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**IPPF SURVEY OF UNMET NEEDS IN FAMILY PLANNING
1971-76**



**This report covers the main findings of the IPPF
Unmet Needs Survey presented by the Secretary General
to the Members Assembly, Edinburgh, 1977.**

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Introduction

Five years ago IPPF undertook its first systematic worldwide survey of trends in fertility and family planning. Its purpose was to explore the world's unmet needs in family planning, covering population and fertility, family planning programmes, national barriers to family planning acceptance and the respective roles of governments, associations and other agencies in organized plans and programmes and international funding.

The Survey provided a baseline of information about current demographic trends and levels of contraceptive practice in the world as a whole. The findings were presented at the IPPF Anniversary Conference in 1973 and were used to formulate guidelines for future IPPF priorities.

Among the ten guidelines laid down at the Conference, two in particular reflected the lessons of the Unmet Needs Survey. They called for the improvement and expansion of fertility regulation services, with emphasis on more effective distribution methods, and for the integration of family life and population education throughout the formal education system, for out of school youth and for adults within programmes for workers.

In adopting the guideline on fertility regulation services IPPF was renewing its commitment to a role in the provision of contraceptives, directly or indirectly. Its support to conventional clinic services continued, but great effort was placed on promoting community-based distribution services as a means of making contraceptive supplies more accessible to those distant from or wary of family planning clinics. The use of non-physician personnel, in the clinic or elsewhere, was identified as another means of making contraceptive services more flexible and accessible. In 1976-77 IPPF also increased its efforts to provide sterilization for those freely accepting this method.

Some idea of the effect of these strategies may be gained from IPPF service statistics. The number of CBD programmes throughout IPPF rose rapidly from three in 1971 to 29 in 1976. In addition, associations were promoting systems for distribution of contraceptives by field workers; within the past two years over 20 of these schemes have been initiated.

Within the clinic, 48 associations permit midwives and nurses to carry out medical duties without the direct supervision of doctors. During 1977, more than \$2 million in additional funds have been allocated for new and expanded sterilization programmes.

The guideline on population and family life education offered two types of approach; programmes designed for youth and "integrated programmes" for adults and workers, combining aspects of health or welfare with family planning. By 1976 rural programmes and integrated programmes had been set up by 57 associations. 61 associations were engaged in some form of activity which included youth as an audience, 44 of these concentrating on specific aspects: i.e. students and school children, out-of-school youth, training for teachers and youth leaders and to the involvement of youth volunteers in promoting family planning awareness.

International Women's Year 1975 gave impetus to women's development programmes which are now a prominent feature of IPPF work; 43 projects with allocation totalling \$400,000 were approved in 1977.

Against this background of programme development IPPF undertook in 1975-77 its Forward Look Study - "a thorough reappraisal of objectives, priorities and strategies which should guide its work over the next ten to 15 years." Its findings were synthesized from the views and experience of member-associations, Task Forces of volunteers and staff, and expert 'External Assessors'; they were stated in the document presented at the first Members' Assembly in November 1977.

In this study emphasis was once again placed on new delivery systems and family planning education for young people along with improvements in status of women and clear criteria for allocation of resources.

A further contribution to the corporate thinking of the IPPF was made by the Unmet Needs Survey, repeated in 1977, to obtain up-to-date estimates of the world situation and a five year review of changes in the status of family planning.

As in 1972, the Unmet Needs Survey drew upon international data sources and IPPF members, grant-receiving associations and regional offices for information about every country in the world and was conducted under the guidance of Professor J Corbett McDonald, formerly head of IPPF Evaluation Department and now honorary consultant to the department.

Comparison with 1971 findings suggests that while the situation is not profoundly different, some areas of the developing world have undergone change and may now be approaching a stage of demographic transition, characterized by low mortality and fertility rates.

In terms of programme priorities however the results show with renewed force the magnitude of need for supplies and information, the world's reliance on organized programmes, the gap between urban and rural programmes, and the ever-more urgent need to reach young people. Thus the Survey complements the Forward Look Study, offering a quantitative basis on which to judge priorities at regional and national level.

The main Survey findings were described by the Secretary-General at the Members' Assembly in November 1977. This report has been prepared to reach Regional Offices, associations and all those who provided information as soon as possible. Their co-operation is gratefully acknowledged and comments or requests for further details will be welcome.

Method and sources of information

The 1976 Survey was carried out by the same method as for 1971. Demographic data were taken from UN Demographic Yearbooks, supplemented by US Bureau of the Census. The same methods of calculation were used wherever possible.

The number of questions in the association questionnaire was reduced to compensate for the short time allowed for collecting information. Published sources were used for government service figures; the inquiry about international funds was omitted. This enabled the Survey to be completed in time for the Members' Assembly.

Availability and reliability of data

Demographic changes take a long time to show their effect and so a review of population statistics 1971-6 was unlikely to produce many surprises.

* IPPF and its Future; An IPPF Working Paper, September 1977.

Comparisons were limited further by lack of data. The most reliable and complete evidence comes from countries where rates are already low. Elsewhere, estimates for one or both of the years under review may be lacking or changes may appear which are really the result of improved statistical procedures or even of differences in presentation inspired by political or other considerations.

UN Demographic Yearbook statistics are derived from national censuses and so may be out of date for some countries. Between 1965-74, 179 countries had censuses (i.e. complete enumerations of the population) representing 74% of world population. However, the only topics universally covered were total population, sex and age. The margin of error in estimates derived or updated from these sources may be greater than any possible degree of change over five years. Among the remaining countries, 25 including 17 in Africa had never had a census.

Results from sample surveys and population projects were not used in the Survey since the primary purpose of reviewing demographic data was to compare figures from one year to another from a consistent source.

The association questionnaire was sent to 105 countries representing 63% of world population (87.2% excluding Russia and China), the same proportion as in the 1971 Survey.

94 associations returned long questionnaire and another provided partial information, representing 90% of IPPF members and grant receiving countries compared with 93% in 1971. A further four were completed by secretariat staff. All Regional Offices (except Europe) completed a 'short' questionnaire for non-IPPF countries. No new estimates were available for Russia and China.

The 1976 Survey produced a slightly higher proportion of replies to questions on levels of contraceptive practice and knowledge and access to programmes. Fewer associations estimated proportions of programme effort by government and non-government agencies, or abortion levels. However, reliability of answers had improved for most questions. 20% more replies were based on some data rather than guesswork or personal experience, for questions on contraceptive practice and knowledge and even more for abortion.

'Programme effort' and age of new acceptors were less reliable than before, possibly because the Survey allowed only a short interval for data collection after the end of the financial year. However, 1976 information could be regarded as comparable with and rather more reliable than that for 1971, with data on 'access to programme' and proportionate programme effort still on a rather low level of reliability.

Further efforts will be made to check questionnaire data against reliable indicators, to assist associations in gathering valid and useful information about national needs and the status of family planning programmes.

Survey Findings

World population

World population increased steadily from 3.6 billion to 4 billion in 1971-6. The global rate of natural increase showed little change, having been sustained by large numbers of women entering the fertile age range. These numbers resulted from high birth rates in the previous generation and also from falling death rates which allowed an increasing proportion of young people to survive into the fertile age range with consequent high birth rates. In regions with high rates, decreasing numbers of deaths would help to maintain population growth even if births were decreasing.

Nevertheless, the global annual rate of growth slowed down to 1.8% from 2.1% in 1971 (table 1). The world crude birth rates fell from 35 to 30. The crude birth rates of population is not a reliable indicator of fertility because it is heavily influenced by the proportion of women in the fertile age range; if the proportion is high, a decline in total fertility rate may not be reflected in the crude birth rate. However CBR is a convenient way of comparing the populations of different countries and regions.

Only 24% of the world's population now lives in countries with reported crude birth rates of over 40, including 98% of the population in Africa, 73% in the Middle East and 43% of Latin America.

World population and levels of crude birth rates
(population in '000s)

CBR	25 or less		26 - 39		40+	
	Pop ⁿ	Percent World Pop ⁿ	Pop ⁿ	Percent World Pop ⁿ	Pop ⁿ	Percent World Pop
1971	1093	29.6	1049	28.4	1548	42.0
1976	1164	28.9	1698	47.2	962	23.9

As in 1971, 71% of the global population lives in countries with crude birth rates of 26 or over. The shift from higher to lower rates within this group is due to five major countries, India, Pakistan, Mongolia, Burma and Egypt, which reportedly achieved crude birth rates of less than 40. For India (34.6) and Pakistan (36), this represented a fall of 8 and 14 points respectively. Possible errors in these estimates may be compensated for by high figures for some Latin American countries currently thought to be experiencing decline in CBR.

Among countries with rates of less than 26, over half were European. Nine developing countries had come into this category since 1971; the majority of these were islands.

In the Middle East and North Africa the proportion of population in very high birth rate countries declined though low birth rate countries still constituted less than 1% of the regional population. The situation was more ^{of} less unchanged in Latin America and East & South East Asia; in the latter a slightly larger population in high birth rate countries than in 1971 can be attributed to high rates of growth in Indonesia, Philippines and Thailand (figure 1).

Current fertility declines may be a good augury for family planning programmes, since contraception is one of the major means of controlling fertility, but the full force of population momentum has yet to be felt and the problem of population size in relation to resources and development remains acute. The fertility of the 1970's and 80's will ensure a young age structure and hence continued population growth during the next century.

Projections by Frejka⁽¹⁾ show that even if the world achieved a net reproduction rate of 1 by 2025 it would then have 10-11 billion inhabitants. A more gradual and realistic rate of decline (projection 5) would result in an ultimate population of 15 billion before a net reproduction rate of 1.0 was reached in 2100. Less developed countries would then have increased their numbers by four or five times. To achieve even this, the current family size of nearly five must be reduced to less than four by 2000.

Linear decline of fertility to net reproduction rate of 1.0 in years' 2020-5 and 2040-5 (Frejka)

	Projection 4, NRR = 1 in 2020-5		Projection 5, NRR = 1 in 2040-5	
	Population (millions)	Total fertility Rate	Population (millions)	Total fertility Rate
1980	4436.3	4.27	4460.3	4.39
2000	6422.1	3.33	6669.8	3.69
2100	11168.8	2.11	15102.3	2.11

Though it implies unchanged fertility in developed countries projection 5 still may not represent the maximum limit of population growth since future mortality decline and fertility levels may have been underestimated (figure 2).

Socio-economic factors (figures 3-5)

There was little improvement in factors thought to be associated with fertility levels (table 1). Infant mortality rates, perhaps the most sensitive indicator of environmental conditions, showed a slight decrease for the world as a whole from 90 to 85/1000 but statistics were particularly uneven in quality. In 60% of countries no change, or changes of less than \pm 10% were recorded. Nearly half of these were countries with 1971 rates already below 25/1000 (W. Europe, N. America, some E. European and Western Pacific countries). Increases (up to 50 points) were reported for Africa; more commonly rates were reduced, the greatest decreases (up to 100 points) occurring in Africa and the Middle East. Very high rates had previously been reported for countries in these regions; the substantial reductions reported from 1971-76 gave rise to the apparent overall decline in infant mortality.

(1) Frejka, Tomas, The Future of Population Growth. Alternative Paths to Equilibrium, Wiley & Sons, New York and London 1973 pp 224 and 225

Data was least complete in the Middle East, Africa and ESEAO, most available in MENA and Africa. Bearing in mind the link between quality of data reporting and high levels of infant deaths, these regions could be regarded as having the severest problem of infant mortality, with Africa experiencing the highest levels. Moderate declines seemed probable in Latin America and in some Asian countries (including W. Malaysia, Singapore and Philippines) Egypt and Sudan, Mauritius and some other small countries.

1975 figures for GNP per capita showed that the gap between rich and poor countries had widened in absolute, though not in relative, terms.

	<u>1970</u>	<u>1975</u>
N. America	4507	7020
W. Europe	2049	4747
China	129	350
W. Africa	125	290
Indian Ocean	99	200

Though reflecting current market prices these figures are not valid indicators of living standard. They merely reflect the scale and degree of poverty which still afflicts a major part of the developing world.

UN literacy estimates have not been published since 1973, but educational enrollment for females (1st and 2nd grade) indicated little improvement in the past five years. However, in the Western Pacific and in a majority of Latin American countries half or more girls were enrolled; so were most of the Caribbean and S. East Asian countries for which figures were available. In MENA and Africa only a small proportion of countries reached this level of enrollment. Female education is an indicator not only of socio-economic development but of the status of women which in turn is generally associated with family planning acceptance.

Women at risk, family planning and abortion

The numbers of women at risk rose at the rate of 2.5% per annum to reach 558 million in 1976 as compared with 496 million in 1971. The entry of large numbers of women into the fertile age range operated to keep this rate higher than the population growth rate.

* The number of women aged 15-44, multiplied by a factor of .628, to allow for proportions sterile or sexually inactive and for the time necessary to achieve three desired pregnancies.

West Africa experienced the highest rate of increase (21%) over the five year period, followed by Latin America and East and South East Asia (20%) and Indian Ocean Region (17%). In the Middle East, W. Pacific and Caribbean regions rates were similar to Europe (5%-8) and lower than North America (14%).

Contraceptive practice

According to association estimates, 35% of eligible couples were practising a contraceptive method regularly, compared with 31% in 1971: a world increase of about 1% a year. Western Pacific, Europe and North America had more than half of couples practising (figure 6) but a large part of the developing world was still at, or below, the 20% practice level. In MENA, Asia and the Caribbean however, the percentage practising was increasing sufficiently fast for western levels of practice, say 65%, to be achieved in the foreseeable future.

For regions where practice levels are low and rising only slowly, the outlook is bleak. Great effort would be required to reach 65% practice, even at current rates of increase. West Africa for example would require 182 years (2159 AD), and Latin America 87 years (2064 AD) compared with 31 years in the Middle East and 11 in the Caribbean.

From these rough estimates contraceptive practice levels, as distinct from age at marriage and proportion of population married, would not be sufficient to achieve the fertility decline assumed by Frejka for zero population growth by 2025, or even, in the case of West Africa and Latin America by 2100. Less developed regions alone would by then have reached 10 billion on the more optimistic projection, 13 billion on the alternative. One optimistic feature of these reported practice rates was that 1971-6 increases were highest, except for Latin America, in regions with low practice levels. If these changes were maintained as rates, (i.e. doubling in 5 years) rather than percentage changes, low-practice regions would rapidly reach levels at which family planning had a real impact on fertility decline.

Meanwhile 361 million women remain unprotected. Even excluding Russia and China (where international agencies are not active) the reduced figure is still 263 million. Over 60% of this number is made up of 15 countries each with over 2 million couples not practising (figure 7).

25% of these women were in India and two thirds of the total for Latin America were located in Brazil, Colombia and Mexico.

Among couples practising throughout the world the use of modern methods (oral contraceptive, IUD and sterilization) had increased in all regions with sterilization accounting for 74% of use in Indian Ocean Region. Increases in orals and IUDs was most noticeable in the Caribbean region, East and South East Asia region and Africa. Separate estimates for injectables were not made. 43% of couples were using other methods; large proportions of withdrawal and rhythm users were reported in East and West Europe, and of condoms in the Western Pacific (table 2).

Increased percentages of couples practising contraception do not necessarily indicate greater impact on fertility. As those already practising grow older, their potential fertility diminishes and so the contribution made by family planning efforts to fertility decline decreases. Hence any real improvement in levels of practice depends on the proportion of young couples involved. Age-specific rates of practice were not covered in the survey, but studies of countries where most practising couples are in contact with organized programmes indicate a shift towards younger programme acceptors.

Abortion

According to the available estimates, approximately one pregnancy is deliberately terminated for every three live births in the world as a whole, suggesting a total of 34 million abortions per year.

Fewer associations gave an abortion figure, as distinct from an estimated range, but a higher percentage of answers were based on data rather than guesswork or personal experience. This perhaps indicated that associations without access to recent abortion statistics preferred not to make yet another guess.

	<u>No of replies</u>	<u>Replies based on data</u>	
		Number	Percentage
1971	89	32	36
1976	69	56	81

The number of countries (106) with no or few legal abortions decreased, reflecting legislative changes since 1971. The overall distribution of illegal abortions remained practically unchanged. 16 countries reported no abortions at all. High legal rates, above 200/1000 live births, occurred mainly in Europe and Western Pacific countries and were often combined with high illegal rates. Eastern Europe rates had nevertheless declined. Of 41 countries reporting no legal and less than 50 illegal abortions per 1000 live births, 29 were in Africa. All Latin American countries reported some illegal abortions, mostly at high levels. Asian countries had illegal rates up to 200 and low legal rates (figure 8).

North America showed a clear increase in legal abortions. Estimates of legal abortions increased noticeably in India (along with growing numbers of illegal abortions), Indonesia and Turkey reported increases in illegal abortions.

Among 180 countries for which abortion estimates were recorded, the largest single group had low abortion and low contraceptive practice levels. 46 of the 58 countries in this category were in Africa and MENA. The majority of Latin American countries had high abortion and low practice rates. The majority of very high abortion estimates were for West and East European countries with high practice levels.

Contraceptive knowledge and access to information and education programmes

The global proportion of couples with adequate knowledge of contraceptive methods remained the same in urban areas and actually increased in rural areas. 86% of all countries reporting knowledge levels estimated that half or more of urban couples had adequate knowledge and 51% did so for rural couples, compared with 80% and 41% respectively in 1971. East Africa had improved most.

Although adequate knowledge among rural couples was claimed by more associations no marked changes were indicated since 1971; the improvement was made up of small favourable shifts in several regions. However, MENA and Indian Ocean estimates were more conservative than previously; Pakistan's assessment was lower for urban and rural and Sri Lanka gave a low separate estimate for rural instead of the former combined total. Even in N. America

(Canada) 'most' couples were regarded as having sufficient knowledge rather than 'all' as before. Since reliability of answers had improved on this question, better information and more cautious estimates may have been used. In any case, with only half the couples of the world having sufficient knowledge to plan their families, a need for family planning information was clearly indicated in all regions (figure 9).

Percentage of couples with adequate knowledge

	Urban	Rural	Total
World (excluding USSR and China)	70%	51%	55%
Developing regions	67%	46%	49%

The proportion of adults reported as having adequate access to information and education programmes, had hardly changed since 1971, except for women after childbirth.

Access to information and education programmes 1971-1976

	Adults		Women after childbirth	
	N. America & Europe	Other countries	N. America & Europe	Other countries
1971	64	55	57	40
1976	68	56	77	55

Among youth levels of access were low. Despite some improvement over 1971, estimates for "other countries" showed that three quarters of children under 15 and over half those over 15 still had no access to I&E programmes.

	Youth 15		Youth 15	
	N. America & Europe	Others	N. America & Europe	Others
1971	32	16	46	32
1976	30	23	51	43

For those over 15 years old 27 countries reported improved access; but 14 other remained in the 'very few' category. Except for Sudan, all MENA countries reported less than 40% of youth over 15 with access: two thirds of African countries also fell below this level. ESEAOR and Caribbean countries concentrated in the 20-60 range access. Those reporting access for 'almost all' youth over 15 were Singapore, Colombia, Sudan, the Caribbean and four European countries.

For youth under 15, only 18 countries showed any improvement. 41 provided access for 'very few' in this age group, compared with 50 in 1971, and in all regions the majority of countries reported less than 40% with access. Thus the level of access for youth under 15 was uniformly low.

Countries reporting greater access than in 1971 included only 5 of the 15 countries with more than 2 million women at risk and unprotected by contraception. These were Indonesia, Colombia, Mexico and, for youth over 15 only, S. Korea and Japan.

Organized family planning programmes

A substantial proportion of practising couples were in continuing contact with organized contraceptive services, a situation more or less unchanged from 1971. About 60% of countries reported that more than half of practising couples were served by organized programmes; most associations in Africa and Asia were in this category. Larger proportions of unsupervised practice were reported in Europe, North America and Latin America, but only 13% of women at risk lived in countries where 'most' or 'almost all' couples practised without guidance.

Family planning programme acceptors

Organized contraceptive programmes accounted for 22.4 million recorded new acceptors, thus keeping up with increased numbers of women at risk.

	Women at risk not practising (millions)	New acceptors	
		Number (millions)	Percent of women at risk not practising
1971	249.6	12.9	5%
1976	263.6	22.4	8.5%

The 'acceptor index' (1) showed that Indian Ocean and ESEAO programmes had substantially increased their impact; while MENA, Latin America and the Caribbean were keeping up with the flow of women into the fertile age range. In E & W Africa, the index value had not improved much since 1971 and was still well below the 'break even' value of one.

Acceptor index values 1971-76

	1971	1976
East Africa	0.44	0.65
West Africa	0.15	0.17
Middle East & North Africa	1.47	1.35
Indian Ocean	1.79	3.32
East & South-east Asia & Oceania	1.20	3.38
Western Hemisphere	5.7	3.4
Caribbean	0.86	1.96
L. America	0.56	1.08
N. America	2.24	3.38
World (excluding USSR and China)	1.21	2.5

IPPF had 2 million new acceptors (including N. America and Europe), an increase of 16% over 1971 figures. This represented a tenth of all new acceptors in organized programmes and rather less than 1% of all women at risk (outside Russia and China) unprotected by contraception. The overall age distribution of IPPF acceptors had not changed except for a slight increase at younger ages. West Africa, W. Pacific, ESEAOR showed an increase in acceptors under 25, but Latin America had hardly changed and MENA and IOR (perhaps because of sterilization) recorded smaller proportions of young acceptors (figure 10).

The overall proportions of oral contraceptives, IUD and sterilization acceptors were roughly unchanged from 1971 but condom acceptance had increased and injectables, reported by 44 countries, had contributed 1.5% of total new acceptors (table 3).

Even allowing for possible under reporting in the past (many condoms having been previously classified with other methods), the 1976 condom figure appears to represent a genuine increase in use of the method. The number of associations reporting condom acceptors in the clinic rose from 36 in 1971 to 58 in 1976.

(1) An acceptor index value of 1 represents the number of women or couples which must be recruited to maintain current levels of contraception.

Over 1.5 million of IPPF's new acceptors were recruited by 73 associations in developing countries which reported programme statistics for the year. 21% of this number were in community-based programmes in Western Hemisphere and Indian Ocean regions. Sterilization cases represented 10% of new clinic acceptors in these countries, the number of associations offering sterilization having increased from 5 in 1971, to 35.

Availability of organized programmes

Only 5% of the world's population had no organized family planning programme of any kind - the same proportion as in 1971. The proportion of programmes run by governments alone increased slightly, and there was also a definite shift towards combined government and association programmes (table 4). The proportion of private programmes alone, mostly in small countries, decreased. Brazil was the only large country in this category.

Proportion of world population covered by private and government programmes

	Private	Government	Private & Government	None
1971	13.0	30.0	52	5
1976	4.7	32.2	58	5

While these figures indicate widespread government involvement they do not show the relative contribution of association and government to combined programmes. 39 associations provided over 80% of the national I&E effort. For training of medical and other personnel, 80% of effort was provided by 20 and 33 associations respectively. 17 associations provided 80% of effort for medical and clinical services. The associations' contribution was substantial for all types of programme in Africa, Latin America and the Caribbean.

The proportion of financial effort contributed by government had increased for all types of family planning service as shown by the proportion receiving 'mostly' of 'nearly all' government support.

Percentage of associations reporting effort
'nearly all' or 'mostly' by government

	No of Countries	Clinical Services	I & E	Training Medical	Other
1971	86	43%	19%	37%	25%
1976	80	56%	31%	47%	36%

The majority of other countries reported 'very few' services by government. As in 1971, government and association did not often contribute in equal proportion to any type of service. One or the other bore the major costs (figure 11).

International assistance

The amount of population assistance doubled since 1971 to \$290 million in 1976 (estimated \$314 million in 1977), but was still only 2% of total official development assistance. A temporary increase occurred in 1974.

The amount handled by UN agencies went up by only 50%; whereas IPPF's budget increased 2½ times. Fifteen new governments were added to its list of donors, 11 from developing countries.

Spending by national governments on domestic family planning programmes rose from nearly \$408 million to approximately \$670 million in 1975. India set aside \$688 million for the current Five Year Plan 1974-9. Pakistan proposed to earmark nearly \$31 million for development period 1977-83.

It is difficult to draw any conclusions about the real increase in value of funds allocated to family planning.

Barriers to family planning

The overall incidence of serious or moderately serious barriers to full acceptance of family planning had increased slightly (figure 12). A more important change was in the nature of barriers reported.

The incidence of barriers recorded by North America, Europe and Caribbean countries had decreased but Latin America reported an increase. As before

laws and regulations and attitudes of government or medical profession were not serious barriers, each being mentioned by about 20 countries. Only religious attitudes, mentioned by 45 remained as a relatively serious barrier, especially in Europe and N. and Latin America. On the part of the acceptor, antipathy to modern methods was again a serious obstacle in only 28 countries.

Thus barriers which depended on policies of other agencies and attitudes towards family planning appeared in general to have decreased in importance. Judgements as to what constitutes a barrier are evidently influenced by the associations' view of country needs and its own role.

For example, 44 associations reporting over 50 illegal abortions per 1000 live births nevertheless described themselves as having no serious legal barriers.

Among the operational factors affecting acceptance of family planning, lack of staff improved (45 mentions) but was still an important barrier, lack of public media (37) remained at the same level and lack of finance (47) had worsened. Lack of supplies was least important with only 12 mentions.

The most frequently mentioned barrier, inadequate access to supplies and information (53), was prominent in all regions and had also worsened since 1971. This indicated awareness of the need for greater scale and availability of programmes, a frustration echoed in the low levels of access to programme reported for young people and those in rural areas.

Summary

The IPPF Survey of Unmet Needs in Family Planning is unique in attempting to establish a baseline of systematic information about family planning and fertility trends throughout the world. It gives a picture of programme needs and priorities on a global scale and describes the role of family planning associations in the context of government activity.

Much of the information required for the Survey was available only in crude and unreliable form. Lack of data prevented many associations from describing their national situation precisely; the need for information might well be included in their unmet needs. Nevertheless, even imperfect data can illuminate major needs and problems which must be tackled if the world's family planning priorities are to be met.

The brief demographic review included in the Survey emphasized the scale of the problem and the world's rapid progress towards a total population at least three times greater than its present 4 million inhabitants. Though its rate of growth has slowed down and the global birth rate has declined slightly, large numbers of women are still entering the fertile age range, creating the lag in population decline which renders large numbers of births inevitable in the near future. Already 558 million women are "at risk" of unwanted pregnancy.

On the positive side, levels of contraceptive practice have been maintained and some parts of the world show distinct signs of change. Indian Ocean, MENA, ESEAO and the Caribbean had higher practice rates, as well as higher acceptance rates in organized programmes, than in 1971. If these rates of change were maintained, modern levels of practice could be achieved in the foreseeable future. A distinction can be drawn between regions where change is occurring even though current levels of practice are relatively low, and others where practice levels are static at a rather low level (Latin America) and others, less densely populated, where contraceptive practice is still extremely limited (East and West Africa). This distinction also holds roughly for levels of knowledge and programme activity.

Wider availability of legal abortion and a decrease in the incidence of official attitudes as barriers to full acceptance of family planning were favourable aspects of change for 1971-76. Organized family planning programmes have expanded to keep up with increasing numbers of women at risk; more effective contraceptive methods are being promoted; family planning knowledge and access to programmes has increased, at least among adults.

Nevertheless, only half the adult population of the developing regions have adequate knowledge. Access to information and education programmes is largely restricted to adults and women after childbirth; and the lag between contraceptive knowledge and practice noted in the 1971-72 Survey seems to be more pronounced.

The world depends heavily on organized programmes. 65% of women at risk live in countries where organized programmes serve half or more of practising couples, the majority in Asia and Africa where practice rates are low. Organized programmes reach only 8.5% of women at risk of unwanted pregnancy.

High illegal abortion rates persist especially in Latin America and though abortion has been legalized in many parts of the world abortion services are, as in India, a major unmet need.

From these findings the foremost needs in world family planning can be summarized. Large numbers of women are at risk, particularly those in 15 large countries which together contain 60% of all women not yet protected by contraception (outside USSR and China). Modern methods of contraception and safe abortion are still not available to the majority of women.

Priority groups have been identified but are not being reached on a large enough scale. Younger acceptors of efficient methods must be recruited if they are to exercise their human right to control fertility. Many factors in the modern world are encouraging smaller desired family size, including family planning programmes themselves. The deficiency in numbers of young family planning acceptors, the relative failure of information services to reach rural couples and youth and the discrepancy between levels of knowledge and practice are indications that family planning programmes are failing to meet human needs.

Operational factors such as lack of staff, finance and access to programmes were most frequently quoted by association as barriers to family planning acceptance but were often not sharply defined. For example few associations mentioning lack of staff as barriers, specified the type of staff required.

Associations also differed in their perception of barriers. Only two mentioned regulations preventing para-medical personnel from inserting IUD's, although only 48 associations permit midwives and nurses to carry out clinic duties unsupervised by doctors. Associations reporting over 50 illegal abortions per thousand live births nevertheless described themselves as having no serious legal barriers. The overall picture however was one of inadequate access to family planning services and information, showing that associations were fully aware of programme deficiencies. They were already playing a substantial part in all types of service programme and a continuing role in information, education, training and contraceptive delivery systems was clearly indicated.

IPPF's overall position had strengthened with increasing external support. Income from donor governments had more than doubled, allowing steady programme expansion. A substantial part of programme development was directed towards promoting more accessible distribution services and more effective methods such as sterilization, and reaching rural communities, youth and other target groups through the integrated approach.

The problems indicated by the Survey might be summed up as problems of priorities. Large countries with increasing numbers of women at risk have problems of a different order for other countries. Even if fertility is declining the rate of decline must accelerate in order to check population growth rates.

The Survey findings appear not merely to justify IPPF efforts at identifying criteria for resource allocation but to place urgent priority on areas where population numbers are swelling most rapidly. They clearly indicate the need for all possible effort towards the goal of making family planning freely available throughout the world.

Acknowledgements

The co-operation of Miss E Hofstatter of the Population Council, Inc. and of Mr J Gelb, USAID Family Planning Division in providing information about national family planning programme acceptors and of Dr Malcolm Potts in making abortion data available before publication of his book* is gratefully acknowledged. Dr S Baum, USAID Bureau of the Census once again provided demographic data for the Survey.

* Potts M, Diggory P, and Peel J, Abortion Cambridge University Press 1977

Figure 1 REGIONAL RATE OF POPULATION GROWTH, 1976.

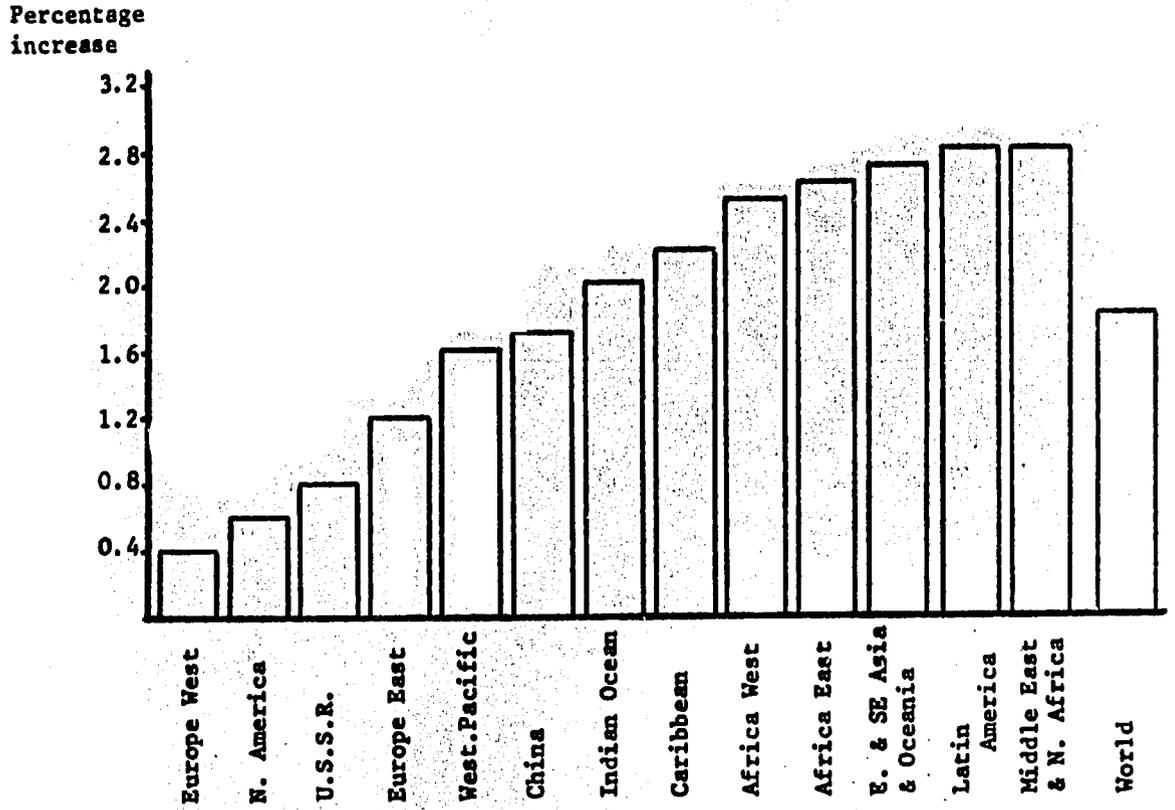
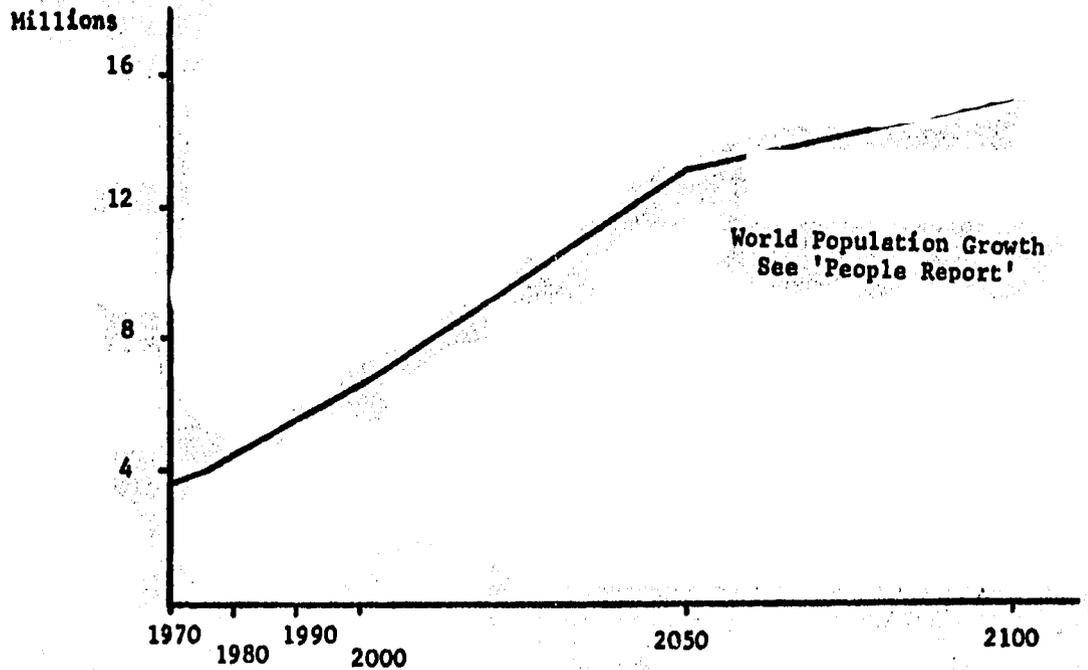


Figure 2 WORLD POPULATION GROWTH, 1970 - 2100.



Source: T Frejka, 1973.

Figures 3,4 & 5 SOCIAL AND ECONOMIC INDICATORS

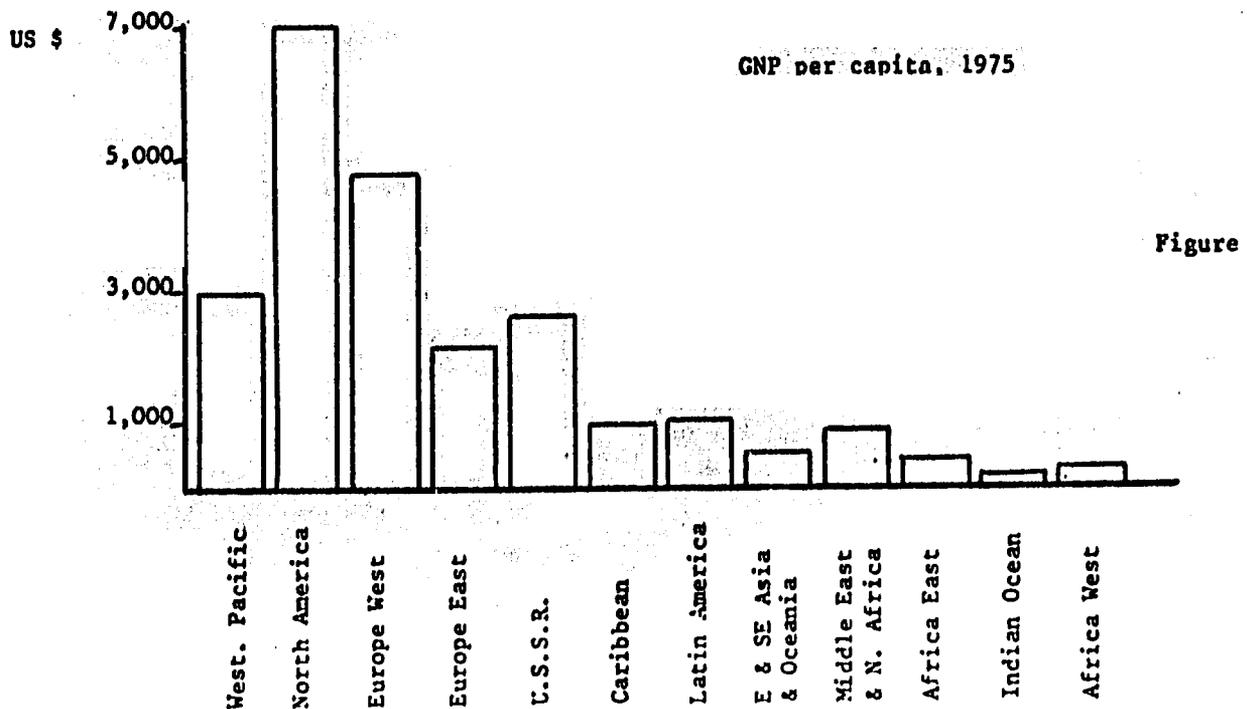
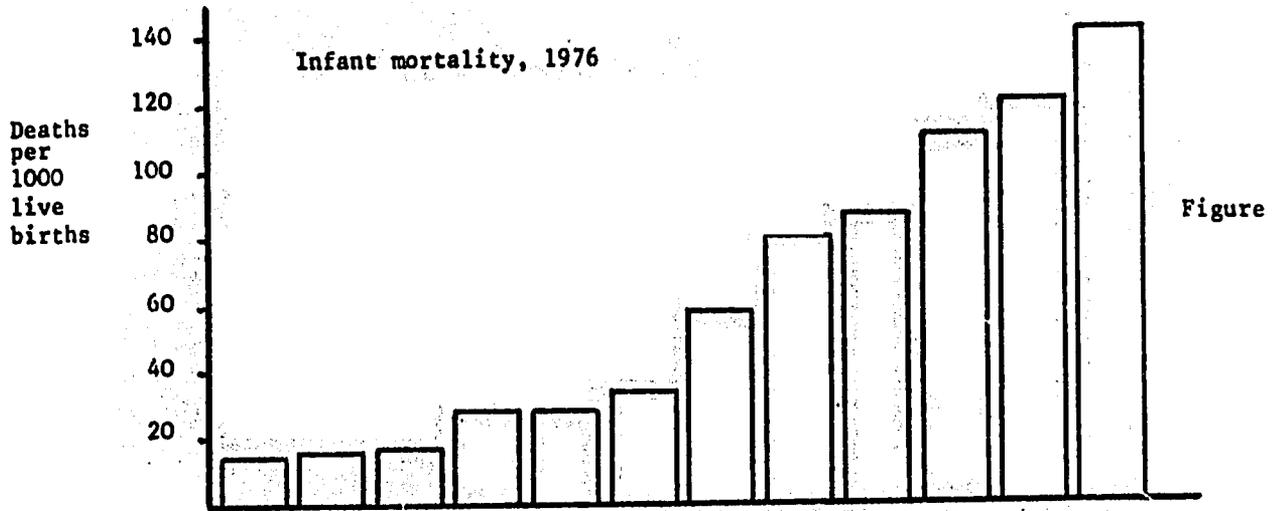


Figure 6 CONTRACEPTIVE PRACTICE LEVELS, 1971 & 1976.

% of eligible couples practising

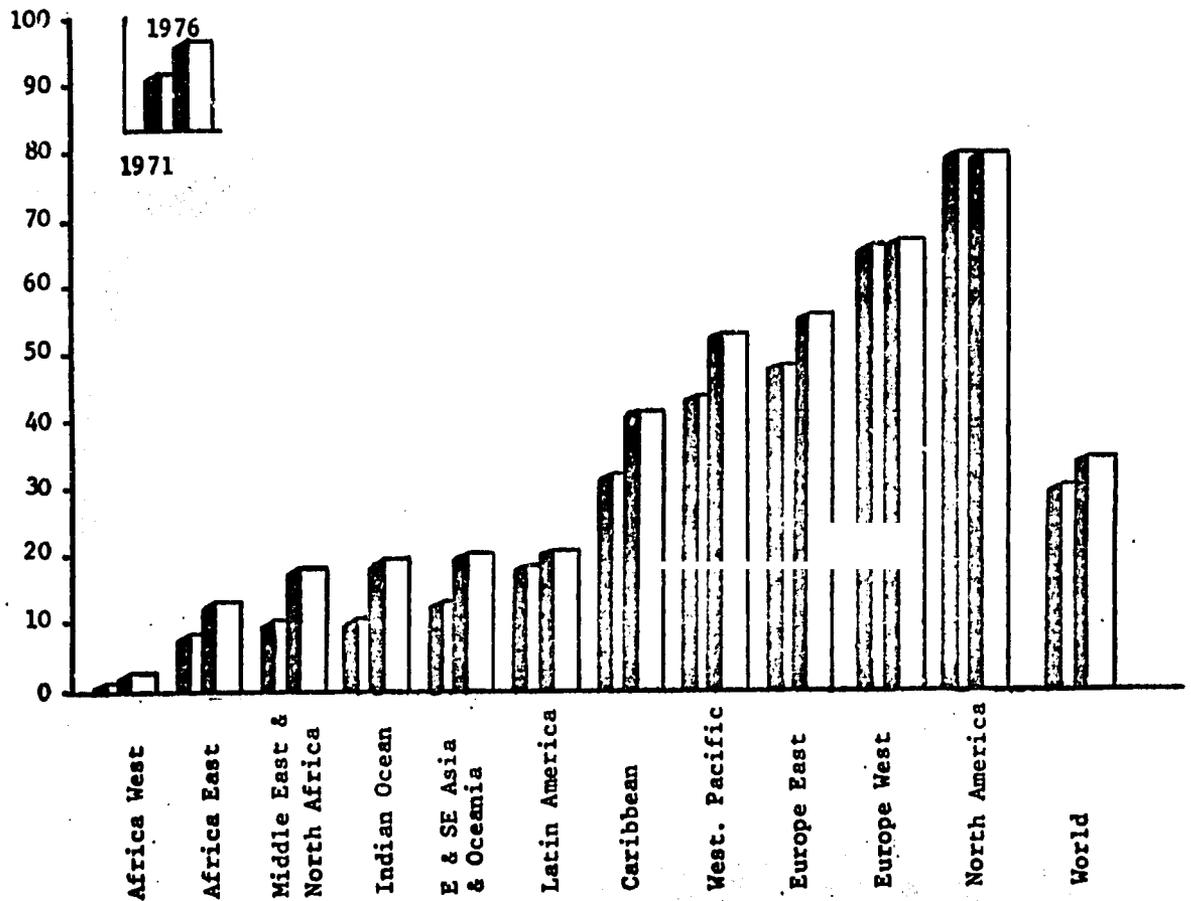


FIGURE 7 WOMEN AT RISK STILL UNPROTECTED - 15 COUNTRIES 1976

Birth Rate 1976	10 million & over	6-9 million	2-5 million
Over 40	<u>INDONESIA 15.4</u>	<u>NIGERIA 8.6</u> <u>BANGLADESH 9.2</u>	PHILLIPINES 4.5 THAILAND 4.2 IRAN 3.6
26-39	<u>INDIA 65.2</u> <u>BRAZIL 13.9</u>	<u>PAKISTAN 8.8</u> <u>MEXICO 7.1</u>	EGYPT 3.0 COLOMBIA 2.1 S.KOREA 2.8
25 & under		JAPAN 6.5 U.S.A. 6.0	

All women at risk	558 million
World total women at risk not protected	263 million
15 large countries with over 2 million unprotected	161 million
7 large countries with over 2 million unprotected & CBR over 25	128 million

Figure 8 ABORTION WORLDWIDE, 1976

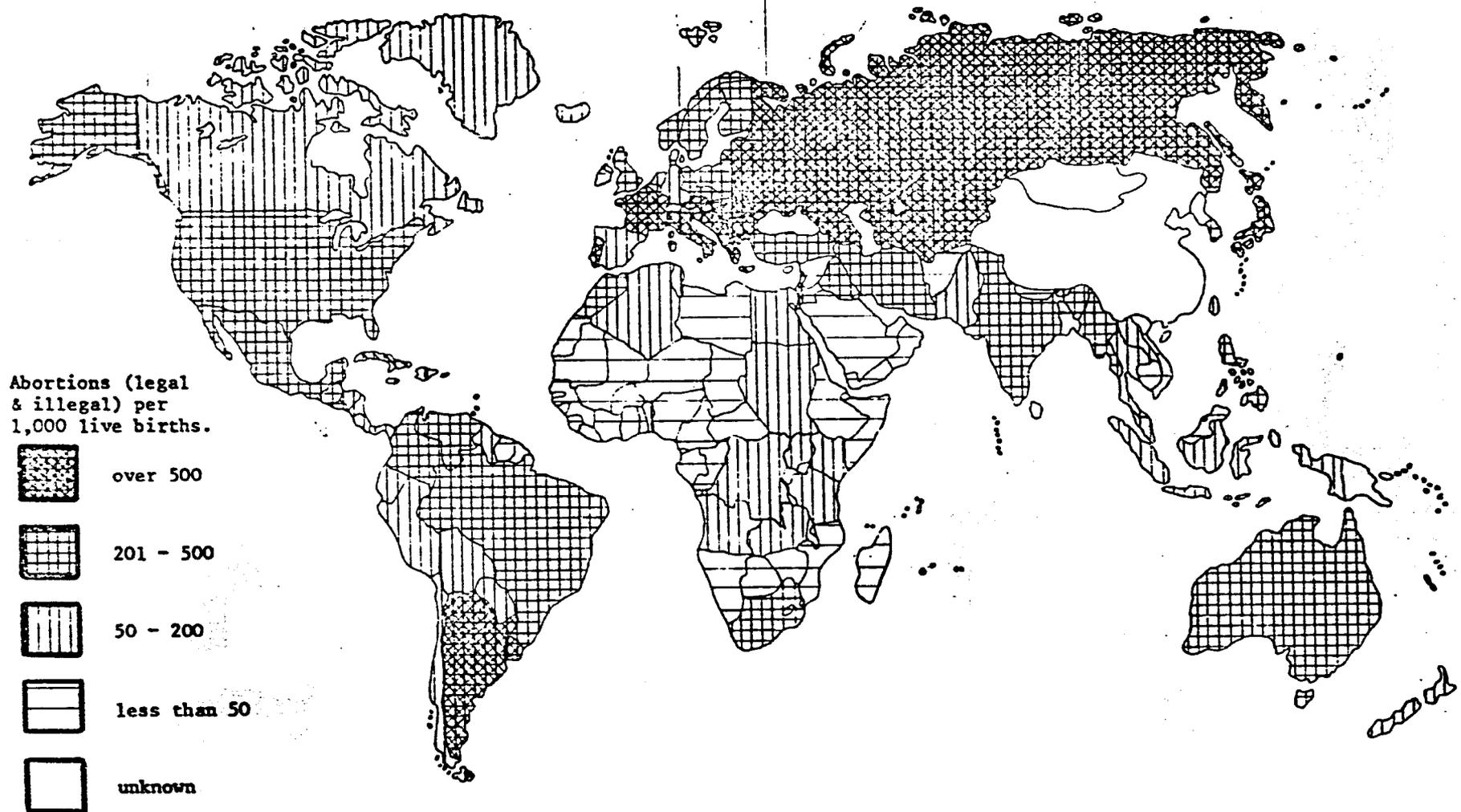


Figure 9 PROPORTION OF WORLD POPULATION WITH KNOWLEDGE OF FAMILY PLANNING, 1976

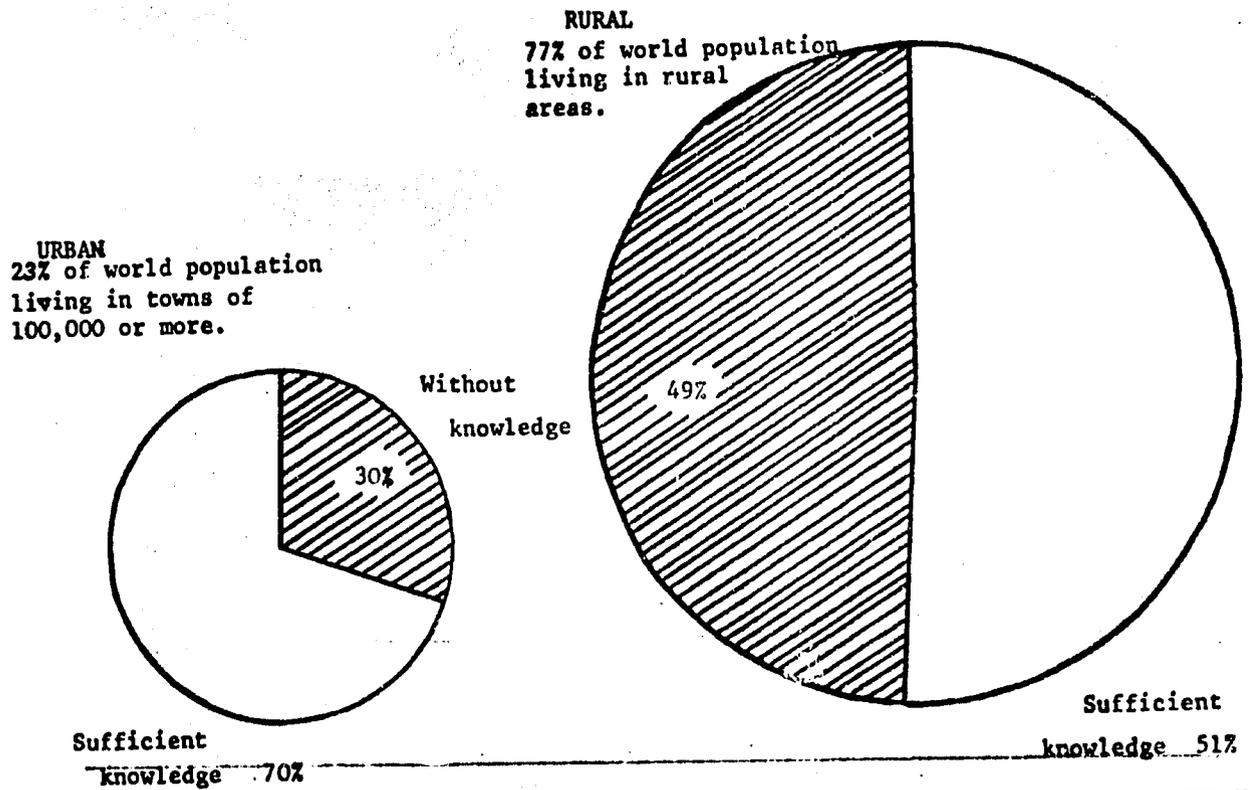


Figure 10 PROPORTION OF NEW ACCEPTORS AGED UNDER 25 YEARS - IPPF, 1971 & 1976

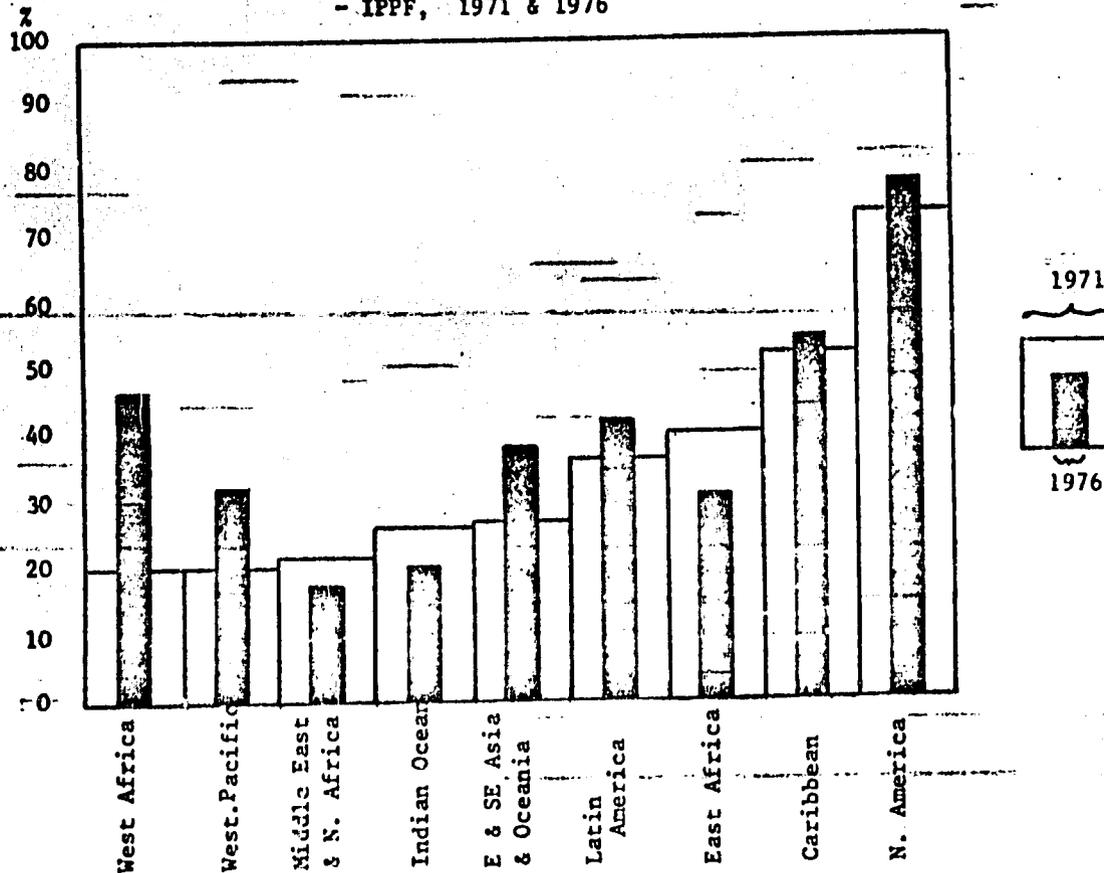


Figure 11 ASSOCIATION CONTRIBUTION TO SERVICE PROGRAMMES, 1976

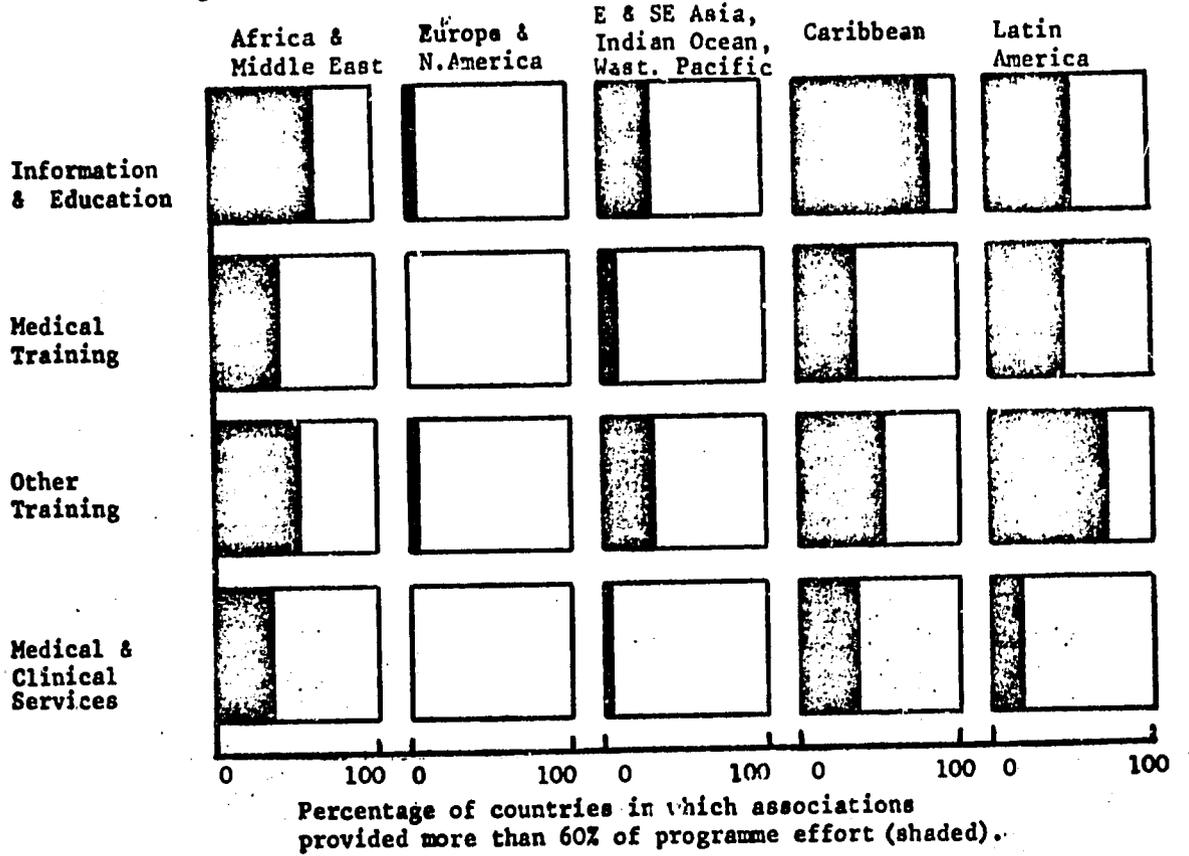


Figure 12 SERIOUS OBSTACLES TO FAMILY PLANNING - IPPF, 1971 & 1976

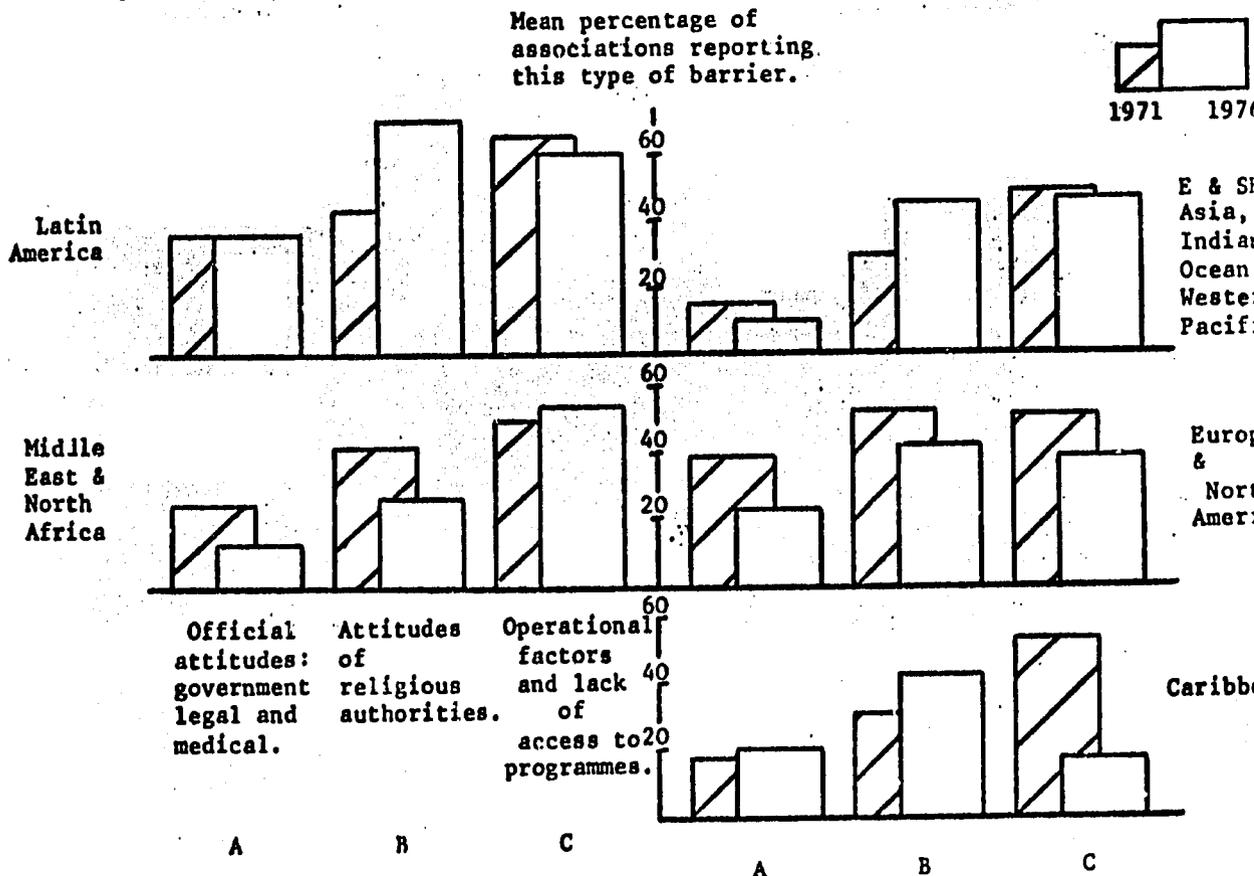


TABLE 1 WORLD POPULATION, SOCIAL AND ECONOMIC INDICATIONS

Region	Population ('000's)		Rate of Natural Increase (Average)		Infant Mortality Rate		GNP Per Capita		Percentage Female Educational Enrollment 1973
	1971	1976	1960-70	1971-76	1970	1976	1969	1975	
AFRICA - East	126,662	145,599	24	28	139	110	223	400	35
West	141,229	162,878	23	29	148	142	125	290	26
EUROPE - East	171,587	181,018	11	11	54	28	1,155	2,150	79
West	328,951	334,430	9	3	23	17	2,049	4,747	90
U.S.S.R.	245,066	256,644	12	9	25	28	1,769	2,620	91
INDIAN OCEAN	712,393	810,978	25	18	121	121	99	200	41
MENA	178,277	165,233	30	21	133	87	293	870	34
ESEAO	309,938	345,549	28	22	110	80	269	530	54
CARIBBEAN	27,119	27,638	21	16	62	34	542	960	69
L. AMERICA	259,601	295,714	30	25	79	58	458	1,040	67
N. AMERICA	228,601	237,314	14	7	20	16	4,507	7,020	98
W. PACIFIC - China	787,176	875,000	18	(21)	122	-	129	350	-
W. PACIFIC - Others	172,350	186,423	17	16	24	15	1,134	2,970	91
WORLD	3,688,950	4,024,418	21	18	90	85	821	1,450	
Countries with birth rates under 25	1,126,885	1,164,304		<u>CDR</u> 9		20		4,290	93
26-40	1,047,015	1,898,341		14		110 78	without India	340 440	49 (excluding China)
40+	1,515,050	961,773		17		95		390	41

TABLE 2 PRACTICE RATES 1971 and 1976

REGION	YEAR	WOMEN AT RISK	PRACTICE %	ORALS & IUD	STERILIZATION	OTHER	ANNUAL INCREASE IN PRACTICE RATE	WAR NOT PRACTISING
E. AFRICA	1971	16,900	8.2	48	1	51	1.08%	15,514
	76	19,674	13.6	61.5	7.5	31		16,998
W. AFRICA	1971	19,100	1.2	72	1	28	0.34%	18,870
	76	23,200	2.9	87.5	0.1	12.4		22,527
E. EUROPE	1971	23,400	48.7	14	<1	86	1.46%	12,004
	76	24,910	56	18.9	0	81.1		10,960
W. EUROPE	1971	40,900	66.2	27	2	71	0.16%	13,824
	76	43,228	67	31	2.14	66.86		14,265
U.S.S.R.	1971	33,100	40	5	0	95		19,860
	76	(34,652)	(43)					(19,752)
INDIAN OCEAN	1971	92,100	10.9	16	61	23	1.82%	82,061
	76	111,923	20	16	74	10		89,538
MENA *	1971	24,400	10.7	73	1	26	1.52%	21,789
	76	21,069	18.3	82.4	1.4	16.2		17,213
ESEA0	1971	41,200	13.8	57	3	40	1.42%	35,500
	76	49,566	20.9	75.12	8.08	16.8		39,207
CARIBBEAN	1971	3,500	32.4	25	2	73	1.9%	2,366
	76	3,769	41.9	58.2	14.7	26.7		2,190
L. AMERICA	1971	34,300	18.9	72	2	27	0.48%	27,817
	76	41,127	21.3	73.9	2	24.2		32,367
W. AMERICA	1971	29,200	80	43	15	42	0	5,840
	76	33,419	80	50.4	16.6	33		6,684
CHINA	1971	112,200	35	34	33	33		72,930
	76	(124,714)	(37)					(78,569)
WESTERN PACIFIC	1971	25,200	44.1	19	6	75	1.8%	14,087
	76	27,250	53.1	22.5	9.1	68.4		11,612
WORLD	1971	495,500	30.9	31	16	53		342,390
	76	(558,501)	(35)					(361,882)
WORLD, EXCLUDING U.S.S.R. & CHINA	1971	350,200	28.7	33	11	56		249,600
	76	399,135	34	38	19	43		263,561

* Excluding Iran (4.4 million women at risk) which in 1976 formed part of IPPF Indian Ocean Region.

TABLE 4 PROPORTION OF REGIONAL POPULATION BY TYPE OF PROGRAMME

REGION	YEAR	PRIVATE	GOVT.	PR. & GOVT.	NONE
E. AFRICA	1971	41	1	46	13
	'76	12.7	1.1	70.7	15.5
W. AFRICA	1971	60	0	13	27
	'76	10	0	67.7	22.3
E. EUROPE	1971	0	19	62	19
	'76	0	28.2	53.5	18
W. EUROPE	1971	41	<1	48	11
	'76	1.1	0.1	87.8	11
U.S.S.R.	1971		100		
	'76		100		
INDIAN OCEAN	1971			100	
	'76			100	
MENA	1971	22	12	55	11
	'76	6.6	15.3	71.5	6.6
ESEAOR	1971	4	7	79	9
	'76	0.1	13	74.4	12.5
CARIBBEAN	1971	3	34	59	3
	'76	3.3	53.9	42.4	0.4
L. AMERICA	1971	55	<1	45	<1
	'76	46.9	9.3	43.6	<0.1
N. AMERICA	1971			100	
	'76			100	
CHINA	1971		100		
	'76		100		
WESTERN PACIFIC	1971	2	0	88	9
	'76	0	0	90.4	9.6
WORLD	1971	13	30	52	5
	'76	4.7	32.2	58	5

TABLE 3 NEW ACCEPTORS IPPF 1971 and 1976 - 29 -

REGION	YEAR	AGE OF NEW ACCEPTORS				METHODS ACCEPTED						NEW ACCEPTORS REPRESENTED
		NEW ACCEPTORS REPRESENTED	425	25-34	34+	Or.	Inj.	IUD	C	Oth.	St ^e r.	
E. AFRICA	1971	86,500 (9)	40	30	30	71.6	12.5	4.3	10.5	1.0		86,500 (9)
	76	76,178 (9)	31	51	18	55.3	11.4	14.2	4.9	13.6	0.5	76,178 (9)
W. AFRICA	1971	48,800 (6)	20	43	37	37.7	29.7	8.2	23.2	1.2		48,800 (6)
	76	28,783 (3)	47	27	26	55.6	6.6	12.2	7.4	18.2	0.1	76,188 (9)
E. EUROPE	1971	58,159 (1)	30	49	21	25.7	71.3			3		81,800 (2)
	76		No information			30.9	0	40.8	20.9	7.4	0	14,461 (2)
W. EUROPE	1971	421,400 (5)	57	31	11	58.6	10.3	1.7	16	13.3		421,400 (5)
	76		No information			No information						
INDIAN OCEAN	1971	24,896 (4)	26	42	32	23	7	U	69	41		65,499 (6)
	76	98,101 (5)	21	46	33	24	0.9	4	37.1	3	31	274,429 (6)
MENA	1971	21,263 (6)	22	53	25	63.3	1	23.5	8	1	3.3	86,616 (7)
	76	116,305 (8)	18	49	33	47.7	1.4	30.8	18.6	0.9	0.7	125,579 (9)
ESEAO	1971	122,820 (6)	27	48	25	62.0	41	15.3	6.7	11.6	4	142,042 (7)
	76	56,396 (5)	38	47	15	68	1	9	12	8	2	56,396 (5)
CARIBBEAN	1971	36,259(13)	51.8	37.6	10.5	45	2	10.4	8	28.3	6.2	36,259(13)
	76	57,231(12)	54.5	36.2	9.3	49.8	1.6	6.5	12.8	11.3	17.7	60,902(13)
LATIN AMERICA	1971	247,140(11)	36.0	46.8	17.2	55.8	3.0	35.5	41	2.5	3.2	318,000(14)
	76	164,470(11)	42.3	48.1	9.6	55.4	1.2	34.1	1.5	4.4	2.4	695,713(15)
NORTH AMERICA	1971	307,137(1)	73	17	10	67	0	11.6	0.5	12.8	4.7	307,137 (1)
	76	473,750 (1)	78	19	3	79.7	0	8.9	2.2	6.7	2.5	473,750 (1)
WESTERN PACIFIC	1971	61,921 (2)	20	48	32	64.3	1.6	15.3	11.0	1	7.5	66,559 (3)
	76	75,222 (2)	32.3	40	27.7	32.7	0.3	12.2	39.8	2.6	12.4	75,222 (2)
WORLD	1971	1,436,295(64)	48	35	17	58.3	20.4	2.6	12.8	6.0		1,660,612(73)
	76	1,140,066(55)	52	34	14	55.7	1.5	19.4	10.5	5.7	7.0	1,928,818(71)

* Figures in brackets show the number of countries represented in the age or method breakdowns of new acceptors.