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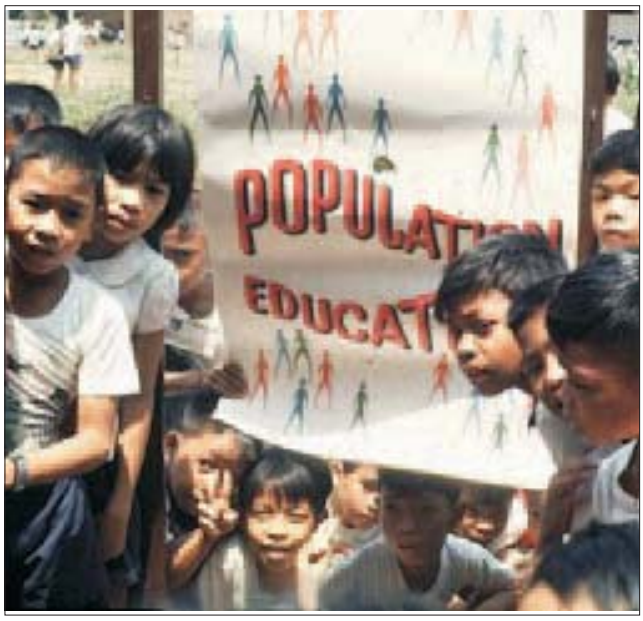

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COVER PHOTOGRAPH

Children holding up a population education poster in the Philippines (photograph courtesy of UNESCO).

The first article in this issue of the *Asia-Pacific Population Journal* examines the factors that influence client loyalty to reproductive health-care clinics in the Philippines and Thailand.

The second article offers a close-up view of the financial situation of elderly persons in Singapore, a country with one of the fastest-growing elderly populations in the world, while the third article discusses barriers to male participation in family planning in West Timor.

Finally, the fourth article transports us to yet another topic and country: the rising trend in menstrual regulation practices in Bangladesh.

Introducing Viewpoint

In consultation with the *Asia-Pacific Population Journal* Editorial Advisory Board, the Asia and the Pacific Division of the United Nations Population Fund (UNFPA) and UNFPA Country Services Technical Teams (CST) for East and South East Asia, the Editor of the *Journal* has decided to launch a new column entitled "Viewpoint".

This column will publish contributions from prominent and outspoken population experts on various issues of importance in the region. "Viewpoint" will touch on issues widely debated in the field of population and development and will be open to a variety of defendable, although perhaps upstream, points of view on a given topic.

"Viewpoint" welcomes contributions/ reactions to published articles from population specialists on the understanding that the article is subject to reviewers' approval and editorial revision.

For further information, please contact: e-mail: escap-population@un.org.

CNN vs. ABC: A Debate Not Worth Continuing!

Having sex for the first time can be likened to driving a car. There is an appropriate time, age and vehicle for a person to begin driving.

By Mechai Viravaidya and John Atkinson*

The debate between the protagonists of the Condoms, Needles and Negotiating Skills (CNN) and the Abstinence, Be Faithful and Use Condoms (ABC) approaches could go on forever. It is time for the proponents on each side to put aside their differences and begin working together to address the HIV/AIDS pandemic. To claim that either approach is superior to the other is to fail to recognize the potential benefits that each approach can have for various individuals, communities and cultures. We must recognize that all individuals are different. It is therefore foolish to limit ourselves by this "either-or" way of thinking.

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The Population and Community Development Association (PDA) of Thailand has had great success in family planning and HIV/AIDS prevention. The organization has always used an approach that permits people of all ages to make informed decisions about their lives. Regardless of whether we are talking about condoms, abstinence, needles, being faithful or negotiating skills, the most important part of HIV/AIDS prevention is that one informs and educates people in an open and honest manner, presenting all the facts that one knows.

Having sex for the first time can be likened to driving a car. There is an appropriate time, age and vehicle for a person to begin driving. In a similar manner, there is an appropriate time, age and "vehicle of protection" for a person having sex for the first time. It is very possible for youth to have sex too early in life, but it is never too early to educate them about it. There is no harm in delaying sexual activity or practising abstinence until a time when an individual is comfortable and ready to have sex. Like a bottle of good red wine, waiting another day, month or year to open it does not matter because it will only get better with age.

Before discussing "C", "N", "A", "B" or any other letters, we must focus on **"S"! "S"** stands for **Safety** and is synonymous with **"P"** for **Protection**. Protection is of utmost importance in the prevention of any sexually transmitted infection, especially HIV. If we choose to debate whether CNN or ABC is the best approach to preventing the spread of HIV/AIDS, we have undeniably failed to do the right thing. From a young age, children must be educated about sexuality in terms of protection, responsibility and the development of negotiating skills.

All individuals are different and we must accept that they will make different choices. By helping children learn about protection as well as develop negotiation skills, we help them to be equipped with the tools they need to make the right choices about sex. To be able to negotiate translates into a greater bargaining power and more alternatives for those who have little or few such choices. Someone who has learned to abstain or say "NO" to having sex has made a good choice, just as someone who has learned to say "YES" with PROTECTION. In the same light, being faithful is a fine choice; however one must still be protected in order to prevent pregnancy. Just as a good pilot always has a parachute, a responsible sexual partner should always protect him or herself.

There is no right or wrong answer to the debate about how to best prevent the further spread of HIV and equip today's young generation for tomorrow's reality. However, there is undoubtedly a sensible answer for doing so. Education can not only help protect people from the risks associated with sexual activity, but it can also help inform them about other issues including drugs and safe drug use. In short, education is the best possible preparation for today's and tomorrow's children and young people. Instead of CNN or ABC, perhaps we should go for **IEP: Information, Education and Protection**.

Note: The Population and Community Development Association (PDA) is a non-governmental, non-profit organization that has been serving and creating opportunities for Thailand's rural poor. Founded in 1974, PDA now operates from its 18 regional development centres, with its headquarters in Bangkok.

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Past research has shown that stronger clinic loyalty among reproductive health-care (RH) clients enhances their willingness to follow treatment recommendations and to keep subsequent appointments. However, relatively little is known about factors that increase client loyalty to RH clinics. In an era of shrinking donor support and increased expectations of clinic self-sustainability, improved understanding of ways to strengthen client loyalty creates a win-win situation for all stakeholders. To this end, the following study examines relationships between RH clients' cognitions, emotions and clinic loyalty in two countries: Thailand and the Philippines. In both countries, cognitive evaluations were important predictors of future loyalty. In addition, the experience of negative emotions decreased clinic loyalty in both countries. However, only in Thailand did the experience of positive emotions significantly enhance loyalty. Indeed, in Thailand, this variable was the strongest predictor. Discussion centres on the significance of this finding and others to clinic managers who wants to increase client loyalty in order to strengthen the positive impacts of their RH programmes.

As a result of improved health care, health insurance and socio-economic conditions, life expectancy in Singapore has soared, resulting in a significant

growth of its elderly population. Although the Government of Singapore has mandated the family as the primary site for elder care, it forecasts that an ageing population would have economic, fiscal and social impacts on the country's resources. Given this scenario, its goal has been to strategically mobilize resources, ensuring that all levels of society are well prepared for the challenges brought on by a growing elderly population and that the vision of "Successful Ageing for Singapore" is attained. This paper seeks to uncover the extent to which Singapore's elderly are "ageing successfully" given current government policies aimed at ensuring the financial security of its citizenry. Attention is given to public-private-community partnerships in the areas of health and employment since those alliances are critical in facilitating economic security for the elderly. While partnerships in health ensure access to good and affordable health-care services, partnerships that increase elderly employability ensure a degree of financial independence and self-sufficiency.

Barriers to Male Participation in Family Planning in West Timor **55**

Attention has been paid to encouraging men to play a greater role in family planning programmes. The number of males using modern contraceptive methods is very low at present. In order to better understand men's involvement in family planning in one region of Indonesia, research was conducted in West Timor (Nusa Tenggara Timur (NTT)). Qualitative methods were used to explain males' participation in family planning. The research points out that marriage and bride price payment are important elements perpetuating male domination over women. Violence against women and drinking behaviour also influence the practice of family planning. Men take major decisions within the family. Although men tend to influence their partners as regards family planning decisions, women still have the opportunity to discuss the options available. In short, males' involvement in family planning has already been initiated in NTT; however, there are specific issues that demand immediate attention. Taking into account local culture and existing local problems is important in formulating policies, programmes and strategies aimed at involving men in family planning.

Menstrual Regulation Practices in Bangladesh: An Unrecognized Form of Contraception **75**

As part of the Government of Bangladesh's health and family planning effort, menstrual regulation (MR) has been declared an "interim method of establishing non-pregnancy" for a woman at risk of being pregnant to reduce female morbidity and mortality associated with indigenous abortion, which is legally restricted in Bangladesh. This policy regarding MR has profound implications for women's reproductive health in Bangladesh as there is an increasing demand for pregnancy termination despite a steady increase in the contraceptive use rate. Survey results indicate that currently married women have a moderately high knowledge of MR, but in most cases they failed to distinguish between MR and abortion. Most of the MR acceptors received MR services to terminate an unwanted pregnancy arising from a method failure or from the non-use of family planning methods. The results suggest that with the promotion of MR services, many abortions are performed under the mantle of MR in order to avoid legal controversy. Recent survey results show that about 5 per cent of the currently married women ever had MR and the number is increasing despite the greater use of family planning methods. This paper examines the characteristics of the MR acceptors and determinants and the reasons for MR practice in Bangladesh. Understanding the reasons for MR acceptance and its demographic impact will assist policy makers in taking appropriate strategies to reduce unsafe abortion, which, in turn, will help to decrease maternal morbidity and mortality.

Influences on Client Loyalty to Reproductive Health-Care Clinics in the Philippines and Thailand

Given the importance of loyal clients to effective treatment as well as to clinics' financial stability in a world of shrinking donor resources, understanding predictors of client loyalty is increasingly important.

By Dana L. Alden, Julieta DelaCruz and Pongsa Viboonsanti*

Studies of factors that affect client loyalty to reproductive health (RH) clinics are limited. This is the case even though the International Conference on Population and Development held at Cairo in 1994 noted, among other issues, the importance of understanding how client perceptions of quality and satisfaction

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impact continued use of RH clinics (Ashford, 2001). From the client's perspective, stronger clinic loyalty enhances willingness to follow treatment recommendations and keep subsequent appointments (RamaRao and others, 2003). From the clinic's perspective, stronger loyalty results in more positive word-of-mouth and repeated visits. Visit continuity in turn increases staff's ability to deliver quality care and reduces higher costs of recruiting new clients to replace one or two-time users (Sandaram, Mitra and Webster, 1998).

Seeking to improve managerial understanding, the following study identifies important factors related to client loyalty in outpatient RH clinics located in urban areas in two developing countries. Both studies were undertaken during the summer of 2001; the first, in Chiang Mai, Thailand and the second, in Quezon City, the Philippines. Following a brief review of the literature on client loyalty in health-care settings a model outlining potential predictors of clinic loyalty is presented. Results are discussed thereafter and the paper concludes with a section on managerial implications.

Client loyalty and health-care

When evaluating reproductive health-care (RH) quality, early researchers tended to focus exclusively on clinical "outcome-based" information or "... the way the individual is treated by the system providing services" (Mensch, Arends-Kuenning and Jain, 1996, p. 63). More recently, RH researchers have regularly included client perceptions in assessing clinic service quality, documenting linkages between such perceptions and modern method adoption/maintenance (see the "participatory" framework recommended by Engender Health; Bradley and others, 2002).

Despite such advances, extensive search of the literature revealed relatively few studies that emphasized client loyalty in a clinical health-care context. Indeed, Roberge and others (2001, p. 53) conclude that loyalty has been "scarcely addressed in the literature on continuity of care". Those authors define loyalty as an ongoing, consistent relationship over time between a patient and a doctor and note that it is related to the concept of longitudinal care. Corbin, Kelley and Schwartz (2001) suggest that health care has traditionally focused on individual encounters, which is appropriate for certain types of services such as trauma and other emergencies. However, in other situations such as the delivery of RH clinical services, a long-term orientation stressing retention and client loyalty is far more important. Lain, Steiber and Edge (2000) note that loyalty often results from exceeding patients' expectations. However, Mittal and Lassar (1998) found that

feelings of satisfaction alone do not guarantee loyalty. Trust in the physician and strong interpersonal relationships are also important (Roberge and others, 2001; Thom and Campbell, 1997).

Client loyalty: model development

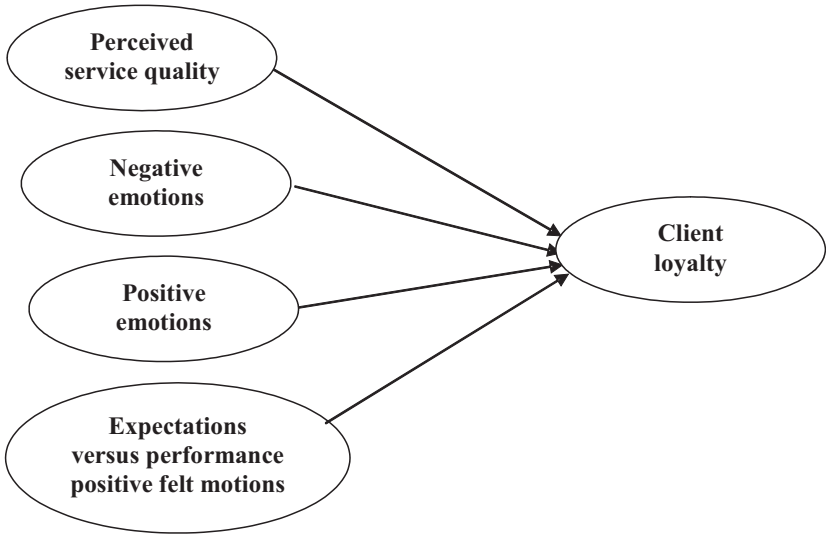
Seeking to better understand the factors that influence client loyalty to RH clinics in developing countries, the authors tested a model using survey data from urban clinics in Chiang Mai, Thailand and Quezon City, the Philippines (see figure 1). That model reflects the theory referred to collectively as the coping framework. The framework hypothesizes that a combination of cognitive processes (e.g., performance appraisals) and emotional responses (positive/negative feelings) leads to a coping response (behavioural intention; Lazarus, 1991) or an action tendency (readiness to engage or disengage from some object; Frijda, Kuipers and ter Schure, 1989).

As shown in figure 1, four major influences on clinic loyalty are hypothesized. Based on the coping framework (Lazarus, 1991), two involve cognitive evaluations of service quality and two involve emotional feelings experienced during the service delivery process. Drawing from the literature, the first cognitive predictor consists of evaluations that range from strong to weak on: a) physical aspects of the clinic (e.g., cleanliness of waiting area; Hoffman and Bateson, 2002); b) access (e.g., appointment waiting time, fees, convenient operating hours; Shaffer and Sherrell, 1997); c) quality of information from clinic staff (e.g., understandability and trustworthiness of medical information received during visit; Zeithaml, Berry and Parasuraman, 1996); and d) staff caring (e.g., perceived helpfulness and empathy of clinic staff; Koerner, 2000). The second cognitive predictor is based on the health-care "discrepancy model" (Sitzia and Wood, 1997) and involves clients' evaluations of how much overall service quality exceeded or fell below their expectations at the end of the visit. Given the well-documented relationships between positive cognitive evaluations and future behaviour (RamaRao and others, 2003, Koenig, Hossain and Whittaker, 1997), the authors expected that both would directly influence clients' loyalty.

In addition to the cognitive evaluations of quality, emotional feelings experienced during the clinic visit are likely to affect loyalty. Although rarely investigated in health-care contexts (see Bélanger and Dubé, 1996), the impact of emotions during a service experience has been examined in other service settings (Syzmanski and Henard, 2001). For example, research by Yu and Dean (2001) indicates that positive emotions are more strongly associated with loyalty than negative emotions. Spreng and Patterson (2003) found that only negative

emotions were significantly related to loyalty intentions. However, those studies took place in settings that are not as emotional as an RH clinic (i.e., academic institutions and health clubs). In an RH clinic, it seems probable that both positive and negative feelings during the RH clinic visit will impact loyalty, with higher frequencies of positive emotions increasing and negative emotions decreasing client loyalty.

Figure 1. Proposed model of RH client loyalty



The universal nature of the coping framework (Lazarus, 1991) suggests that cognitive and emotional predictors will affect client loyalty in both Thailand and the Philippines. However, other research indicates that the relative importance of those predictors will vary in each country. Hofstede's (1983) 50-nation study found that Thai culture emphasizes the importance of emotional factors related to relationship maintenance to a greater degree than Filipino culture, which places more emphasis on assertiveness and material acquisitiveness. This difference is reinforced by Hallinger and Kantamara (2001) who examined the influence of culture on formal education in Thailand and report that Thai culture stresses the maintenance of positive feelings in work and play, a concept referred to as sanúke (fun, enjoyment, having a good time). As Fieg (1989, p. 59) notes, "Thais have more of an expectation that all of their activities will be suffused with sanúke. Work, study, and even religious services must have an element of sanúke if they

are to absorb a Thai's interest". Hallinger and Katamara (2001, p. 399) also note that without sanúke, "it is difficult to engage in the ongoing motivation of Thai staff in any organization".

Given the relatively stronger weight placed on relationship maintenance in Thailand and the coexisting concept of sanúke, it seems likely that positive emotional factors will be more central to client loyalty in Thailand than in the Philippines. Hence, while the authors expected that cognitive and emotional antecedents would predict client loyalty in both countries, it was also hypothesized that the experience of emotions in general and positive emotions in particular would be relatively more important to loyalty in Thailand than in the Philippines.

Method

Study sites

In the Philippines, four smaller reproductive health clinics served as study sites. The clinics were located in Quezon City (a working class suburb of Manila) and were part of an affiliated organization known as the Institute for Child and Maternal Health (ICMH). In Thailand, one larger clinic serving lower middle and working class women in Chiang Mai and affiliated with the International Planned Parenthood Federation (IPPF) served as the study site. All clinics in the study were dedicated to providing comprehensive RH services other than abortion. Table 1 provides general RH and development indicators for the two countries (2003, 2004 ESCAP Population Data Sheets). As indicated in the table, Thailand appears to have made relatively more progress in terms of those RH indicators. However, it should also be noted that the Philippines has similar levels of children in secondary schools and a substantially higher percentage of individuals living in urban environments.

Study design

Post-visit surveys, conducted by trained female researchers who were not employed by the clinic under study, served as the central data collection method. Prior to the surveys, focus groups, led by professional native female researchers, were held with clinic clients. The focus group results, coupled with the literature review described earlier formed the basis for specific questionnaire items. The items were designed to measure client evaluations of service quality, the emotions experienced during their visit, whether clinic performance exceeded or fell below their expectations and future loyalty intentions. Following double-back translation (Brislin, 1980), the questionnaire was reviewed by another focus group in each

Table 1. Reproductive health and other development indicators: Philippines versus Thailand[a]

Indicators	Philippines	Thailand
Total fertility rate (per woman)	3.1	1.7
Annual growth rate (per cent)	1.7	0.8
Infant mortality rate (per thousand)	28	20
Percentage of births attended by trained health personnel[b]	56	85
Percentage urban	62	31
Secondary school enrollment ratio[c]		
Males	73	78
Females	79	80

[a] Unless noted, data from *2004 ESCAP Population Data Sheet*.

[b] From *2003 ESCAP Population Data Sheet*.

[c] Number of children enrolled in secondary school/number of children who are of secondary school age. From *2003 ESCAP Population Data Sheet.*

country for relevance, clarity and ease of use. Some modifications were made to assure maximum comprehension on the part of the respondents.

Interviewer training emphasized the importance of putting clients at ease about confidentiality and anonymity. Immediately after the clinic visit, the clients were asked if they would participate in a satisfaction survey sponsored by a local university for research purposes only. They received a small gift for participating but were unaware of the gift until the survey was completed. Clients were surveyed at different times over multiple weeks in order to increase representativeness.

Sample characteristics

Four-hundred clients were interviewed in the Philippines and 200 were interviewed in Thailand. The average age of the Filipino sample was higher than in Thailand (30 versus 23.5). In addition, the age ranges were different: 18 to 57 in the Philippines versus 16 to 30 in Thailand. To better standardize the samples and facilitate comparison, analyses with the Filipino data set were limited to those clients whose ages were in the same range as the clients in Thailand. This reduced the sample size in the Philippines to 223, which was similar to the number of respondents from Thailand. Demographic data for both samples are provided in table 2.

Table 2. Sample demographic characteristics

	Philippines samples	Thai samples
Sample size	223	200
Average age	25.4	23.5
Average years of formal education	10.5	12.0
Percentage married	95.5	48.0
Percentage not married	4.5	52.0
Average number of children	1.84	0.50

The demographic data in table 2 indicate that the samples are fairly well-matched on age but vary in other ways that reflect the different sociodemographic characteristics of the two countries (see table 1; ESCAP Population Data Sheets 2003, 2004). For example, despite similarity in terms of the age cohort, Filipino sample members were more likely to be married and had significantly more children. In addition, the average education level of the Filipino

Table 3. Clinic services reported used by clients (percentage of sample)*

	Philippines sample	Thai sample
Service type		
Receipt of oral contraceptives	23	35
Receipt of condoms	17	3
Contraceptive injection	11	20
Insertion/removal of IUD/norplant	11	3
STD check/pap smear	11	39
Emergency contraception	5	3
Pregnancy test	34	49
RH counseling	42	27
Receipt non-contraceptive medicine	45	10
General health counseling self	54	14
General health counseling other	45	3
Other	27	17

* Percentages (rounded-up) do not total to 100 as clients checked more than one service if used.

sample was lower than the Thai sample. However, the difference is not substantial with only 1.5 years more on average of formal education in the Thai sample. Comparison of reported past visits to a reproductive health clinic indicated that the Filipino sample was more experienced ($\chi^2(4) = 158.6$, $p<0.001$). Table 3 presents the clients' various reasons for visiting the clinic. While most clients in both countries visited the clinic for reproductive health-related services, higher percentages of clients in the Philippines reported seeking other services as well.

Table 4. Study measures – Cronbach's Alpha and Means

Multi-item sum scale measures	Philippines		Thailand	
	Means	Alphas	Means	Alphas
Service quality performance (8 items, 8-point scale)	5.8	0.94	6.3	0.78
Expectations versus performance (3 items, 7-point scale)	5.2	0.84	4.9	0.77
Frequency of negative emotions (6 items, 5-point scale)	1.9	0.84	2.5	0.87
Frequency of positive emotions (6 items, 5-point scale)	3.5	0.93	3.1	0.91
Clinic loyalty (4 items, 7-point scale)	5.7	0.93	5.6	0.87

Study measures

Clients indicated how strongly they agreed or disagreed (8-point scale) with eight evaluations of service quality, e.g., "all of the clinic's waiting areas were very comfortable". Principal components analysis revealed one factor with all eight items in the Philippines (70.5 per cent cumulative variance) and one major factor with only two cross-loadings in Thailand (57.4 per cent cumulative variance). Hence, evaluation quality was treated as a single dimension. Taken together, these statements represented the first cognitive evaluation predictor referred to earlier and are provided in figure 2.

The second cognitive construct – how much overall performance exceeded or fell below expectations – was measured with three items and a 7-point scale, e.g., "Overall, I think the quality of the clinic service that I received today was … "much worse than I expected" (1), "pretty much as I expected" (4) or "much better than I expected" (7). The frequency of negative and positive felt emotions was

Figure 2. Performance items used in service quality scale 8-point agree-disagree scale

Clinic tangibles

1) All the clinic's waiting areas were very comfortable
2) All of the clinic's facilities (waiting room, toilet, exam room, etc.) were very clean

Access to RH services

1) The price I paid for clinic services was very low
2) I spent a short time at the clinic getting services today

Perceived information quality

1) I really trust the information I got from the doctors and nurses
2) It was very easy to understand all of the health care information I got from the doctors and nurses

Personal care

1) Everyone who works in the clinic (including non-medical staff) was very polite to me
2) Everyone who works in the clinic (including non-medical staff) seemed to care a lot about me

assessed with four items for each construct on a 5-point scale that ranged from "never or almost never felt" to "very often felt". Client loyalty was tapped with four measures indicating likelihood to engage in positive word-of-mouth and return to the clinic in the future using a 7-point scale that ranged from "not at all likely" to "extremely likely". As indicated in table 4, internal reliabilities on all scales exceeded acceptable levels and as a result, sum scale averages were created for each variable and used in subsequent analyses.

Result

Testing the model

Regression was used to test the two hypotheses. The first hypothesis stated that positive service quality evaluations, overall performance exceeding expectations and positive emotions would all increase clinic loyalty. By contrast,

Table 5. Regression analysis results

Model indicators	Philippines	Thailand
F-test	F(7,197) = 31.6**	F(7,187) = 49.8**
Adjust R2	0.512	0.638
Betas		
Perceived service quality	0.283**	0.139*
Expectations versus delivery	0.402**	0.291**
Frequency of positive emotions	n.s.	0.345**
Frequency of negative emotions	-0.122*	-0.152**
Age	n.s.	0.142**
Education	n.s.	n.s.
RH clinic experience	n.s.	n.s.

** p=0.001; * p<0.05

Note: n.s. means not significant.

the frequency of negative emotions was expected to reduce clinic loyalty. Age, education and RH clinic experience were included as covariates to control for confounds and are not discussed further. Table 5 presents the regression results.

As can be seen from the analyses, both regression models are significant at $p<0.001$. Furthermore, both possess high $R_{2\ adjusted}$ (0.512 in the Philippines and 0.638 in Thailand), indicating that the overall model explains substantial portions of the variation in clinic loyalty in the two countries. These findings strongly support the authors' first hypothesis.

The most important predictor of clinic loyalty in the Philippines was how much performance exceeded expectations (0.402, $p<0.001$). Evaluations of service quality were second (0.283, $p<0.001$). Emotions played a relatively small role with only negative emotions reaching significance – the more frequently clients felt negative emotions, the less loyal they were likely to be (-0.122, $p<0.03$). Thus, for the RH clients in the Philippines, cognitive factors were decidedly more important predictors of clinic loyalty than emotional factors.

In Thailand, the frequency of positive emotions was the most important predictor of clinic loyalty (0.345, $p<0.001$). This was followed by the cognitive factor; how much performance exceeded expectations (0.291, $p<0.001$). As in the Philippines, the frequency of negative emotions was inversely related to loyalty

(-0.152, p=0.001). Interestingly, evaluations of service quality were the least important predictor of clinic loyalty for Thai clients (0.139, $p<0.05$). Thus, supporting our second hypothesis, the experience of emotions in general and positive emotions in particular were stronger predictors of clinic loyalty in Thailand than in the Philippines.

Discussion

To date, reproductive researchers in developing countries have examined influences on medical outcomes (RamaRao and others, 2003) and client satisfaction (Koenig, Hossain and Whittaker, 1997). However, work on factors related to clinic loyalty is limited. Given the importance of loyal clients to effective treatment as well as to clinics' financial stability in a world of shrinking donor resources, understanding predictors of client loyalty is increasingly important. Thus, the first contribution of this study is to propose and find support for a model of cognitive and emotional influences on RH client loyalty in two developing countries, the Philippines and Thailand.

Both higher perceived quality on individual service attributes and larger differences between overall performance and expectations increased client loyalty. Furthermore, negative emotions felt during service delivery resulted in lower clinic loyalty in the two countries. Despite such similarities, important differences were also observed. In particular, the effect of positive emotions on loyalty was not significant in the Philippines, but it was in Thailand. More importantly, the frequency of positive emotions during the visit was the strongest predictor of clinic loyalty in Thailand. This result was obtained while controlling for three potential confounding variables: age, education and RH clinic experience.

Strong theory from the cross-cultural literature suggested that normative values concerning the importance of enjoyable, fun experiences in Thai culture (referred to as sanúke, Hallinger and Katamara, 2001) would likely increase the impact of positive emotions in Thailand as compared to the Philippines. Thailand's higher rating on the importance of relationship maintenance as identified by Hofstede (1983) was cited as a possible reinforcing factor. However, the observed difference between the two countries on this variable was even stronger than expected. This finding suggests the importance of future research. Such research is needed to determine whether or not a similar relationship between positive emotions and clinic loyalty holds in other cultures that are comparable to Thailand on relationship maintenance, e.g., Guatemala, the Republic of Korea, Uruguay, Yugoslavia and the East African region,.

For those countries in which positive emotions are found to be strong predictors of clinic loyalty, additional emphasis on managing the client's emotional experience during the visit may well enhance clinic loyalty. Positive emotions may be less direct and more subtle than negative emotions and may be more challenging from a management perspective. However, certain steps can be taken to maximize the likelihood of positive emotional experiences. For example, staff could keep an index record of individual client's "likes" and "dislikes". If a client mentions that she is proud of her child's performance in school, this could be noted on the record and the next time she visits, the attending physician or nurse could simply ask how the child is doing in school. Given the positive emotional ties to the child the client has previously expressed, this question alone may well arouse positive emotional feelings. Increasing the frequency of positive emotions in turn should enhance loyalty to the clinic.

Of course, positive emotion primes are likely to vary dramatically by culture and within culture by individuals. Care will be required to avoid the appearance of "prying" into clients' personal lives. In addition, in cultures such as Thailand, positive emotional feelings may more likely result from mild joking interactions than references to objects associated with positive feelings. Thus, in addition to being sensitive about the way positive associations are aroused, it is critical to develop a deeper understanding of culture-specific factors that most easily facilitate those emotions.

On the cognitive side, in both countries, it is clearly important to monitor differences between clients' overall evaluations of expectations and performance. In the Philippines, that difference was the most important predictor. In Thailand, it was second after positive emotions. Given the complexity of the service provided, the stronger impact of overall differences between expectations and performance on clinic loyalty (versus evaluations of individual performance attributes) has face validity and intuitive appeal. Furthermore, support for this finding is provided by a fairly recent meta-analysis of factors influencing customer satisfaction (Syzmanski and Henard, 2001). However, other authors have reported a stronger role for individual service quality attribute evaluations (e.g., waiting time, see Taylor and Cronin, 1994; Shaffer and Sherrell, 1997). With such mixed evidence, it is important to measure both attribute-level performance evaluations and overall evaluations of whether performance exceeded expectations.

In addition, in this study, the attribute-level performance evaluation scale was treated as one dimension. In other contexts, however, the use of multiple dimensions could prove useful. For example, employing a multidimensional scale allows managers to track the relative importance of each dimension to client

loyalty. Thus, if staff caring issues grow increasingly important and access issues diminish, clinic managers can reduce resources used for access (e.g., reducing the number of routes a "mobile clinic" travels as public transportation to the fixed site improves) and increase those for staff caring (e.g., increasing the level of year-end bonuses given to staff who demonstrate strong client-centred care). Furthermore, managers should carefully pre-test all performance measurement items through focus groups and small surveys to ensure that meaningful criteria are included in the scale (see Alden, Hoa and Bhawuk, 2004).

Limitations

The limitations in this study suggest potential avenues for future research. First, there is the inherent limitation of a one time, cross-sectional study in terms of external and internal validity. While broadly representative of women with lower resources levels who use urban RH clinics in the Philippines and Thailand, the present sample may not generalize to the overall population of urban users of public RH clinics. Second, the sample did not include women who live in those countries but do not visit RH clinics. Future study of non-users (including those who have never gone and those who went but do not want to go again) would provide a richer description of the universe of factors related to loyalty as well as clinic switching or service discontinuation. Finally, while the high R-squared values in both countries suggest that the basic model has strong predictive validity, it is likely that factors not included also influence clinic loyalty. For example, in collectivist cultures, family and peer influences are likely to impact individual client decisions regarding the future clinic use (Fikree and others, 2001). The inclusion of such factors could further enhance the cross-cultural understanding of client loyalty.

Despite such limitations, this study clearly demonstrates the value of considering client evaluations and feelings as a component of overall reproductive health-care quality. The linkages between those factors and client loyalty are strong and as a result should be regularly monitored along with standard quality measures. Furthermore, while future research is needed to confirm those results, the fact that the importance of cognitive and emotional loyalty predictors in Thailand and the Philippines differed suggests that culture remains an important influence that must be considered when developing and managing reproductive health-care services in the Asian and Pacific region.

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"Successful Ageing for Singapore"?: Financial (In)Security of Elderly Persons

In its attempt to meet the challenges of its growing elderly population it is inevitable that the Government of Singapore may have to compromise its economic growth objective.

By Theresa W. Devasahayam*

Many developed countries across the world have populations that are rapidly ageing. In East and South-East Asia, Singapore, together with Japan, the Republic of Korea and Thailand, has the fastest growing 65 years and older population (Westley, 1998: 1; Gubhaju, 2003: 3). While Japan has doubled its proportion of

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elderly persons from 10 to 20 per cent over 28 years, Singapore will reach this demographic leap in 17 years. In 2003, 7.6 per cent of the Singapore population was over 65 years of age (Ministry of Community Development and Sports (MCDS)**, 2004a). Owing to improved health care, health insurance and socio-economic conditions, life expectancy has increased in Singapore with large numbers of people from the pre-war baby boom era surviving into their 60s and forming the country's growing elderly population.[1] According to estimates for 2004, life expectancy at birth for men stands at 76.9 of age and for females at 80.9 (Department of Statistics, 2004). As such, demographers have attested to Singapore having the fastest ageing population in the world (Ogawa, 2003: 95-96; Mehta and Vasoo, 2001: 186; ESCAP, 2002); it has been projected that its ageing population is growing at an unprecedented rate of 3.7 per cent annually (MCDS, 2004b), with the oldest-old cohort (aged 85 and above) growing the fastest (Chan, 2001: 3).

Forecasting that an ageing population would have economic, fiscal and social impacts on State resources, the Government of Singapore has adopted a policy mandating the family as the primary site for eldercare (Lee, 1999: 83), based on the notion that the family would provide the best emotional and psychological support (Prescott, 1998; Mehta and Vasoo, 2000: 127). That policy has been executed in different arenas: housing, the Maintenance of Parents Act, the way in which payments can be made for health-care services and the Parent Relief Scheme. In terms of housing, a newly married couple has the option of purchasing a government-subsidized apartment within the same housing estate of either parent. Should this be the case, the couple is entitled to a special grant (Lee, 1999: 84; Huang and Yeoh, 1994: 55; Teo, 1996: 283). The Maintenance of Parents Act is a harsher approach to reinforcing the role of the family in eldercare as negligent children may be penalized if they fail to provide financially for their parents (Mehta, 2002: 153). That children are allowed to use savings from their own Medisave account (a national compulsory savings fund towards paying for the health expenses incurred by their parents) also has the same effect of reinscribing the familial role in eldercare. The Parent Relief Scheme, an annual deduction in taxes, claimed by working caregivers for their aged parents in case the latter do not have sufficient savings, also highlights the family role.

In stressing individual's and family's responsibility, the State policy towards eldercare does not imply a "hands off" approach on the part of the

** As of 1 September 2004, the Ministry of Community Development and Sports has been renamed as Ministry of Community Development, Youth and Sport.

Government. Its role, however, has been focused mainly on providing targeted services to individuals and organizations for meeting the needs of the ageing community in the areas of health care and other financial subsidies related to eldercare. The community at large has also been heavily involved in providing mainly health-care services as well as short- and long-term care services to meet the special needs of that population. Operating with partial funding from government sources, voluntary welfare organizations (VWOs) serve a variety of needs from the setting up of homes for the elderly and day care centres to integrating older persons into the society. While the private sector was a service provider in eldercare in a limited way in the past, this has changed recently. The Government has now adopted the "Many Helping Hands" approach of involving families, the community, the private sector and the elderly themselves in solving problems related to Singapore's ageing population.

In response to the urgent challenges presented by a fast growing ageing population, the Inter-Ministerial Committee (IMC) on the Ageing Population was established in 1998 for three reasons: (a) to identify the challenges brought about by a rapidly ageing population, (b) to develop policy directions, and (c) to lead a coordinated response among different sectors to address the specific challenges of the elderly population. In 1999, six IMC Workgroups were tasked with reviewing and making recommendations in the following areas: (a) social integration of the elderly, (b) health care, (c) financial security, (d) employment and employability, (e) housing and land use policies, and (f) cohesion and conflict in an ageing society.

As the Government of Singapore is aware that resources need to be mobilized strategically to meet the needs of its ageing population, its goal has been to ensure that all levels of society are well prepared for the challenges and opportunities presented by this cohort, ensuring that the vision of "Successful Ageing for Singapore" is attained. In light of this, the present paper focuses on the following question: to what extent are Singapore's elderly persons "ageing successfully" given current government policies for ensuring financial security of its citizenry? Attention is especially given to public-private-community partnerships in the areas of health and employment since those alliances are critical to facilitate economic security for the elderly. While partnerships in health are necessary to ensure that the elderly have access to good health-care services at an affordable cost, partnerships that increase their employability will ensure that they are capable of earning an income so as to attain a degree of independence and self-sufficiency.

Financial security of the Singaporean elderly: Context and conditions

As mentioned earlier, the position of the Government of Singapore has been that of stressing individual and family responsibility. At the individual level, older Singaporeans are expected to be healthy, active and secure. It is desirable that they age with respect and dignity, while leading fulfilling lives within the family and community settings. At the level of the family, it is expected that extended families provide care for elderly Singaporeans, reinforcing Confucian ideals. The goal is that family relationships should be complementing the independence of the older person. So far as the frail and ill are concerned, the family is defined as the primary support group. Hence, the overall position of the Government of Singapore is anti-welfare, in keeping with the ideologies of "efficiency" and "pragmatism". The Government's aim is to maintain financial subsidies for social welfare purposes at the minimum "in order to avoid conflicts with its growth objective, which constitute[s] the foremost and single-minded priority of state action" (Khan, 2001: 1; Lee, 1999: 89).

The greatest concern, thus, of the Government is the financial security of its fast ageing population so that they do not become overly reliant on government resources for their health-care needs (Mehta, 2002: 156), which in turn, would jeopardize the expansion of community long-term care and lead to increasing taxes (Mehta and Vasoo, 2001: 197). With rising costs of living in Singapore, the State intends that health costs should be borne by the individual. The Singapore elderly are expected to be independent, relying on savings from their own Central Provident Fund (CPF), a mandatory savings fund that can only be accessed at the age of 55. On accessing this Fund, it is required that the minimum sum in the retirement account of Singapore dollars 80,000 (US$ 1 = S$ 1.7) be left untouched[2]. Currently, government non-pensionable and private-sector employees contribute 20 per cent of their income to their own accounts, while employers contribute 13 per cent[3] (Central Provident Fund, 2004). Derived from an accumulation of an employee and employer's joint monthly contribution towards the CPF, there are three main accounts within the Fund: the ordinary, special and Medisave[4] accounts. As of 31 December 2002, 3 million people have participated in the CPF scheme with a total of S$ 96.4 billion.[5]

Although purported to provide the most comprehensive coverage in comparison with old-age security plans found in Asia (Chan, 2001: 8), it is not without imperfection. An obvious flaw of the CPF scheme is that a single-tier financing tool for old age is always risky, especially when the objectives of the

scheme are constantly being expanded to include other objectives than those originally intended (Orzag and Stiglitz (2001) and Gill, Packard and Yermo (2003) as cited in Asher (2004: 2114)). Although this Fund was first implemented as an old-age security scheme in 1955, it has undergone a series of transformations as Singaporeans are now permitted to use those savings before reaching 55 years for paying housing loans, approved investments and insurance, medical and education expenses and making transfers to parents' retirement accounts.

On the drawback of extending the original objectives of CPF to include other objectives, Asher (2004: 2115) citing Salvatore (2003) emphasized that when additional objectives are added to the CPF instrument, it can only result in suboptimal outcomes as held by economic policy theory. Such was the case in 1986 when account holders were granted the flexibility of using their savings for investments, a scheme which in 1997, culminated into the CPF Investment Scheme (CPFIS). This was followed by a further relaxation of rules in July 2001 when account holders under 55 were allowed to invest savings from the special account in lower-risk financial investments. In July 2002, CPF holders were also allowed to purchase foreign currency unit trusts and property trusts listed on the Singapore Stock Exchange while they were initially limited to approved private-sector investment products.[6] As of end-September 2002, around 700,000 CPF members invested more than S$ 44 billion in various investments.[7] While private-managed investments may be preferable because of competition and higher risk-adjusted returns, there is always the probability of losses (Westley, Lee and Mason, 2000: 4). In this case, Singaporeans who have converted some of their CPF funds into investment funds have actually put their retirement savings at risk since they are more likely not to receive positive returns in times of economic downturn.[8] It is also worth noting that the Government does not guarantee such investments should losses be incurred. In other words, if the individual encounters losses as a result of having used his/her CPF savings for investment purposes, no guaranteed minimal sum is assured by the Government. In addition, investments offered under CPFIS are subject to administrative and processing fees borne only by the account holder. Those fees accumulated over time have the effect of "eating" into the account holder's actual returns. While the Government clearly encourages the circulation of funds to drive the economy, they seem to have little interest in protecting those who have endeavoured to use their retirement savings toward investments.

Medisave was another objective added to the CPF instrument when the Government intended to increase the share of total health expenditure by transferring greater responsibility to individuals (Asher, 2004: 2114). Since individuals are permitted to use savings from that account to pay for approved

health-care expenses even before retirement, the Fund tends to get depleted before it actually becomes useful in old age.

The most serious attack leveled against the CPF scheme is its "subordinat[ion] to achieving [a] high level of home-ownership" by allowing Singaporeans to pay for housing with those savings (Asher and Nandy, 2004: 14). The majority of Singaporeans channel the bulk of their CPF towards settling payments for their primary residence (usually a government-subsidized Housing and Development Board apartment). While that guarantees the person housing (Aw and Low, 1996: 104-105), a drawback is that the individual is left with little for daily maintenance on reaching old age. Although in response to that dilemma the Government reduced the CPF housing loan cap from 150 per cent to 120 per cent of the property value,[9] this has not had a substantial effect on ensuring that Singaporeans will reap greater income security in old age. In addition, it has been argued that the action taken to discourage Singaporeans from putting large sums of their CPF savings into property was actually met with other policies that encouraged similar housing investments.

The CPF scheme has also been criticized for serving primarily the needs of higher-educated and, in turn, higher-income earners. Chan (1999: 93) found that there exists a monotonic relationship between education and the percentage of older Singaporeans holding CPF accounts. While 71 per cent of those with secondary education and beyond maintained CPF accounts, those with no education holding accounts stood at 26 per cent. The difference was explained by the fact that Singaporeans possessing education were more likely to be employed in occupations that mandated a contribution to CPF. Paradoxically, those in need of a retirement plan are also those who are most likely to be struggling financially and have fewer savings for old age. It is precisely that group of Singaporeans who are less likely to participate and be able to reap the benefits of the CPF scheme.

With increasing anxiety that a Singaporean's CPF may not be sufficient to meet his/her needs on retirement, the CPF Board announced a new policy where the distribution of savings channeled to each account within CPF (ordinary, special and Medisave accounts) changes depending on age with the assumption that needs shift accordingly (Chan, 2001). Essentially, the amount channeled into each account decreases as the person matures in age, which means that less is taken away from the individual as she/he approaches retirement. It is interesting to note, however, that the amount allotted towards the Medisave account increases as the individual grows old because of the assumption that the demand for health-care services increases with ageing. Table 1 shows the previous and new target contribution rates:

Table 1. Target contribution rates with previous rates appearing in brackets

Age	Ordinary account	Special account	Medisave account	Total contribution
35 years and below	22(24)	5(2)	6(6)	33(32)
35-45	20(23)	6(2)	7(7)	33(32)
45-55	18(22)	7(2)	8(8)	33(32)
55-60	10.5(9)	0(0)	8(8)	18.5(17)
60-65	2.5(2)	0(0)	8.5(8)	11(10)
65 and above	0(0)	0(0)	8.5(7.5)	8.5(7.5)

Source: Central Provident Fund, 2004.

In spite of this new policy, there is fear that the majority of Singaporeans will still be unable to retain the minimum sum expected for retirement and that they will not have adequate savings because of the rising costs of living in Singapore and the expenses they are likely to have incurred out of this Fund (Asher, 1996).[10] With this in mind, the Inter-Ministerial Committee (IMC) and the Economic Review Committee (ERC)[11] recommended that the special account [12] cannot be accessed until retirement and that the minimum sum be raised to S$ 80,000 from S$ 75,000. Under the minimum sum scheme, an individual receives a monthly annuity on retirement at age 62 for approximately 20 years. Alternatively, the individual has the choice of buying a life annuity from a private insurance company with this Fund, from which the individual may receive monthly payments for the rest of his/her life. Either way, the individual will receive a monthly income until his/her CPF minimum sum is exhausted.

Health security: State schemes, individual contributions

It has been documented that 88.8 per cent of the elderly population in Singapore are ambulant and capable of carrying out the activities of daily living (MCDS, 2004c). Although this may be the case, it is most likely that the majority of them have health problems brought on by ageing and it is inevitable that regular medical attention and medication are required. Security in terms of long-term care in old age is therefore undoubtedly associated with financial security.

Previous surveys of older Singaporeans have found that about 20 per cent of them found medical costs beyond their budgets, while another half stated that anxieties in meeting high medical costs reinforced feelings of financial insecurity

(Phua, 2001: 173-174). Currently, the elderly have access to polyclinics at a 50 per cent discount rate. The Government maintains a co-payment policy, which demands that individuals pay a portion of the overall charges from his/her Medisave account, while the Government subsidizes the rest (Mehta, 2002: 154; Phua, 2001: 173). However, the destitute or frail may obtain medical assistance for free under the public assistance scheme. At the level of primary health-care, the elderly have access to a basic health-screening test for a nominal fee of S$ 4.00. For major medical treatment, Medisave ensures that a Singaporean has financial resources to pay for his/her hospitalization expenses, approved outpatient treatments and medical insurance premiums, regardless of age. However, Medisave covers only basic medical costs, which is limited to a maximum of S$ 300 per day of hospital stay and varies according to the kind of surgery. Those who desire a fuller coverage are forced to purchase a more expensive plan from a private insurance company, many of whom can afford to pay the extra sum because they are working. Singaporeans have the option, however, of using their Medisave to purchase a government illness insurance scheme called Medishield[13] with premiums varying with age. Unfortunately, this scheme does not cover those above 80 for whom health care is most needed (Asher, 2004: 2116). Another downside is that the Medisave savings can only be withdrawn on death, which obviously benefits not the individual but his/her immediate family members.

In spite of the drawbacks of the Medisave account, older persons who may not have accounts of their own, because they did not work, are allowed to access the Medisave accounts of their immediate family members (Phua, 2001: 173). Among the beneficiaries of this provision are older women who have been dependent on their husbands' savings throughout their married lives and who often do not have their own savings. Should those women become widowed, they may seek their children's help instead.[14]

Repeatedly, the Government's position is to minimize its own liabilities in financing health care and transferring this responsibility to individuals (Asher, 2004: 2116). This does not mean that it is not conscious of the needs of low-income older persons through various schemes (see Appendix 1(c), Overview of the Eldercare Master Plan (FY 2001 to FY 2005, 2002)). The Interim Disability Assistance Programme for the Elderly (IDAPE) is one such scheme, reaching out to individuals with disability aged 70 years and above and who are unable to perform three of the six activities of daily living (ADL): mobility, feeding, transferring, dressing, washing and toileting. Under this scheme, eligible Singaporeans receive monthly payments set at S$ 150 per month (up to six months) (MCDS, 2004d). A criterion for eligibility is that the individual's monthly household income must not exceed S$ 700. Should the

income range from S$ 700 to S$ 1,000, the monthly payout would be S$ 100 per month. This non-contributory scheme appears as a last resort to help those in the lowest income group (Lee, 1998: 300).

In 2003, about 4,800 Singaporeans have received payouts through IDAPE. The payouts are substantial given that those households' incomes are below S$ 700. However, the amount remains too meager for the family to seek professional and institutionalized eldercare services for disabled older persons. Therefore, it is more likely that a relative becomes the primary caregiver of the older person. In playing this role, the caregiver is drawn away from engagement in wage labour. Over time the role of the principal caregiver intensifies (MCDS, 2002: 24), further drawing him away from employment. The danger of this pattern persisting in lower income households means that those households are placed at greater risk of slipping deeper into poverty. Moreover, it must be recognized that subsidies eventually serve to encourage dependency and are taxing on government resources. Instead, the allotment of subsidies should come hand in hand with schemes that raise the income levels of those families, providing employment opportunities or skills upgrading training, for example.

Currently, statistics show that eight economically active people aged 15-59 years are supporting one person aged 60 and above. With the growing elderly population, this ratio will decline. Projections show that by 2010, four economically active persons will be supporting one older person while by 2030, the ratio will be 2.5 to one (Ministry of Manpower, 2004; see also Vasoo, Ngiam and Cheung, 2000).[15] Given this scenario, keeping the elderly engaged in wage labour is a sure way of decreasing the dependency ratio. In addition to ensuring elderly persons some degree of financial security, engaging them in the labour force would enable them to contribute to the economy. As life expectancy increases, it is more likely that the elderly, especially the young-old cohort (60-69 years), are sufficiently fit to continue engaging in wage employment. In recognizing the labour value of the elderly cohort and how it potentially affects the country's economic performance, the statutory retirement age was extended to 62 years in 1999, with propositions that it should be raised to 67 years in the future (Ministry of Manpower, 2004). Moreover, it is assumed that increasing the retirement age will in effect compensate for the increase in national expenditures on this group (Cheung (1994) as cited in Gubhaju, 2003: 12). Having the older population work also delays the process of their using up their CPF savings. Hence, the current position of the Government is to encourage continued employment so that the elderly remain active in society, apart from being able to gain a useful income.

Table 2. Employment status of elderly Singaporeans, 1995 and 1999

Employment status	Total percentage 55 years and above (1995)	Total percentage 59 years and above (1999)
Total		
Employed	27.4	16.2
Unemployed	1.5	5.1
Economically inactive	71.1	78.6
Male		
Employed	44.3	27.8
Unemployed	1.8	4.9
Economically inactive	53.9	67.3
Female		
Employed	12.1	7.7
Unemployed	1.3	5.3
Economically inactive	86.6	87.0
Total (N)	**4,750**	**1,981**

Source: Chan (2001: 13).

According to findings from the 1995 National Survey of Senior Citizens and 1999 Survey of Transitions in Health, Wealth and Welfare of Elderly Singaporeans, it was found that male elderly are more likely to be employed (28 per cent) compared to female elderly (8 per cent), a trend which follows from the male as breadwinner model evident in Singapore society at large (see table 2). The reasons cited for working varied across the different ethnic groups (Chan, 2001: 14). While Chinese claimed that they felt boredom and thus chose to work, Malays and Indians reported working because they felt they could still lead active lives. In terms of monetary incentives, 25 per cent of the elderly Chinese sample was motivated by the financial need to work, while 16 per cent of Malays and 22 per cent of Indians cited the same reason.

Health and financial security: State-private partnerships

As life expectancy increases, visits to the doctor become more frequent, raising the elderly or his/her caregiver's health-care expenditures, and creating

pressures even on middle-income families (Phua, 2001: 179). It is clear that the financial costs associated with ageing are of great concern not only to the Government but also to the individual. Increasingly, Singaporeans are purchasing insurance policies from local private companies to ensure financial security on retirement above the minimum sum they would have accumulated on top of their own savings. For most policies, individuals pay a monthly sum for periods of up to 10, 20 or 30 years, depending on the kind of plan purchased and the age of the policy holder. Usually, the purchase of insurance policies is such that by the time the individual reaches retirement, the policy has matured, enabling the policy holder to amass a substantial sum for the maintenance of daily living. Although the costs of plans increase when purchased at a later age, purchasing a policy earlier in life has the benefit of allowing this lump sum to be invested further. However, the downside of having individuals purchase a policy for financial protection in old age is that it assumes that the person has adequate savings over a considerable length of time to pay for the premiums of the policy. Hence, such financial arrangements are only applicable to those individuals who are relatively secure economically, while ruling out others who are not able to commit themselves to monthly payments.

In addition, health insurance schemes purchased from private companies are relatively exorbitant for many Singaporeans, granted that the median monthly household income stands at about S$ 3,607 as recorded in Singapore's 2000 census (Singapore Department of Statistics, 2004). For Singaporeans aged 60 years and above, a large proportion (89.2 per cent) has low levels of education and has been in low skilled or unskilled jobs before retirement (Singapore Department of Statistics, as cited in MCDS, 2002: 5). It is precisely this group that has limited savings and would have difficulties paying for health-care services (MCDS, 2002: 5), let alone private health insurance plans. This former point is underscored by Chan (2001: 8) who found stark differences in CPF coverage across the age cohorts with a significantly higher percentage of those aged 55 to 59 covered by CPF (52 per cent) compared to those aged 70 to 79 (25 per cent), with fewer still in the oldest-old category (14 per cent). Among those with CPF savings as reported in the 1999 Transitions in Health, Wealth and Welfare of Elderly Singaporeans: 1995-1999 Survey, 31 per cent had less than S$ 5,000, while 25 per cent of those surveyed had absolutely no savings left. For this group of elderly, there is little choice but to rely on government-subsidized services for their health-care needs.

It is worth noting that in response to the needs of the country's growing older population, the Supplementary Retirement Scheme (SRS)[16] came into effect in April 2001. Although the SRS is meant to complement the CPF scheme, the

former is voluntary as Singaporeans can contribute any amount[17] they wish (subject to a ceiling) till retirement or after the individual reaches the prevailing statutory retirement age, whichever is earlier. Managed by the private sector [18], the SRS shares a few features with the CPF scheme in that those savings can be used towards housing and medical payments after retirement. In addition, participants in this scheme have the option of using their savings to purchase a range of investment products marketed both by the service provider and various financial institutions. This scheme, however, differs from CPF in that contributions are subject to attractive tax benefits such as tax relief, while investment returns may be accumulated tax-free (with the exception of Singapore dividends), while only 50 per cent of the withdrawals at retirement is subject to taxation. Another differing feature is that only employees can contribute to the SRS. With the SRS in the event of an early withdrawal (made before the statutory retirement age), 100 per cent of the sum withdrawn is subject to tax, in addition to a 5 per cent penalty for premature withdrawal[19]. However, although the scheme allows for the flexibility of individuals investing their savings, investments are not guaranteed against losses should a financial institution become bankrupt. As in the case of investing with CPF savings, there is a considerable degree of risk involved when an individual decides to "grow" his/her retirement funds in the commercial market. As of 31 December 2003, the total number of account holders stood at 24,383 with the bulk of participants aged 36 to 55 (Ministry of Finance, 2004b). In addition, the total SRS contributions were S$ 548 million, which grew from S$ 313 million in December 2002 and S$ 157 in December 2001.

The private sector has reared its head in the eldercare scene in another way, this time purportedly reaching out to a larger segment of society. The IMC recommended a national long-term care insurance scheme to assist individuals in defraying costs incurred in the event of severe disability. In June 2002, Eldershield was introduced with two Premium Plans provided by two local insurance companies: the Regular Premium Plan and the Single Premium Plan. In the former plan, an individual policyholder pays premiums annually until the age of 65. In the latter, a lump sum premium is paid at the onset. For those covered under the Regular Premium Plan, they are only able to claim for disability after age 65. In both plans, automatic deductions will be made from the Medisave accounts of Singaporeans (and permanent residents) from age 40. Should a Singaporean under those plans become disabled, Eldershield pays a monthly cash benefit of S$ 300 up to a maximum of 60 months. Disability in this case would refer to not being able to perform any three of the six activities of daily living (ADL). Premiums may also be used towards nursing home charges, whether in the home or in institutional settings. As that plan was only launched in 2002, a special arrangement of

subsidies was made for older Singaporeans aged 56 to 60 to assist them in paying their premiums.

Of the 1.18 million Singaporeans eligible for Eldershield, about 40 per cent opted out of the scheme. On the viability of the scheme, since the probability of becoming disabled is low (going by 2000 statistics that 88.8 per cent of Singaporeans are mobile)[20] and that only 782 claims were made out of 675,000 persons who were insured,[21] it is more pressing that the Government addresses the shortcomings of the Medisave Scheme to cover those no longer working and contributing to this account (MCDS, 2004d). Moreover, the Eldershield Scheme disadvantages women as they are expected to pay higher premiums from 28 per cent to 41 per cent (Devasahayam, 2003c: 27) based on the assumption that they live longer than men and thus suffer a higher probability of being disabled in older age (Business Times, 2002; Ofstedal and others, 2004; Mehta and Vasoo, 2001: 188; Gubhaju, 2003: 11). A related disadvantage they suffer is that they are more likely to have fewer savings than men because of not working or opting out of the labour force to provide care for their families. Moreover, many women would have either entered the labour force at an older age compared to men, dominating lower-paying services and manufacturing jobs (Cheng, 1980 and Lee, 1992, 1995 as cited in Lee, 1999: 82-83; Lee, 2000: 82), although this may have been to some degree different for Indian women (Lee, 2001: 169).[22] Hence, the financial insecurity of women also translates into insecurity in terms of long-term care in their old age.

In contrast to Eldershield, a more successful health security scheme for the elderly, judging from its take-up rate, is the Primary Care Partnership Scheme (PCPS),[23] entailing the collaboration of medical experts from the private sector (MCDS, 2004d). In cases of elderly persons who are able to perform independently all six ADLs, but who struggle in covering increasing medical costs, the Government has implemented this scheme, making basic outpatient medical and dental services available to the needy elderly at rates similar to those offered in government-run clinics across the country. Under this scheme, the Ministry of Health pays private doctors and dentists to provide low-cost basic outpatient medical and dental care to lower-income older persons. That scheme also enables elderly people who have difficulties traveling to the nearest polyclinic to see a private doctor or dentist located near his/her residence instead. Eligibility for the scheme includes having a per capita income of S$ 700 per month or less, while Singaporeans under the Public Assistance Scheme, regardless of age, also qualify. Should the elderly person require special care, the doctors and dentists under this scheme are required to refer patients to the polyclinics or the National Dental

Centre. Since December 2002, more than 15,000 elderly have opted for this scheme. On the part of the private medical community, a total of 570 doctors and 210 dentists have participated in this scheme. As in IDAPE that aims to reach out to the elderly poor, PCPS has a heavy toll on government resources and therefore is not a viable solution in the long run. Eldercare solutions should include foreseeing the potential problems of the elderly poor that may arise in the future and guaranteeing that per capita incomes rise with increasing living costs.

By and large, private sector services for the elderly are invariably targeting the affluent in society. Another obvious contribution of the private sector in providing care for the elderly are privatized nursing homes. As of January 2000, there were 24 private sector nursing homes compared to 23 nursing homes provided by voluntary welfare organizations (Mehta and Vasoo, 2001: 190). Given that privatized nursing homes are profit-making, they charge high fees and thus have been associated with the well-to-do.

Financial security through employment: State-private partnerships

Retaining older workers in the workforce is a strategy for ensuring financial security among this cohort. Conscious that older workers may not have the relevant and up-to-date technological skills required in a changing economy, the Government has made it possible for older men and women to participate in retraining and skills upgrading programmes. Aware of the potential contribution that the elderly can make to society, the People for Jobs Traineeship Programme (PJTP) was set up and aimed at aggressively absorbing elderly workers into the workforce (MCDS, 2004e). The Ministry of Manpower under the management of the Singapore Workforce Development Agency launched this scheme in 2001. Under this Scheme, the Government provides incentives to private-sector employers to recruit older workers, although those aged 40 to 49 are also covered. Companies are allowed to claim for wage support for each PJTP worker it recruits should it put in place arrangements aimed at helping workers retrain. For employing a worker aged 40 to 49 years, the monthly wage support is 50 per cent of the monthly gross salary or S$ 2,000 per month, whichever is lower for up to a period of six months. For workers aged 50 years and above, there is an additional three months of wage support at 25 per cent of gross salary or S$ 1,000 per month, whichever is lower. Since February 2004, it has been recorded that more than 5,000 companies have registered under this scheme and more than 16,000 older workers have found employment. However, it is not known whether the older workers are under-employed or if the elderly are presented a salary structure comparable to that of their younger workplace peers, particularly in a climate of economic recession.

Moreover, it is unclear if this scheme has actually helped older workers whose savings are low, as they are likely to be the most needy compared to those who have had steady jobs in the past.

Health and financial security: State-community partnerships

Community organizations have long been seen as vital stakeholders in providing programmes and services to promote continued support for Singapore's older population.[24] It has been mentioned before that greater coordination is needed between the numerous organizations and the public sector given that the services for the elderly are multi-disciplinary and multi-dimensional (Mehta, 2002: 173). Recently, stress has been put on transforming the image of the services of these organizations from a "'welfare' provision" targeted at the poor, frail and elderly to those meeting the needs of the rich elderly as well, given the fast changing demography of the country (MCDS, 2002: 7). IMC has also recommended that community-based facilities for the elderly be planned and constructed as part of the national infrastructure, as in schools and hospitals (MCDS, 2002: 7). Given the uneven distribution of eldercare services across the island, with most "standing alone", the Services Review Committee has recommended that multi-service centres at the community level be constructed with voluntary welfare organizations (VWOs) as the main service providers (see Appendix 1(a), Overview Eldercare Master Plan (FY 2001 to FY 2005, 2002)).

Eldercare services under the MCDS were improved in the last few years with Singapore successfully securing S$ 93 million through the IMC[25] (Ngui, 2002). Aware of the role played by VWOs and the need for government financial assistance towards those services, an Eldercare Fund was set up in April 2000. VWOs receive government financial assistance (up to 90 per cent of capital funding and 50 per cent of recurrent funding), which is drawn out of the interest accrued by this Fund (see Appendix 1(a)). Given the inadequacy of relying on government funding alone, VWOs also have to turn to donations to secure up to 50 per cent of their recurrent expenditure (Phua, 2001: 178).

Community contribution to eldercare assistance is most evident in the area of health-care provision. Health-care services managed by VWOs include day care centres, day rehabilitation centres, dementia day care centres, and home care services such as home help, home nursing and home medical services. While the Government may be responsible for providing subsidies to the elderly, it does not directly provide affordable targeted services to the elderly, depending rather on VWOs. However, there are also organizations that do not directly receive

government funding, but donations made to them are tax exempt, hence demonstrating government support of their work.

Community organizations also see the necessity of facilitating financial independence (or at least partial financial independence) among the elderly through employment. The community organization SAGE (the Singapore Action Group of Elderly) promotes active ageing by providing a low cost and efficient job match service as well as by keeping a database of jobs and job-seekers. However, only ambulant job-seekers are allowed to register for this service, which means that the semi-ambulant interested in work and in need of financial resources have to seek out other channels for work.

Present and future challenges

Studies have shown that the majority of Singaporeans will not be prepared for old age as they have inadequate savings (Asher, 1996 and 2004). The 1995 national survey of Singapore's elderly population showed that only 2.2 per cent of this group saw their CPF funds as a major source of income while the majority depended on children or relatives, attesting to the fact that this pension scheme has failed to achieve its original objective (Ofstedal and others, 2002: 75). As a consequence, there is an urgency to create a viable alternative to the current financial security scheme in order to address this challenge. Priority should be focused on the need for professionalism in redesigning the current CPF scheme and analysing its effectiveness in addressing the needs of the elderly (Asher and Nandy, 2004: 24). In recent years, findings show that the ratio of contributions to withdrawals (including retirement withdrawals) has been close to two thirds (Asher and Nandy, 2004: 5). Given that most Singaporeans are "eating into" their CPF accounts (to pay for housing and other transactions), measures need to be put in place to cap the rising costs of housing, particularly public housing and to keep it at more affordable costs. Perhaps there are lessons to be learned from other developed countries as well, whose aged populations have been growing. While the public sector covers 75 per cent of the national health expenditure in most other developed countries, Singapore's CPF scheme only accounts for 25 per cent of the share, especially from the time health schemes were subsumed under it (Asher, 2004). Thus, it is in the power of the government to ensure that its growing elderly population is assured of a range of good and affordable health-care services and that health care continues to be a public good accessible to large segments of the Singapore population, although the onus to take on this decision may come at a cost. In its attempt to meet the challenges of its growing elderly population, it is

inevitable that the Government of Singapore may have to compromise its economic growth objective.

The Government policy mandating the family as the primary site of eldercare is also inherently problematic given that the modern Singapore family is undergoing tremendous demographic, social and economic changes, as do familial structures in most other developing countries in Asia (Westley, Lee and Mason, 2000: 2). As pointed out by Gubhaju (2003: 11), the decline in fertility rates accompanied by an increase in life expectancy means that there will be fewer numbers of caregivers in contrast to earlier generations. Turning to women, the policy does not acknowledge their experience of "structural lag" consisting of the inflexible structures that determine their roles as nurturers and caregivers while in reality there have been major changes occurring in their lives (Riley and Riley, 1994: 16). Should the caregiver's role in any way place her at risk in terms of performance and possible future promotion, her own old-age security may be negatively affected (Devasahayam, 2003c: 43-44). Thus, it is important for the Government to see the relevance of formulating policies that are gender-sensitive, taking into account how cultural norms, positing a gender division of labour in the household, disadvantage women as they are saddled with the primary responsibility of managing home while also engaging in paid work to cope with the rising costs of living.

A related policy that needs attention is the Parent Relief Scheme. Although it is commendable that in the Year of Assessment 2001, the Government reported a revenue loss of S$ 125.48 million in providing tax breaks to caregivers, this Scheme serves to reinforce the Government's position that the family is responsible for eldercare rather than to meet the actual needs of the families involved in providing care for elderly persons. Moreover, mandating the family role in caregiving potentially erodes the savings pool of the caregiver(s) and, as mentioned before, places them at risk of not being able to care for themselves in old age. Obviously, this scheme is not a solution to eldercare as it does not take effect should the caregiver lose his/her job, a common outcome especially in times of economic downturns. Given this situation, it is inevitable that caregivers are under pressure to rely on their own savings, potentially depleting them and jeopardizing their own efforts at saving for old age. It is for this reason that Chan (2001: 2) said that "enhanc[ing] levels of familial support while at the same time ensuring individual preparation for old age" may not be easily achieved. Furthermore, a policy that encourages over-dependence of the elderly on the younger members in the family in effect deflects from the idea that older persons have the potential of

engaging in wage employment and becoming financially independent, even partially.

This leads to another pressing challenge; the Government's aim should be to encourage active ageing through employment by taking steps to create genuine opportunities leading to this end. It is clear that the main reason for the extension of the retirement age of Singaporeans from 60 to 62 was to facilitate the employment of this very age group (Ministry of Manpower, 2004). Nonetheless, their engagement in the wage sector is not possible because of insufficient jobs for this group in the first place. Furthermore, that job advertisements single out younger workers has the effect of discriminating the older workers in addition to shrinking the pool of potential jobs for the latter (cf. Chan, 2001: 13). Currently, there is a dearth of best practices for finding employment for the elderly, although there exists a few fragmented efforts by the Government as well as community organizations. In the Eldercare Master Plan for FY 2001 to FY 2005, S$ 30.6 million has been set aside to fund programmes for the healthy elderly (see Appendix 1(b), Overview of the Eldercare Master Plan (FY 2001 to FY 2005), 2002). Unfortunately, those programmes aim to engage the elderly in volunteer, social, sports and recreational activities rather than create employment opportunities for them. In reality, "successful ageing" should be synonymous with productive ageing that is tied to employment for the elderly (ESCAP, 2002) and not merely keeping them "happy and healthy". Thus, aside from creating employment opportunities for the elderly, they should not be denied access to jobs. Absorbing the elderly into the workforce has other benefits: the dependency ratio decreases, income per capita and savings increases, investments and productivity rises, and public expenditure decreases (Nizamuddin, 2003: 100). Since the falling of fertility rates will have an effect on the labour structure, there is every reason, as argued earlier, for the Government to seek actively to employ retirees who are still able to contribute economically to the country (*The Straits Times*, 2004: p. H7). The Government is in the best position to assist the elderly as it is a major employer and has the mandate and resources to bring about structural changes (Devasahayam, 2003b).

Another challenge is to entice more productive and skilled elderly to stay in the workforce by stressing the benefits that come out of working. It is interesting to note that when compared with other countries in the Asian region with thriving economies such as Japan,[26] it was found that the labour force participation rate in Singapore of the cohort 50 and above is still markedly lower suggesting that a significantly large number of Singapore's elderly are not actively engaged in the labour force (Shantakumar, 1999). In 2001, the labour force participation rate of

the elderly was 11.6 per cent while in 2003 the figure dropped slightly to 11 per cent (Devasahayam, 2003a), although the numbers engaged in part-time work has been increasing (Phua, 2001: 174). Incentives for employers to recruit older workers were put in place by decreasing employer's contribution to the employee's CPF (Phua, 2001: 174), although this policy may have been implemented for the added purpose of making businesses more competitive.[27] Furthermore, the Retirement Age (Amendment) Act (Section 4A) permits employers to reduce older employees wages by 10 per cent provided this action has been mutually agreed upon by both the employer and employee.[28] Nonetheless, both policies are a two-edged sword as they decrease the amounts of savings for the current working population, which eventually has a negative cumulative effect on their own savings in old age. Moreover, enticing employers to recruit older workers requires that a number of other obstacles be surmounted. First, the Government has to be aware of the urgency of harnessing the labour of this cohort before their skills become obsolete and their productive years end. Furthermore, the problem of the majority of people in this cohort having relatively lower educational levels also needs to be overcome (MCDS, 2004c). In the past, the trend has been that some older workers have had to leave the labour force prematurely as they had difficulties retaining their new jobs. In addition, there is the challenge of retaining such workers in the labour force when an economy is undergoing restructuring, especially in times of global economic changes.

Furthermore, the Government needs to put in place protective mechanisms for older workers who are seeking employment, especially in times of economic downturns. Such situations bring on their unique set of consequences on the elderly since being an older worker has both advantages and disadvantages. While older workers are more likely to be retrenched, they are less likely to be hired soon after losing their jobs because of the structure of the job market. Although work experience is a sought after attribute in an employee, having more years of work experience also suggests a greater bargaining power for higher wages on the part of the older worker, which may potentially deter an employer from hiring him/her. In addition, older workers may be stereotyped as possessing less drive and energy as compared to their younger counterparts. Since those problems are linked to the way the labour market functions, it is important for the Government to address them through policy interventions. The urgency to act is compounded by the fact that those problems will not disappear but rather exacerbate in future generations given that the older population in Singapore will continue to grow. Hence, putting in place a greater variety of schemes that would secure employment for older people will also benefit those in the coming generations.

It must also be reiterated that the elderly population in Singapore is not homogenous but instead marked by socio-economic and gender differentials. In spite of Singapore's developed status, a lower income group exists for whom ageing is a dimension of social life bound up with poverty and vulnerability, especially in the context of financial security, as older people have fewer opportunities for generating income for themselves. Structural change needs to come into play since for those people "vulnerability and poverty interact with each other creating a vicious circle in which the two reinforce each other" (United Nations, 2003: 5). In addition, when implementing policies for the current working population, policy makers need to analyse critically the old-age savings scheme in terms of its effectiveness against different cohorts with changing needs and varying categories of elderly people (Chan, 2001: 9). Community care services for the lower income group tend mainly to provide very basic or poor quality care, while the nursing homes with superior facilities tend to cater to the very rich. This unequal distribution of eldercare services needs to be changed. In terms of funding towards VWO services, in the past, grants were capped once a VWO was able to raise a certain level of funds. Instead of penalizing such VWOs, they should be provided incentives to raise more funds to improve the quality of care and to receive more patients, especially from the lower income group. Moreover, government grants offered to VWOs should be made more effective by "differentiat[ing]…the case-mix of patients, like age, gender, severity of disease, and complicated conditions. [As such,] it may be desirable to target the limited government subsidies to those in greatest need and have more refined subventions to balance the affordability of patients and their families with means-tested user charges" (Phua, 2001: 180). Moreover, additional funding from other sources for the management of VWOs should be sought. Co-opting the private sector through upfront donations should also be explored since they are known to contribute actively to other community activities such as cultural pursuits and the arts.

Finally, proactive efforts on the part of the Government are needed to transform the stereotypical images and ideas of older persons held by the larger community. Stereotyped images of the elderly as frail and needing care are rife in Singapore society. Current media portrayal of the elderly tends to focus on them in the family setting as well as in a nurturing role, thus divorcing them from the worker identity. In addition to private-sector corporations, many government bodies are equally culpable of generating such images on their websites and posters. The Government can play a vital role in recreating the image of older workers as valuable and not redundant workers, whether or not they choose to work full- or part-time. Thus, the idea of working irrespective of one's age should

be repeatedly highlighted rather than merely linking wage employment with vague notions of active ageing. Only in this way would there be a real interest in viewing the older people themselves as untapped resources, beneficial to the wider community rather than "free riders" of the country's economy.

Endnotes

1. Declining fertility rates, given the effective family planning policy of the late 1960s into the early 1980s, have also caused the elderly population to increase as a percentage of the total (Saw, 1989).

2. This amount will increase to S$ 120,000 in 2013.

3. Employee and employer contributions and amounts credited to the ordinary, special and Medisave accounts vary depending on age, residence status and employment sector. For details, see Central Provident Fund, 2004.

4. While self-employed Singaporeans need not contribute to the ordinary and special accounts, it is compulsory for them to contribute to the Medisave account.

5. This figure was cited in the economic and political report of the Embassy of the United States of America entitled *The Central Provident Fund: Challenges Ahead* (Embassy of the United States of America: Singapore, 2004).

6. Insurance-related products rather than unit trusts or other financial instruments are the most preferred forms of investment of Singaporeans. This figure was cited in the economic and political report of the Embassy of the United States entitled *The Central Provident Fund: Challenges Ahead* (Embassy of the United States: Singapore, 2004).

7. This figure was cited in the economic and political report of the Embassy of the United States entitled *The Central Provident Fund: Challenges Ahead* (Embassy of the United States: Singapore, 2004).

8. It was reported in the *Business Times* (2000) that nine out of ten CPF members who had risked their savings in the stock market suffered losses. In this case, they would have been better off having left their savings in the account, although the returns would have been much lower (see also Tan, 2001).

9. Before the July 2002 cap, CPF statistics as of December 2001 recorded that S$ 57 billion had been used towards public housing and S$ 33 billion towards private housing. This figure was cited in the economic and political report of the Embassy of the United States entitled *The Central Provident Fund: Challenges Ahead* (Embassy of the United States: Singapore, 2004).

10. It has also been argued that the highly unequal wage structure, low returns credited to the accounts and high transaction costs contribute to the low balances in the CPF (see Asher, 2004: 2118).

11. The ERC is a subcommittee that emerged from the IMC to look into financial matters related to the running of eldercare services.

12. The account within CPF that accumulates at a faster rate as it derives a return of 4 per cent compared to the ordinary account that accrues a 2.5 per cent interest rate.

13. This is a health insurance that assists the individual to settle part of the medical expenses accumulated as a result of prolonged hospitalization and certain outpatient treatments for serious illnesses. This plan is meant to complement an individual's Medisave savings should it come under great strain owing to prolonged illness. That plan has both deductible and co-insurance features.

14. Chan (1999) found that elderly Singaporeans possessing CPF accounts are significantly less likely to depend on their children for financial support. For this reason, fewer men than women were found to depend on their children's Medisave savings (Chan, 1999: 98; Phua, 2001: 178).

15. Compare this to the old-age dependency ratio. It was 9.5 in 2000 and is projected to rise to 12.5 in 2010, 20.6 in 2020 and 36.4 in 2030 (Knodel, Ofstedal and Hermalin, 2002:47).

16. Details may be found in the SRS booklet (Ministry of Finance, 2004a).

17. Contributions refer to earned income but does not include rental income, interest income or CPF withdrawals.

18. The three operators of the SRS scheme are Development Bank of Singapore (DBS) Ltd., Overseas-Chinese Banking Corporation (OCBC) Ltd. and United Overseas Bank (UOB) Ltd. Although they are considered commercial (private) banks, the Government owns shares in DBS, the largest bank in Singapore.

19. The penalty does not come into effect on death, permanent incapacitation (if a person is physically or mentally handicapped or bedridden) or bankruptcy. However, in the event of death, the SRS balance will be transferred to the estate and subject to estate duties.

20. See Ministry of Community Development and Sports (MDCS), 2004c.

21. It is interesting to note that only 75.7 per cent were approved, 15.5 per cent failed the disability assessment, while 4.5 per cent were excluded for other reasons.

22. It was found that Malay women were most likely to encounter financial insecurity as a result of not having formal schooling. Moreover, a large number of them took up jobs that lacked CPF coverage (Lee, 1999: 83; Lee, 2001: 174-175).

23. This scheme was first implemented in October 2000 on a pilot basis among a few clinics. In 2002, it evolved into a scheme that was extended nationwide.

24. Rodan (1993: 96) observed astutely that the preponderance of community organizations is the result of the Government "selectively transfer[ring] various costly economic and social functions and responsibilities from the state to the individuals and communities". The eldercare work of the voluntary welfare organizations is a good case in point, as the Government views the provision of such services as a liability should they end up having to provide them.

25. This sum of money was received from the Ministry of Finance with cabinet approval, which is the usual channel of funding.

26. In Japan, the Government has encouraged private employers to retain older workers on retirement, although they may be transferred to a lower position with a reduced salary. Westley (1998: 4) reports that about 70 per cent of Japanese companies with 30 workers or more consider this to be organizational practice.

27. Recently, the Government of Singapore reduced employers' CPF contributions to encourage them to recruit workers with the intent to make businesses more competitive. However, this implies that the savings of the present working population will decrease, suggesting that they will have less in old age.

28. Should both parties not reach a satisfactory agreement, the older worker has the option of retirement.

APPENDIX 1(a)
Overview of the Eldercare Master Plan (FY 2001 to FY 2005)

Programmes and services	Existing provision[a]	Provision for FY 2001 to FY 2005	Five-year budget[b]	Desired outcomes
Physical infrastructure {NEW}	-	Three Multi-Service Centres	S$ 29.8 million (US$ 1 = S$ 1.7)	To allow for a more seamless delivery of services to the elderly and their families. To serve as one-stop social service centres for all age groups. To optimize land use and use of common facilities.
Restructured Funding Policy for VWOs providing targeted services {NEW}	Capital cost: 90 per cent, based on the Government's cap. Recurrent expenditure: 50 per cent, based on the lower of the Government's expenditure cap, or the VWO's actual expenditure, or the VWO's deficit.	Capital cost: 90 per cent, based on the Government's cap. For programmes that can be accounted on per capita basis: • A sliding subsidy scale will be introduced, with higher subsidies for the lower income. For programmes that cannot be accounted on a per capita basis: • Recurrent expenditure: Programme funding pegged at 50 per cent of the Government's cap will continue, with the deficit-funding rule removed.	Reflected under Programmes for the Healthy Elderly and Programmes for the Frail Elderly	To encourage efficiency, maintain service standards, and at the same time give focus on affordability of services to end users.

Source: Eldercare Master Plan (FY 2001 to FY 2005) (2002).

Notes: [a] As of end December 1999.
[b] Budget is for programmes and services under the MCDS' purview.

APPENDIX 1(b)
Overview of the Eldercare Master Plan (FY 2001 to FY 2005)

Programmes and services	Existing provision[a]	Provision for FY 2001 to FY 2005	Five-year budget[b]	Desired outcomes
Restructured Funding Policy for VWOs providing targeted services (continue...)		Injection of competitive elements in the selection and funding of VWOs.		
Programmes for the Healthy Elderly			S$ 30.6 million	To engage the elderly in volunteer activities and to encourage them to actively participate in social, sports and recreational activities.
• Mutual Help Scheme (MHS)	MHS implemented in 180 Senior Citizens' Clubs	To implement MHS in another 142 senior citizens' clubs.		
• Islandwide Befriender Service	2,714 elderly clients	To reach out to another 1,500 elderly clients in areas not covered by NL networks.		
• Seniors Activity Centres (SACs) under the MCDS-HDB Project	24 centres	No new SACs will be set up from FY 2001 onwards. NLs will be set up instead. The existing SACs will gradually be enhanced to NLs.		
• Neighbourhood Links (NLs) {NEW}	-	20 centres		
• Funding for developmental projects to be owned and managed by seniors. {NEW}	-	S$ 1 million a year (US$ 1= S$ 1.7)		

Source: Eldercare Master Plan (FY 2001 to FY 2005) (2002).

Notes: [a] As of end December 1999.

[b] Budget is for programmes and services under the MCDS' purview.

APPENDIX 1(c)

Overview of the Eldercare Master Plan (FY 2001 to FY 2005)

Programmes and services	Existing provision[a]	Provision for FY 2001 to FY 2005	Five-year budget[b]	Desired outcomes
Programmes for the Frail Elderly			S$ 14.9 million	To support families in the care of their elderly members.
• Gerontological Counselling	-	-		
• Day Care Centres for Senior Citizens	575 places	373 places		
• Funding for Case Management Service {NEW}	-	Three Case Management Services		
Residential Care			S$ 2.6 million	To ensure help is rendered to the destitute elderly and low income elderly persons who for various reasons are unable to live with their family.
• Sheltered Homes	19 homes	Status Quo		
Programmes for Caregivers			S$ 0.1 million	To provide a focal point for families to obtain information and training to cope with the stresses of care-giving.
• Carers' Centres {NEW}	-	Two Centres		
Public Education (PE) Programmes	S$ 1.17 million for FY 2000	S$ 3 million a year	S$ 15 million	To raise the public's awareness and interest on ageing issues. To strengthen the PE capabilities of VWOs.

Source: Eldercare Master Plan (FY 2001 to FY 2005) (2002).

Notes: [a] As of end December 1999.

[b] Budget is for programmes and services under the MCDS' purview.

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Barriers to Male Participation in Family Planning in West Timor

Barriers to family planning, such as violence against women and drinking behaviour, need to be eliminated in order to increase equitable male involvement in family planning.

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The International Conference on Population and Development (ICPD) held at Cairo in 1994 emphasized women's role in the development process and urged governments to intensify their efforts in order to advance gender equality, equity and empowerment of women (United Nations, 1995). One of the important issues

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raised during ICPD was broadening the scope of family planning to address a wider range of reproductive goals. The involvement of males was one of the recommendations of the ICPD Programme of Action. Promoting women's rights and men's participation in reproductive matters were seen as key elements to improve reproductive health. In particular, it was argued that further progress in family planning would depend on men changing their attitude and behaviour regarding their responsibility towards reproductive health and gender issues.

Historically, most countries have overtly targeted women in family planning programmes (Lasee and Becker, 1997; Bankole and Singh, 1998), while males have been largely excluded from such programmes that provide family planning services (Edwards, 1994). Most modern contraceptive methods are designed to be used by females. Men seem to be less concerned than women about family planning, perhaps because the former do not carry the burden of pregnancy directly. The lack of male involvement in contraception is also related to the limited methods available (Ringheim, 1993). The technology has been slow to produce contraceptive methods for men (Anderson, 2001) owing to limited funding and lack of commercial interest in male fertility regulation (Ringheim, 1995). In addition, there are barriers to the expansion of male participation in family planning. While men should share the responsibility with their partners, those who want to take responsibility for contraception have limited choices; either undergo a vasectomy or use condoms. Ideally, a variety of contraceptive methods should be available to men.

The study of male participation in family planning has been growing. Several demographic surveys have suggested that men may want larger families than their wives (Anderson, 2001). In West Africa, men want four more children than women, though in Bangladesh, East Africa, Egypt, Morocco and Pakistan, men and women express similar desires in terms of family size (Ezeh, Seroussi and Raggers, 1996). In Indonesia, the husband's approval was found to be the most important determinant of contraceptive use (Joesoef, Baughman and Utomo, 1988) while in Kenya the wife's perception of her husband's approval of family planning emerged as most powerful in explaining contraceptive use (Lasee and Becker, 1997). Other studies revealed that poor communication between husband and wife is an important barrier to the adoption of contraception (Omondi-Odhiambo, 1997). The success of contraceptive use depends on the agreement and cooperation of the husband, while communication between spouses also improve the chances of effective family planning. The studies indicate that men have a potentially important role in determining whether women adopt family planning.

In Indonesia, the ICPD Programme of Action has had an important impact on population policies. It has attracted attention to the importance of human and family development, to changing attitudes towards reproduction and to increasing the quality of services through taking a client-centered approach to family planning information and services. The emphasis on a comprehensive reproductive health approach in population programmes has led to increased attention to providing quality care to clients (Office of the Coordinating Minister for Social Welfare and Poverty Alleviation/NFPCB, 1998). In order to respond to such changes and to the new era of national development, the national family planning programme has recently developed a new vision framed in the slogan: "Family quality by the year 2015". There is also a new mission statement regarding reproductive health, reproductive rights, gender and women issues (BKKBN, 2001). In general, this programme emphasizes strengthening women's empowerment and gender equality in family planning and improving the quality of family planning services and reproductive health.

Although the Government of Indonesia has had success in reducing fertility and improving reproductive health, some issues surrounding that success need increasing attention. The Indonesian family planning programme has long targeted women as recipients of its services. The number of male acceptors using modern contraceptives is very low. Recently, the State Ministry for Women's Empowerment/National Family Planning Coordinating Board (NFPCB) has called for a major increase in male participation in reproductive health. The NFPCB aims to increase acceptance of male methods from 1.1 per cent of all acceptors to 10 per cent by the year 2005. In addition, to increase male participation, the Directorate for Enhancement of Male Participation was formed as part of a reorganization of the NFPCB. Male involvement in family planning means not only increasing the contraceptive use but also encouraging males to take responsible roles in household matters.

In order to understand male involvement in family planning in one region of Indonesia, research was conducted in West Timor (Nusa Tenggara Timur (NTT)). West Timor has various ethnic groups and religious denominations. This may provide insights into cultural and religious dimensions of family planning behaviour. The main objective was to examine the role of men in decision-making concerning family size, fertility control, motivation to have children and contraceptive use. This research examines the role of men in reproductive decision-making in the Atoni/Dawan and Alor societies. Among those groups, men play an important role in decision-making regarding contraceptive use and family planning. Male participation in family planning may be associated with

gender disparities and cultural behaviour in the community. Some values and cultural norms affect men's family planning decision. The patriarchal system and traditional marriage give men more power over women. The higher social status and role of men in those societies also encourage males to dominate the family decision-making process.

Methodology

Timor has different ethnic groups and religions in various regions. Therefore, a multi-centred study was designed in order to gain insight into the cultural and religious determinants of the family planning behaviour. Three areas were studied: Timor Tengah Selatan (TTS), Timor Tengah Utara (TTU) and Kupang, the capital city of NTT. TTS and TTU represent rural areas with Timorese population dominated by Christian/Protestant and Catholic religion, respectively. In the city of Kupang, the study focussed on an area with a Christian/Protestant Alorese population.

Qualitative methods[1] were employed to obtain information concerning male participation in decision-making, contraceptive use, fertility control, family size, demand for children, marriage arrangements and spousal communication. This study used standard in-depth interview techniques, applying a broad set of guidelines and procedures to gather information about male participation in family planning. Fifty-five informants, including males, females, couples, informal leaders and family planning providers from the three selected areas were interviewed. Interviewers encouraged informants to talk about their experiences, especially in relation to the reproductive decision-making and the family planning programme.

Interviews were private and confidential. Using a tape recorder in conjunction with note taking was a useful means of covering the full dimension of the conversation. The recorded information was transcribed in full. These files of transcribed interviews constituted the main information for this study. The majority of interviews were conducted in *Bahasa* Indonesia, the national language, but some relied on Dawan/Atoni, the indigenous language of Western Timor. Several themes had been defined for analysis in this study: *adat istiadat* (customs), *belis* (bride price), system of marriage, value of children, pregnancy prevention, choosing contraceptives, contraceptive histories, spousal communication, pregnancy before marriage, violence against women and decision-making processes.

Results

Marriage, "*belis*" and male dominance in family decisions

Traditional marriage systems in Indonesia, particularly the payment of bride, are important factors conditioning male and female responsibility in the family. Bride price, known in NTT as *belis*, is still common throughout the Eastern provinces of Indonesia. The payment of *belis (susar manukat, air susu ibu,* or *oemafutu aimalala*) could indicate that a woman has been "bought" by a man or his family. Respondent PH, a traditional leader from Insana, TTU, said, "*belis* means as if buying something, so sometimes it's expensive". However, some people do not favour this interpretation. Rather, *belis* is seen as a compensation to the woman's parents for their efforts in raising their daughter. It indicates appreciation for the suffering of the mother when the child was born and during the girl's upbringing, as BD and MH, the traditional or *adat* leaders in TTS and TTU, explained:

> BD: "…we have a special term, it is not *belis* but *susar manukat*"
>
> Interviewer: "What does it mean?"
>
> BD: "It means the things given to a girl's parents. In the past it was called *belis*. But we think that *belis* is the term of the Belu people, it means to buy, they have to buy a girl. So for us it is wrong, we are not buying someone's child. We bring *susar manukat,* which means giving something from the heart. We appreciate the effort of the girl's mother and father and the fact that they accept the man their daughter is marrying. …in the traditional *adat* forum and church, *belis* is no longer an appropriate term; we say *susar manukat*, that means we recognize that the parents have been tireless in their effort to bring up the daughter". (INS15)
>
> MH: "…in Mollo, we don't use the term *belis.* We have a special term *oemafutu aimalala. Oemafutu* means hot water. Hot water refers to the moment the mother delivers the baby, when she is *tatobi* (pressed) with hot, very hot water. Then *aimala* is baked using big pieces of wood burned down to coals, placed under the bed where the mother lies down. …Here people do not use *air susu mama* [(breast milk) to refer to bride price], only *oemafutu aimalala*, hot water with fire …So *oemafutu aimalala* is for example one million rupiah, three cows, or silver coins, that is enough…" (KAP10)

Marriage is crucial in Timorese societies, because each marriage creates an alliance and a system of exchange. Each marriage establishes or reinforces a long-term relationship or series of exchanges between two descent groups. On the occasion of marriage, families also engage in the exchange of goods and services. The exchange seems only symbolic but has some economic, social, as well as demographic, functions or meaning (Mari Bhat and Halli, 1999).

Atoni/Dawan and Alor societies have three forms of marriage: traditional marriage, church or religious marriage, and civil registration. The law has caused some confusion in the NTT case because, although the relationship between religious marriage and civil registration is clearly specified with regard to marriage under the law, the relationship to *adat* or custom remains vague. Regardless of what the law requires, the majority of people in NTT consider that to be married without an *adat* ceremony is undesirable.

From the view point of *adat*, the most important matter to be settled is the bride price. Traditionally, the bride price consists of money and animals. The bargaining about the bride price is initiated by women of the bride's family who generally ask for an amount larger than they expect to settle on, based on their perception of the wealth of the groom's family. Bride price negotiations rarely fail and eventually, the bride price is fixed at about one or two million *rupiah* (1 USD = 9 IDR). However, bride prices vary widely, since their determination depends on many criteria. Sometimes, the bride price requested and obtained by the bride's parents reflects their social and economic standing in the community.

When men pay *belis*, it means that the woman becomes a part of the man's family. A married woman has to move to her husband's family. Women are not permitted to continue to use their father's name. They lose their birth family line. It is also viewed as a means for men to claim ownership of women. Implicitly, males have authority over females in their household activities.

Traditionally, the status of a man is higher than of a woman in both family and social activities. Men dominate decision-making within the household in a range of formal and informal ways.

BD, one of the traditional leaders in Insana, explained:

> "…it is no secret, here men have so many rights. So, we have heard from their wives but often the wives hand over all the decisions to their husbands. There is no restriction on her giving opinions, suggestion or ideas, but she can't take the attitude that it should be that way. She can, say in family affairs, she has rights, but later the one who considers the matter and makes final decisions is the husband". (INS15)

AD had been head priest in Kiupukan, TTS, for ten years, in the course of which he became particularly depressed seeing the low status of women in Timor. He said:

> "As people here say, you, as women, know nothing…that's our business, you stay in the background". (INS13)

The unequal distribution of power between men and women tends to keep women in a subordinate position in all aspects of family matters, alike in the community, domestic and public spheres. Thus, women are subject to male dominance.

In agrarian societies, males' control over private property in land restricts women's economic independence (Folbre, 1994: 106). The Atoni/Dawan society is based on the agrarian economy. The control over economic resources is one of the key sources of power in NTT society. That power is exercized in both public and private institutions within the society. The law, social policy, custom or *adat-istiadat* and physical strengthen tend to give men more power than women.

Women cannot easily gain equal power in the Atoni/Dawan society. The case of pregnancy before marriage is an illustration of men's "superordination" as opposed to womens' subordination. The *adat* law or customs in NTT enable a woman's parents to receive the payment from the man if their daughter becomes pregnant before any form of accepted union is negotiated.

MF, 17 years old, from Insana, became pregnant, while the man she named as the father denied that he was responsible for the pregnancy.

> Interviewer: "So, how did they solve this problem?"
>
> MF: "The main thing is to solve the problem. They said just to keep quiet, that there was no need to get married. Now I know what he's like. But I didn't want to marry him and we settled for compensation".
>
> Interviewer: "What kind of compensation?"
>
> MF: "It means that they didn't want us to get married, so they paid compensation, in the form of money".
>
> Interviewer: "How much?"
>
> MF: "At that time, they gave two hundred and fifty… two hundred and seventy five, with a cow. My parents said that there was no need to ask for more…" (INS18)

PH and MH, traditional leaders from TTU and TTS explained their views on the case of premarital pregnancy, in the traditional law or *adat* that allows men to avoid responsibility through paying compensation. But, if a man takes responsibility, he also has to arrange the marriage according to *adat*.

> Interviewer: "So, is it a problem if someone gets pregnant before she is married?"
>
> PH: "No, there is no problem if someone takes responsibility, the man. If a man does not take responsibility for the pregnancy there can be a scandal. According to *adat* in this case he must pay a fine such as two cows". (INS09)
>
> Interviewer: "… but what if the girl is already pregnant before marriage is proposed?"
>
> MH: "If she is pregnant before the marriage is proposed, it causes embarrassment to the girl's parents. According to *adat*, we have to go there [to the woman's family] to arrange marriage. We have to *tutup pintu* (close the door), *tutup pintu muka* (close the front door), *tutup pintu belakang* (close the back door), after that we return to three things [needed for getting married according to *adat* or custom]". (KAP10)

A man can refuse to marry a pregnant woman but he is required to pay a fine determined by an inter-family consensus according to the *adat* law. In this context, a woman's personal position is weak while the men — her lover as well as her father – decide on the transaction.

Violence against women

Male violence against women is common in the daily life of Timorese. It needs to be understood in the social context of male responsibility. Violence against women is a product of the social construction of the traditions and beliefs, which allow men to assume dominance and control over women. Men use violence to control women's behaviour. Men tend to behave violently in the family because they assume the right to use violence as a tool of their authority.

YT and SY are experienced medical doctors at a community health centre in NTT. They explain that the phenomenon of wife beating exists within a context of generalized violence against women in this society. However, violence within the family is substantially underreported:

YT: "In this society we can say often, often people [behave violently in the family]. Here, men dominate their wives".

SY: "Usually, [women] do not come to the *puskesmas* (community health centre). If their husband has beaten them, they do not mention that. … Later, when we really try to investigate them, they will [open up] Very rarely do they want to tell us". (ALO10)

The subordinate status of women in this society is well understood. Physical force and violence are the ultimate resources used to keep a group subordinate in any society. Violence within families is a complex social problem. From the sociocultural model, violence is examined in the light of the socially structured variables such as inequality, patriarchy, or cultural norms and attitude about violence and family relations (Gelles, 1999). Asymmetrical gender roles in a patriarchal culture explain why men are more violent than women. The differences in gender role socialization can make men ignore or deny feelings of shame, disgrace and dishonour through violence (Gilligan, 2000: 56). Likewise, cultural norms socialize women into submissive roles and perceptions about men's dominating behaviour are perpetuated. Culture and habit determine gender-based roles both for men and women (Necci, 2001).

Understanding the role of alcohol in NTT could help better apprehend violence against women. Drinking alcohol is very common in this society. A traditional alcoholic drink, known as *sofi*, is easy to find. It seems that at all traditional ceremonies, *upacara adat* or traditional rituals, *sofi* is available. AD, a Catholic priest, said:

AD: "At all traditional ceremonies, even when someone has died, we always see people drinking. It seems that drink has become *makanan pokok* (the staple food), it is already in their blood when they are born". (INS13)

Nevertheless, the relationship between drinking and domestic violence is difficult to understand because other factors are involved, and this relationship is not always clear or linear (Banks and Randolph, 1999). The pattern of alcohol use and violent behaviour differs across cultures and subcultures (National Research Council, 1993: 18). In some cultures people drink and become violent. By contrast, people may drink and be passive (Gelles and Cornell, 1990: 18). In NTT, the trend seems to tend towards violence.

Drinking behaviour is actually an important factor related to men's participation in family planning in NTT. The mainly Catholic population of TTU

claimed to practise natural family planning methods. Yet lack of self-control makes this method ineffective. Drinking behaviour in this society can cause this method to fail, because under the influence of alcohol, people cannot control themselves.

AD, as a priest, is particularly depressed at the authoritarian, irresponsible and often violent behaviour of men. He believes that this cultural characteristic makes natural methods totally impracticable. He pointed out:

> AD: "It is difficult to implement natural family planning, because that is a requirement of men, who are also *peminum* (drinkers/alcoholics). So [they] can't control themselves. Every time he could be in contact with his wife…Therefore Ibu E [one of the family planning providers] from natural family planning said, "It is difficult to promote natural family planning if they do not change their drinking behaviour". (INS13)

The interview above shows that drinking behaviour could lead to a failure of the family planning programme. Men have an important role to play in implementing this programme. The success of family planning, especially people who use natural methods such as the rhythm method, withdrawal or abstinence, depends on the consent and cooperation of men.

Family planning decisions

With regard to having children, women generally depend on men's decisions. Although a woman might disagree with her husband's decision, she cannot refuse to do what he says. It seems that women are too submissive to oppose their husband's authority. Sometimes, the husbands decide on the number of children without considering their wives' opinions.

Respondent YM in Kapan, TTS, 35 years old, has four children. As the head of household, he decided to have five children without his wife's consideration. This is reflected in the following interview.

> Interviewer: "…So, how did you decide that five children was right for you and your wife. Did you talk together about how many children you wanted?"
>
> YM: "No".
>
> Interviewer: "So, you yourself wanted five. What about your wife?"

YM: "My wife wanted five children. If God gave her five children, that's ok. If not, four was enough. If God granted her long life, she would undergo operation [sterilization]". (KAP09)

From the information above, one understands that the man's view greatly influences decisions about family size. Having many children is highly desirable for men. The presence of children indicates a man's virility and authority. Studies elsewhere suggest that men have more influence in family size determination (Isiugo-Abanihe, 1994) while in most countries men want larger families than women (Bankole and Singh, 1998).

When people in NTT got married, they usually had plans about family size, even though some of them were reluctant to give a precise number. However, some cases indicate that some couples decide the number of children differently. They get married and have children as the main purpose of marriage. The purpose of marriage in NTT goes beyond the traditional one of forming families, producing children and continuing of the patriarchal family line.

Getting married for the purpose of having children is expressed in the following interview with respondent DT, a 37-year-old man who has four children:

Interviewer: "When you got married, did you already have a plan to practise family planning?"

DT: "Not yet… We got married just to have children, for …*penerus keturunan* (to continue the family line), that's all. Because it is very common here, planning to get married is not just getting married. Getting married means wanting to have children". (KAP08)

Respondent AS, a 58-year-old man, who has seven children explained:

"…From my observation and also my experience, it's not customary to determine how many children we want. It's not being done… What I see in this society is that couples never talk about it. Especially, young couples who get married, they don't talk about it. They just accept the number of children they get…" (KAP03)

It seems that the religion has influenced men to think about family size. They state that they will accept as many children as God will give them; the number of children they have is thus left to God.

Respondent PH in Insana, with seven children, is a former village leader. After marrying he obviously thought about family planning, but only practised natural family planning for spacing. Later, he decided to undergo a vasectomy. The Catholic religion through the Bible influenced his decision to have many children:

> Interviewer: "Have you been thinking about having any children?"
>
> PH: "I've never thought about it before because in the past there was no family planning. I've just looked at the *Injil* (Bible) for my guidance. … God promised to Abraham, go out from your village, at that time God had an agreement with him, He would make his descendants as many as dust or like grains of sand on the beach, to fill the world". (INS09)

The "older" and the "younger" generation considered family size from a different viewpoint. The older generation used to get marry and have as many children as God would give them. They needed many children to help them in their work in the fields and also support them in old age. Unlike the older generation, the younger generation now prefers to have a smaller number of children because they are concerned about the future, especially their children's education.

Some information was provided by GM, 34 years old. GM is a village leader in Susulaku in Insana, TTU. He only has two children. Although his parents tried to persuade him to have more children, he did not want to:

> "Not only my parents-in-law but also my own parents said that I should have many children. But I didn't say anything. I just kept silent. I told them I would have children according to my own judgment. I think that my parents' judgment was only about having more children, but they didn't consider ongoing responsibility. So till now we're thinking of one or two children… If we have many children it means we can't develop". (INS17)

The decision to limit fertility is tied to a strong desire to ensure a brighter future for their children by providing them with an education. This decision is basically related to the economic situation of the families. Economic concerns are a common reason for limiting family size. This finding relates to Caldwell's intergenerational wealth flow hypothesis (Caldwell, 1976). Low fertility is a characteristic of the parents that primarily provide for their children and make investment in their education. The wealth tends to flow mainly from parents to children. If the wealth instead tended to flow from children to parents, having a large family would bring economic benefits to the parents.

In NTT, having sons is important, the most important reason being to continue the family line. In addition, carrying the family name, the property of family and old-age support are also important reasons for wanting sons. Demand for male children is related to social activities, especially in some *adat* or traditional ceremonies, and land property or other rights that are automatically and exclusively the concern of men. The extent that sons are preferred over daughters is the area of greatest gender asymmetry and may account for men's desire to continue to have more children to maintain the patriarchal system (Mason and Taj, 1987). Because of the central role of sons in this society, parents prefer sons over daughters. Respondents PP and AL, traditional leaders from TTS and TTU explained:

> PP: "If all the children are *nona* (girls), later on they will *kawin keluar* (marry outside) and then lose their *fam* (family name) such as Pai, there are no descendants… But if we have sons, we have defined descendants. It always progresses like that. But if all of them are *nona*, another *fam* will take them, then we lose our line of descendants". (KAOP07)
>
> Interviewer: "…in this society, is the value of son higher than daughters?"
>
> AL: "Yes it is. Sons have a strong role to play in the family. If the family has a son, he will *tongkat estafet* (pass the stick) from his parents, but a daughter will not. The oldest son controls everything in his family. The oldest son has the authority". (INS16)

As long as the society continues to value patriarchy, son preference will endure. Lacking offspring of a specific gender may drive parents to keep having children (Bongaarts, 1998). Son preference is still common in West Timor, therefore, a couple tends to try to have at least one son. This has led couples to keep on having children until they have reached their desired number of sons.

In most cases, couples in NTT practise family planning for spacing, butnot to stop having children altogether. In this context, women usually have the responsibility for using a contraceptive method.

Respondent DT, 37 years old, has four children. After he got married, he immediately wanted to have children. When they had two children, he and his wife decided to join the family planning programme, out of a desire to adequately space subsequent births. He pointed out:

DT: "Thinking about family planning for spacing, my wife practises family planning. We received information from the family planning provider, if we practised family planning; it was not for…not wanting to give birth, but to control the timing. In the long term, only then would we have children…So after we had two children, I told my wife to practise family planning". (KAP08)

Sometimes, men refuse to use contraceptive method themselves. When they want to stop having children, the husbands try to persuade their wives to use a contraceptive method. MS, 42 years old, took the decision to use contraceptives. He has five children, even though he wanted three. His wife started using the pill after the third child. After the fourth, his wife used an IUD which was not successful; she became pregnant with the fifth child. Finally, her husband told her to use an implant. MS, as a paramedic and family planning provider, had good knowledge about family planning. So, he surely knew what the appropriate contraceptive was for his wife. MS stated:

"We thought, it should be three [children], but because of that failure [in using contraceptive] we discussed sterilization but my wife refused. Then I proposed an injection, but she didn't want that either. Finally, she decided to take the pill. While she was on the pill, the fourth [child] came. So my wife didn't want to use any method anymore. She had an IUD but it didn't work [that was] fifth [child]. My wife doesn't want to be sterilized. [She said] I don't want [to use] any of them, but implant. I told her to have the implant, [it has been] already two years". (KAP02)

In this context, although men tend to take the major decision regarding contraceptives use, women also have the opportunity to make a decision themselves. Wives' opinions are important in choosing a contraceptive method. This indicates that communication and consensus between husband and wife are important in practising family planning. When women want to change the method used, husband and wife often discuss whether a better contraceptive is available. The communication is based on understanding personal interest and mutual needs.

In addition, men who had achieved their desired number of children made an effort to stop having more children by practising family planning. The benefits of having a small family also encouraged them to practise family planning. In some cases, the men became directly involved in the family planning programme by using male contraceptive methods, such as condoms and vasectomy, often as a last resort after their wives tried some methods and failed, or after their wives suffered side effects of some of those methods. Out of concern for their wives' health, some

men started using contraception themselves. Respondents SV, EM and YM explained:

> SV: "Because my wife's health condition was affected, she said that I had to practise family planning. I had already proposed family planning three months ago, as [my wife] was disturbed and so she changed [to another method]. If it is not compatible, I'll go directly to BKKBN and I'll have a vasectomy, I will have a vasectomy…" (INS07)

> EM: "…after that [after having 4 children] my wife and I thought about our lives, because if we didn't practise family planning, their [our children's] future would be neglected. So we were thinking to control fertility and I suggested that my wife practise family planning. Finally, my wife used a contraceptive and felt it was very difficult, because if [she] stopped [practicing] we would have more children. Finally, we compromised; if there were any methods for men… I chose vasectomy. I went to Kefa, to a [family planning] worker and I had a vasectomy." (INS02)

> YM: "…because I thought that my wife was getting sick, I decided to use condoms". (KAP09)

An international study of the decision to have a vasectomy found that concern for the women's health was the primary reason across all countries and for both genders (Landry and Ward, 1997). A bad experience with contraceptive use made women reluctant to try any other family planning method. The wives' decisions not to use any contraceptives were mostly supported by their husbands.

By contrast, in some cases, wives discouraged their husbands from undergoing vasectomy out of fear for their husbands' health. Their perception was that vasectomy could make their husbands weak and affect their ability to perform daily activities.

Respondent TP, aged 33 with five children, did not want her husband to undergo a vasectomy owing to a lack of clear knowledge about the procedure. Similarly, respondent MS's wife did not allow him to undergo the treatment.

> Interviewer: "Did you ever think that your husband would use family planning?"

> TP: "No I didn't, I didn't want that".

Interviewer: "You mean that you didn't want your husband to practice family planning?"

TP: "Yes, never mind about that".

Interviewer: "Why?"

TP: "Someone said, I've heard that if a man is sterilized, he will not be good afterwards… Later [he] will not be able to work, nor will he be strong". (KAP06)

MS: "I offered to have a vasectomy, but my wife has heard complaints from men who had vasectomies, so my wife didn't want me to undergo the operation". (KAP02)

There is much distrust in NTT about male methods, especially vasectomy. Some women seemed worried that if their husband had a vasectomy, his ability to perform sexually would be undermined. In addition, women depend economically on men. This situation makes women worried in case their husbands become unable to cultivate the land, this being the family's main source of income.

Conclusion

The involvement of men in reproductive health was recommended at the International Conference on Population and Development held at Cairo. Since then, attention towards male participation in family planning has increased globally. Recently, the Government of Indonesia has been concerned about male participation in family planning. However, the importance of studying this issue has not yet been recognized. The present study was undertaken to examine males' involvement in family planning, particularly the role of men in reproductive decision-making in Atoni/Dawan and Alor societies of West Timor (NTT). The case study is important since NTT is a male-dominated society with an entrenched patriarchal system that influences decision-making in the family and the society.

This study indicates that marriage and *belis*, or bride price, are correlated with authority and power so that the male domination in family decisions is maintained. In addition, violence against women is common, indicating that men use physical force to perpetuate dominance over their partners. In this society men are viewed as strong, physically dominant and aggressive, while women are viewed as weak, physically submissive and vulnerable. The male-initiated violence is related to drinking behaviours.

In addition, this study finds that women refer to their husbands before taking decisions, especially with regard to family planning. Men claim the ultimate authority over reproductive decisions matters based on their economic power. However, women still have an important role to play in decision-making as the interviews revealed. Husband-wife communication occurred when considering contraception, although sometimes there was a disagreement between them. In such cases, the husband's opinion generally prevailed.

Having children is important for economic and social reasons. This study shows that the older generation tends to have many children, while the younger generation tends to have less. In developing countries, younger couples tend to be more egalitarian in their fertility decision-making than the older generation (Hull, 1983). Emerging economic and education concerns encourage younger couples to change their life style, including the size of their family.

However, in reality, the couples who desire smaller families are often faced with a dilemma arising from existing *adat* and culture. The desire for a large number of children and a preference for sons over daughters, were common features of the society till now, influencing fertility decisions. The factors influencing family size preferences include the strong patriarchal system, the lineage orientation in the kinship system and demographic conditions (Mason and Taj, 1987). Therefore, the pressure from the older generation and a society that maintains a patriarchal system are as many significant barriers to achieving small families.

Although in West Timor the family planning programme was introduced more than 20 years ago, the number of males using modern contraception is still low. The non-use of contraceptives by males in NTT is due to the persistence of certain social problems. Nevertheless, in many cases, men are deeply involved in the decision-making process surrounding family planning. This study suggests that male dominance and gender inequality in NTT communities can hinder the formulation of policies and strategies that encourage male participation in family planning.

Barriers to family planning, such as violence against women and drinking behaviour, need to be eliminated in order to increase equitable male involvement in family planning. The success of practising family planning, using both modern and traditional methods implies self-control. The lack of self-control, often as a result of alcohol consumption can lead to a failure of family planning programmes. In addition, women need to be empowered through improved education and enhancement of their legal rights. Women should be guaranteed the right to control their own reproductive capacities. However, male support remains important. Men must understand that gains obtained by women benefit the entire society.

Recommendations

Men must be increasingly involved in all programmes that relate to the family, while they also should support women in their reproductive health needs and decisions. Quality family planning services should provide adequate information and methods of fertility regulation, as a crucial means of achieving and enhancing reproductive health. It is important to encourage male involvement in reproductive and family planning programmes and services. Equally important is the commitment to broader social policies. The government policy should be strengthened on those issues in the wider context of social and political policies.

Reproductive health programmes, especially the family planning programme should adopt a combined gender perspective in sexual health services. Involving men will require significant changes in the structure of the programme as well as considerable adaptability and possibly re-education on the part of staff involved in the programme. The dissemination of appropriate information and services for men may help change attitudes and stereotypical behaviours.

In addition, more research focusing on male reproductive health concerns should be carried out. Several previous studies focused on female perception owing to the fact that data were available from female perspective only. Data based on reports of reproductive intentions from both male and female will surely lead to better and more comprehensive studies.

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Endnotes

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Menstrual Regulation Practices in Bangladesh: An Unrecognized Form of Contraception

Unwanted pregnancy continues to be a major health problem in Bangladesh, despite the fact that there has been a steady increase in the contraceptive use rate over the last two decades.

By M. Mazharul Islam, Ubaidur Rob and Nitai Chakroborty*

Menstrual regulation (MR) refers to any chemical, mechanical or surgical process used to induce menstruation and thus to establish non-pregnancy either at the time of, or within a few weeks of, the due date of the menstruation (Population Information Programme, 1973; Tietze and Murstein, 1975; Dixon-Muller, 1988). It involves the vacuum aspiration of the uterine lining and is usually done within few weeks (preferably eight weeks or less) following a missed menstrual period.

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The idea of "removing menstrual irregularity" or "bringing on the period" – as oppose to abortion – is widespread in many cultures (Newman, 1985; Dixon-Muller, 1988). Whether MR is a deliberate substitution for abortion or is simply perceived as a means of ensuing a "healthy" or "non-pregnant" state depends in part on the perception in different cultures of the possible causes of a delayed menstruation. The ambiguity surrounding a late menstrual period can also be an effective and politically acceptable way for a Government to offer MR services as a health measures where abortion is legally restricted or prohibited. MR thus occupies a legal gray area that could offer significant possibilities for expanded reproductive health services in countries where abortion is currently restricted or prohibited.

In Bangladesh, induced abortion is illegal except to save the life of a woman. However, in the mid-1970s, the Government of Bangladesh declared MR as an "interim method of establishing non-pregnancy" for a woman at risk of being pregnant, whether or not she is truly pregnant (Ali, Zahir and Hassan, 1978:31). MR is, therefore, not regulated by the Penal Code restricting abortion in the country. As part of the Government's health and family planning effort, this policy regarding MR services as a means of reducing female morbidity and mortality associated with indigenous abortion has profound implications for women's reproductive health. The practice of dangerous, illegal abortions – either self-induced or performed by mostly untrained indigenous practitioners – is widespread in the country (Dixon-Muller, 1988; Measham and others, 1981).

In Bangladesh, MRs are performed by a trained paramedic or doctor within eight to ten weeks of a missed menstrual period or within eight weeks of gestation by a hand-held syringe or electric aspiration machines without any pregnancy test. But practitioners must examine the woman physically to make sure she does not have an advanced pregnancy, that is, not more than eight weeks since the onset of her last menstruation. However, there is no guarantee of such complete compliance of MR procedures regarding the use of trained MR providers or duration of pregnancy. Several authors have suggested that with the promotion of MR services, many abortions are performed under the mantle of MR to avoid legal controversy (Akter and Rider, 1983; Piet-Pelon, 1998). Besides, many untrained traditional practitioners or poorly trained personnel are also providing services in unhygienic conditions increasing the risk of reproductive morbidity and mortality (Rob, Islam and Chakroborty, 2002). MR services are available throughout the country in the government health facilities and are primarily performed by trained paramedics known as Family Welfare Visitors (FWV). In addition to the government facilities, a limited number of NGO clinics also provide such services.

Available records from hospitals and clinics suggest a rising trend in MR and abortion, which is supposed to decline as contraceptive use becomes more widespread and as users attain proficiency in method use. It is hypothesized that the increasing use of MR services are partly due to the decline in desired family size and also to poor use-effectiveness resulting in high failure and discontinuation rates of modern contraceptive methods. In this respect, it is important to investigate the reasons for MR acceptance and issues related to service delivery.

According to the 1999-2000 Bangladesh Demographic and Health Survey, 33 per cent of women in union reported that their most recent pregnancy (in the five years preceding the survey) was unintended (Mitra and others, 2001). While it is most likely that the level of unintended pregnancy decreases with the increased use of family planning methods, it has risen in recent years in Bangladesh. Most cases of unintended pregnancies arise from contraceptive non-use, misuse and method failure (Forrest, 1994; Adetunji, 1997; Bongaarts, 1997). Unintended pregnancies are more likely to result in unsafe abortion or MR and low birth weight (Bitto and others, 1997; Eggleston, 1997; Gase, 1996; Kost, Landry and Darroch, 1998; Forrest, 1994). The level of unintended pregnancy also can serve as an indicator of the state of women's reproductive health and of their degree of autonomy in determining whether and when to bear children. Therefore, it is evident that women's needs are not sufficiently met by the family planning programme. The question that has a direct relevance to the programme is the level of demand for pregnancy termination in Bangladesh. Several small studies collected information on the subject but it is extremely difficult to determine the magnitude and frequency of pregnancy termination based on existing information (Ahmed and others, 1996; Caldwell and others, 1997; Hossain, Kamal and Akhter, 1997). There is a great need to understand the role of pregnancy termination in family formation, so that the family planning programme can reach those women more effectively.

The paper examines the knowledge and attitude towards MR practice and analyses the characteristics of MR users in Bangladesh, using both quantitative and qualitative data. It also analyses the contraceptive use behaviour of the MR users and underlies reasons for accepting the method. The findings of the study are expected to have important policy relevance in Bangladesh and other developing countries where pregnancy termination is widely practised. Understanding the reasons for MR acceptance and its demographic impact will assist policy makers to take appropriate steps to reduce unsafe abortion, which will decrease maternal morbidity and mortality.

Data and methodology

The study utilizes both qualitative and quantitative data. The major source of quantitative data is the 1999-2000 Bangladesh Demographic and Health Survey (BDHS). The 1999-2000 BDHS collected information on respondents' background characteristics, pregnancy history and their outcomes, contraceptive use history, marriage and fertility preferences. Information on knowledge and ever use of menstrual regulation (MR) as well as types of last pregnancy termination were also collected through a nationally representative sample of 10,544 ever-married women of age 15-49, of which 9,720 were currently married. Among the 9,720 currently married women, 367 had ever accepted MR services during the five years preceding the survey. This constituted the authors' study population.

Apart from the 1999-2000 BDHS, a qualitative survey on MR acceptors was conducted to complement the quantitative findings of the BDHS. This complementation of qualitative and quantitative methods ensures a more comprehensive analysis and maximizes the information and quality of the data, reducing also the chances of bias. The major objective of the qualitative survey was to understand the dynamics of MR acceptance, such as knowledge, attitude and timing of MR and the reasons and decision-making process of MR acceptance. The qualitative survey was independent of the 1999-2000 BDHS.

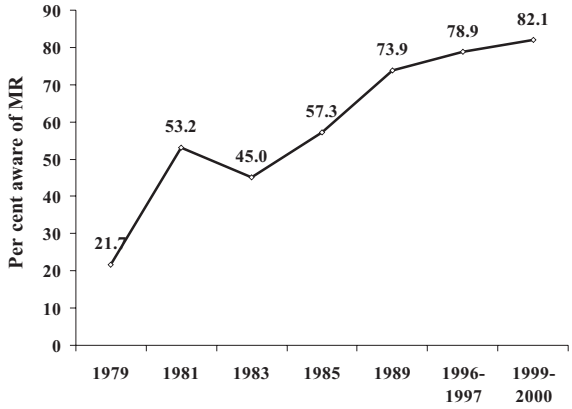
Qualitative information was collected through in-depth interviews and focus group discussions (FGDs). The FGDs and in-depth interviews were conducted in two selected rural and two urban areas in March and April 2002. The two selected rural areas are Gazipur upazilla (subdistrict) of Gazipur district under Dhaka division and Dumuria upazila of Khulna district under Khulna division, while the two selected urban areas were located in Dhaka and Khulna metropolitan areas. FGDs were arranged with the help of service providers (mainly FWV) working in the areas. The service providers were requested to identify MR acceptors who had used MR in the recent past. In each area, seven to nine MR acceptors of different age groups were selected to participate in the FGDs. The research team also conducted in-depth interviews on ten selected MR acceptors from each area and interviewed them either at home or at the clinic. The service providers of the respective areas helped to identify the acceptors for the in-depth interviews as well. Although 40 MR acceptors were interviewed, two interviews had to be discarded owing to the poor quality of the initial tape recording, leaving 38 in-depth interviews for detailed analysis. Trained female sociologists were involved in conducting the in-depth interviews and FGDs.

Findings

Knowledge of MR

Figure 1 presents time series data on knowledge about MR among currently married women of reproductive age from 1979 to 1999-2000. The data were obtained from the Contraceptive Prevalence Surveys (CPSs) and the successive BDHSs. A very high knowledge about MR in recent years is evident among the currently married women, as 82 per cent of the women ever heard of MR in 1999-2000. There is an increasing trend in knowledge of MR. For example, the knowledge has increased from 22 per cent in 1979 to 82 per cent in 1999-2000.

Figure 1. Knowledge of MR in Bangladesh, 1979 -2000



Sources: 1979, 1981, 1983, 1985 and 1989 CPSs, 1996-1997 and 1999-2000 BDHSs.

As expected, the knowledge about MR is more prevalent among MR acceptors. More than nine in ten (92 per cent) MR acceptors who participated in in-depth interviews were reported to have prior knowledge about the procedure (table 1). Most women received the information from family planning field workers (45 per cent), relative/friends (42 per cent) or other MR acceptors (24 per cent). The role of the mass media as a source of information about MR appears to be insignificant (2.6 per cent). Although, Bangladesh has an extensive network of domiciliary health and family planning services through a large number of female field workers, it was surprising that a large number of women learned about the procedure from relatives/friends or MR acceptors. There is no doubt that the informal network plays a very important role in providing information about MR services.

Most of the MR acceptors (92 per cent) were not able to make any distinction between MR and abortion. According to MR acceptors, both the terms refer to pregnancy termination. Participants in the FGDs also held similar views. The respondents mentioned several closely associated Bengali terms for MR or abortion such as "*pete fela*", "*baccha fela*" or "*baccha nausto kora*" meaning "washing out the uterus" or "cleaning the period". All of those terms refer to destroying the foetus. This indicates that in most cases, pregnancy termination was done under the name of MR, while MR appeared to be an unrecognized fertility control measure that women employed to terminate an unwanted pregnancy.

Table 1. Knowledge about MR and abortion among participants in the in-depth interviews

Knowledge about MR/abortion and timing of MR	Percentage (n = 38)
Ever heard about MR	
Yes	92.1
No	7.9
Source of information	
Radio/TV	2.6
Family Planning workers	44.7
Doctor	5.3
Relatives/Friends	42.1
MR acceptors	23.7
Know difference between MR and abortion	
Yes	7.9
No	92.1
Duration of pregnancy when MR can be performed?	
≤ 8 weeks	58.0
9-11 weeks	29.0
Do not know	13.0
Duration of pregnancy when MR was done	
< 6 week	13.2
6-8 week	60.5
9-11 week	21.1
12 +	5.3
Mean duration of pregnancy at the time of MR (in week)	**8.0**

MR within 8 weeks of gestation is prescribed as most safe. This was known by more than half (58 per cent) of MR acceptors. More than one in ten (13 per cent) MR acceptors did not have any idea about the duration of pregnancy when MR can be performed, while 29 per cent mentioned that it could be performed between 9 to 11 weeks. When the MR acceptors were asked about their own experience and at what duration of pregnancy they had accepted MR services, nearly two thirds (74 per cent) reported having had MR service within the prescribed eight weeks of gestation. About one fourth (26 per cent) of the MR acceptors had performed MR beyond the prescribed period, which may create reproductive health problems. On average, women had MR services at eight weeks of gestation.

Table 2. Percentage of currently married women who ever accepted MR by age, division and place of residence, BDHS 1999-2000

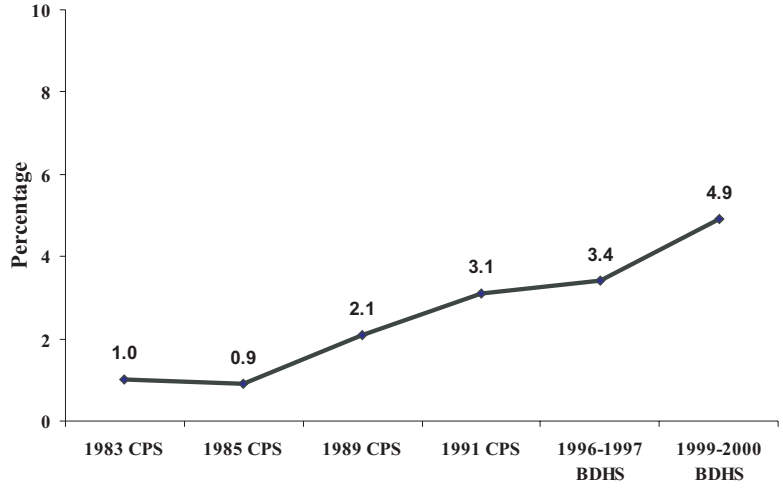
Characteristics	Percentage having ever used MR
Age	
< 20	1.9
20-24	3.8
25-29	5.1
30-34	6.5
35-39	8.4
40-44	6.3
45-49	4.7
Administrative division	
Barisal	6.3
Chittagong	4.2
Dhaka	4.7
Khulna	5.8
Rajshahi	5.3
Sylhet	2.9
Residence	
Urban	9.5
Rural	3.8
Total	4.9
Number	**9,720**

"Ever used" MR

Table 2 presents the percentage of currently married women who ever had MR services by selected characteristics. Among the currently married women aged 15 to 49, about 5 per cent ever had MR services. Young women aged less than 20, i.e. adolescents were less likely to accept MR services, while women in their late thirties were more likely to accept the services. Women living in the urban areas accepted MR services more frequently than women living in rural areas (9.5 per cent versus 3.8 per cent). Among the six administrative divisions, Barisal shows the highest use rate of MR (6.3 per cent), immediately followed by Khulna (5.8 per cent) and Sylhet division, the latter showing the lowest use rate of MR.

Figure 2 depicts an increasing trend in MR practice in Bangladesh, which rosefrom only one per cent in 1983 to 5 per cent in 1999-2000. Despite the increased use of family planning methods, the rate of MR is also increasing. The rising trends in MR use may be associated with method failure, which in turn may be related to the incorrect use of the methods. This leads to question of efficacy of the family planning methods used.

Figure 2. Ever used of MR among ever married women during 1983-2000, Bangladesh



Sources: 1983, 1985, 1989 and 1991 CPSs, and 1996-1997 and 1999-2000 BDHSs.

Timing of MR

The timing of MR during the reproductive cycle has an important relevance to fertility, if the couples utilized the procedure for averting an unwanted pregnancy. The age, parity and duration of marriage of a woman at the time of MR are among the most important factors in the decision-making process. Table 3 shows the distribution of women who had accepted MR services by age and the duration of marriage at the time of the procedure. The age and parity of women show a curvilinear relationship with the acceptance of MR. Young women within their twenties or having two children are more likely to accept MR. The average age of MR acceptors was 27 years, while women accepted MR on the average 12 years after the marriage. The average number of children at the time of MR was around three.

Table 3. Percentage distribution of MR acceptors among currently married women during the five years preceding the survey by duration of marriage and number of living children, BDHS 1999-2000

Age at the time of MR		Marital duration at the time of MR		Number of living children at the time of MR	
Age	**Per cent**	**Duration**	**Per cent**	**Children**	**Per cent**
<20	15.6	0-4	25.0	1	13.1
20-24	23.6	5-9	19.4	1	20.3
25-30	21.7	10.14	24.4	2	25.6
30-34	19.2	15-19	14.7	3	18.9
35+	20.0	20+	16.4	4	9.7
				5+	11.5
Total	**100.0**		**100.0**		**100.0**
Mean	**27.4**		**11.5**		**2.4**
Number	**367**		**367**		**367**

Gestational age and pregnancy

Table 4 shows the distribution of women who received MR services according to the duration of the gestation. It appears that about 64 per cent of the MR acceptors received MR services within eight weeks of conception. The average gestational duration was 8.1 weeks. About 11 per cent received the services after 12 weeks of conception. This raises a major concern about the proper compliance of the procedure, while also raising a policy-related question: how come did women with 12 or more weeks of gestation not come earlier and how can they be informed about the proper timing to perform MR?

Table 4. Distribution of currently married women who resorted to MR during the five years preceding the survey by duration of pregnancy, BDHS 1999-2000

Duration of pregnancy (in weeks)	Women who had MR	
	Number	Percentage
≤4 weeks	9	2.5
5-8 weeks	225	61.3
9-11 weeks	93	25.3
12+ weeks	40	10.9
Total	367	100

Median duration of pregnancy at the time of MR: 8.1 weeks.

The distribution of the 38 MR acceptors who participated in the in-depth interview by their duration of pregnancy indicates that most women (63 per cent) accepted MR for the third or higher number of pregnancy (table 5). It is also interesting to note that 11 per cent of the MR acceptors received MR services to postpone their first pregnancy while another 26 per cent used the method to postpone their second pregnancy. MR experience at the first or second gravity may be due to the fact that they did not want a child at that moment for financial or other reasons. The following cases illustrate the settings.

Saju (not real name) is 21 years old and her husband is 32. She has been married for seven years and has a daughter. Her husband looks after the family business. She was married at 14. She became pregnant immediately after marriage as they did not use any contraceptive method. She terminated her first pregnancy by MR. Her husband and in-laws had advised her to terminate the pregnancy. Her husband accompanied her to the FWC and FWV performed the procedure. The service provider charged taka 250 (1USD≈60.99Tk). Few days after the procedure she began bleeding continuously. Her husband took her to FWC and MR procedure was repeated. The respondent did not know much about MR before she accepted the procedure. She had heard about MR from her aunt. Till today, she blames herself for accepting MR. She says she did not realize what she was doing as she was young at the time. After the MR she was unable to become pregnant for many years. She thought God had punished her. Currently she is taking oral contraceptive pills and would like another child in the next 5 years.

Table 5. Distribution of MR acceptors by gravidity: evidence from in-depth interviews

Gravidity*	Percentage (N = 38)
1	10.5
2	26.3
3	10.5
4	21.0
5+	31.6
Mean	**3.2**

* Gravidity is an indicator of pregnancy experience which indicates live births plus fetal deaths.

Characteristics of ever acceptors of MR

Table 6 presents the characteristics of women according to use and non-use status of MR and family planning methods. For comparison purposes, the authors have considered three categories of women: MR acceptors, ever used family planning methods and never used family planning methods or MR. The results indicate that MR acceptors and users of family planning methods are relatively older than non-MR acceptors. The average age of women who ever accepted MR is 29 years compared with 27 years for women who neither accepted MR nor used any contraceptive method. The higher average age of MR acceptors and family planning method users compared with non-acceptors of MR or family planning implies that women usually accept MR procedure or family planning methods at higher ages, once having had the desired number of children. The MR acceptors, on average, had 2.6 living children compared with 2.0 children for non-acceptors of MR or non-users of contraceptive methods. The sex composition of living children shows that the proportion of boys was higher among MR acceptors than among non-acceptors. The desire for no more children was stronger among MR acceptors and family planning users than among non-acceptors of MR or non-users of family planning methods. For example, more than 60 per cent of the MR acceptors or ever user of family planning methods did not want any more children compared with 40 per cent of non- acceptors of MR or non-users of family planning methods. The desired number of children was slightly lower among MR acceptors (2.3 children) compared to non-acceptors of MR or non-users of contraceptive methods (2.7 per cent). This indicates that MR acceptors were more likely to have an unwanted pregnancy than other groups, which necessitated them to seek MR services.

Table 6. Percentage distribution of MR acceptors in the five years preceding the survey, ever user of family planning methods and never users of family planning or MR by selected socio-economic characteristics, BDHS 1999-2000

Characteristics	MR acceptors in the last five years (n = 367)	Ever used family planning methods (n = 7,190)	Neither contraceptive nor MR user (n = 2,163)
Current age			
<20	8.6	13.2	30.8
20-24	21.7	18.8	19.1
25-29	22.5	20.9	13.5
30-34	22.2	17.1	10.1
35 and above	25.0	29.9	26.5
Mean age	29.2	29.8	27.3
Ideal number of children			
2 or less	68.9	63.2	51.9
3	21.7	22.7	22.0
4 or more	9.4	14.1	25.8
Mean ideal number	2.3	2.4	2.7
Number of living children			
0-2	56.1	51.3	68.7
3-4	30.0	32.6	17.5
5 and more	13.9	16.1	13.9
Mean number of livingchildren	2.6	2.7	2.0
Sex composition			
Boy > Girls	40.6	38.6	28.5
Boy = Girls	30.3	26.4	41.9
Boy < Girls	29.2	35.0	24.6
Desire for more children			
Want more	35.6	31.7	56.5
Want no more	61.7	65.8	40.1
Undecided	2.8	2.5	3.7
Women's education			
No schooling	27.5	41.8	54.2
Primary	28.6	30.1	28.4
Secondary and above	43.9	28.1	17.3
Mean year of schooling	5.0	3.8	2.4

.../

Table 6. *(Continued)*

Characteristics	MR acceptors in the last five years (n = 367)	Ever used family planning methods (n = 7,190)	Neither contraceptive nor MR user (n = 2,163)
Husband's occupation			
White-collar	44.4	30.2	19.3
others	55.6	69.8	80.7
Work status			
Earn cash	20.3	19.6	12.3
No/not workinh	79.7	80.4	87.7
Wealth index			
Poor	15.0	31.8	44.8
Middle	32.8	36.6	35.3
High	52.2	31.6	19.9
Media exposure			
Yes	66.9	50.8	38.9
No	33.1	49.2	61.1
Women's mobility status			
Yes	80.0	72.8	59.1
No	20.0	27.2	40.9

MR acceptors or ever users of family planning methods were generally better educated than non-acceptors of MR or family planning methods: 44 per cent of the MR acceptors had secondary and above level of education compared with 17 per cent among non-users (table 6). MR acceptors were economically better off than non-acceptors of MR, as more than half (52 per cent) of the MR acceptors had higher wealth indexes compared to 20 per cent among non-acceptors. The husbands of the MR acceptors were more likely to have white-collar jobs than non-acceptors. Besides, women who had accepted MR services were more likely to be engaged in cash earning than their counterparts. Obviously, women working for wages, outside their home, were living under different circumstances, being exposed to different influences, than women who stayed home and carried out traditional duties. Furthermore, MR acceptors had higher autonomy and mass media exposure than the women who had not accepted MR (table 6).

Patterns of contraceptive use by MR acceptors

Table 7 shows the patterns of contraceptive use among MR acceptors and non-acceptors. The contraceptive use rate was substantially higher among MR acceptors than among non-acceptors. About 73 per cent of the women who had received MR services were using contraceptive methods at the time of the survey, compared to 53 per cent of non-acceptors. However, both groups had a similar pattern of method use with oral contraceptive pills being the most widely used method followed by traditional methods. The most striking feature of the contraceptive use behaviour of MR and non-MR acceptors was that MR acceptors were more likely to use condoms, while non-MR acceptors were more likely to use injections, although in most cases they had accepted MR to avoid unwanted pregnancy. This finding may have important policy implications for programme managers. Women seeking MR services can easily be recruited into more effective long-term methods of family planning through motivational programmes.

Table 7. Percentage of women who were currently using family planning methods by MR acceptance status, BDHS 1999-2000

Method	Current use	
	Had MR during last five years (n = 367)	Did not have MR during last five years (n = 4,862)
Any method	**73.4**	**53.1**
Pill	33.7	22.7
IUD	3.6	1.6
Injectables	9.9	7.1
Condom	10.1	4.1
Sterilization	1.2	7.4
Traditional	14.9	10.1
No method	26.6	46.9
Total	**100**	**100**

The findings presented in table 8 suggest that similarly to the general population, the majority of MR acceptors were using oral pill (29 per cent) before accepting MR, followed by traditional methods (11 per cent) and condom (9 per cent). However, after accepting MR, more than three fourth (79 per cent) accepted family planning methods, most of them using oral pills (40 per cent), followed by traditional methods (13 per cent), condom (12 per cent) and injections (7 per cent). Only one per cent (3 women) accepted sterilization and another 6 per cent IUD.

The percentage of non-users of family planning methods dropped from 49 per cent before accepting MR to 21 per cent after having undergone MR, i.e. more than half (55 per cent) of the non-users of family planning methods before accepting MR became users (of family planning methods) after accepting MR.

Table 8. Percentage distribution of women who received MR services during the five years preceding the survey by method of contraceptive used according to pre- and post-MR experience, BDHS 1999-2000

Method	Use of contraception among MR acceptors	
	Before MR	After MR
Any method	51.4	78.6
Method used		
Pills	28.9	40.0
IUDs	0.6	5.8
Injections	2.8	7.2
Condoms	8.6	11.7
Sterilization	-	0.8
Traditional methods	10.6	13.1
None	48.6	21.4
Total	**100.0**	**100.0**
N	**367**	**367**

Table 9 presents the distribution of women according to the specific method used during pre- and post-MR acceptance. It is observed that few women who were using contraceptive methods prior to MR acceptance, became non-users after they accepted the procedure. Those who became users from being non-users, in most cases, accepted oral pills (34 per cent), followed by traditional methods (9 per cent), IUD (8 per cent), condom (8 per cent) and injections (5 per cent). A majority of the women who were using family planning methods prior to MR did not switch to another method after the acceptance of MR. For example, 64 per cent of oral pill users continued the method after the procedure. The switching was most evident in the case of IUD and injectables.

It should be noted that a very high post-MR contraceptive use level implies that after having encountered an unwanted pregnancy which was satisfactorily resolved, the women became highly motivated to accept family planing methods. However, the relatively higher rate of oral pills and traditional methods use raises concern about the efficacy of the post-MR contraception.

Table 9. Percentage distribution of post-MR family planning method used by pre-MR family planning method acceptance, BDHS 1999-2000

Pre-MR method used	Post-MR method used							
	Pill (n = 144)	IUD (n = 23)	Injection (n = 28)	Condom (n = 44)	Sterili-zation (n = 3)	Traditional methods (n = 47)	Any method (n = 284)	Total (n = 367)
Pills	64.4	1.9	9.6	6.7	1.0	6.7	90.4	104
IUDs	50.0	0	0	50.0	0	0	100.0	5
Injections	20.0	10.0	50.0	0	0	0	80.0	10
Condoms	25.8	3.2	3.2	58.1	0	3.2	93.5	31
Traditional methods	15.8	7.9	2.6	5.3	0	60.5	92.1	38
None	34.3	8.0	5.1	8.0	1.1	9.1	65.7	179

Results of the in-depth interview shows that out of 38 MR acceptors, 33 (87 per cent) were using family planning methods, mostly pills, prior to under-going MR procedure (table 10). Such a high rate of contraceptive use by women prior to MR leads to question about the reasons these women experienced such high rates of contraceptive failure. The reason apparently lies in their choice of preventive measures. Before accepting MR, more than half of the acceptors were using either pills (32 per cent) or condoms (29 per cent) while the rest was mostly using traditional methods (24 per cent). Those methods had high failure rates. The findings from the in-depth interviews also suggest that about 82 per cent of the MR acceptors were using a family planning method during their post-MR period with a similar method mix as before the MR operation. However, several MR acceptors switched to more effective methods such as injections and IUDs.

Determinants of MR practice

To identify the factors affecting the use or non-use of MR, the logistic regression model has been fitted with the use of MR as dependent variable by assigning the value 1 if the women ever used MR in last five years preceding the survey or 0 otherwise. The results presented in table 11 indicate that several factors were associated with the acceptance of MR. Women's age, number of living children, women's education, husband's occupation, wealth index, women's mobility, women's employment status, administrative division, place of residence and mass media exposure are among the significant predictors (at 5 per cent) of MR acceptance.

Table 10. Contraceptive use history of MR acceptors: evidence from in-depth interviews

Contraceptive use history	Percentage
Ever used family planning methods before MR	
Pills	31.6
Injections	2.6
IUDs	-
Condoms	28.9
Traditional methods	23.7
None	13.2
Total	**100.0**
Methods currently using	
Pills	34.2
Injections	15.8
IUDs	10.5
Condoms	10.5
Traditional methods	10.6
None	18.4

The age and number of living children show a significant positive relationship with MR acceptance. Women's level of education is also a strong predictor of acceptance of MR. Women with secondary and above level of education were twice more likely to accept MR than women without any education. The women whose husband has a white-collar job were more likely to accept MR. The women with a higher degree of mobility are also more likely to be MR acceptors compared to those having restricted mobility. In addition, the women who are engaged in cash earning activities are more likely to accept MR than those who are housewives. The household wealth index –proxy measure of women's economic status– shows a significant positive relation with MR acceptance (table 11).

There are significant variations in MR acceptance among the administrative divisions. Compared to women from Dhaka division, residents of Barisal, Khulna and Rajshahi divisions are more likely to accept MR, while the residents from Chittagong and Sylhet are less likely to adopt the method. The latter two divisions are known for their lower level of family planning use and high fertility. Religious conservatism is known to be high in Sylhet and Chittagong which might cause a low use rate of MR in those two divisions. Urban residents are 1.5 times more likely to accept MR compared to rural residents.

Table 11. Multivariate logistic regression estimates showing the association of ever use of MR among currently married women with some selected sociodemographic characteristics, BDHS 1999-2000

Characteristics	Estimates B	Odds ratio	p-value
Current age			
<20 years	-0.968	0.379	0.000
30 years and above (ref : 20-29 years)	0.297	1.346	0.012
Age at marriage			
< 15 years (ref : 15 years and above)	-0.124	0.883	0.250
Living children			
0-2	-0.566	0.567	0.000
5 and above (ref: 3-4 children)	-0.099	0.905	0.500
Ideal number of children			
Less or equal 2 (ref: 3 or more)	0.156	1.169	0.157
Maternal education			
Secondary or higher	0.717	2.048	0.000
Primary (ref: no education)	0.322	1.380	0.016
Husband's occupation			
White-collar (ref: farmer/labourer etc.)	0.342	1.408	0.000
Wealth index			
High	0.410	1.507	0.016
Middle (ref: poor)	0.155	1.167	0.300
Media exposure: yes	0.438	1.550	0.000
Women's mobility: yes	0.272	1.313	0.026
Work status			
Earn cash (ref: unemployed)	0.266	1.304	0.025
Division			
Barisal	0.457	1.550	0.018
Chittagong	-0.172	0.841	0.254
Khulna	0.290	1.336	0.062
Rajshahi	0.430	1.538	0.001
Sylhet (ref: Dhaka)	-0.292	0.740	0.284
Residence			
Urban (ref: rural)	0.435	1.545	0.000

-2 log likelihood = 3,450; p-value < 0.001.

Reasons for accepting MR

The women who participated in the FGDs reported that they had received MR services mainly in order to terminate an unwanted pregnancy as they did not want any more children or wanted to space births. The unwanted pregnancies occurred mostly following methods failure or to a lesser extent, non-use of family planning methods immediately before the conception. As most women were using oral pills or injections, methods failure occurred mainly because of a lack of complete compliance or irregular use. Women acknowledged forgetting the due date of injections at times or forgetting to take the pill regularly. The incorrect use of family planning methods was thus primarily due to negligence or to a lack of effective knowledge about the method.

Table 12. Percentage distribution of MR acceptors who participated in in-depth interviews by reasons for accepting MR

Reasons	Percentage*
Irregular menstruation	5.3
Do not want anymore children	39.5
Spacing of births	18.4
Health/medical reasons	15.8
Economic hardship	21.0
Family problems	7.9
Number of cases	**38**

* Total percentages will not add to 100 owing to multiple responses.

The in-depth interviews also revealed varied reasons for accepting MR services. The findings, presented in table 12, suggest that approximately 40 per cent of women utilized MR services to terminate an unwanted pregnancy as they did not want any more children. A large majority of MR acceptors reported that the pregnancies resulted either from a contraceptive failure or the non-use of contraceptive methods. The findings suggest that owing to inappropriate and irregular use of family planning methods, especially oral pills, condoms and injections, the women became pregnant. Birth spacing and health concerns appeared as the next most prominent reasons for accepting MR. Economic hardship was also mentioned as an important reason for using the method. Some women reported not being able to afford the financial costs of rearing another child. Others cited health problems (such as blood pressure and asthma), as reasons for MR. It is interesting to note that in a few cases, women had to resort to MR because of their husbands' refusal to use a family planning method. The following cases describe some of the reasons:

Rahima is 37 and has been married for 20 years. She completed primary level of schooling, while her husband completed the higher secondary level. They have four living children; three girls and one boy. She does not want any more children. Her husband is a small trader and they live in their own house. Rahima used oral pills but discontinued owing to side effects. Her husband used condom irregularly therefore she became pregnant. She was six-week pregnant when she had MR. The provider charged 150 taka (1USD ~ 61 Tk) and she had to purchase medicine from the market. She had fever for 15 days and experienced other minor complications. Currently she is using injectable contraceptives and does not want any more children. She did not consult anyone except for her husband. Initially, she was afraid of the MR procedure.

Taslima is 20 years old. She has two years of schooling and is a member of an income-generating NGO. Her husband, 25 years old, has six years of schooling. He is a plumber. They live in a slum area and have a daughter. Her first conception was aborted spontaneously after three months of pregnancy. She terminated her third pregnancy by MR. She was taking oral pills but did not like it. Owing to side effects, she took it irregularly and became pregnant. Though the pregnancy was unwanted she did not want to abort it. However, her husband forced her to as his income was not sufficient to bear the expenses of another child. Her husband wanted to accompany her to the clinic but she requested him not to come as she felt embarassed. After the MR was conducted she experienced some problems. She had bleeding and lower abdominal pain. The doctor prescribed her some medicine. In the future, she would like another child. Currently, she is using IUD. She had limited knowledge about MR. She thinks MR can be done up to five months of pregnancy. She heard about the procedure from neighbours. She consulted a health worker and was advised to go to a clinic located in Mohammadpur. Taslima views MR as a complex procedure not well received by elderly persons. She blames herself for having accepted the method.

Attitude towards MR

One of the purposes of the in-depth interviews and FGDs was to understand the perceived social impact of pregnancy terminations particularly what families and communities feel about MR and their attitude towards it. It is evident from

FGDs that MR acceptors often try to hide the fact that they underwent the procedure, owing to social stigmas. A substantial proportion of MR acceptors considered it a sin and feel guilty for having accepted MR. According to respondents, religious leaders and elderly people do not support the practice.

The results of the in-depth interviews on 38 MR acceptors indicated that about 42 per cent of the acceptors did not support MR, despite having accepted the procedure (table 13), while the same proportion of women expressed regret for having undergone MR. In addition, 26 per cent reported facing social/mental problems following the procedure. Most women (79 per cent) considered MR as offensive to their religion. MR acceptors reported that the overwhelming majority (87 per cent) of the community had a negative attitude towards MR. In general, community members are perceived as not very supportive of the procedure.

Table 13. Opinion on the acceptability of MR

Attitude towards MR	Percentage
Support MR	
Yes	57.9
No	42.1
Feeling remorseful for having accepted MR	
Yes	42.1
No	57.9
Is it against religion?	
Yes	78.9
No	21.1
Facing any social/mental problem?	
Yes	26.3
No	73.7
Attitude of the community towards MR	
Positive	13.2
Negative	86.8
Number of cases	**38**

Discussion and conclusion

In spite of a nationwide family planning programme and a moderately high rate of contraceptive use (more than 50 per cent), mistimed or unwanted pregnancies are still very common in Bangladesh. Many women face the need for a pregnancy termination and opt either for the menstrual regulation (MR) method or for a traditional abortion. The present study shows that currently married women and acceptors of MR have a moderately high knowledge of MR, while most of them obtained information about the method from relatives and family planning workers, but not from the media. This is probably because MR is advertised neither in the print nor in the electronic media. In addition, women tend to obtain information about sensitive issues through the informal network of family and friends rather than from the media. The finding that the great majority of MR acceptors do not view MR and abortion differently should be considered in the broader policy context.

Evidence from the BDHS data suggest that women's education, number of living children, exposure to media, husband's occupation, economic status and women's mobility are among important predictors of MR acceptance. Not surprisingly, urban women who are older and employed are more likely than others to seek MR.

Unwanted pregnancy continues to be a major health problem in Bangladesh, despite the fact that there has been a steady increase in the contraceptive use rate over the last two decades. Bangladeshi women have a very high level of awareness of contraceptive methods but detailed knowledge of how the methods actually work is not widespread. Although most MR acceptors want to limit their family size, they are not using the appropriate methods. Among MR acceptors oral pills remain most widely used.

The findings demonstrate that unwanted pregnancies result either from the non-use of contraceptive or from contraceptive failure, both of which are related to the poor quality of family planning services, particularly counseling. The major recommendation emerging from this study is that service providers should focus increasingly on counseling, particularly the use of longer acting methods, and more effective use of contraceptive pills. The clients should be informed about the consequences of not taking the oral pill as per the requirements. Particularly, the service providers' knowledge about actions to take in case the client misses the pill for more than two days needs to be improved. Similarly, service providers' knowledge about emergency contraceptive pills (ECP) needs improvement, while ECP should be made widely available in rural areas. Women seeking MR could easily be recruited into more effective long-term methods of family planning. The strategy should be based on an effort to improve the overall

reproductive health of women, which implies an improvement of the quality of service delivery, information and support services.

Although most Bangladeshi women wish to limit the size of their family, there is a negative feeling about MR as a method of fertility control. Even though women accepted MR as a method of fertility regulation, most women still consider MR as sinful. It is noteworthy to mention that the majority of MR acceptors think MR is offending religion. The study findings demonstrate an urgent need to implement a policy focused primarily on providing information through the mass media and ensuring that service providers are trained adequately to perform their duty. Potential clients need to be well-informed about the MR procedure, its proper timing and advantages over a traditional abortion. Considering the prevailing sociocultural and religious belief, a massive public education campaign would elicit some negative reactions. Therefore, words need to be spread primarily from woman to woman. In this context, the role of the village-level family planning workers – the Family Welfare Assistants (FWAs) – is especially important. In fact, some FWAs currently refer women to health posts for MR or even take them there themselves. Sexually active women also need to monitor closely the timing of their menstruation.

The quality of MR services requires immediate attention. MR providers should exercise increasing caution regarding the timing of the MR procedure and should not conduct it beyond the safe period. MR acceptors should attend follow-up visits. The MR training curricula should be reviewed and updated to fully benefit from new clinical procedures.

The increasing availability of MR services in both the public and private sectors in Bangladesh has undoubtedly reduced the incidence of dangerous illegal abortions and abortion-related mortality and morbidity, yet it could not eliminate the need for traditional abortion practices. Therefore, an expanded MR programme would bring significant new opportunities for women to control safely and effectively the timing and number of children they desire. For women who are determined to terminate a suspected or known pregnancy, high quality MR services could clearly provide an excellent point of entry into the regular use of other fertility regulation methods.

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Original contributions are invited, especially papers by authors from or familiar with the Asian and Pacific region. Ideally those papers will discuss the policy and/or programme implications of population issues and solutions to problems and report on experiences from which others may benefit.

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