he not only has adequate and relevant information, but that these are processed and packaged effectively and efficiently. This can only be possible in the context of proper understanding of the audience and its environment.

Basic processs and principles for planning and implementing effective communication campaign

The 'P' Process of Communication, developed by the Johns Hopkins University Center for Communication, is one of the best IEC strategies that have been used successfully. (See Box in page 40) The 'P' process is a dynamic, cyclic and continuous exercise:

1. Analysis

Analysis is a painstaking procedure that requires both care and patience. Its importance can not be overemphasized because it can make or break the entire program.

It should include a review, through the developmental research and/or the baseline survey to be conducted by experts for gathering both quantitative and qualitative information on the following:

- Audiences, and their knowledge, attitudes and practices related to Islam's teachings on women's rights on health and well-being, etc.
- Existing problems, for example, resistance to adopt new health practices such as family planning and child survival techniques
- Institutional capabilities to determine which agencies have the interest, internal capability and external support to carry out an effective communication project
- Communication capacity to determine available media and communication resources and previoius relevant activities

2. Design

The design stage should result in an overall strategy and work plan that identifies and defines the following:

- *Objectives*, which should be specific, realistic, prioritized, measurable, attainable and timebound, will form the basis for project assesment.
- *Audiences*, which should be segmented by demographic, geographic, cultural, psychological, or other relevant characteristics.
- *Strategies*, which should be developed, taking into consideration the program objectives, audience segmentation, principle research findings, behavior analysis, etc.
- *Work plan*, which should include a promotional plan, a training plan, an evaluation plan, a monitoring plan, a management plan (sharing out of responsibility) and budgeting.
- *Messages*, which should address the needs, concerns and level of knowledge and awareness of the intended audiences. The message also should be credible. There can be no greater sources of credibility than the Holy Quran and the authentic tradition of the Prophet (PBU).

Appeal, image and mood of messages should also be decided for better acceptance.

1) *appeal*, which could be rational, educational or emotional.
2) *image*, which could be rural vs. urban; simple vs. sophisticated; modern vs. traditional, etc.
3) *mood*, which could be serious; scientific, religious, family oriented or scholarly.

Since all messages cannot be given at once, phasing out, mixing and integration are very important.

- *Media*, which should be multiple and coordinated for impact and timing.

There is the need to determine the efficiency and role of each form of media and to integrate them in such a way as to be mutually supportive. Each form of media has its own advantages and disadvantages:

1) audio media

Radio's network and far reaching advantages makes it a very important channel of communication. The entire nation can be reached. The large listenership of radio is connected with its easy accessibility and relative cheapness. Radio is also handy, convenient to carry, unobstructive and easy to operate. It is possible to lightheartedly listen to the radio while engaging in other activities, hence it lends itself well to the rural audience.

Radio is particularly useful for general awareness, sensitization, as

well as sustaining and reinforcing interests. It can also be used to give factual information. Most people turn to the radio for the latest news, for entertainment or education. By using the indigenous languages, audience outreach can be increased further. It does not mean that radio is the panacea for all purposes. Its open nature, for example, means audience's attention can be easily dispersed. Therefore many listeners often find it difficult to follow the story or contents of messages. The recourse to a Listening and Viewing Center could help reduce this problem.

2) audio/visual media

Vivid, live, attention getting, with a power to amuse and stir emotions positively or negatively, the audio/visual media such as TV and video programs and movie films are crowd pullers and useful tools for behavioral change, instruction and discussion forum. They can be used for sensitization of gate keepers, opinion leaders, etc.

The TV and the videoplayer, which are expensive and therefore mostly the preserve of the educated elite, can also be installed and used at the Listening/ Viewing Center for community-based information activities.

3) print media

While the audio/visual media are transient, the print media, that include leaflets, posters, bill boards, pamphlets, books and journals, lend themselves to permanency.

Though the printed materials can not be used to inform a practically illiterate audience of the message, they are excellent media for educated individuals, particularly policy makers and opinion leaders.

4) interpersonal communication

It is particularly useful to complement the mass media. It can be effective, especially in conjunction with culture- based traditional media. "Whereas the mass media provide information quickly and repeatedly to a large audience, interpersonal communication addresses individual concerns, gives immediate feedback and leads to greater in-depth understanding."

For our purpose "Mallam" is the veritable medium of messages and can work as the best interpersonal communicator.

The use of various media depends on availability of resources and manpower as well as the nature of the audience. In general, multi-media approach reinforced by interpersonal communication is the best.

- Promotional activities

Promotional activities that use various media range from meeting, conference, special events, distribution of items and mementoes (e.g. T-shirts and buttons) to the phone-in in the urban areas.

3. Development, pre-testing and revision

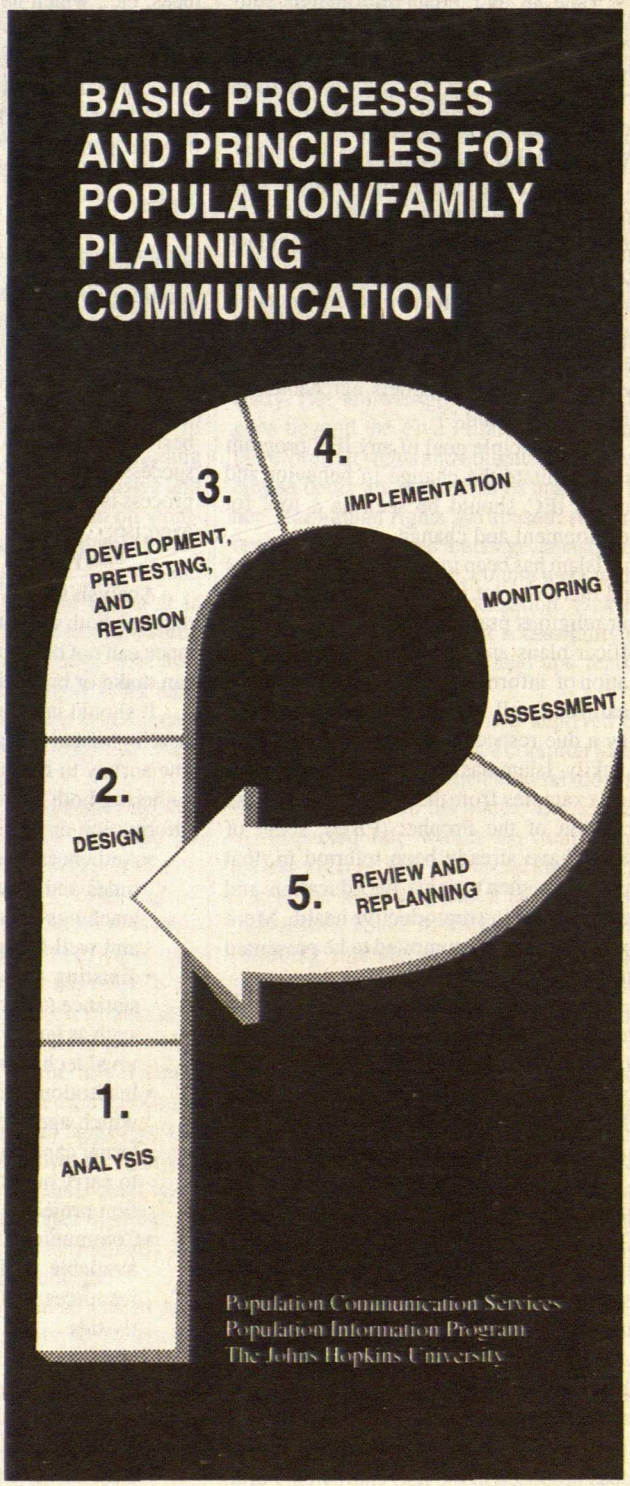
Message development should be guided by the analysis and design conducted during the first two stages. Messages should be simpler, clear, specficic, positive, attention-getting, action-oriented, and compatible with cultural belief systems and national policy.

Crucial to effective communication is the testing, before production, of any message among audiences for whom they are intended. Suitability of messages, e.g. acceptance of messages by gate keepers, readability and visual literacy should be pretested through the Focus Group Discussion (FGD), etc. Pretesting is necessary to detect weakness and subsequently revise messages and materials before embarking on production of materials on a large scale. It is important to involve materials and program designers as early as possible to avoid costly mistakes.

4. Implementation, Monitoring and Assessment

Implementation is the stage during which the plan is put into action. *Monitoring* and *assessment* provide information to the project manager on outputs and impact for making necessary revisions. These three processes overlap so that monitoring and assessment can lead to timely improvement in the overall approach.

Implementation, usually the most costly stage, begins with actual use of communication materials. The IEC manager must ensure proper distribution, maximum reach



and frequency as well as phasing. Distribution strategy must be perfected in such a way that it blends with media mix and dissemination.

The training component is very important and should ideally take place well ahead of the implementation stage.

Care must also be taken to integrate interpersonal support and other follow up activities centered on the community-based approach.

Monitoring looks at project outputs compared with the original work plan and budget. It helps project managers identify and correct problems so as to improve effectiveness and efficiency.

This should be an ongoing activity throughout the program's life span. It must be carried out systematically for project managers to detect and correct problems such as flaws and oversights early so that quality and vitality of the program will be ensured.

Assessment measures project impact in terms of target audiences and objectives. Project assessment should be undertaken in terms of realistic, measurable outcomes which should be spelled out in the project objectives.

Assessment can be made through observations, interviews, analysis of records, etc. Information on the following should be collected:

- level of the program execution at each stage
- whether messages actually reached the intended audience and how often
- whether the contents of messages were learned and retained
- persons who have been affected and under what circumstances
- groups of people who have been affected most and under what circumstances
- whether the target audience actually changed their behaviors (for better)

Such information is useful for implementers as well as decision and policy makers to improve the program. Effective monitoring and evaluation are essential ingredients of success.

5. Review and replanning

Review and replanning stage entails both the analysis of overall impact and application of that analysis for replanning future activities.

The communication process is a continuous one. Significant changes in attitudes and behavior take time and effort. This process is cyclical, adjusting to the changing needs of audiences and building systematically on past experience.

Enabling women to lead a better life

It would pay IEC managers and implementers high dividends if we could plan any IEC intervention program, keeping the people in mind first and foremost. The people must be our reference point. We should pay attention to their concrete problems, needs, and fears towards new ideas, etc., under the social inhibitions. We should "Learn to Listen to and Listen to Learn" from the people, because they know and feel their problems far more than the program personnel. "When one sits on a bedbug and is bitten by it, one does not need to be told to get up by the bedbug before he gets up," said a clan chief in Uyo, Akwa Ibom during his interview with us.

The role of the IEC managers is to use his/her tools of learning to assist women define their goals, and solve their problems to enable them to lead a better life.

We know that there is a discrepancy between the ideal and the reality of Islam in many Islamic societies. Most issues, including the ones concerning women's rights on health and other matters, are due to cultural and social misinterpretation and/or poor understanding of its true teachings.

We are highly aware that such disparity can be rectified just by leaving those problems with Islam, a timeless religion that is open to flexibility in addressing itself to solving contemporary issues. We can and should consult the divine Holy Quran and the Sunnah of the Prophet (PBU) so that we will be guided and inspired to make concerted efforts to reasonably improve the overall welfare of women.

Soliciting the goodwill of men in general and "Mallams" in particular are the first step to be taken in the right direction. ■

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"Reproductive Revolution" Continues in Indonesia

New survey findings reveal that the world's fastest growing countries will continue to study Indonesia as a model for promoting contraceptive use and smaller families.

More than 33 million women now use modern contraceptives like the pill, injection or IUD in Indonesia, a major achievement in this 17,000-island country. Indonesia has effectively promoted family planning to even the most isolated members of society. In some villages, a public gong is hit nightly to remind local women to take their birth control pill.

The survey results also indicate that family size has decreased in the world's fourth most populous country.

"The fertility level in Indonesia has undergone a notable decline in the past 25 years, from 5.6 births per woman in the 1960s to 2.9 births in the early 1990s," writes State Minister for Population Dr. Haryono Suyono in the Indonesia Demographic and Health Survey (IDHS) Final Report. Jakarta and Yogyakarta are below replacement level fertility. The total fertility rate (TFR) has dropped to 1.9 births per woman in Jakarta and 1.8 births per woman in Yogyakarta.

Many Indonesian women are embracing the two-child family norm, a fertility level that will eventually lead to a stationary population size. Overall, 36 percent of women say that their ideal family size is two children.

These findings are based on the 1994 IDHS, which was conducted by the Central Bureau of Statistics, in collaboration with the State Ministry of Population/National Family Planning Coordinating Board and Macro International Inc. (Maryland, USA). Funding was provided by the Government of Indonesia, the United States Agency for International Development, and the World Bank.

A newly-married couple in Jakarta: TFR dropped to 1.9 in Jakarta

- Challenges Ahead -

The IDHS results reflect the many achievements in Indonesia as well as the major challenges ahead in meeting the needs of women and their families.

Reaching and Serving Potential Users of Family Planning

The family planning program faces the challenge of reaching the women with "unmet need" for contraception. An estimated 11 percent of married women have an "unmet need" for family planning: they are not using contraception, but do not want any more children or intend to space their next birth by at least two years.

More than one out of four contraceptive users stops using a method within a year of starting, the majority because of side effects, health concerns, method failures, or cost and availability issues. This suggests that improvements may be needed in counselling women in the selection of methods, follow-up care, and accessibility of services.

Making Motherhood Safer

The number of women who die as a result of pregnancy-related causes is relatively high, with 390 maternal deaths for every 100,000 births (1989-1994). Most of these deaths are preventable with adequate medical care and assistance at delivery.

Many women, however, do not have trained medical care at delivery. Most births take place at home and many deliveries are assisted by traditional birth attendants. Women at the greatest risk during pregnancy, such as mothers under age 20 or over 35, are less likely to have highly trained delivery assistance.

Improving Child Survival

While considerable progress has been made in improving child survival, about one child in 11 still dies before reaching the fifth birthday.

A number of factors influence a child's survival. The 1994 IDHS indicates that children are at greater risk when their mothers have a limited education; are under the age of 20 at birth; have had 7 or more previous births; have had a previous birth less than 24 months before; and did not receive antenatal care or medical assistance at delivery.

Many children in Indonesia are also vulnerable to vaccine-preventable diseases. Only one-half of children 12 to 23 months have been fully vaccinated against the following six major diseases: tuberculosis, diphtheria, pertussis, tetanus, polio, and measles.

About the Survey

The 1994 IDHS, one of the most ambitious national surveys ever undertaken in Indonesia, is based on interviews with 28,000 reproductive-age women. A primary objective of the IDHS is to provide government institutions with information necessary for improving family welfare. This survey is also part of the worldwide Demographic and Health Surveys project, which is managed by Macro International Inc. and funded by the U.S. Agency for International Development. ■

Key Statistics on Fertility

INDONESIA DEMOGRAPHIC AND HEALTH SURVEY

Couples are having smaller families in Indonesia, with fertility declining from nearly 6 children per woman in the late 1960's to fewer than 3 in the early 1990's.

Women in DKI Jakarta and DI Yogyakarta have the smallest families, with fertility rates under two children per woman. In contrast, women in rural areas and in Outer Java-Bali II tend to have three or more children on average.

Fertility in Indonesia has declined at a nearly unprecedented pace. Fertility levels, however, will need to decline further to reach the country's long-term goal of around 2 children per woman. This is the level that ultimately leads to a stationary population size.

Ideal Family Size

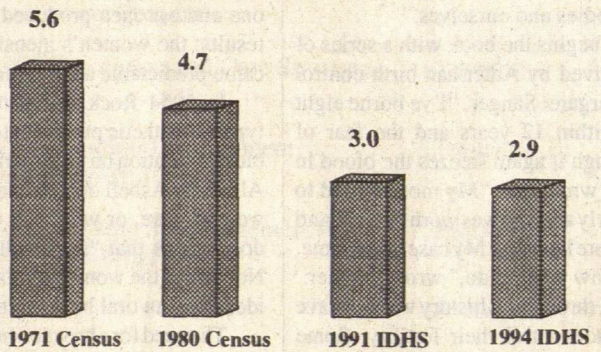
If unwanted births could be prevented, many women would have slightly smaller families. Total fertility in Indonesia would decline to an average of 2.4 births per woman, instead of nearly three.

The wanted fertility rate suggests that women in Java-Bali desire around two children. In contrast, women in Outer Java-Bali I and Outer Java-Bali II want families of nearly three children.

Wanted fertility among women ranges from under two children in DKI Jakarta, DI Yogyakarta, East Java, and Bali to a high of 4. 5 children in East Timor. Women are wanting and having three or more children in Dista Aceh, North Sumatra, West Nusa Tenggara, East Nusa Tenggara, Southeast Sulawesi, and Maluku.

How has family size changed?

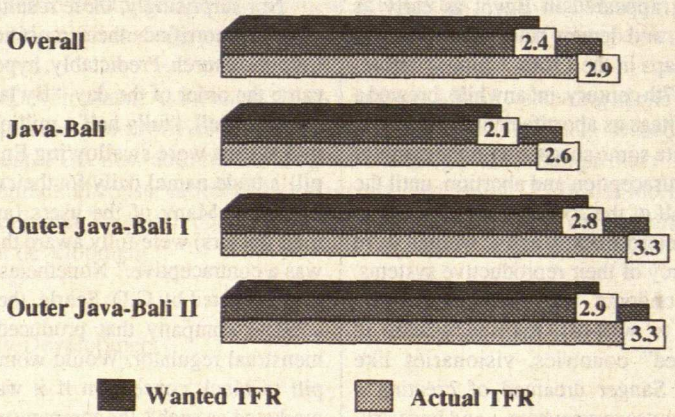
Trends in the Total Fertility Rate (TFR)



Average number of children per woman

How has family size changed?

Trends in the Total Fertility Rate (TFR)



Source: Central Bureau of Statistics - State Ministry for Population/National Family Planning Coordinating Board - Ministry of Health

Continuing to Engender Debate

TITLE: The Pill: A Biography of the Drug that Changed the World

AUTHOR: Bernard Asbell

PUBLISHER: Random House. New York. 1995. 411 pages. US$25 hardcover

Reviewed by Eleanor J. Bader

Bernard Asbell's *The Pill* is an ode to technology, a lovesong to the "drug that changed the world." Lauding the birth control pill as "the perfect contraceptive," Asbell credits the drug with "transporting all of us, in a most personal sense, into a new epoch of seeming mastery over our bodies and ourselves."

Asbell begins the book with a series of letters received by American birth control pioneer Margaret Sanger. "I've borne eight children within 12 years and the fear of going through it again freezes the blood in my veins," wrote one. "My mother used to deliver yearly and she was worn out, old and broken before her time. My case is the same. I do not know what to do," wrote another.

Indeed, throughout history women have attempted to control their fertility. Some have tried to avoid pregnancy by invoking magic. Sixth century Greeks, for example, believed that pregnancy could be avoided by wearing a cat liver in a tube on the left foot, while European women in the Middle Ages advocated spitting three times into the mouth of a frog. Other methods of pregnancy avoidance, says Asbell, were more pragmatic. Pessaries made from dried crocodile dung appeared in Egypt as early as 1850 BC, and lemon rinds were used as cervical caps in the 1700s. Chinese herbalists in the 7th century, meanwhile, brewed a variety of teas as abortifacients.

Despite some success with these methods of contraception and abortion, until the second half of the 20th century most of the world's heterosexually active women were at the mercy of their reproductive systems. While condoms and diaphragms were available to well-off, married women in "developed" countries, visionaries like Margaret Sanger dreamed of creating a method for use everywhere—and by everyone—that would be "as easy to use as an aspirin." In the early 1950s, Sanger teamed up with Katherine McCormick, an American feminist who was as "rich as Croesus," to research the development of "contraceptive control."

Doctors Gregory Pincus and Abraham Stone were among those who worked on the McCormick-funded project. According to Asbell, the pair took their earliest cues from Russell Marker, an American scientist working in Mexico, who had created an exact chemical imitation of human progesterone from cabeza de negro, a plant root. What they discovered was startling: "progesterone could work as a contraceptive, at least in small mammals."

Further experimentation in both fertility control and infertility led to new findings about the role of progesterone in reproduction. Dr. John Rock, an American, initiated a drug trial on a small group of females with "menstrual irregularities" in 1952. A combination of alternating doses of progesterone and estrogen produced unprecedented results: the women's menstrual cycles became predictable and regularized.

In 1954 Rock began testing a newer type of synthetic progestin to see if it would block ovulation on 50 American volunteers. Although Asbell does not tell us who these women were, or why they volunteered, he does tell us that "the results were perfect. Not one of the women ovulated... They had identified an oral birth control pill."

The need for a broader-based test sample became imperative and the scientists, for reasons that are not stated in *The Pill,* chose Puerto Rico as their site. The results of their tests, however, were as promising as those achieved by Rock: nobody who took the pill as directed became pregnant. Later tests in Haiti produced almost-equally positive results—a failure rate of only1.7 per 100 women.

Not surprisingly, these results cheered some and horrified others, most notably the Catholic church. Predictably, hypocrisy became the order of the day. "By late 1959," writes Asbell, "fully half a million women in America were swallowing Enovid [the pill's trade name] daily for their menstrual disorders. Many of the users (and surely their doctors) were fully aware that the pill was a contraceptive." Nonetheless, the pill was marketed by G.D. Searle, the pharmaceutical company that produced it, as a menstrual regulator. Would women take a pill to block conception if it was openly marketed as such?, the company wondered. Finally, in January, 1960, Searle decided to "go out on the longest limb in pharmaceutical history. They decided to file an application with the Food and Drug Administration (FDA) to license Enovid—exactly the same pill, the same formula already approved for menstrual disorders—as a contraceptive." Five months later, in May 1960, the pill was formally approved. By the end of 1961, 408,000 American women were taking it as a contraceptive; by 1962 the figure was 1,187,000; in 1963 it was 2.3 million. Twenty-some years later, in 1984, approximately 80 million women worldwide were users.

Yet the pill, and birth control generally, continues to engender debate. Despite the fact that Catholics over the world use contraception as often as other constituencies, the Church continues to oppose all forms of birth control except rhythm.

Asbell's reporting of dissent within the Catholic Church—and what has happened to the courageous parishioners, bishops and nuns who have openly expressed their support for birth control, abortion and liberalized attitudes towards sexuality itself—makes for fascinating reading. Nonetheless, Asbell's failure to address the equally virulent anti-birth control activities of the Orthodox Jewish and Fundamentalist Christian communities is disturbing. Furthermore, in his zealotry to tout the pill as the "perfect contraceptive," he glosses over some extremely important issues. We now know, for example, that the Haitian and Puerto Rican women on whom the earliest pills were tested received dosages far stronger than those recommended today. What happened to these women? What were the long and short-term effects of taking the drug? Did they contract cancer? Did they have children after they stopped taking the pill? Have these children experienced health problems? Even more important, Asbell never tells us why Puerto Rico and Haiti were chosen as test sites. Likewise, American women were the earliest sample to be tested on. Why were they dropped as subjects? And what happened to these early pill takers?

Asbell is equally superficial and dismissive in his discussions of feminist criticisms of the drug and the possible link between cancer and the pill. While there is no denying that access to contraception has improved the quality of life for heterosexually active women throughout the world, *The Pill* would have benefitted from a deeper, more probing investigation of the issues raised by the contraceptive's critics. ■

The Asian Center for Population and Community Development

The Asian Center for Population and Community Development (ACPD) was established in 1978 as the international training arm of the Population and Community Development Association (PDA), Thailand's largest non-governmental organization. The training activities were funded initially by the Pathfinder Fund and the Japanese Organization for International Cooperation in Family Planning (JOICFP). Since 1979, the Royal Netherlands Government has become the major source of support for the Center.

Program administrators and field managers as well as training officers and program planners from NGOs, government, and donor agencies come to ACPD to learn and share their experiences in community-based fertility, health and development programs.

The Asian Center has hosted more than 2,400 workshop participants from 48 countries. Over 8,600 guests from 54 countries have benefited from the orientations, field observations and personalized study tours conducted by the Center.

Trainers from PDA and experts throughout the Asian region lead our workshops, conferences and training courses and the Center's technical and consulting services continue to be in great demand.

All ACPD courses are geared toward practical applications so that participants can implement similar programs in their own countries. The courses provide unique opportunities for participants to meet with government and non-government trainers and resource persons who are accomplished in health, health, development, HIV/AIDS, income generation, rural development, etc. Participants also gain by networking and sharing in the knowledge and experiences of other participants from different countries.

1997 International Training Course Schedule

Course 1 Jan. 13-31	Design and Management of Community-Based Family Planning, Health and Development Programs	(3 weeks)
Course 2 Mar. 10-28	Community-Based HIV/AIDS Prevention and Care Strategies	(3 weeks)
Course 3 May. 12-23	Family Planning, Health & Community Development Participation and Observation Study Tours	(2 weeks)
Course 4 Jul. 23- Jul.11	Gender Issues in Development: Design & Management of Income Generation and Fertility Programs	(3 weeks)
Course 5 Sept. 1-19	Basic Training of Trainers	(3 weeks)
Course 6 Nov. 10-21	Business Initiatives in Rural Development (BIRD)	(2 weeks)

Tuition: US$1,900 for 3-week course; US$1,400 for 2-week course
Tuition covers instructional costs, training materials, transportation related to in-country travel, certificate awards, general medical care and administrative costs.

About PDA The Population and Community Development Association (PDA), initially a family planning agency, has now become the largest and most diversified private non-profit development organization in Thailand. Based on a philosophy of integrated community development, PDA now administers programs ranging from urban primary health care and HIV/AIDS & STD prevention to environmental conservation and rural income generation. PDA has more than 500 staff and over 12,000 volunteers active throughout Thailand, providing ACPD participants ample opportunities to witness first hand integrated approaches to rural development.

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Visit Kazakhstan and Kyrgyzstan to Be Welcomed by Friendly People

Snow-covered mountain ranges viewed from Almaty, Kazakhstan

A young Kyrghyzian woman

A Kyrghyzian bilingual woman

A waitress at a cafe in Almaty

A curious child in Almaty

A Kyrghyzian woman playing the three-stringed komuz

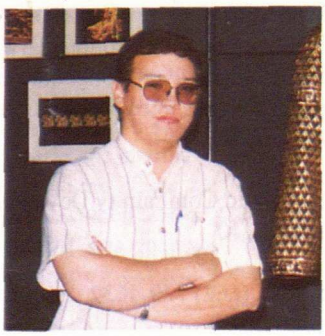
Students in Bishkek

A mother with her daughter in Almaty

A Kazakhstan male doctor

A Kyrghyzian dancer

A florist in Bishkek



A Kazakhstan father of two children

A guide at a museum in Almaty