Swedish International
Development Authority

SWEDISH ACTIVITIES IN THE FIELD OF FAMILY PLANNING

BIBLIOTECA
DANIEL COSIO VILLEGAS
EL COLEGIO DE MEXICO

301.426
In 61d
no.5

(7/8)
312(061.3)

18109
H

FAMILY PLANNING

The Swedish International Development Authority, SIDA, presents in this brochure two reports on Family Planning one dealing with "Swedish Assistance in the Field of Family Planning" and the other with "Methods and Research in Family Planning in Sweden".

The two Reports are preceded by a policy statement on "Swedish Foreign Aid in Family Planning", which was given on March 9, 1966 by Ernst Michanek, Director General of SIDA, to the Government Operations Subcommittee on Foreign Aid Expenditures of the United States Senate, Washington D.C.

Stockholm, April, 1967.

Table of contents

"Swedish Foreign Aid in Family Planning" by Ernst Michanek, Director General, Swedish International Development Authority, SIDA, Stockholm p. 3

"Swedish Assistance in the Field of Family Planning". Memorandum prepared by Carl Wahren, Swedish International Development Authority, SIDA, Stockholm p. 15

- Ceylon p. 16
- Pakistan p. 23
- Tunisia p. 29
- Turkey p. 30
- Gaza
- Morocco p. 31
- Kenya - Mauritius - Nepal
- International Action
- Future Activities p. 32

"Methods and Research in Family Planning in Sweden" by Ulf Borell, M.D., Professor of Gynecology and Obstetrics, Karolinska Institute, Stockholm p. 33

- Family Planning Methods used in Sweden
- The Swedish Legislation on Abortion p. 36
- Present Research in Human Reproduction in Sweden p. 38
- A Demographical Research Project p. 41

SWEDISH FOREIGN AID IN FAMILY PLANNING

By Ernst Michanek, Director General, Swedish International Development Authority, SIDA, Stockholm, Sweden.

Mr Chairman,

We have come here to talk about the most urgent problem of the present-day world: the problem of hunger and overpopulation. This is, I submit, one and the same problem. The starvation in the developing countries is increasing because of the increase in population. The starvation and death of many millions of men can be checked, only if the enormous increase in population is checked. We can do something about this situation - and we must do it.

You have been kind enough, Senator, to invite us to appear before this Sub-committee. Your invitation was addressed to the Government of Sweden and based upon the activities undertaken by that Government in the field of population and family planning. I am most honored to represent Sweden here in my capacity as the Administrator of the Swedish government authority for international development. With me are my advisor in the field of family planning, Dr Ulf Borell, professor at the university and head of the department of Gynaecology at the Karolinska University Hospital in Stockholm, and Mr Carl Wahren, administrator of foreign aid programmes of family planning and research.

In the discussion on foreign aid we will speak of the vicious circle of poverty, ignorance, and disease, which prevent economic, social and cultural development. In international and domestic policies we

fight for human rights - rights concerning life, work, education, security for all, etcetera.

In Sweden, we consider it a human right for all parents to plan the size of their families - including the case of subfertility - and to be assisted with a view to getting the number of children they can provide for.

In Europe, and in North America, birth control has obviously been known and widely practiced for centuries. This goes for people of all nations and denominations - only that in some countries and some parts of the Western society family planning is discussed more openly than in others.

We have no right to reserve this knowledge for a few. On the contrary, we are under obligation to disseminate it - for ethical reasons, for reasons of morale, for social reasons and - let us not forget - for economic reasons.

In the 19th century and still not many decades ago, Sweden, although very thinly populated, had a problem of overpopulation. More than a million Swedes emigrated to America for economic reasons. People even starved to death in years of crop failure. - Sweden's population problem to-day is rather one of underpopulation in spite of the fact that we now have twice the population of a century ago: We have a shortage of manpower. Sweden is now an immigration country.

In my country we would never think of trying to deprive our people of their right to knowledge in questions of human reproduction. If I may speak in my former capacity as Sweden's Under Secretary of labor and social affairs: We try in every way to see to it that all children born should be children welcome and should have a right to affection, adequate care, and education.

We think the rest of the world should have the same opportunities. This is why in our foreign aid program we have entered the field of population control.

Swedish foreign aid is not large. However, our aid program this year, which totals 65 million dollars, represents five to six times more than only five years ago. All parties in Sweden are agreed that we must move still faster towards the goal of one per cent of our gross national product being used for aid purposes. Our official foreign aid to-day financially represents one third of that target figure, and our gross national product grows at the annual rate of some 4 per cent.

As an ardent supporter of the United Nations, Sweden devotes half her foreign aid funds to the multilateral assistance programs of the U.N. and its specialized agencies. In fact this year Sweden - a nation of 8 million people - ranks second to none but the United States as contributor to the United Nations Development Programme, carrying some 8 per cent of the total costs against 40 for the United States.

Our foreign aid program includes bilateral programs in a few countries. We are financing and running some institutions for vocational and professional training, e.g. in the field of agriculture. We have entered the field of financing food purchases for starving nations. We give credits for grain storage projects, agricultural water supply and the like. And we are working in the field of health, preventive medicine, nutrition - and family planning.

Swedish public opinion demands that we devote more of our efforts to family planning. But for reasons of lack of experience and particularly of shortage of personnel, financially only a modest part of our aid budget so far has gone into family planning. We are in-

creasing this part, and eager to increase it more, but until such time as we have found ways of attracting badly needed experts - experienced doctors, demographers, sociologists, and the like - a strongly hampering factor will remain.

We are in no doubt regarding the interest and motivation among the population of the developing countries in such an increased activity. This is borne out by evidence from research activities, reported to this committee from many competent quarters, and in other ways. Swedes abroad report back how they are approached by local citizens from all strata of the community begging for information: "How do we go about having as few children as you have?" In an increasing number of cases we are now being approached by representatives of foreign governments who wish to discuss assistance.

As in other cases of requests for aid, because of our limited capacity, we would have liked to refer such questions to the multilateral programs which we support so strongly, i.e. to the United Nations. But for many long years the intergovernmental organizations have not been in a position to assist. This is why Sweden has felt compelled to try on her own to give foreign aid in the field of family welfare including family planning. Indeed we would have liked to co-operate multilaterally with other governments - but for many years we have had to pioneer among the industrialized countries for lifting the ban on family planning activities as part of the official aid programs.

Sir, I speak of governments. Before mentioning more about the official activities I wish to stress what has been done by non-governmental institutions. The largest and most active private institutions working in this field are the Population Council of New York and the other American institutions working with the support

of, above all, the Rockefeller and Ford Foundations. They deserve the highest praise for truly historic achievements. What they have done by way of research, investigations, planning, training and pilot schemes in many developing countries - and in this country - is in my opinion without comparison the most important international effort so far to meet the requests from the developing countries for assistance in formulating and carrying through population programs.

These American institutions need no financial assistance from outside - but we have been happy to share with them problems, findings and experience.

For many years, the pioneering International Planned Parenthood Federation, IPPF, with headquarters in London, which is a non-governmental federation of national or local organizations all over the world, has been devotedly working on family welfare programs. The Swedish International Development Authority has taken up co-operation with the IPPF in order to pool experiences and resources, and Swedish financial assistance towards the budget of the IPPF has recently been granted.

In the United Nations the Swedish activities aimed at creating awareness of the problem of overpopulation began in the early 1950's. There were indications of an awareness among leaders of some developing countries, that problems were arising as medical science and international efforts helped decrease the death rates rapidly, while birth rates remained unchecked. A Swedish demographer in the Population Commission of the United Nations brought up the issue of population policy in 1951 - and was invited to India to study that country's situation and to advise the government on family planning measures. But from the same year, sitting as a Swedish delegate to the United Nations Economic and Social Council,

I remember being warned not to mention this question in official interventions at the risk of being brought to silence by procedural moves or otherwise.

In the following years Swedish delegates tried many times in the committees of the General Assembly or in U.N. functional commissions, in Unicef and the World Health Organization to bring the matter up for discussion. In 1960 Sweden and five governments from developing countries tried in the General Assembly to break the ice, but in vain. In 1962 eleven sponsor governments succeeded, by a very tight margin, though, in getting the matter discussed - but the most important paragraph of the proposed resolution was defeated: the United Nations was not allowed to include family planning in its technical assistance activities, even at the request of governments.

In the meantime, world population reached an increase rate of some 80 million people a year ...

In 1958, the governments of Ceylon and Sweden agreed to co-operate in family planning, starting a pilot project for "action cum research" on the island. Research, training and individual assistance was undertaken. By now we seem to be able to state, that in the main research area the birth-rate has gone down by some 30 per cent. The Swedish project is since last year incorporated in the national program for family planning in Ceylon, in which the government has engaged the whole health service system of the country. Sub-fertility cases are, of course, also treated. The project has now entered a "service cum training" phase. Under a new agreement between the governments Sweden is also financing the supply of contraceptives for the national program.

For four years, Pakistan and Sweden have been co-operating in a family planning project. Swedish experts have helped in organizing

a few pilot clinics, in training medical and paramedical personnel, in the preparation and production of audio-visual aids for the dissemination of knowledge in the field of contraception and in other ways. Last year a very ambitious Family Planning Scheme for Pakistan, covering the five year plan period 1965-1970, was prepared as a result of co-operation between American experts, the Pakistanis and the Swedish team. And now the Swedish experts are involved in what I believe is so far the greatest effort in the world to introduce a large-scale national family planning program in a large country - a country of 100 million people, in which we know that the number of inhabitants will become 200 million before the end of this century if present trends prevail. Financial assistance is now being given by Sweden to cover the costs in foreign currencies for purchases abroad (and not in Sweden, by the way) of contraceptive supplies.

Other small programs aimed at linking the services in the field of maternal and child health with the teaching of contraceptive techniques have been introduced by Sweden in Tunisia, and in the Gaza strip as part of an assistance program for Palestine refugees.

A fuller report on these Swedish bilateral activities has been handed over to Senator Gruening's office. [x)]

Some countries other than the ones I have mentioned have made official or semiofficial requests for assistance in the field of family planning, and the Swedish International Development Authority is now considering how best to deal with them. During the last 10 months I have myself studied Family Planning projects in Japan, Korea, Hong-Kong, Singapore, Tanzania and Egypt, and my collaborators have been also in Turkey, Morocco, Tunisia and Taiwan for the same purpose. We have also studied different activities at American universities in the field of research and training.

x) "Swedish assistance in the field of family planning". This report appears on pp 15 - 32 in an amended version including new activities started before April, 1967.

I mention this in order to stress in how many countries the governments are now aware of the problem and ready to take action, and many more could be mentioned. It was, therefore, late but very appropriate, that a number of United Nations bodies last year took a positive attitude to the population problem in general. In 1965 the first U.N. expert team was set up to study population programs in India at the request of the government, and we are eagerly waiting for its report.

We hope that soon the time will be ripe for operative programs to be undertaken by the United Nations. In the meantime / the Swedish government has made known, that we are ready to support financially, by funds-in-trust, and if possible otherwise, operative programs which Unicef, WHO or others might be willing to start.

From our experience, although limited, I should like to draw some conclusions with respect to family planning activities.

1. PLANNING

A careful planning of field activities must precede operations and much of the planning must take place in the field. Planning teams should be composed of experts in various fields - medical, sociological, demographic, etc. Demographic surveys and sociological studies are particularly important for the planning and for the evaluation of results. The magnitude and the complex character of the problem indicates, that foreign personnel can not do very much of the real down-to-earth field work. International experts have their greatest role to play as planners, research leaders, advisors. The bulk of the job must be performed by national personnel.

2. THE ROLE OF WOMEN

In the planning and execution of programs, the central role of women in the family planning must not be overlooked. After all, one of the most important aspects of the population policy is to improve the health, not to say, save the lives of the mothers, to give women a status in the family and the community, and to strengthen their possibilities of really contributing to development.

3. FAMILY PLANNING, AND MOTHER AND CHILD HEALTH SERVICES

It seems important to integrate, wherever possible, family planning activities in Mother and Child Health promotion and copule them with the preventive health services. Indeed it is important to include services for the sub-fertility cases in the program.

4. PERSONNEL AND TRAINING

The problem of operative personnel is particularly complicated in the case of family planning. It is difficult already to make a job description, still more difficult to find suitable persons - each field project is partly unique and must be adapted to local conditions. Specialized field personnel is needed for information services and motivation, for distribution of information material and contraceptive supplies, for training in various fields, for clinical services and for follow-up studies. The personnel needed will in most cases be in need of special training. It is very important that training institutions get possibilities of taking up this special training, and that they can serve as international training institutes for personnel from abroad, from developing countries as well as from the donor side. I think the United Nations ought to take up a training program for field personnel.

What has been done already in this field and in population research by American universities is of utmost importance - I might mention the universities of Chicago, Harvard,Johns Hopkins, the University of Michigan, Ann Arbor, and the University of California, Berkeley. Indeed it is difficult to get proper training for field activities in industrialized countries - but I have been very impressed by what I have seen myself of practical field work in Chicago, undertaken by a university institution and the Planned Parenthood Association there.

The pioneer experiences of the Population Council of New York, the Ford Foundation, and the International Planned Parenthood Federation must be taken care of and utilized by all parties concerned - and may I say, Mr Chairman, that this sub-committee is doing a great contribution by putting together so much useful information through this dialogue.

5. RESEARCH

A lot of research remains to be done. Professor Borell will elaborate this question a little later. In regard of contraceptive methods there is not yet a final answer to the question of methods: which are the most safe - pills or the intra-uterine device or some other - and which are the simplest for women and men in various cultural and social environments? (May I mention in this context, that the programs should include several kinds of contraceptive methods - be in keeping with individual needs and cultural belief. We have found, for instance, that in cases of inconvenience or failure of one method a set of others should be at hand in order to counteract the tendency to resort to abortion in such cases.) - The institutions in the United States have already played a great role in research and institutions all over the world must co-operate continually and if possible under some kind of overall

planning. Research in other fields - demography, sociology, methods of communication, economy etc. - should also aim at assisting in a proper evaluation of the impact of human reproduction to the individual, the family, the nation. If it is true, and I believe it is, that a dollar paid into family planning services can save 300 dollars in costs for education, such facts should be given and disseminated more widely.

6. COORDINATION

International coordination is badly needed in family planning. We need a center for information and discussion and we must try to achieve a rational division of labor between different parties and institutions.

Aid-giving agencies have to consult each other and coordinate their investigations and operations. In other fields the United Nations bodies, consultative groups or consortia are available for international coordination. In this field it is particularly important to get the private institutions involved in a coordination machinery which they can accept.

Mr Chairman, three years ago I appeared in this building as a witness invited by the Sub-committee on Employment and Manpower under the chairmanship of Senator Joseph S. Clark to speak about Sweden's labor market policies. On that occasion I said, that I and my colleagues had not come here pretending to carry with us solutions or even suggestions. We confined ourselves to tell how we have tackled certain labor market problems in Sweden, and we hoped that our hosts would find the information useful in their efforts to meet problems confronting the United States.

This time I cannot be quite as modest as that. I am talking this time of a problem confronting the whole world, a problem of equal concern to all nations. This is a field of activity, in which a concerted international action is necessary. Small countries like mine can do little more than speak of it, undertake some pilot projects, finance some subsidiary activities as a part of a great program.

The problem requires action on the part of all nations - and not least the leading nations of the world. The US Agency for International Development has taken up important activities in this field recently. Thus, the United States has started the engines - and we are hopeful. But I dare say that we are waiting impatiently for the take off. We understand now that the United States government is aware that this country must make a greater contribution to the solution of the world's greatest problem. I am sure it can do it. I trust it will do it.

But, Sir, time is running short.

SWEDISH ASSISTANCE IN THE FIELD OF FAMILY PLANNING

By Carl Wahren, Head, Family Planning and Research section, SIDA.

The present surging increase in population seriously threatens the success of the greatest task of our day, i.e. the international development effort which aims at providing tolerable living standards to that large majority of mankind which is now almost always in want. Thus, Sweden has welcomed the opportunity to contribute its modest share towards a positive development by acceeding to requests from governments for assistance in family planning activities.

The Swedish Government was for several years the only one to operate official assistance programs in the field of family planning. The inter-governmental organizations were not in a position to help - in spite of the efforts to enable them to do so, in which Sweden has taken part together with an increasing number of other countries. Nor were other developed countries prepared to assist, although family planning is widely practiced by their own peoples. It would seem, however, that the tide turned in 1965, both in the United Nations and in a number of member countries, with respect to international co-operation in this field.

At present, there are basic agreements concerning technical co-operation in the field of family planning between the Government of Sweden and the Governments of Ceylon, Morocco, Pakistan, Tunisia and Turkey. Sweden and the United Nations Relief and Works Agency for Palestine Refugees (UNRWA) have concluded an agreement regarding assistance in the field of education and health care, including family planning, in the Gaza Strip. Contraceptives have been supplied to Kenya, Mauritius and Nepal. Besides, the following countries have recently submitted requests for Swedish family planning assistance: India, Korea, Malaysia and the United Arab Republic. A number of other countries in Asia and Latin America have inquired about

the possibilities of co-operation in the same field. Sweden collaborates with the International Planned Parenthood Federation (IPPF). This co-operation includes substantial Swedish financial support to the various IPPF activities in a number of countries.

In the following some of the above mentioned activities are described in closer detail.

I CEYLON

The Sweden Ceylon Family Planning Project

A. The First Agreement

On May 22, 1958, Sweden and Ceylon signed a bilateral agreement concerning technical co-operation in the field of family planning. The Government of Sweden and Government of Ceylon agreed

> "to co-operate in order to promote and facilitate a pilot project in Community Family Planning to take place in two or more rural areas in Ceylon with the aim of extending such activities, on the basis of the experience found, on a nationwide scale".

1. Objectives

According to the Agreement, the purpose of the Project should be:

to make a scientific assessment of the attitudes towards family planning in the areas concerned;

to investigate the possibilities of family planning in the areas concerned;

to give instruction in the methods of family planning to the people in the areas; and

to assist in training Ceylonese health personnel in work of this kind.

2. Plan of Operation

The work was planned along the following lines:

- to undertake a thorough census in two areas and subsequent checking-up;
- to perform attitude-surveys of the fertile groups in the two areas in order to investigate their interest in family planning;
- to open Family Welfare Centres in the areas concerned, thereby starting the executive family planning activities. The centre was to include an Ante-Natal Clinic, a Post-Natal Clinic, and a Well-Baby Clinic;
- to supply birth control materials free of charge to those families who wanted them; and
- to perform follow-up-surveys on the acceptability - and thereby potentiality - of family planning.

3. Activities

The activities started in September 1958. A Swedish gynaecologist, who was also a specialist in obstetrics and family planning, began a family planning pilot project in two rural areas. Research cum Action became the basic principle of the Project.

Two rural areas were selected in collaboration with the Ministry of Health and the Family Planning Association of Ceylon. They were:

a) A village area some 25 miles south of Colombo. The population consists entirely of Sinhalese Buddhists earning their living mostly as cultivators of rice, coconut, and rubber. In 1958 the population was about 7 000. Some 20 per cent of the population were illiterate.

b) A large tea estate up in the mountains. The population numbers some 7 000 Indian Tamils. Their religion is mostly Hinduism. About 75 per cent of the population were illiterate.

These two areas have constituted the main testing areas, particularly the one called "Village Area". This district is a so-called subdivision representing the smallest administrative unit in the Public Health Service, and as such very appropriate for testing different ways of action, thereafter to be tried in administrative units of larger size

Project staff

The Project has based as many of its activities as possible upon local staff. The only permanent Swedish expert has been the Director. During various periods, however, he has been assisted by medical, sociological, educational, and demographical expertise from Sweden to help him with specific problems. The Project has arranged and financed additional training abroad for some counterpart personnel. At present, the Counterpart to the Director is finishing up a two-year study program in the United States.

Contraceptives used

In the beginning, the main contraceptives used were condoms, vaginal foam tablets, IUD:s and orals. 1965-66 witnessed a rising trend for IUD:s all over the island. The use of foam tablets is declining and caps are practically non-existant. Orals have so far not been very popular.

Subfertility

Family planning also includes dealing with the problem of subfertility. This seems to have played quite an important psychological rôle.

Education

Apart from organizing and supervising the clinical family welfare work, as described in the above mentioned plan of operation, the Project has assisted in training the following categories of Ceylonese Health Staff:

Postgraduated Doctors, Doctors, Medical Students, Public Health Inspectors, Public Health Nurses, Public Health Midwives, Dispensers, Health Educators, and Social Workers.

4. Extension of activities

Partly because of the good results obtained from the Pilot Project, partly due to the increasing Ceylonese interest in family planning, it was decided to extend the activities of the Project to new areas.

In co-operation with the Department of Health, the Project during 1962 selected the Point Pedro area with a population of 95 000, and during 1963 the Polonnaruwa-Matale District with more than 350 000 inhabitants as action areas. During 1964, the activities in the sub-district Village Area were extended to cover the entire district (with about 185 000 inhabitants).

Thus, the activities of the Project were first tested in a small administrative unit, then in a unit of medium size, and finally in the largest public health administrative unit.

5. Preliminary results

The Sweden Ceylon Family Planning Pilot Project has produced some promising results in its main research area. A preliminary statistical survey indicates a strong downward trend in the village district birth rate since 1959. By the end of 1964 the rate had

gone down roughly 30 %. The age-specific birth rate has shown a falling trend particularly for the group 25-35 years of age.

However, certain factors such as the short distance of that district to Colombo and season variations in the population structure necessitates a more refined demographic analysis aiming at the most accurate estimate possible as regards sources of error. Such a final analysis is carried out at present. It is reasonable to believe, though, that the declining trend is due mainly to the activities of the Project.

B. The Second Agreement

In 1965 the new Government of Ceylon decided to introduce family planning on a nation-wide scale. According to a new Agreement the two governments were

"convinced of the necessity of promoting the welfare of families in Ceylon,

considering that such promotion should include the transfer to the families concerned of the knowledge and the means required to space childbirths in accordance with the wish of the parents,

encouraged by the results so far achieved of their technical co-operation in the field of family planning in accordance with their Basic Agreement of May 22, 1958".

1. Objectives

According to this Agreement the main task of the Project during the ensuring three years will be to:

assist in the training of appropriate medical and other suitable personnel on all levels to serve families requiring assistance in family planning;

supply contraceptives;

advise on the field work; and

carry out research relating to family planning.

Thus, the Ceylon Project has passed into a phase of "Service cum Training", as the local Government has started a program on a nation-wide scale.

2. Plan of Operation

The target of this program is to reduce the Crude Birth Rate of the country by at least one third during a 10-year period started in January 1966.

This target is to be achieved by dividing the country into regions and implementing the knowledge of family planning during three phases.

Training Phase

Within one year the entire public health staff in one region - area A - will have received basic training in family planning.

Introductory Phase

Family planning services will be introduced in area A, which is supervised by the previously trained staff. In the meantime the training starts in a new area - area B.

Maintenance Phase

The activity in area A will be run entirely by local health staff, thus providing the services on a long term scale. The training phase starts in a new area - area C -, the introductory phase starts in area B, and so on.

To get the educational plan implemented, a qualified Swedish educational assistant has been appointed to the Project. This expert assists in organizing training courses intended for key personnel at the different training centres. Evaluation of the training methods and their effects will be undertaken regularly by another Swedish specialist in the field.

A family planning program is obviously of little value if there are no contraceptives in stock. Therefore Sweden has begun to supply considerable amounts of contraceptives which could otherwise not have been obtained due to shortage of foreign exchange. Sweden also provides equipment for family planning clinics, a number of vehicles, and some training materials.

C. Comments

After 6 years of pilot field activities the Sweden Ceylon Family Planning Project has shown some promising statistical results. Furthermore it has proved that locally employed health staff can be trained in, and used for, implementing family planning activities within the regular health program. When in 1965 the Ceylonese Government decided to extend the family planning activities to a nation-wide scale, the Project shifted its emphasis from Action cum Research to Service cum Training. It is felt that the Project has so far fulfilled two vital functions:

a. It has demonstrated that family planning is not only beneficial to the families but acceptable to them as well. Therefore, family planning logically forms part of an integrated family welfare scheme.

b. Thus, it would seem that the Project has contributed towards the creation of a positive attitude to family planning in all

quarters, which in its turn has led to the adoption of a nation-wide family planning program.

From the beginning of the Project in 1958 through last fiscal year (ending on June 30, 1966), total Swedish Project expenditures in Ceylon amounted to roughly US $ 800 000. This year's budget allocations total about US $ 600 000.

At present - April 1967 - the Swedish personnel include the Director, one Educational Advisor and one Administrative Assistant. Roughly 40 Ceylonese are employed by the Project.

II PAKISTAN

The Sweden Pakistan Family Welfare Project

A. The First Agreement

From time to time officials in Pakistan had emphasized that the growing population pressure threatened to thwart the efforts to raise the standard of living of the Pakistani people. The growing awareness of the national consequences of the population increase led the Government of Pakistan to integrate a nation-wide family planning program in the second Five Year Plan (1960-65).

After an official Pakistani request for Swedish technical assistance in the national family planning campaign, Mrs Ulla Lindström, Swedish Cabinet Minister, visited Pakistan in the beginning of 1961, in order to negotiate the main lines of co-operation.

On October 4, 1961, Sweden and Pakistan signed a bilateral agreement for the purpose of co-operation within the scope of the Family Planning Scheme of the Government of Pakistan. The par-

ticipation on the part of the Swedish Government in the Pakistani Family Planning Scheme was at that time to take place in the area of Karachi, then Capital City of Pakistan, in Hyderabad in the Province of West Pakistan and in Chittagong in the Province of East Pakistan.

1. Objectives

The objectives of the Swedish participation in the Pakistan Family Planning Scheme were as follows:

to organize and supervise a number of model clinics;

to organize and participate in the training of health personnel, i.e. Postgraduated Doctors, Doctors, Medical Students, Lady Health Visitors, Nurses, and Midwives;

to assist on a consultative basis the clinical activities in cases of subfertility;

to assist in the planning of the National Research Institute of Family Planning in Karachi;

to assist in the educational drive to create an atmosphere conducive to family planning in order to evoke a general motivation for birth control;

to train future Pakistani educators in family planning methodology and audio-visual aids under a scholarship program in Sweden; and

to supply certain necessary equipment for the above mentioned activities.

By providing consultative services in cases of subfertility in addition to birth control assistance, the Sweden Pakistan Family Welfare Project emphasized its aim to provide family planning in the true sense of the word.

2. Activities

Three Swedish teams were established in Pakistan working within the frame of the Project, each team consisting of one physician and one nurse. The Swedish personnel was assisted by local Pakistani health staff and a Swedish administrative assistant.

In Karachi, the clinical services were from the beginning concentrated to the family planning clinics attached to the obstetrical-gynaecological departments of two of the main hospitals. The Project assisted in establishing family planning activities at five other public hospitals and health centres. Several private clinics received advice for the purpose of practising family planning methods.

In Hyderabad, the main activities were carried out at the Liaquat Medical College Hospital, and the Lady Dufferin Hospital, a private hospital for female patients. Contacts were made with several big factories in the area, the health centres of which included family planning in their services. The Hyderabad section arranged special training for village "dais" (untrained and as a rule illiterate midwives), in order to find out their ability, interest, and willingness for participation in the family planning program. At the end of the course the "dais" were interviewed. Their answers indicated a strong interest in family planning and with few exceptions they declared their willingness to give advice to the villagers.

In Chittagong, the main family planning activities, previously attached to the Red Cross Maternity Hospital, were shifted to a separate building, rented and equipped by the Swedish Project, giving better facilities for IUD insertions and training.

At the various sections courses were held regularly for the training in family planning of different categories of medical and para-medical personnel. In addition, certain civic groups and some categories of Government employees received similar information. The work of the Swedish experts mainly consisted in advising, training, administration, and supervision.

In 1963, three Swedish audio-visual experts were sent to Pakistan. They worked as advisors in planning a major educational effort intended to promote motivation for family planning and to spread knowledge of the already existing family planning clinics. Equipment for the production of audio-visual aids was given by the Swedish Government and a number of Pakistani students were trained in information techniques in Sweden. Communication Media Sections were set up in Karachi, Lahore and Dacca.

B. The Second Agreement

In the Third Pakistan Five Year Plan, family planning has been given a prominent position. The population program, aiming at a national mass movement, is comprehensively described in a document named "Family Planning Scheme for Pakistan during the Third Five Year Plan Period 1965-1970". During the compilation of this Scheme the Pakistani Authorities were assisted by experts from the Population Council of New York, the Ford Foundation, and the Swedish Project. (An informal, fruitful co-operation between the said parties has developed in a number of fields.) The Family Planning Scheme manual was printed at the Swedish Pakistani Communication Media Section in Lahore.

The objective of the Scheme is to reduce the birth rate from 50 to 40 per mille during the five year period. The Plan describes in great detail the measures of administrative, educational, and medi-

cal nature that will be necessary for the implementation of the ambitious target.

A new agreement between Sweden and Pakistan, covering the period of the Third Five Year Plan (1965-1970) was signed on March 1, 1966.

1. Objectives

The Project shall consist of such clinical, communication media, and other services as will be specifically agreed between the two Governments. The Project shall assist the family planning promotion in Pakistan in the following ways:

assist in elaborating a program of training of Pakistani personnel;

assist in the training of such personnel, within or outside the training institutions established by the Pakistani Authorities;

assist in organizing and supervising such family planning clinics as might be established by the Pakistani Authorities;

establish such family planning clinics as may be agreed upon;

assist in carrying out research in the field of family planning.

The Swedish Government shall

make available a Consultant on family planning to the Government of Pakistan, as Director of the Project;

make available such other personnel of various professional categories as shall be specifically agreed between the two Governments;

employ such local personnel as may be requested by the Director;

assist in providing such equipment and contraceptive supplies for family planning purposes as may be specifically agreed between the two Governments.

2. Delivery, storage, and distribution of contraceptives

In connection with the Agreement the Swedish Government has declared its willingness to provide the Government of Pakistan with condoms in such quantities as are actually consumed in Pakistan during the period of validity of the Agreement. A Swedish consultant assists in arranging storage facilities and distribution lines.

C. Comments

The Sweden Pakistan Family Welfare Project has been in action for roughly five years. Its aim has been to assist the far-reaching national Pakistani program in sectors where Sweden had something to offer and where such assistance seemed crucial. So far, the Swedish Pakistani Project has covered only limited research aspects, research being one of the main activities of the American university groups working in the field of population. It is predominantly an action project. In these circumstances it is too early to venture an evaluation of the Project. However, one very important conclusion may be drawn from the past experience. In the present situation of population pressure, there seems to be a strong need not only within the sphere of medical activities. What appears to be needed, above all, is a major educational effort, aiming at a maximum dissemination of birth control information to the general public.

From the initiation of the activities in 1961 through last fiscal year, Swedish expenditures totalled close to US $ 2 million. The allocations for the current fiscal year amount to roughly US $ 1,15 million.

At present - April 1967 - the foreign, mostly Swedish, personnel attached to the Project include the Project Director, two Administrative Assistants, two Medical Doctors, two Communication

Experts, one Printing Expert, three Clinic Supervisors, one Research Advisor and one Supply Advisor. The Project employs some 120 Pakistanis.

III TUNISIA

A. Mother and Child Health Centre in Tunisia

According to Article I of an Agreement between the Governments of Sweden and Tunisia signed on March 23, 1963, a Mother-Child-Health Centre (MCH) shall be established within the framework of a joint integrated development project in the district of Kelibia in Tunisia.

1. Objectives

The purpose of the MCH Unit is to provide medical treatment and consultation services in preventive medicine. At the same time this unit shall provide Tunisian medical personnel of all categories with training facilities.

A family planning clinic is integrated in the MCH Unit. Information regarding birth control methods and related problems is given to the local health staff and other medical and para-medical groups.

Some basic research in the field of nutrition is to be included in the activities.

2. Activities

It has been agreed that the following foreign experts be attached to the Centre:

One Gynaecologist, one Pediatrician, two Midwives, and two Nurses.

Tunisian counterpart staff has been appointed by the Tunisian Government in order to gradually take over the activities.

The Centre is located in new premises constructed at the expense of the Swedish Government, and will start functioning on full scale during 1967. In the meantime activities are undertaken in provisional premises. Building costs total some US $ 900 000.

B. Support to the National Family Planning Program

Sweden is providing the National Family Planning Program with medical equipment for IUD-clinics.

IV TURKEY

An Agreement has recently (1967) been signed with the Government of Turkey concerning co-operation in family planning. The activities will consist of deliveries of contraceptives, since Turkey has received advisors from other donors and has adequate health personnel but lacks foreign currency for imported goods necessary for the implementation of the program.

V GAZA

According to an Agreement signed in 1963 between the Government of Sweden and the UNRWA regarding assistance in the fields of education and health care in the Gaza Strip, Sweden contributes:

to the training of teachers at secondary schools for refugee girls in the field of home management, including biology, hygiene, and child care;

to the construction, staffing, and operation of a health project for the benefit of refugee children and mothers in Gaza.

The promotion of family planning is integrated in both activities.

The activities are administered by the UNRWA and began in 1964-65.

VI MOROCCO

Through an exchange of letters in 1966 Sweden has provided the National Family Planning Program with equipment and a number of vehicles intended for mobile family planning activities mainly in the rural areas.

VII KENYA - MAURITIUS - NEPAL

Sweden provides the Mauritian Family Planning Program with contraceptive supplies. This assistance is administered in collaboration with the IPPF, the Population Council of New York, and other donors. The IPPF has acted as an intermediary in distributing Swedish contraceptive gifts to Kenya and Nepal.

VIII INTERNATIONAL ACTION

Convinced about the necessity for an international concerted action in the field of population Sweden has introduced or co-sponsored initiatives in this direction in various international bodies.

Sweden has arranged, co-financed, and participated in international gatherings on a high level to promote information about family planning and its benefits for individuals, families, and nations.

IX FUTURE ACTIVITIES

Sweden intends to increase its family planning assistance. Since the Swedish population policy became known, the number of proposals for co-operation has been rapidly increasing, which clearly indicates the needs felt for support on the part of the developing countries themselves. As a matter of fact the demand has put the Swedish International Development Authority (SIDA) in a position where it encounters economic and administrative difficulties in dealing with the requests at an optimal speed and efficiency. There is a particular shortage of family planning experts representing various scientific aspects of this highly complex problem. International co-operation is much called for.

During spring, 1967, the Swedish Parliament will make appropriations for the fiscal year 1967/68. SIDA has proposed that a Population Studies Institute be founded in Sweden to co-ordinate research and advanced training in family planning and related matters. The proposal put forward to the Government also envisages a considerable expansion of the family planning assistance to a number of new applicant countries.

METHODS AND RESEARCH IN FAMILY PLANNING IN SWEDEN

By Ulf Borell, M.D., Professor of Gynecology and Obstetrics,
Karolinska Institute, Stockholm.

Mr Chairman,

As Chairman of the Swedish International Development Authority's Advisory Group on Family Planning and as professor of gynecology and obstetrics at the Karolinska Institute in Stockholm, I wish to thank the Subcommittee on Foreign Aid Expenditures for this opportunity to describe the methods and research in family planning in Sweden.

My remarks today are prepared to tell you more about the family planning methods used in Sweden, the Swedish legislation as it concerns abortion, present research in human reproduction in Sweden, and the need for international cooperation in demographic research projects.

If you should wish me to expand on a particular portion of my testimony, I will do so. This subcommittee has provided a public forum from which the population problems which affect all of us may be discussed and, perhaps, some new light will be directed towards the problem areas.

Let me begin by discussing

1. FAMILY PLANNING METHODS USED IN SWEDEN

Already in the 1930's the birth rate was very low in Sweden, being 14-15 births per 1000 inhabitants (now it is roughly 16). Oral contraceptives and intra-uterine contraceptive devices were not available at that time, but the conventional contraceptive methods

were widely used. Legal abortions were only few, illegal abortions - although statistics are not available, of course - were too many.

For a long time objections have not been raised against giving advice on family planning on a large scale. Swedish physicians, in general, are not inhibited by ethical or religious reasons from prescribing contraceptives.

As Sweden has no problem of overpopulation there was no urgent national need for new contraceptive methods, all work done within the field of birth control being designed to help individual couples or families.

It is only recently that the Swedish National Board of Health has sanctioned the use of oral contraceptives and intra-uterine contraceptive devices, except for cases of gynecological diseases in Sweden; in such cases they have been long used. The effectiveness of the pills is superior to any other of the available contraceptive methods. Today, out of approximately 1.8 million women aged 15 to 49, about 150 000 take the pill, which can be obtained only on a doctor's prescription. This measure has been taken to follow up users of these drugs in order to enable early diagnosis of unforeseen side-effects.

The possible side-effects of oral contraceptives have been much discussed by physicians and laymen, on television, on the radio, and in the press.

The Swedish National Board of Health has instructed the members of the medical profession to record and report any unusual complications suggestive of being due to oral contraceptive therapy. Cases of thromboembolic disease including thrombophlebitis have been reported, but there is no convincing evidence of a relationship between oral contraceptives and these diseases. Our experience concerning this point agrees with the observations made in other countries.

On the other hand, we have found that a slight risk of hepatic dysfunction was associated with oral contraceptive therapy. Following cessation of oral contraceptive therapy, however, the disturbed hepatic function promptly returned to normal in all cases found. We have now made it a rule not to prescribe oral contraceptives to women with a history of hepatic disease or gall bladder trouble. The facts involved in the causation of hepatic dysfunction are unknown. It has been suggested that this complication was due to drug allergy or genetic factors. It is rather surprising that little attention has been reported to this side-effect in other countries as it is easy to detect.

Because hepatic disease is quite common in developing countries, special attention should be given to a possible increase in its incidence in users of oral contraceptives.

Swedish doctors engaged in family planning in Pakistan have tried to introduce oral contraceptives in several clinics in that country. Unfortunately, discouraging results were obtained. The majority of the women who had been given the drugs free of charge discontinued taking them after one or two months, probably because they had not been informed that they might experience initial side-effects such as nausea and vaginal bleeding in the beginning of the treatment. In my opinion it is not expedient to give oral contraceptive therapy on a nation-wide scale in those developing countries where the routine work of doctors and their assistants is so exacting that they have no time left for giving detailed directions for use of oral contraceptives. This is a very time-consuming task particularly in the case of illiterate women.

A few developing countries such as South Korea and Taiwan appear successfully to have checked population growth by the use of intra-uterine contraceptive devices. These are easy to apply, and the risk of complications appears to be negligible.

Scientific surveys from different countries would indicate that increasing motivation for family planning brings in its wake an increasing incidence of abortions until an efficient family planning program has been implemented. I suggest that governments embarking upon national family planning should be aware of this possible interrelationship. The high degree of effectiveness of oral contraceptives, however, has meant that induced abortion is virtually unknown among users of oral contraceptives as unplanned pregnancies occur seldom, if ever. The intra-uterine contraceptive devices are less consistently effective than the pill due to the expulsion rate of approximately 15-20 percent. Thus, the widespread use of these devices might tend to increase the demand for abortion, at least in an initial stage.

2. THE SWEDISH LEGISLATION ON ABORTION

Prior to 1938 in Sweden, all artificial miscarriages were regarded as a punishable offense. It had nevertheless become an accepted practise that abortion should not be punishable if childbirth would be likely to endanger the woman's life or health. In this purely medical indication for abortion it was required that two physicians should be prepared to give a written statement confirming the necessity for an operation. The number of illegal abortions apparently was high at that time, roughly estimated at 20 000 a year.

Under the 1938 Act the interruption of pregnancy was permitted in some well defined cases, where there were strong medical, medico-social, humanitarian or eugenic reasons. Of great importance was that a legal abortion could be performed if - due to the woman's illness, physical defect (medical reason) or weakness (medical-social reason) - childbirth would seriously endanger her life or health.

The law, however, hardly led to the anticipated reduction in the number of illegal abortions. In 1946, a new indication for legal abortion was added, abortion being allowed also if the woman´s living conditions were such "that her physical or mental powers would be seriously impaired through the birth or care of a child". Thus the advisability of abortion should be evaluated on the basis of environment, social and financial conditions, as well as medical considerations.

In the beginning of the 1950´s, the annual number of legal abortions was around 6 000, to compare with about 100 000 live births annually. During the second half of the decade, the annual legal abortion figures gradually dropped and reached the level of around 3 000 per 100 000 live births in 1960. In later years again the figures have increased to around 6 000, now to compare with 120 000 live births per year. - My personal conviction is, that the number of illegal abortions has decreased very substantially since the 1930´s - due to better contraceptive techniques, improved social welfare measures, etc.

Other preventive measures have been taken with a view to conteracting abortion. Legislation has, e.g., been passed which prohibits dismissal from employment on account of pregnancy or childbirth. Services for the support and advice of pregnant women have been established. A number of social security and welfare measures have been added in order to improve the living conditions of children, to support the natural desire for raising a family, and to increase the feeling and the actual state of security of expectant mothers.

In view of the injury to the foetus caused by thalidomide, the Abortion Act was again revised in 1963. Abortion is now allowed if the child might be assumed to suffer from a serious disease or physical defect due to injury during its foetal life.

The Swedish Abortion Act of 1938, as amended, makes no distinction between Swedish and foreign citizens. In the last years an increasin number of foreign women have come to Sweden to get an abortion, particularly since the reporting of such a case in the world press. In three years, from 1962 to 1965, more than 700 foreign women applied for abortion at the Karolinska University Hospital, 292 of whom came from the United States. Only in 3 percent of all these cases was an abortion granted under our law. Legal abortion was performed in only 13 of the 292 cases from the United States (4.5 percent) after decision by the National Board of Health. In approximately 65 percent of the cases considered there was no indication at all for abortion according to the Swedish law; pure socio-economic reasons were given, unmarried status referred to, etc.

To a large extent foreigners lack knowledge of the preventive emphasis in the Swedish abortion legislation, which aims at finding better alternatives than abortion by various relief measures. Since those who come to Sweden in these cases normally cannot be given social aid, the often long journey results only in disappointment and money spent in vain. In practise it is only on manifestly medical grounds that a foreign citizen can gain permission for abortion in Sweden. But as a rule in such cases abortion can be obtained in the applicant's homeland as well.

About 25 percent of the women to whom I have referred who came from the United States had been advised to come to Sweden by a physician in the United States in order to get a legal abortion. The remaining 75 percent had been misled by newspapers and magazines.

3. PRESENT RESEARCH IN HUMAN REPRODUCTION IN SWEDEN

Swedish research in human reproduction is characterized by the philosophy that whenever possible, basic information on these pro-

cesses should be obtained in clinical experimentation. As a typical example I would like to inform you briefly about the activity at the Karolinska University Hospital in Stockholm, where a special chair in human reproductive endocrinology is likely to be created in the near future.

The present work at my department is conducted under the directorship of Dr Egon Diczfalusy and is concentrated on the study of the endocrine regulation of reproductive processes in the human female. These studies have two major directions, namely:

a) studies on the endocrine regulation of ovarian function
b) investigations of the endocrine regulation of gestation in the human being.

It might be recalled that the mode of action of oral contraceptives, intra-uterine devices, or even injected human gonadotrophins is incompletely understood, and we believe that an improved knowledge of the mode of action of these agents must result in improved methods of regulating fertility and sterility.

Present studies are directed to the exploration of the mode of action of a new type of contraceptive pill developed by the Syntex Corporation of the United States and called low level supplementation. This method is believed to interfere with fertility without inhibiting ovulation. Studies are now in progress on the effect of this method on the secretion of pituitary gonadotrophins, biosynthesis of ovarian hormones, uterine motility and vaginal cytology. The Stockholm group was the first to induce successful ovulation and pregnancy by the use of human gonadotrophins, and present studies are aimed at the elucidation of the hormonal factors responsible for the induction of multiple pregnancies which are rather frequent in this type of treatment.

The other line of research involves studies on the endocrine regulation of gestation in the human. It was known for some time that steroid hormones are indispensable for the maintenance of gestation and that these hormones are produced by a temporary endocrine organ, the placenta. However, the Stockholm group has shown that the placenta lacks some of the essential enzyme activities responsible for the formation of the steroids. However, the enzyme functions are present in the fetal organism, which, on the other hand, lacks some of the important enzymes present in the placenta. These studies led to the development of a new concept, that of the feto-placental functional unit, and we think that as a result of these studies it will be possible to find specific steps in the hormone production which are vulnerable to exogenous hormonal or pharmacological influences.

These studies were made possible by a research grant of $500 000 from the Ford Foundation, but the work is also supported by the United States National Institute of Health (giving a training grant of $350 000), and the Medical Research Council of Sweden ($12 000 yearly). In addition, the international pharmaceutical industry has also shown a great interest in supporting the basic research conducted in this laboratory; for the time being financial support is received from the Syntex Corporation, Palo Alto, California ($20 000 yearly), the Leo Company, Hälsingborg, Sweden ($12 000), the Schering Ag, Berlin, Germany ($6 000), and the Philips-Duphar Company, Weesp, the Netherlands ($6 000).

During the past three years (1963-1965), 25 postdoctoral fellows wer trained in reproductive endocrinology at the laboratory. The country of origin of these fellows was: the United States (11 fellows), Italy (4), Canada (3), Germany (2), and one fellow each from the following countries: Brazil, Australia, Belgium, Ireland and Austria. The fellowships for these investigations were provided by

different agencies. Thus 6 were Ford Foundation fellows in reproductive endocrinology, 5 were supported by fellowships from the NIH and 3 from other US philanthropic organisations. Two fellows were holders of the Sir Henry Wellcome fellowship from Great Britain, 4 fellows were supported by the Medical Research Councils in Sweden, Canada and Germany, and 2 fellows were holders of fellowships sponsored by the Schering and Syntex Corporations. Finally, 3 fellows were on leave of absence from their Universities.

It is hoped that this training program can be extended in the near future to include fellows also from South America and from developing countries in Africa and Asia.

The Ford Foundation also supports a smaller program at the University of Lund under the direction of Dr Lars Philip Bengtsson. This program is directed to the exploration of the mode of action of intra-utering devices when they inhibit implantation.

Other groups in Stockholm, Gothenburg and Uppsala, headed by Drs Odeblad, Brody and Gemzell, are studying the physico-chemistry of the cervical mucus and the effect and disposition of human gonadotrophins.

It is my hope that the Swedish government will provide a considerably increased financial support and that these studies can be extended and intensified in the future.

4. A DEMOGRAPHICAL RESEARCH PROJECT

Engagement in the population problems in the economic development of developing countries requires adequate methods for analysis of the situation and trends and for the evaluation of the efforts. As for the population aspects, research is now carried out at the Demographic Institute, University of Gothenburg, Sweden, by

Professor Hannes Hyrenius and his associates. The purpose is to develop so-called demographic models as a scientific instrument for studying the inter-relationships between the population changes and the economic and social development in various types of populations and economies.

The project consists of two parts. The first is the development of the methods. A necessary component is the reliable statistical data that exists in Sweden on population and economy since more than 200 years, i.e. Sweden's development from a truly underdeveloped status to a highly industrialized one.

The second part of the project is the application of the model on various populations in order to obtain knowledge about the population's role in the development. The demographic models will be useful both for the planning in advanced industrialized countries and for the analysis and development-planning in the less developed areas.

It seems desirable to establish international co-operation in this field both through a suitable international body and through direct teamwork between individuals and institutes in various countries, developed as well as underdeveloped.

Tryckt vid Sthlms stads Arb.v.byrå 1967