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# **Improving the Efficacy of Family Planning Policies in Indian, Chinese, Tanzanian Contexts, And Beyond**

By: Jayce O'Shields

January 29, 2015

## **Intentions and Methodology:**

In this paper, I will first present the problem of global overpopulation and the solution of decreasing populations to replacement level fertility using effective family planning and contraceptive policies. I will then describe the Indian state of Kerala as a model cultural context in which fertility rates have significantly declined in recent history and explain how Kerala can provide insight into efficient family planning and contraceptive strategies. Next, I will examine extant state and non-governmental organization (NGO) family planning and contraceptive policies in India, China, and Tanzania, and in comparison to the Kerala mode, make general recommendations on how to improve their efficacy. Subsequently, I will briefly discuss special considerations needed in approaching family planning efforts in other areas. I will finally suggest general ways in which NGO and state family planning strategies can be tailored to any cultural climate as part of a larger effort to reduce the global population growth rate.

I began this project by searching for literature and online sources discussing family planning and contraceptive policies in India, China, and Tanzania and local sociocultural factors that may affect policy efficacy. I chose to attend the 4<sup>th</sup> Cross Cultural Health Care Conference in Honolulu, Hawaii, to ascertain how cultural competency is effectively incorporated into national and international development efforts.

When I conducted background searches of the speakers at the conference, I found the work of several corresponded very closely with the scope of this project. I therefore prepared questions for them and scheduled interviews with them to be held during the weekend of the conference.

Dr. Christina Higgins's research on the efficacy of NGO educational models promoting safe sex in Tanzania was very applicable to understanding how efforts to increase contraception utilization were being received in an East African context. Ms. Rosalie Thackrah's doctoral research on integrating cultural competency into midwifery education for students working in aboriginal Australian settings was helpful in understanding how to tailor approaches to discussing family planning and contraception to cultures in which it may be considered taboo. Dr. Dana L. Alden's recent work outlines how to effectively target and tailor patient decision aids to various cultures, which contributes to understanding general ways to effectively integrate cultural competence in healthcare settings. Mr. Gerald Ohta from the Hawaii Department of Health (DOH) assists in drafting equal access legislation for individuals of various cultures, so I was confident he would be able to provide insight into making wide-reaching policies and laws more culturally inclusive and effective in initiating change.

While at the conference, I attended the presentations of Dr. Higgins, Ms. Thackrah, Dr. Alden, and Mr. Ohta in addition to a wide array of other presentations that were relevant to this project.<sup>1</sup> Following the conference, I began synthesizing information from the initial literature search, interviews, and conference presentations to construct general

ideas of how wide-reaching development policies can integrate local cultural models to maximize efficiency in reducing population growth.

## **Introduction: The Problem**

Largely due to increased survival to reproductive age, global population has increased sevenfold in the past 200 years and is projected to reach 9 billion in the next 35 years ("Population Trends"). The world's people will immensely suffer if their combined biological needs exceed the Earth's carrying capacity. According to the World Resources Institute, a 69% increase in food calories will be needed to sustain the 2050 population no more than two generations in the future (Ranganathan 2013). An abundance of strategies to combat the challenges of overpopulation include minimizing waste, promoting healthier diets, boosting agricultural yields, maximizing aquaculture productivity, and developing sustainable energy sources. The need to decrease population growth rates to replaceable fertility levels is arguably one of the most important strategies for dampening the substantial need to increase resources. At replaceable fertility levels, the number of individuals being born will equal the number of individuals dying, resulting in no net increase in population. The sooner effective means to slow population growth in areas with considerable fertility rates are implemented, the sooner the global population growth rate's velocity will decrease. Once the global population growth rate is lessened and sustained at replacement fertility level, strategies to maximize the efficiency of resource utilization could be implemented, allowing further population growth and prosperity. Because of the time sensitivity of this issue, thorough investigation of plausible solutions must become priority for all national and global institutions, and wider use of effective family planning strategies and utilization of contraception are direct solutions to excessive population growth.

## **Part I: Kerala and India**

India is home to one seventh of the world's population (Central Intelligence Agency. "India") and is therefore also a potential epicenter for significant global population growth and a country in which the need for effective family planning and contraceptive policies is quite pronounced. Fortunately, India is also home to one of the few examples of places where fertility rates have been effectively reduced to sustainable levels: Kerala. Kerala is exalted as a social paradise where an almost ideal combination of certain sociocultural factors have contributed to a healthy decline in fertility rate, so for the purpose of this paper, it will serve as a paragon and guide for suggesting family planning and contraceptive policy strategies. Kerala's success in lowering fertility rates has been attributed to two key concepts: 'people development' and the empowerment of women (Goodpal 2014).

A development model focused on improving the local people's quality of life included improving accessibility to quality healthcare, eliminating poverty, and increasing literacy in Kerala, which produced substantial positive change in the sociocultural atmosphere (Goodpal 2014). In contrast with Western strategies of centering development models on economic growth, the significant decrease of fertility rates in Kerala highlights the need to

"put people at the center of development and develop economy along with social and political processes according to what they need. In fact, people need many more

things other than economic growth; such as freedom to participate in social and political processes and activities, opportunity for spiritual growth, family life and relations, easy access to social support systems and quality health services, freedom from all forms of insecurities, clean environment, sufficient leisure time and so on” (Goodpal 2014).

Strong support from the state’s enlightened leadership for the people development model combined with an egalitarian ethic made the sociocultural environment hospitable to reducing fertility rates (“Box 4.1 The Kerala ‘model’”). Substantial efforts to increase literacy had immense impacts on the people development model, and it was only estimated to cost \$26 per person to maximize literacy (McKibben). With increased literacy, increased widespread education soon followed, and educated couples began to realize that the land’s resources could not support large families (McKibben). The need for large families was also minimized with decreased child mortality. Health care clinics were established with local doctors that, in addition to providing IUDs and other family planning services, delivered much needed basic health care for children and therefore dissuaded couples from needing to have multiple children (McKibben).

Complementing and partly constituting the people development model, the empowerment of women also had a major impact on reducing fertility rates. A matrilineal culture in Kerala led to decreased social stigmas of women being economic burdens on their families and encouraged women’s pursuit of literacy and higher education (“Box 4.1 The Kerala ‘model’”). Higher rates of education among women were also important as they led to an increased tendency to marry later and bear fewer children (McKibben). Additionally, the expansion of employment opportunities without barriers to female participation gave women more outlets through which they could become empowered contributors to the larger society (“Box 4.1 The Kerala ‘model’”).

Beyond a people development model and the empowerment of women, other sociocultural factors seemed to have had some impact on lessening fertility rates in Kerala. It took some influence from the militancy of the caste-reform groups and the development of leftist ideals to encourage the widespread education of Kerala’s citizens (McKibben). Religion seemed to have had its effect too as Christian citizens of Kerala tended to use traditional methods of contraception (i.e. abstinence, withdrawal) and Muslim citizens exhibited a tendency to use temporary methods (i.e. condoms, pills) (Rajaretnam 2000). Possibly due to a decreased dependence of economic prosperity on having a large family to cultivate rural fields, urban residence also correlated with an increased use of contraceptive methods (Rajaretnam 2000). By removing caste distinctions, gender discrimination, and illiteracy, which subsequently also increased political discussions and activism, Kerala became a thriving, prosperous exemplar for population control (McKibben).

In an attempt to decrease fertility rates similarly to the success exhibited in Kerala, countless family planning and contraceptive policies are currently in place throughout all levels of the world’s governments and multilateral NGOs. Outlining the advantages and disadvantages of all of them would be a daunting task. Therefore I will critically analyze a few policies in their respective contexts in order to provide general insight into how these organizations might critically assess and modify their policies individually and successfully reduce fertility rates.

It may be beneficial to first consider applying the insights from decreasing fertility rates in Kerala to NGO efforts in similar Indian states. Generally, NGO policies are aimed at doing what the NGOs consider best for the public with specific attention paid to technological needs, cost, and supply, whereas the grassroots communities prioritize understanding the information provided by policy efforts and the availability of related resources (Rajaretnam 2000). The Family Planning Association of India (FPAI), the national branch of the International Planned Parenthood Federation (IPPF), is one NGO that hopes to effectively improve family planning programs in India according to their stated objectives:

“A community-centred approach is at the core of FPAI's work. Our programmes are designed to deliver improved health and standards of living, better decision-making, and greater self-reliance. It aims to enable men and women to form local voluntary groups to initiate action in communities. Work primarily focuses on under-served rural areas and urban slums. The organization exploits a variety of media to impart its message, including film, radio, newsletters, journals and other print materials, as part of a wide-ranging education programme addressing topics such as family planning, maternal and child health, the risks of unsafe abortion, infertility, the prevention of sexually transmitted infections (STIs) and counselling for newlyweds” (“India”).

In Maharashtra, a coastal state in western India north of Kerala and home to the city of Mumbai, many sociocultural challenges face FPAI attempts to decrease fertility rates. However, one may argue that efforts in Kerala might be similarly implemented and tailored to the people of this comparable region to similar success. According to Hall, Stephenson, and Suvekar (2008), sterilization is the main form of contraception in Maharashtra, where abortion is used as a back up method. Unfortunately, an abortion costs two months' wages. Because of the local prevalence of Hinduism, immoderation in the form of frequent pregnancy is looked down upon, which leads women to have abortions secretly, only furthering the associated social stigma.

To compound this problem, local healthcare professionals encourage sterilization as the main form of contraception, and alternatives are rarely discussed. A lack of public transport also greatly limits the accessibility of this already narrowed range of services. Unfortunately, most forms of contraception, and especially misconceptions about their side effects, invoke generalized fear in the local people. Hindu ideals of moderation and self-discipline encourage traditional methods of contraception, which are not very effective. Some women believe there are 'safe days' during the menstrual cycle when having sex is least likely to result in conception, but upon investigation, it was found that the 'safe days' were actually the days conception is the most likely (Hall, Stephenson, and Suvekar 2008).

The fact that men migrate into and out of the community for work make adherence to effective forms of contraception challenging for the local people as well. Temporary methods of contraception would seem more favorable if men were not away for extended periods at a time, but some may be too expensive to utilize consistently for those extended periods. Permanent contraceptive methods (i.e. tubal ligation, hysterectomy) on the other hand seem to be accompanied by a stigma of infidelity. One may consider male birth control methods, but vasectomies are also highly stigmatized, as locals believe they will limit the men's dexterity and therefore their economic output. Because the economic

contribution of men is seen as considerably more valuable than that of women, the responsibility of being sterilized continues to rest upon the women. But even before being sterilized, there are social pressures on women to conceive children, especially boys, by their in-laws. Contradictory pressures, misconceptions, and stigmas therefore contribute to blurring the decision-making process for the women of Maharashtra.

A combined limited access to media and low education and literacy rates means most information about contraception comes from female friends and relatives, which perpetuates the aforementioned misconceptions and stigmas (Hall, Stephenson, and Suvekar 2008). The FPAI strategies overemphasize the use of media to distribute information, and therefore very limited amounts of information are received in areas of low literacy like Maharashtra.

If the main initiatives proven to be so effective in Kerala were introduced in Maharashtra, it seems that immense progress could be made. By incorporating a 'people development' model that focuses on improving literacy and increasing access to basic health services as well as a commitment to women's empowerment, fertility rates in Maharashtra may be reduced. The FPAI might be more effective in fulfilling their family planning objectives if it adopted aspects of the Kerala model. It is important to note, however, that even though Maharashtra is similar to Kerala in many sociocultural facets, it is also dissimilar in a few. For example, while Kerala has large Christian and Muslim populations, Hindu influences are more predominant in Maharashtra. Sociocultural nuances between Kerala and Maharashtra must be considered when discussing contraception options and ideas about sexual behavior. This will produce more culturally tailored family planning and contraception policies under the FPAI's main objectives and therefore more effectively reduce fertility rates in these areas.

## **Part II: China**

As a giant comparable to India in population numbers, China is also a place of potential concern regarding population growth. Surprisingly enough, China has had a strict state family planning policy in place since 1979. The commonly named one-child policy was implemented when a missile weapons engineer named Song Jian projected a substantial population boom, and using Marxist theory mixed with modernization goals, convinced leaders within the Chinese government to initiate a strict restriction on population growth (Greenhalgh 2005). Even with a lack of appropriate demographic information and acknowledgement of unpredictable factors that may have affected future population growth, the Chinese leaders accepted Song Jian's quasi-science as irrefutable, scientific fact, requiring all Chinese couples to have only one child. Over the 35 years of the policy's existence, several exceptions and adjustments have been made. Following the initial restriction to one child per couple, second child exceptions were allowed, but only in less than 5% of births (Greenhalgh 2005). Present-day enforcement is only a fraction of its initial vitality, but despite reaching replaceable level before 1993 (Greenhalgh 2001), the policy is still in place. Other exceptions to the policy have been implemented since its initiation, and therefore an increase in fertility rate has resumed.

Issues with the strict one-child policy were considerable in the rural population that made up three quarters of the nation in 1979 because "abundant research had shown that the organization of rural socioeconomic life and entrenched gender values made at least

two children and one son vital to peasant security and even survival" (Greenhalgh 2005, 268). In 1994, an ethnographic study of three villages in rural Shaanxi province outlined how fertility rates changed in response to government actions (Greenhalgh, Zhu, and Li 1994). Immediately following the implementation of the policy, the province quickly developed one of the lowest fertility rates in the nation, but, over time, the trend reversed. Economic development and increased policy enforcement from higher-level authorities through various means were crucial to regaining effective population control.

Some of the most important factors influencing the success of population goals in rural China were economic (Greenhalgh, Zhu, and Li 1994). Increasing technological sophistication of vegetable cultivation by increasing access to information and education with the emphatic support of state officials was paramount. Diversification of the economy to rely less heavily on vegetable cultivation naturally led to increased income, the affordability of leisure time for children, and consequently a growing idea that children were not necessary to provide free labor resources.

Increased policy enforcement affected various aspects of the policy and local compliance in Shaanxi. The government raised monthly wages of local cadres, penalized sub-provincial units for not meeting quota, and most importantly doubled allocations for population work, making population goals a shared priority with economic goals. A reward program for parents with two daughters provided an old-age pension after 60 years of age, provided by national and local community funds. The multilateral implementation of the local, party-led Birth Planning Association consisting of influential community members to support population control served to increase the trust of the locals in the policies (Greenhalgh, Zhu, and Li 1994). The routinization of surgical procedures and gynecological exams via the Birth Planning Association (BPA) decreased the stigma of undergoing sterilization or having an early term abortion and subsequently improved the general health of the women and their families. Shifting responsibility of enforcing family planning policy to the BPA allowed local leaders to integrate local culture into maximizing policy compliance. The BPA determined that the best time for sterilization and other surgical procedures was in the winter because it corresponded with a lag in the agricultural cycle, so economic loss from loss of labor was not significant, and because of the cold, there was a reduced risk of infection. Fines were imposed on couples with out-of-plan births, and, if the fines weren't paid, the couples were removed from the local registries to receive community land at the time of their child's marriage. Linking quality reproductive care and old age pensions for families without sons to encourage policy compliance resulted in people complying of their own accord.

A concurrent shift in family values also began to develop as a result of initial compliance with the policy and the subsequent reduction of fertility rates (Greenhalgh, Zhu, and Li 1994). Families began to believe that one child of each sex made up the ideal family. Having two sons was thought to be okay, but the idea grew that sons were unreliable in caring for their parents in old age, and because they would need to be allotted community land upon marriage, more boys meant a greater cost of arable farmland to the community. Having three children was thought to be too many because the time and energy necessary for their care by the mother reduced her economic output and were therefore too expensive. Uxorilocal behavior also altered stigmas from couples only having two daughters when they started having sons-in-law move into their homes. It lessened the

rate of married women leaving their families and usually brought new skills and economic potential to the homes of those families.

In comparison with Kerala, a culturally tailored 'people development' model and the empowerment of the local women in Shaanxi in the mid 1990s seemed to have exhibited success in declining fertility rates (Greenhalgh, Zhu, and Li 1994). Improving literacy and education, especially related to agricultural cultivation, strengthened and diversified the economy. The provision of higher quality routinized healthcare services removed stigmas surrounding contraceptive methods. The empowerment of women via uxorilocal marriage arrangements seemed to encourage utilization of family planning services. A more recent study of this area would reveal more information about the long term effects of these factors on local fertility rate. It is incredibly important to note that the success of these strategies relied on being culturally tailored to the communities of Shaanxi through the BPA. Because vegetable cultivation was the main source of income, policies regarding the season of sterilization procedures and increasing access to education revolved around the agricultural cycles. And because farmland was a precious commodity to the Shaanxi people, ownership of farmland was integrated into the rewards and penalties compliance system. Local values and driving societal forces must be considered when developing effective and thorough family planning policies.

Unfortunately, because of the strict nature of the one-child policy and the strength with which it was enforced, the Chinese people have made many sacrifices in the past three and a half decades. Since the initiation of the one-child policy, a snowball effect has damaged the social climate. Because of deeply engrained male preference and resulting female infanticide and sex-selected abortions exacerbated by the one-child policy, male to female sex ratios have grown substantially (Greenhalgh 2001). In addition to removing a large group of women, this demographic shift has created a social outcast group of unmarried men. These unmarried men in their desperation have contributed to the increase in illegal means of procuring brides including kidnapping and investment in 'mail order brides' (Greenhalgh 2013).

Interestingly enough, some Chinese interlocutors express positive responses to the one-child policy. In complete agreement with the government policy, one interlocutor said:

"the population problem simply cannot be seen from an individual perspective, as Westerners are wont to do, because it is a national problem. Marring every aspect of life in China—from development to living standards, the environment, and much more—China's "population bomb" is everyone's problem" (Greenhalgh 2001, 864).

This individual highlights the Marxist ideals of collectivist thought that bore the policy and a nationalistic devotion to ensure the survival of the Chinese people as a whole. A second interlocutor professed that, under this policy, "women have been treated no better than animals...that is a fact.' But their suffering and sacrifices will be worth it in the long run because the next generation will not be treated like animals" (868). This opinion emphasizes an interesting feminist sentiment in the scope of Marxist collective ideology by justifying the sacrifice of present-day women for the sake of generations of women to come.

The perspectives of these interlocutors underscore Dr. Susan Greenhalgh's insistence that the one-child policy and similar policies should not be condemned through the Western individualistic lens (2001). Western strategies may not initially consider



sacrificing human freedoms to achieve a goal of reaching replacement level fertility. Although these interlocutors may be expressing support for these policies publicly in order to avoid negative consequences of speaking out in opposition to their government, it should be considered that maybe a one-child policy was indeed a culturally tailored policy that was effective and justified in the Chinese cultural context.

China's one-child policy is important to understand because it exposes the very important point that advantages and disadvantages of certain population control methods must be weighed and analyzed from different perspectives. Feminists, bioethicists, and policymakers may propose different solutions to the same problem, and all concerns must be addressed in relevant cultural contexts and synthesized into a policy of maximal efficacy and sensitivity. The extreme nature of the one-child policy had effective results of reaching below replacement level fertility only 15 years after its implementation for one of the biggest populations in the world at the time (Greenhalgh 2001). However, the Chinese people at large also paid great social costs in abiding by this policy. A middle ground has to be found in which policies are firm enough to be effective, but also cause minimal damage to the social wellbeing of present-day citizens (Greenhalgh 2001). Greenhalgh outlines a model of policy implementation that includes framing the goal appropriately, implementing a policy that will effectively reach that goal, and enforcing that policy to some degree, which is an important policy model to consider because it allows framing and enforcement to be dependent upon local needs (Greenhalgh 2005).

Highlighting the Chinese one-child policy also sheds light on potential dynamics of state family planning policies that may differ from more individualistic family planning programs favored in the Western world. State laws have to be revised over time and sometimes abandoned to adapt to shifting sociocultural conditions. Perhaps the weaning of strict enforcement and the growing number of exceptions to the policy in the recent past are ways in which the government is responding to the fact that replacement level fertility was met more than 20 years ago. Strict adherence to this one child-policy may have a negative impact on the Chinese population, but abandonment of the policy may result in a population boom and an annulment of the previous decades' work. Population projections and updated statistics must be continuously incorporated into the policy's goals. Overall, this case study shows how vigorous government support and prioritization for family planning programs are needed in order for them to be effective, but also warns of the dangers of sacrificing social freedoms as a result of that prioritization.

### **Part III: Tanzania**

Even though the populations of many other countries cannot begin to compare to those of China and India, African nations including Tanzania make up 27 of the top 30 largest national fertility rates in the world with Niger, Mali, and Burundi at the top (Central Intelligence Agency 2014). Tanzania, for example, has a fertility rate of 4.95 births per woman (Central Intelligence Agency 2014) and is therefore also the subject of my research about effective family planning and contraceptive policies. There are many NGOs working in Tanzania, but I will focus on a World Health Organization (WHO) initiative called Life Skills Education (LSE), which is supported by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), the U.S. Agency for International Development (USAID), and the United Nations Children's Fund (UNICEF).

In 2008, PEPFAR was part of a \$48 billion initiative to fight HIV/AIDS, tuberculosis, and malaria worldwide ("About PEPFAR"). While combatting HIV and implementing family planning programs are seemingly different kinds of projects, they are alike in the means of reaching their goals via effective condom distribution and utilization as well as safe sex education and promotion. In order to promote effective family planning and contraceptive methods, condoms and safe sex practices must be implemented and utilized. PEPFAR's goals include "ensuring that agencies focus on core competencies," "better coordinat[ing] to maximize the effectiveness of U.S. government (USG) assistance," and "invest[ing] in innovation and operations research to evaluate impact, improve service delivery and maximize outcomes" ("About PEPFAR"). In order to fulfill its objectives in family planning, USAID "supports field-driven program design and implementation" and "advances research and innovation," while focusing on the importance of access to contraception and family planning services ("HIV and AIDS").

Both PEPFAR and USAID support LSE in promoting safe sex in Tanzania. LSE is implemented to teach life skills to local people in the hopes of those skills translating into "positive behavioral change" in relation to safer sex practices and widespread use of contraception (Higgins 2009, 65).

I interviewed Dr. Christina Higgins about her experiences analyzing the LSE curriculum.<sup>2</sup> Dr. Higgins has done research on the cultural efficacy of the LSE curriculum in Dar es Salaam, Tanzania, and perceived many pitfalls of strategies that promote safe sex through education (Higgins 2009). Higgins says LSE

"has its roots in western psychology...[and] promotes the idea of the rational individual who can take actions that will improve one's quality of life once the skills are mastered. [LSE] treats a lack of knowledge as the main obstacle to HIV/AIDS prevention and follows the logic that through expanding people's knowledge base they will automatically have greater control over their destinies" (70).

Dr. Higgins outlines the curriculum's use of 'contrast devices' to "establish the LSE perspective towards safe sex as superior to lay perspectives" (Higgins 2009, 73). Using contrast devices, the educator asks questions of the local people that are almost impossible to disagree with in order to corral the individuals. But, when the educator uses LSE to the exclusion of local knowledge while teaching the ten life skills, local people resist. For example, a group of Tanzanian interlocutors did not accept the secular approach from LSE on the concept of empathy in one of Higgins' analyses (Higgins 2009). It is not until the educator remodeled the concept of empathy to fit into a Muslim context, that local people appreciated it. Higgins writes: "Taking actions to help those in need likely fits the young men's local cultural model much better as it conforms to the Muslim tenet of *sadaka* ('charity to the poor')" (77).

The frequent deviations from the lesson plan to resolve cultural tensions with the lesson, as in the case of empathy, are often perceived as interruptions when they could be used as opportunities for local Tanzanians to discuss their cultural perspectives (Higgins 2014). Taking time to understand the perspective of the Muslim students would be enlightening in regards to maximizing the reception of LSE. Western educational models may idealize secular approaches, but these models must be reconsidered as most Tanzanians have religious affiliations.

Higgins criticizes the LSE educational model's heavy reliance on literacy through lectures, reading aloud, PowerPoint presentations, and writing on poster paper and blackboards because these can become barriers in areas like Tanzania where literacy is low. Higgins explained: "Tanzanians are some of the most chatty people in the world. They can just talk for hours and engage in huge conversation. But to have the whole room silent and listen to one person kind of monotone.... They didn't get it".<sup>2</sup> Higgins expresses a strong belief in the need to amend educational models to include more dialogic forms of education and "[treat] actual experiences as the basis of education" (Higgins 2014, 14). Higgins says that each ward even within the city of Dar es Salaam has its own challenges that could be further integrated into educational sessions to maximize connections between the information and the local people.

According to Higgins, other issues with the LSE arise when roleplaying is introduced. In roleplays designed to encouraging safe sex, male characters are almost completely absent (Higgins and Norton 2010). This may further perpetuate the idea that women are to blame for the consequences of unsafe sex. Dr. Higgins therefore stresses the need for accountability of the educators and the use of a critical eye in planning the educational tools. Higgins believes: "Strict adherence to the global cultural model in LSE...seems to alienate audiences. Educators will be more effective...if they can establish a shared understanding of the local societal problems that their target audiences face, and if they can use local cultural models in teaching life skills" (Higgins 2009, 82).

Higgins says:

"Because LSE was borne on a rationalist ideology in which knowledge leads to empowerment, the structural constraints of lived, local experiences are entirely excluded from educational sessions. It is clearly difficult for people living under the duress of poverty to prioritize self-awareness, relationship skills, and stress management when they are struggling to make ends meet or, as in the case of many Tanzanian women if they have little control over their sexual relationships" (Higgins 2009, 82).

It is important to be aware of major structural and material challenges that face these populations while providing these services and distributing information. Economic challenges are the most pronounced in Tanzania, according to Dr. Higgins.<sup>2</sup> Obstacles have to be identified and lessened in order for local people to be able and willing to actively engage with LSE and for policies to be viable initiators of family planning and contraceptive utilization in Dar es Salaam.

Although there seems to be quite a few major challenges facing LSE educators, Higgins believes there are advantages to the LSE approach as well. Its approach leads the educator of the group to establish shared perspectives without pointing out specific actions of specific members of the group, which improves group cohesion. LSE is also a legitimate venue where people can meet to discuss these issues, even if managing effective group sessions can be challenging.

Higgins believes that educators "seem to only be successful if they demonstrate the relevance of local knowledge in the global curriculum life skills, and if they finds ways to transform resistance to global cultural models through appropriating and localizing their messages of prevention" (Higgins 2009, 81). USAID, PEPFAR, and comparable

organizations would achieve greater results if they stood by their objectives wholeheartedly and made large-scale efforts to improve their policies' efficacy.

Outside the realm of LSE, Higgins describes other sociocultural factors that may hinder intercultural communication surrounding family planning and contraception. She stresses the need to acknowledge and validate traditional forms of medicine as legitimate options that must also be considered. When Higgins witnessed biomedical doctors conversing with traditional healers, she noticed that "the discussion of local knowledge and local language was more often treated as an aside to the official business at hand, which was to read through the NGO-sanctioned materials and fill in knowledge gaps that the healers were presumed to have" (Higgins 2014, 8). Again, this seems to be a missed opportunity to engage with local ideas of healing and medicine and use information gained to connect more closely with the people when discussing family planning and contraception options. Completely invalidating local knowledge and practices will only lead to a reciprocal invalidation.

Specifically in relation to family planning and contraception, Dr. Higgins believes that associated stigmas are not thoroughly acknowledged or discussed. She says nobody talks about birth control in Tanzania because of taboos, religion, and cultural traditions.<sup>2</sup> She professed that sometimes members of the upper class will engage with Western logical discourses surrounding the issue, but most discussions at other socioeconomic levels are mostly confined to the private sphere. In Tanzania and Sub-Saharan Africa, condom use and other forms of contraception can be interpreted as an accusation or a confession of infidelity, especially in the realm of marriage.<sup>1</sup> Using condoms can also be seen as blocking the flow of life energies associated with semen.<sup>1</sup> These stigmas must be thoroughly investigated and acknowledged in the realm of family planning and contraceptive services.

Cultural trauma and local history are also issues of great concern when dealing with Western developmental efforts in Tanzania and many other African nations. Higgins said: "Generally there is a lot of concern that they're not being treated the same because they have been treated as an exploitable population in the past and they're familiar with other stories of exploitation".<sup>2</sup> The local population may feel that they have been historically used as guinea pigs in drug testing and therefore may be suspicious of any substance that Western NGOs distribute, including birth control pills and lubricated condoms. Higgins emphatically believes that is important to engage with these concerns. Interlocutors must be seen as logical, and their concerns must be acknowledged and discussed in order to find ways to relieve the associated tension and mistrust.

According to Higgins, one of the most important sociocultural obstacles to promoting safe sex is a dominating patriarchal culture.<sup>2</sup> Women spend less time in the public sphere and are unable to make independent decisions regarding their sexual practices. Sometimes, boys may date girls and use condoms initially, but after six months, the boy may feel like he knows the girl well enough and feel that condoms are no longer necessary. These problems are often exacerbated by instances such as the aforementioned LSE roleplaying in which women are blamed for the consequences of unsafe sex. Higgins explains, "The idea of trying to get at men's sense of gender responsibility is a step in the direction forward...what's going to happen first, I don't know. Neither [women's empowerment nor effective contraceptive utilization] seems possible without women able to take control".<sup>2</sup>

When I asked Higgins who is responsible for bringing cultural competency to the table, she said, "Tanzania is a hierarchical place, so I would argue that it is more on the shoulders of the organizations and their outreach people who make the first connections to the community".<sup>2</sup> It will be difficult to break the mold because NGOs have been tacitly accepted as the epicenters of secure job opportunities in these communities. The NGOs and NGO educators are not critiqued by the local people and are therefore less effective at accomplishing their goals and maximizing the use of funding and resources.

Kerala's themes of people development and the empowerment of women are expressed again throughout this case study of Tanzania. Educational models like those integrated in LSE fail largely due to low levels of literacy and heavy reliance on what effective Western educational models look like. Lack of attention to women's empowerment exacerbates many of the failures of these educational models as women are less likely to attend educational sessions and are generally given less of a choice in utilizing the strategies taught therein. In a Tanzanian context, it seems that integrating cultural context is an even larger challenge than previously outlined in India and China. Cultural trauma and local history, misconceptions and stigmas, contrasting religious ideas and a passive engagement with the NGOs all have major impacts on the efficacy of family planning and contraception policies. Therefore, every aspect of policies and efforts to reduce fertility rates in Tanzania must be informed through and designed around local cultural models.

#### **Part IV: Special Considerations**

India, China, and Tanzania may be representative of nations in which the need for effective family planning and contraceptive policies is most dire, but there are examples of other areas where very specific factors must be considered.

The Turks and Caicos Islands in the Caribbean was believed to have one of the largest population growth rates in the Caribbean and Latin America combined. However, minimal efforts and research were focused there, maybe because the nation is a United Kingdom territory and was not seen as a problem area. The fertility rates have decreased recently, but this case highlights the importance of prioritizing where efforts should be targeted based on statistics and demographics. The need for accurate statistics in turn calls for an emphasis in accurate reporting of statistics. And exempting certain nations from these efforts because they are part of the Western world cannot be encouraged.

Aboriginal communities in Australia also present important factors to consider when creating effective family planning and contraceptive policies. First of all, access to family planning services and contraception is essentially absent in most of these communities, and adequate nutrition needed to lessen child and maternal mortality is often drastically low. Access to basic healthcare and contraception always has to be the first priority in family planning policies. Secondly, there is a strong traditional value of having large families early on as means to overcome high infant mortality rates and serve as an insurance policy for parents' care as they age. In Dr. Rosalie Thackrah's presentation at the Cross Cultural Health Care Conference, she explained that large families may be all an aboriginal woman has and also all she wants.<sup>1</sup> Western rationale of reducing family size can be seen as an imposing perspective in these communities, and the subtlety of approaching the 'sacred business' of reproduction is of paramount importance in these communities,<sup>3</sup>

which also compounds the difficulty of assessment and consultation on factors that contribute to decreasing fertility rates there. Access, local family values, and the tone in which family planning is discussed are therefore significant factors to consider when implementing efforts to reduce fertility rates.

Hawaii is a U.S. state that is home to a large mix of different cultures originating from Asia to North America. The Hawaii DOH has therefore made strides in providing culturally tailored media for healthcare information. DVDs in multiple languages have been produced, allowing patients to take their treatment decision aids home to discuss their options with their families in a private setting.<sup>4</sup> Committees of people from different ethnic groups in Hawaii meet to review the media and ensure the means of relaying information and options are culturally appropriate. Surveys are taken by patients to assess the effectiveness and relevance of the DVDs, and those assessments are then analyzed with intent to modify the media to better address the concerns of the people. Of course, the option of having a DVD would not be able to be incorporated into family planning strategies in many other areas of the world, but its promise for better decision-making and distributing information is significant. Dr. Dana Alden's work on patient tailored decision aids is similarly promising (Alden et al. 2014). The Hawaii DOH focuses on incorporating couples' dreams, goals, and hopes for the future in family planning discussions, which may encourage patients to reconsider having an excessive number of children. These are strategies that may be effective in other Western areas with diverse multicultural contexts if cultural tailoring is implemented when appropriate.

## **Part V: General Recommendations**

Now that I have presented a few specific cases in which effective population control policies must be integrated, I will synthesize the lessons of these areas into general recommendations for strategies on how to improve family planning and contraceptive policies worldwide. I will first outline the general processes by which policies are implemented and conveyed by NGOs and state governments. I will then suggest general characteristics that all policies must have to be the most effective in various contexts.

### **General Policy Implementation and Conveyance:**

Understanding the processes through which NGO and state family planning policies are implemented will expose steps that could be improved. It seems that NGOs would first collect and analyze data to decide where efforts should be focused. Then, NGOs probably draft their goals and design a policy to fit these goals. After proper funding is established, NGOs would initiate efforts in the targeted areas and distribute their services. Reception of the NGO's services would then precede the retention and utilization of the services by the people. Finally, one would expect goals to be met as indicated by the results.

In contrast to NGOs, state policies would ultimately follow a different implementation process. Although the first two steps of data assessment and policy planning would be similar to the NGO process, state policies are expected to be effective immediately once implemented, so the next step after implementation is to enforce the policy through various means. Only then would the results be expected to reach policy goals.

### **Research-Based Planning:**

Using research to motivate every aspect of the previously described policy implementation process is probably the most influential factor affecting policy efficacy. Information from local cultures is priceless when designing a policy, and important technological research can often inform efficient distribution strategies. Data collected to inform policy goals must be accurate and representative of the target population, and it is critical that representatives of the target population are also included in planning the policy as primary sources of information to ensure cultural relevance and appropriateness. Research on strategies to most effectively buffer outsiders' cultures' effects on healthcare distribution efforts should also be integrated.

Continuously conducting widespread assessments of the efficacy of NGO policies is very important, and even though it is helpful after efforts have been initiated, cultural data gathered from preliminary research could be also used to project the efficacy of NGO policies before they are implemented. Before planning their policies, NGOs could deploy researchers to gather information, then, with the help of target community representatives and local narratives, draft policies based on informed projections of how effective they would be. This strategy would maximize the use of funds and resources that may be otherwise expunged after attempting to integrate local culture at such a late stage in implementation. Of course there will be unanticipated cultural dynamics, but they would be less of a deterrent and financial risk if accurate information was gathered before the implementation of the policy in the targeted area.

Information obtained once efforts have begun in targeted areas should be used to constantly check and reassess current policies. Higgins stresses, "Policy should be enacted in practice and practice should inform policy, but it's not usually. Once policy is established nobody really goes to check and see that it's working".<sup>2</sup> The assessment phase is crucial to the continued success of NGO family planning policies. Reception of services may be high in some places, but even if reception is high, utilization is never a sure thing. As Higgins explains, "we can only know if we get to go into those bedrooms".<sup>2</sup> Because that is impossible, information has to be gathered on cultural ideas, myths, stigmas, and misconceptions that would hinder the utilization of family planning services provided and used to better inform policy approaches.

Policymakers must stay abreast of the latest research on distribution strategies and use funds to invest in the most effective ones. Policies must be designed with specific timelines, appropriate to the scale of the policies' goals and the pace at which efforts can be received and utilized in each cultural context. Even though efforts may not completely adhere to the proposed timelines, simply having timelines in place increases the likelihood of accomplishing hefty goals by accomplishing smaller goals incrementally.

Most importantly, policy makers must remember that when designing policies and initiating development efforts, quick fixes and large sums of money do not effectively combat issues if they are not carefully designed or budgeted based on information from primary research.

### **Incorporating Kerala:**

The people development model and emphasis on women's empowerment exhibited in the Kerala model should always be integrated into family planning and contraceptive policies. People development includes improving literacy and basic access to healthcare

among other things. Women's empowerment not only includes giving women more opportunities to contribute to larger society, but also informing men about their responsibilities in relation to their wives, girlfriends, and other sexual partners.

The importance of literacy has permeated every one of the presented case studies. Illiteracy partly leads to the formation of misconceptions, myths, and stigmas. Literacy has shown to encourage the pursuit of information and also increase the efficacy and reception of distributing information to the communities. Increasing literacy would render decision aids like Dr. Alden's more widely applicable and effective (Alden et al. 2014).

It is important to remember when attempting to increase literacy that a lack of literacy does not necessarily correlate with a lack of knowledge. These cultures have functioned perfectly well into the present day, and their forms of knowledge and communication must be acknowledged and embraced. As presented in the Tanzanian case study, policies have to integrate alternative and traditional forms of medicine into viable options for family planning and contraception. It is also important to not simply dismiss acculturated myths, stigmas, and misconceptions as unfounded or irrational. Interlocutors have to be seen as logical with valid concerns. Certain myths and stigmas are powerful media through which cultures may express their most fundamental concerns. Understanding local myths and stigmas can improve understanding of the local culture through its insecurities. That understanding can then be used to increase the efficacy of distribution, reception, and utilization of family planning and contraceptive policies.

Access to healthcare services is another important facet of the people development model. Access to condoms in Tanzania undoubtedly has had some success in promoting safer sex practices. Access to basic healthcare in Kerala reduced infant mortality and lessened some need to have a great number of children. The importance of access to healthcare and health information in Kerala is highlighted:

“With virtually all mothers taught to breast-feed, and a state-supported nutrition program for pregnant and new mothers, infant mortality in 1991 was 17 per thousand, compared with 91 for low-income countries generally. Someplace between those two figures—17 and 91—lies the point where people become confident that their children will survive” (McKibben).

It is obvious that access to healthcare services and basic contraception has been successful in reducing fertility rates, but it should be emphasized that access should only compose the foundation of NGO efforts. Access to contraceptives and basic healthcare alone can only be successful in reducing fertility rate to a certain extent. Efforts also must involve fine-tuning of approaches in distribution in order to increase reception and utilization. For example, the 1994 International Conference on Population and Development (ICPD) in Cairo stated that couples should be enabled to decide freely and responsibly and have information and means to fulfill those decisions, and NGOs must ensure informed choices and make available full range of safe and effective methods (Rajaretnam 2000). These requirements, although increasing access to services, do not also prioritize finding ways to increase reception, retention, and utilization of these services.

In the scope of healthcare distribution, Dr. Joseph Betancourt emphasizes the need for shared decision making. He says, “Science and medicine mean absolutely nothing if you can't engage people in meaningful ways so they will be a part of the process”.<sup>1</sup> Less time should be spent explaining and lecturing, and more time should be spent asking patients



questions about their concerns regarding family planning services and contraceptive options. The most important factor Dr. Betancourt attributed to positive change was encouraging incremental change.<sup>1</sup> Substantial large-scale change is not going to happen all at once. Meeting patients in the middle by acknowledging and embracing their concerns can often persuade them to make small changes in their daily lives, and that adds up to measurable change and, in the scope of family planning, a reduction in fertility rates.

The importance of women's empowerment in reducing fertility rates in Kerala was also outlined in the Chinese and Tanzanian case studies. In China, state power that overrode the autonomous decisions of women resulted in the sacrifice of their liberty to live their lives as they saw fit. In Tanzania, Higgins expressed very clear concerns about the importance of empowering women by removing stigmas and enhancing male sense of responsibility in practicing safe sex. Higgins extrapolated on the challenge when she said, "Telling men what to do differently is a huge challenge especially when it gets in the way of pleasure and freedom. I think you can use religion and family values and those sorts of messages to legitimate talking about [birth control], whether they listen or come to the table is another question".<sup>2</sup> Family planning and contraceptive policy makers also have to be mindful that women face the most direct risks associated with birth, surgical contraception, and social consequences of strict one-child policies, including kidnapping, trafficking, and death (Greenhalgh 2001, 874). Dr. Greenhalgh emphasizes that the idea of 'informed choice' has to expand beyond contraception choice to also marriage age, number of children, as well as other aspects of women's lives (874). And the reality of choice only comes from empowering women and convincing men of their shared responsibility.

The Kerala model that includes people development and the empowerment of local women seems to be applicable in very different cultural contexts, and those initiatives should be integrated into any family planning and contraceptive policy to maximize efficacy in reducing fertility rate.

### **Flexibility:**

With healthcare professionals, administrators, educators, and facilitators entering NGOs from various backgrounds and levels of cultural competency, it is very important for policies to be flexible. The most effective NGOs give creative license to the educators and facilitators working in the targeted areas. Higgins warns, "NGOs love generic double speak and that's a donor and funding consequence. It all comes from above".<sup>2</sup> This and other stipulations may influence how general policies have to be worded or framed, so making sure the educators and facilitators in the targeted area understand the policy and also supporting their flexibility in molding the policy to fit the local culture are crucial to the policy's success. Local educators can adhere to the policy and firmly implement it into the distribution and provision of services but also do it in culturally specific ways to ensure optimal reception, retention, and utilization. Incorporating local healthcare professionals and educators seems to have ideal potential for improving trust and minimizing the effect of NGO culture on hindering the distribution process, and therefore policies must allow for their involvement whenever possible as well.

### **Enforcement:**

As I examined in the Chinese case study, policy enforcement can have drastic effects on policy efficacy, especially state policies. Enforcement is a delicate matter that must be

firm to the degree of being effective but cannot threaten the social freedoms and livelihoods of those it is meant to help. Requiring employees of local businesses to attend workshops may be one medium of enforcement that would help increase the local distribution of information.<sup>2</sup> As in the case of Shaanxi, adapting enforcement and compliance systems to local economy and culture can achieve tremendous results without detrimental social consequences.

### **Receptivity:**

It seems the biggest area in which NGOs fail is remaining receptive to feedback, criticism, and outcome assessment results following policy implementation. Feedback is critical to the continued success of any policy and the fine-tuning that maximizes policy efficacy. An NGO cannot implement a policy and automatically expect results to be positive.

Ideally, feedback from researchers on how policies are working among targeted populations would serve to monitor the efficacy of the process and inform policy makers and NGOs on how to maximize their efficiency in reaching their development goals. Shockingly, when Dr. Higgins attempted to relay the information she gathered on the efficacy of LSE in Tanzania, USAID showed no interest in hearing it. Higgins said, "I think there isn't enough examination of practice from policy perspective. I don't think [NGOs] see that as their job. Some of it is hard to see and a bit unconscious. So outsiders can often see things for various reasons because they have fresh eyes, different cultural schemas".<sup>2</sup> Examining practice from a policy's perspective is absolutely and fundamentally the role of the NGOs and their collaborators. Outsiders' perspectives like Dr. Higgins's are crucial to the quality assessment of policy efficacy, and NGOs should hire people like her to conduct the assessments. If efficacy is not considered or prioritized, the policy's goals and purpose were misplaced in the planning period.

Continuous feedback from the local culture is crucial. As Dr. Rosalie Thackrah said:

"Culture is so dynamic and policies have to be fluid and have to respond to the changing nature of culture. Within culture, there's so much variation anyway so to get an overarching policy that is going to address all the intricacies of the culture is very difficult, but you start somewhere. You'd have to take advice from people on the ground about what changes are happening".<sup>3</sup>

In the scope of state policies, feedback from the citizens and state agencies involved in the policies must suggest ways to better reach the state's goals and express concerns that were not acknowledged in the policy itself. An open avenue through which citizens can speak up about their concerns should be maintained. Citizens' concerns must be embraced and actively considered when revising policies. It may be an idea I carry from a Western, American culture, but a government should ideally be a means to protect the people, not control them. In the case of the Chinese one-child policy, a heavily authoritative government strongly discourages critiques with a threat of punishment. Quashing feedback and open expression of ideas does not help meet policy goals. The people are the most accurate medium through which governments can know what is happening on the ground, and they have to be heard and treated as primary accountants of the policies' effects.

In order to be the most sensitive to the effects and social consequences of their policies, NGOs have to be considerate of different approaches to the problem the policies are attempting to solve. Feminist approaches, human rights approaches, and bioethical

approaches are but a few examples. As Dr. Greenhalgh exhibited in the Chinese case study, these approaches then need to be synthesized to be the most effectively and sensitively framed and conveyed through the policies.

In our interview, Mr. Gerald Ohta emphasized that the narratives of the local people have to be amplified and conveyed to the politicians and lawmakers so that they understand the stance of the constituents.<sup>6</sup> Again, the local people understand the problems, the challenges, and the solutions to their problems more than anyone else and must be consulted in every aspect of policy implementation.

### **Cultural Competence:**

When NGOs and other organizations are implanting themselves into various locations within various cultures, the cultural competence of their policies and their efforts immediately have the most impact on policy efficacy. Dr. Alden's work with targeting and tailoring decision aids to individuals within specific cultures is an innovative approach to integrating cultural sensitivity into healthcare provision (Alden et al. 2014). During our interview, Dr. Alden emphasized the importance of developing better assessment tools of policy efficacy and measurement tools of cultural perspectives based on a few aspects (individualistic, collectivistic, independent, interdependent tendencies) he believes are hardwired into every individual, regardless of culture (Alden et al. 2014). During assessment, however, it is important not to confuse causation and correlation. For example, in Shaanxi, assessment tools must empirically measure the number of uxorilocal marriages and show definitively that they caused an increase in the utilization of family planning services. However, this can be very difficult when so many factors and compounding variables affect behavior and decision making processes in various cultures.

When distributing family planning and contraceptive services, it is important to remember that a Western presence can be received differently in different areas. The culture of the NGO educators and healthcare professionals as well as the culture of Western biomedicine itself has to be taken into consideration. With that said, NGOs must also be careful not to over tailor their policies and make generalizations about local culture. Local culture can be thick, thin, or compartmentalized to different levels in each individual.

Reception, retention, and utilization of family planning and contraceptive services are highly dependent on the cultural competency of the NGO workers and their efforts. If the local culture is not integrated into the policy's distribution of information and services, reception will be poor and therefore retention and utilization will also be poor. When discussing who is responsible for bringing cultural competency into these state and NGO efforts, professionals I interviewed had differing opinions. Some emphasized integrating narratives from patients and community representatives into education and training of the healthcare providers. In Tanzania, Higgins says the responsibility rests on the organizations and therefore reemphasized the need to have information gathered from the local culture and integrated into policy design, LSE procedure, and the like. Dr. Thackrah's research in teaching cultural competency to midwifery students working with aboriginal women in Australia also supports this idea (Flavell, Thackrah, and Hoffman 2013). Dr. Thackrah stresses that the recipients of the care have to ultimately decide if providers are culturally competent.<sup>3</sup> Ensuring cultural security should always be the priority in international NGO work. Dr. Thackrah explained that unlearning engrained biases and colored worldviews can be just as important as learning aspects of the target culture.<sup>3</sup>

NGOs and other policy makers must also keep in mind that local history and cultural trauma may have an impact on mistrust with Western organizations. Using information about local history and cultural trauma gathered in the planning phase is critical to effectively distributing family planning and contraceptive services, knowing which products are most appropriate in the local context, and knowing how to approach the subject of family planning in that context.

**Support and Consistency:**

An NGO can fail to be effective if it is not supportive and consistent from the top administrative levels to the level of the locals on the ground. NGOs must prioritize being well versed in cultural competency in order to effectively support healthcare professionals and other NGO workers who have been trained in cultural competency prior to NGO work. Organizations should be consistent with their declared objectives and thoroughly pursue every avenue of fulfilling those objectives. The resolution of problems through the efforts of implemented policies must be framed in clear and appropriate ways. The policy must also appropriately frame the proposed solution and offer specific ways to resolve the problem. Every action thereafter should be a reflection of the policy and the NGO's objectives as to not distract or diverge from the intended goals.

**Conclusion: It Can Be Done**

No family planning policy that exists today is perfect, but efforts to improve policy efficacy must be strengthened and prioritized, as global overpopulation is a looming problem. Fortunately, practical solutions can be implemented to achieve results without violating social freedoms. Although this is arguably one of the biggest projects humankind has ever attempted, it can be completed with international and organizational cooperation, commitment from government leaders, research-based critical planning, the incorporation of proven methods, and NGO prioritization of cultural competence, flexibility, receptivity, enforcement, support, and consistency. NGOs do incredible work in so many areas and work very hard to implement culturally competent policies, but bureaucratic and logistical barriers from administrators and sponsors may hinder the efficacy of their policies in certain contexts. NGOs must combat these obstacles and keep moving forward. As Dr. Thackrah explains, "It's little by little, you make mistakes, you go back, no grand claims. Even while achieving amazing accomplishments, you always have to be willing to admit mistakes along the way. You just keep working at it with the people inclusively."<sup>3</sup> Together we can work to ensure our present success and future sustainability.

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### Notes:

- <sup>1</sup> Presentations attended includes: (Friday, January 16, 2015) "Training Initiatives in Cross-Cultural Health Care" by Tawara Good, M.A.; "Trends in Medical Education Research: Diversity and Culture" by Dr. Kevin Eva; "Shared-Decision Making/Patient-Decision Aids" by Dr. Dana Alden, Dr. Maria Jibaja-Weiss, and Dr. Chirck Jenn Ng; "Using Cultural Competency to Empower Our Future Workforce: NHC OE Pipeline Initiatives" by Dr. Winona Lee; "Legal and Regulatory Updates – CLAS Standards 2.0 Culturally and Linguistically Appropriate Care" by Mr. Mike Leoz, Mr. Gerald Ohta, and Dr. Serafin Jun Colmenares; "Cultural Orientation and Information Framing: A Theoretical Approach for Enhanced Cancer Treatment" by Ms. Ekaterina Shapiro and Dr. Jon Shapiro; "Competing Cultural Models in Tanzanian HIV/AIDS Prevention" by Dr. Christina Higgins; "Challenges in Cultural Competency Assessment; The Use of A Modified Assessment Tool in Cultural Immersion" by Dr. Martina Kamaka; "Black and Minority Ethnic Communities and Dementia: Where Are We Now?" by Mr. David Truswell; "Experiential Learning and Unlearning: Midwifery Students' Reflections on Delivering Health Care to Aboriginal Women in the Remote Ngaanyatjarra Lands, Western Australia" by Ms. Rosalie Thackrah; (Saturday, January 17, 2015) "Diversity Leadership From the Inside Out: by Dr. Janice Dreachslin; "Interdisciplinary Collaborations in Culture/Diversity at UH" by Dr. Jerris Hedges, Dr. Kathryn Braun, Dr. Mary Boland, Dr. Maenette Benham, and Dr. Noreen Mokuau; "Developing A Rational And Sustainable Health Care Plan for the COFA Micronesian Migrants in Hawaii: A Challenge For Hawaii and Its COFA Resident" by Dr. Neal Palafox, Mr. Noda Lojkar, Dr. David Derauf, Mr. Gavin Thornton, Dr. Sheldon Riklon, Mr. Joakim Peter, and Ms. Innocenta Sound-Kikku.
- <sup>2</sup> Interview with Dr. Christina Higgins held on January 17, 2015, at the Cross Cultural Health Care Conference at Ala Moana Hotel in Honolulu, Hawaii.
- <sup>3</sup> Interview with Ms. Rosalie Thackrah held on January 17, 2015, at the Cross Cultural Health Care Conference at Ala Moana Hotel in Honolulu, Hawaii.
- <sup>4</sup> Phone call with Mrs. Candice Calhoun and Lois held on January 21, 2015.
- <sup>5</sup> Skype interview with Dr. Dana L. Alden held on January 26, 2015.
- <sup>6</sup> Interview with Mr. Gerald Ohta held on January 17, 2015, at the Cross Cultural Health Care Conference at Ala Moana Hotel in Honolulu, Hawaii.