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AGENCY FOR INTERNATIONAL DEVELOPMENT

POPULATION TASK FORCE REPORT

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POPULATION TASK FORCE REPORT

I. THE ASSIGNMENT

Early in 1980, IDCA asked AID's assistance in reviewing international population assistance efforts and in projecting the future scope and composition of the U.S. population assistance program. AID was requested to estimate requirements for population assistance for selected countries and to recommend the most efficient division of labor among major population donors, thus to promote a more efficient use of population funds, both geographically and in terms of specific program areas. AID was asked to look at both the donors and the recipients of population assistance.

AID was asked to provide information on country efforts to deal with population pressures as well as to estimate country requirements for population-related assistance. The task force attempted to estimate need for population assistance, first, by categorizing countries in terms of three variables: (1) annual population increase; (2) government commitment to fertility control programs; and (3) socioeconomic setting. Second, the Task Force prepared selected country data sheets which discussed country population program needs and options. Third, we solicited AID Mission comments on these issues.

A.I.D. was also asked to comment on its own program strengths and potentials, on those of other donors, and on better ways of joining forces in the population area. The task force gave particular attention to the

strengths and potential of UNFPA, but also examined the programs of IBRD, IPPF, and the major private U.S. population intermediaries. Again, AID Missions' views on the relative strengths of population donors were sought and are reflected in our conclusions.

Before proceeding to the two main sections of this report, a number of general observations should be made. First, this is a report of an A.I.D. Task Force convened specifically to address a number of specific questions raised by I.D.C.A. The report is neither a full-scale evaluation of the programs of the major international population donors, nor an A.I.D. population strategy for the 1980s. As important as this assignment was, it necessarily competed with other responsibilities for the time and attention of the members of the Task Force. Despite time and staffing constraints, we believe this report is both balanced and complete, and we trust that it will contribute to discussions between A.I.D. and I.D.C.A. on future directions of U.S. population assistance.

Second, while the Task Force attempted to keep its focus on the February 4, 1980 assignment, other considerations entered the discussion from time to time. These included the question that I.D.C.A. and others have raised concerning the desirability and/or feasibility of using LDC commitment to and/or need for population assistance as a more salient factor in determining overall development assistance levels; and the proposition that UNFPA take the lead in coordinating a major international population initiative to respond to the 1979

Colombo meetings' call for a doubling of population assistance by 1985. Relevant as these considerations are for the goals of the study, they are beyond the scope of the present assignment and will only be given peripheral attention herein.

Third, while sympathetic to the need to provide a global overview on such questions as the geographic and functional strengths and potentials of major population assistance donors, the Task Force felt that global generalizations in this area tend to be misleading. We can generalize, but only up to a point, largely because we are not starting from a "clean slate." Countries have and increasingly express preferences for donors, specific types of population programs, and geographic coverage within countries (as in India and Egypt). The concept of division of labor among donors collapses when only one donor succeeds in working in a country. Further, the notion of functional comparative advantages among donors becomes a theoretical construct in the absence of a mechanism for coordinating inputs required for a successful population program. UNFPA may have a comparative (or even absolute) advantage in supplying commodities, since it can purchase vehicles and equipment on the world market. But if the delivery system is inadequate, a country population program will not be much helped by this advantage. There appears to be growing consensus that donor coordination must be done at the country level--that strategizing "at the pinnacle" rarely works (See discussion on pp.28-33).

Fourth, many felt that it was not only inappropriate but also futile to define roles for other donors (especially international donors such as

UNFPA and YBRD) without a mechanism for eliciting their views on where and how their contributions would be most effective, much less for ensuring that those role definitions would "stick." Improving donor coordination is both laudable and desirable; however, A.I.D.'s or I.D.C.A.'s ability to convince other donors to shift their programs and emphases in line with our wishes is limited.

Finally the Task Force's assignment to specify country-specific population assistance requirements and program options was undertaken largely without consideration of budget constraints. The Task Force was nevertheless keenly aware of present budget realities. A.I.D. now estimates a current funding shortfall for \$40 million in population programs; UNFPA estimates its shelf list at over \$100 million (approximately \$35 million of which could be programmed this fiscal year). Were there considerable duplication of effort or clear examples of poor allocation of major chunks of population funds, the question of improving donor coordination might have seemed more pressing. There is, however, more than enough work for all the present donors, given overall need for population assistance and the variety of circumstances in which each donor can work. There was, in short, no clear sense that the present division of labor is inefficient.

II. POPULATION ASSISTANCE: NEEDS OF RECIPIENTS

At present, international assistance to LDC population programs accounts for an estimated 2 percent of total donor aid flows, and population programs reach barely one-third of all couples in developing countries. Based on cost data from successful family planning programs, at least a tripling of current annual international outlays on population programs is required in order to provide services to all individuals who need them. At a time when LDC budgets are stretched to their limits, and when by and large, the "easy" population programs have been launched, an increasing share of the burden is likely to fall on the international donor community.

As a first cut at categorizing developing countries in terms of their claims on population resources, the Task Force developed a Population Priorities matrix which deals simultaneously with three different factors which A.I.D. must consider in determining the level and nature of its support to population programs in developing countries: demographic growth; the socio-economic environment within which population programs must operate; and host country commitment to dealing with population growth. The matrix serves as a convenient device for organizing discussion of program options in the population area; it is much less useful as a device for ranking countries in terms of their claim on U.S. development assistance.

The first, Annual Population Increase, represents in some sense a measure of a country's need for assistance. Everything else being equal,

a country's size and its net annual contribution to world population growth should be important determinants of the scale of population program support.

The socio-economic environment--which we have called Social Setting--helps us to predict the extent to which family planning programs are likely to succeed in bringing about slower rates of population growth. Factors which research has suggested are important influences on fertility behavior--female education and employment, literacy, urbanization, income distribution, social structure, and women's status--are included in this composite category.

Government Commitment can help us predict how much effect programs designed to reduce population growth will have, as opposed to the hypothetical limits imposed by social setting. In other words, social setting may establish the broad boundaries within which family planning programs can work, but government commitment will determine much more importantly how effective government and private sector programs turn out to be. Government commitment in this case involves far more than appropriate rhetoric on family planning. We also look for evidence that countries are actually implementing family planning programs and are undertaking or considering changes in a range of social and economic policies that are likely to affect fertility and demand for family planning services.

Annual population increase helps us to project a country's requirements for population program assistance. However, by itself it tells us practically

nothing about the nature of program effort that is most appropriate to each country's particular circumstances. For that, we need to look at government commitment and social setting. Thus, we can turn from the three-dimensional matrix to the simpler two-dimensional matrix represented below.

SOCIAL SETTING	GOVERNMENT COMMITMENT	
	STRONGER	WEAKER
FAVORABLE	A	B
UNFAVORABLE	C	D

In general, where the social setting is defined as being favorable, one can predict with reasonable certainty that voluntary family planning program efforts will meet with positive results. Middle income countries and/or those that give emphasis to social welfare programs with strong equity considerations and/or societies within which women have relatively strong decision making authority are those that will be most likely to show up in cells A and B. Where government commitment to fertility control is also high (cell A), one can predict that both private and public sector family planning service delivery programs will have a high probability of bringing about significant reductions in fertility. These are the countries where large bilateral family planning projects make the most sense.

FIGURE 1

* * * * S O C I O E C O N O M I C S E T T I N G * * * *

Annual popula-
tion increase

more favorable

less favorable

GOVERNMENT COMMITMENT

GOVERNMENT COMMITMENT

Stronger

Weaker

Stronger

Weaker

400,000 or more

China
Colombia
Indonesia
Korea
Mexico
Philippines
Thailand

Brazil
Burma
Morocco
Peru
Turkey
Venezuela
Viet Nam

Bangladesh
India

Algeria
Egypt
Ethiopia
Iran
Iraq
Kenya
Nigeria
Pakistan
Sudan

Tanzania
Uganda
Zaire

50,000 -
399,999

Benin
Taiwan
Cuba
Domin. Republic
El Salvador
Malaysia
Panama
Portugal
Sri Lanka
Tunisia

Cameroon
Chile
Costa Rica
Ecuador
Ghana
Guatemala
Honduras
Ivory Coast
Jordan

Lebanon
Liberia
Senegal
Nicaragua
Paraguay
Zimbabwe
Rhodesia

Haiti

Haiti
Yemen D.R.
Nepal
Rwanda

Afghanistan
Angola
Bolivia
Cambodia
Chad
Guinea
Laos
Libya
Madagascar
Mozambique
Malawi

Niger
Papua N.G.
Saudi Arabia
Somalia
Syria
Togo
Upper Volta
Yemen A.R.
Sierra Leone
Burundi
Kuwait
Zambia

20,000 -
49,999

Jamaica
Lesotho

Bhutan
Central Afr.
Republic
Congo
Djibouti

Mauritania
Namibia
Oman
United Arab
Emirates

Nov

The countries in cell B are those with relatively favorable social settings but where government commitment is weaker. The reasons for weak commitment may be several, but among the most typical are strong traditional religious beliefs, a military government that equates military strength with numbers of people, an ideological stance that emphasizes development in other sectors as a means of reducing fertility, and simple lack of awareness of the negative consequences of rapid population growth for social and economic development. Among the major program implications for cell B countries are: first, the need for strong efforts to promote private sector family planning program activity; and second, the priority of efforts to bring about changes in official attitudes in order to hasten the advent of government-supported family planning services.

The use of existing A.I.D.-funded intermediaries and support to the several independent international NGOs in the population field can help to promote vigorous private sector activity in many countries where the governments, for whatever reason, are reluctant to embrace public family planning efforts. This approach requires only that the Government not actively oppose population program activities. (Indeed, only a handful of large countries today actively oppose family planning activities.) At the same time that efforts are underway to promote private sector activity, population donor agencies can support various activities in the area of population policy to promote awareness of the population problem and to work toward changing existing official pronatalist or anti-family planning attitudes and policies. A.I.D. has developed a variety of techniques

to promote changes in attitudes and public policies in situations such as those described above.

Cells A and B represent the optimistic side of the equation--the places where strong and effective family planning program efforts can bring about significant short-run declines in birth rates. Cells C and D represent greater challenges--the countries in which the prospects for short-run fertility decline are not as good and where patience and a willingness to stay the course are required.

The countries in cell C are those in which strong and consistent family planning program efforts may be expected to meet with moderate success in the short to medium run. Though social setting is generally unfavorable, there is enough demand for family planning services among many groups that fertility can be expected to decline if services are provided.*

In general, demand for family planning services is likely to be found in urban areas or parts of the country in which, for a variety of reasons, the conditions which define favorable social setting outlined above are present. A first priority in countries categorized in cell C, then, will be selective family planning program support, based upon what is practical in areas of sufficient demand, and information, education, and communication (IE&C) and other program efforts to increase demand for family planning services. In cell C countries nationwide family planning services programs are difficult to carry out, and likely to be expensive, inefficient, and

*An unfavorable social setting not only inhibits demand for family planning services, but also constrains ability to provide those services.

ineffective without substantial advanced planning, institutional development, IE&C and training. Furthermore, the danger exists that if and/or when the programs fail, the government will either become discouraged and abandon all programs or, in rare cases, turn to non-voluntary program approaches.

Cell C countries are places in which population donors might encourage experimentation with alternative forms of family planning service delivery. Cell C countries are prime candidates for what we have come to call operations research in the family planning arena. In addition, countries in cell C are those where, in addition to concerted efforts to expand access, carefully designed incentives programs--directed at both the community and the individual--may be particularly effective in overcoming some of the constraints imposed by the generally unfavorable social setting. Indeed, some cell C countries (e.g. Bangladesh) have already come to the conclusion that the dilemma they face requires extraordinary measures; voluntary family planning programs have not been well received by the population, and continued high fertility is seen as wiping out progress in other development areas. These countries are seriously considering policy measures which go beyond the provision of family planning services, most notably by programs that induce couples to limit the number of children they bear and reward couples that succeed in limiting their fertility. In working in cell C countries, population donors should give careful consideration to supporting measures to reward voluntary family planning under certain conditions.

The countries in cell D are obviously the most difficult for A.I.D. and other donors. These are the countries where the short-run prospects for family planning programs are the least favorable and where government commitment to the provision of family planning services is weak or nonexistent if not overtly hostile. In such circumstances, the most appropriate approach for donors is quiet support for promising private sector efforts, support for small scale innovations, and sustained efforts to bring about a change in public policy and to stimulate government commitment to fertility control.

We recognize that these are extremely broad generalizations which must be modified in the process of analyzing specific country situations. The classification table, for example, obscures the time perspective: Tunisia and Benin may be classified similarly, but Tunisia has been engaged in population efforts for many years and has a crude birth rate of roughly 35/1000 while Benin is just beginning, with a CBR of 49/1000; programs appropriate to each situation will vary greatly.

We also recognize that this global categorization tends to mask significant differences among countries, especially within the African region. We have devised a separate grid for African countries in an attempt to capture important inter-country variations in that region. (Figure 2)

In addition, we recognize that a range of ancillary factors, including LDC government preferences (noted earlier) for certain donors or certain types of population programs make it impossible to specify global program strategies. Appendix B contains selected country statements including

discussion of current programs and future prospects for the major population donors. Following a discussion of the programs and program strengths of the major population donors, we turn to the policy and program issues which this report raises.

Figure 2

African countries

* * * * SOCIOECONOMIC SETTING * * * *

more favorable

less favorable

Annual population
increase

government commitment

government commitment

stronger

moderate

weaker

stronger

moderate

weaker

400,000 -
or more

Kenya
Nigeria
Sudan
Zaire

Ethiopia
Tanzania
Uganda

50,000 -
399,999

Benin
Cameroon
Ghana
Senegal

Ivory Coast
Liberia
Zimbabwe

Rwanda

Mali
Sierra Leone
Togo
Upper Volta

Angola
Burundi
Chad
Guinea
Madagascar

Malawi
Mozambique
Niger
Zambia
Somalia

20,000 -
49,999

Lesotho

Mauritania
Central Afr. Republic
Congo
Djibouti
Namibia

1961

III. POPULATION DONORS: STRENGTHS, WEAKNESSES, AND POTENTIALS

In this section of the report we concentrate on the programs of the three principal donors in international population assistance: the U.S. Agency for International Development, the United Nations Fund for Population Activities, and the World Bank. The material presented here was prepared by members of A.I.D.'s Population task force and augmented by observations from A.I.D. field missions. As noted earlier, we do not believe that this is a sufficient basis for assessing relative strengths and weaknesses of each organization. What follows is A.I.D.'s perspective on the program strengths of each major donor. We strongly urge that I.D.C.A. solicit similar reports on program strengths and funding requirements from the other donors, and reserve judgments on division of labor among donors until that material has been reviewed and evaluated.

A. The Agency for International Development

Although no longer as dominant in overall development assistance as formerly, the U.S. still plays a large enough role, both fiscally and as a source of technical assistance, to exert strong leadership in key areas such as population. A.I.D.'s cumulative population assistance exceeds \$1.3 billion to date, and constitutes about half of all population assistance provided from all sources. A.I.D. has led the way among donors in developing and disseminating the most widely used contraceptive methods in the world today -- the pill and sterilization; in providing quality contraceptives; in developing new "outreach" systems

for delivering family planning and health services that are less expensive and more appealing; in training non-physician personnel to deliver services; measuring program impact and the degree to which fertility and the use of family planning services depend on women's education and employment opportunities, child health, and other social and economic conditions.

Because A.I.D. is held more directly accountable to its source of funding (Congress) than are the other major donors to their funding agencies, it has had to develop a strong measurement program to assess need, determine appropriate programs, and document program impacts. A.I.D. has also taken the lead in developing analytical approaches to measuring the determinants and consequences of rapid population growth, and more important, in integrating these approaches into all aspects of its population program.

It is for these reasons that A.I.D. has been able to develop innovative approaches and programs and has been able to marshal enough funds to push them through to completion, whether it be in the field of research, development of intermediary institutions, support of contraceptive retail sales programs, or the community and household distribution of contraceptives. In Bangladesh, for example, A.I.D.'s strategy recognizes that family planning services alone will not be enough to reduce fertility significantly. In that country, A.I.D.'s program makes use of the media and other motivational activities to create demand for services. The Mission has also announced its intention to concentrate

efforts on women's employment, women's education, maternal and child health, delay of marriage incentives, and other programs to encourage demand for family planning (Dacca 1950).

In Egypt, A.I.D.'s Manoufiya project has demonstrated that house-to-house distribution of contraceptives is feasible and effective in expanding contraceptive use, even in rural areas of this traditional Moslem society. In these and many other instances, A.I.D. has been willing to take risks and has succeeded in breaking new ground and pursuing new approaches to population programs.

One of A.I.D.'s major advantages over other population donors is its strong field presence, both in the form of overseas Missions generally and in its individual population officers, who represent a spectrum of needed technical skills. This in-country presence allows A.I.D. to respond quickly to population program opportunities, to work closely and collaboratively with local institutions and government officials and with the private sector, and to monitor both its bilateral and centrally funded activities. Indeed, wherever the U.S. has had a bilateral assistance program that included population, it has been looked to for leadership by the host government and the other population donors. This was made clear not only in Bangladesh (see Dacca 1950), but also in countries where concern about population growth is just beginning to be articulated. In Rwanda, for instance, A.I.D., Pathfinder, and UNFPA support initial population programs, but the government's de facto population program coordinator gives A.I.D. the major role in all family planning activities. The Mission reported recently that:

...it appears certain that A.I.D. will be asked to accept primary donor responsibility for any comprehensive family planning activity developed here over the next few years. (Kigali 0871)

In many countries in Africa where official interest in family planning is minimal, there are few private voluntary organizations or international agencies working as population intermediaries (e.g., Guinea Bissau, Djibouti, Upper Volta). The general A.I.D. presence in the country makes the U.S. uniquely able to respond quickly if and when opportunities arise to encourage attention to population problems (as well as to make these opportunities happen). A.I.D.'s field office in Guinea Bissau recently called attention to a situation faced in many African countries:

We have raised the subject (population) numerous times at various levels in the GOGB and invariably met with disinterest. (Last year GOGB Minister of Economic Development and Planning argued fervently with the British Minister of Overseas Development that GB needed more, not less, population growth.) Although A.I.D./Guinea Bissau does not intend to venture into health/population sector in GB, we do stand (ready) to respond to any GOGB requests for assistance, beginning with demographic studies (Bissau 0597).

In addition to the strengths that derive from A.I.D.'s field-oriented structure and its early and sustained leadership in developing innovative approaches responsive to particular country requirements, A.I.D. possesses noteworthy strengths in a number of functional areas. For instance, among donor agencies, A.I.D. is particularly effective in developing and supporting family planning service delivery programs. These have included new approaches such as subsidized contraceptive retail sales and community distribution of contraceptives, maintaining an effective contraceptive supply system, and supporting strong intermediary organizations such as IPPF, FPIA, AVS, the Pathfinder Fund, and the Population Council.

In countries which have either declared their preference for non-bilateral population assistance (e.g., Dominican Republic, Honduras) or where the U.S. is no longer involved in bilateral programs (e.g., Colombia),

population programs may be totally dependent on the private and international agencies. These private intermediary programs are seen as flexible, responsive, and able to implement projects quickly (though a number of the intermediaries are in difficult budget straits and are being forced to terminate programs prematurely). In Colombia, for instance, Pathfinder has been involved in a highly successful community-based distribution program of contraceptives in urban areas. In the Dominican Republic, IPPF is involved in a similar community-based distribution (CBD) program as well as in educational and motivational campaigns; Pathfinder has provided funds for voluntary female sterilizations. As the population officer in Guatemala commented:

These private associations allow flexibility in population activities which would otherwise be impossible to implement in a timely manner, allowing for bureaucratic inertia inherent in government to government relations. As private organizations they work directly with private groups in host countries as well as governments, allowing for a wider range of activities than would be possible under government to government arrangements.
(cited in Guatemala 2332)

Often, as in the case of Jamaica, the program combines bilateral and intermediary assistance. The Mission recently summarized the advantages of each approach thus:

The advantage of bilateral funding is that it places the Mission in a close collaborative position with the GOJ, particularly with respect to project planning, management, and evaluation. It allows for reasonable flexibility of response to changing needs as they occur, and it gives the Mission added leverage to enforce adherence to mutually agreed upon project goals and objectives, when for one reason or another they are not being fully addressed by the GOJ. On the other hand, intermediary assistance is most useful in funding activities not originally anticipated in the project paper, in funding projects carried out by certain local PVOs, in funding projects still considered somewhat controversial or peripheral by the host government, and in providing technical assistance and training not available locally (Kingston 2637).

In Honduras, as in many other countries where the government perceives strong religious or political opposition to either a demographic policy or an active family planning program, the U.S. does not have a bilateral program and the UNFPA efforts have been cautious and limited by host government resistance: the private intermediaries are the only source of support for population activities. In Honduras, organizations such as IPPF and Pathfinder are working privately to expand (1) existing programs, (2) the number of government institutions involved in family planning and (3) the client groups of public and private institutions -- thus creating both institutional and popular support for family planning (Tegucigalpa 2273)*.

A.I.D. has also been able to break new ground in the areas of training, information, and education -- for examples, the Program for International Education in Gynecology and Obstetrics (JHPIEGO) at Johns Hopkins University for training of physicians, nurses, and family planning administrators; programs such as the Population Information Program which provides authoritative demographic data and updates on contraceptive developments and delivery system initiatives worldwide. Where there are no bilateral or PVO agencies involved in population-related activities, and where the government is basically not interested, as in Somalia, A.I.D. has been able to sensitize key officials through a variety of training programs supported centrally (Mogadishu 1472). In Burundi, too, the availability of centrally funded training programs has been a particularly effective way of opening a dialogue on population problems (Bujumbura 0933).

* A.I.D. has recently become concerned about the absorptive capacity of the existing private population intermediaries (with their almost \$20 million in unfunded projects) and the possibility of creating or encouraging additional private groups to expand further family planning services available through the private sector. If it is determined that additional institutional resources are required, it is certain that A.I.D. (with its extensive experience in working in the private sector) will take the lead in developing them.

Another area in which A.I.D. is particularly strong is in demonstrating the linkages between fertility and development -- not only the impact of high fertility on development objectives, but also the reverse: the impact of development programs on demand for family planning services. Most of the major population donors have acknowledged the importance of building demand for family planning services and encouraging interest in smaller families, but A.I.D.'s multisectoral program provides the vehicle for "operationalizing" 104(d). In Somalia, for example, in a recent meeting with the Somalia Women's Democratic Organization, the Mission was advised that that organization would welcome assistance in family planning education for Somalia women in the organization's Family Life Centers in rural areas (Mogadischu 1472). In Sudan, population programs are being integrated into existing primary health care projects, and a new five-year health sector support project will include more direct population assistance as does a centrally-funded community-based family health project (Khartoum 2409). In short, where the U.S. has an A.I.D. program it has a variety of mechanisms to respond to such opportunities, even when official policies or attitudes are strongly discouraging (as in many African countries) or where the social setting is unpromising (as in Bangladesh).

Among other strengths of the A.I.D. population program is its strong analytical orientation, whether in the testing of outreach systems for delivering family planning services, in analysis and interpretation of survey findings to measure program impacts, in biomedical research, or in developing overall population strategies that take into account both the supply of family planning information and services and the factors that affect demand for those services. The fact that A.I.D. is able to provide

grant funds is particularly useful in encouraging programs in new or difficult fields, especially when official government commitment is equivocal. The very size of the U.S. population effort is also one of its strengths: the U.S. provides about half of the DAC assistance for population and is the principal donor for UNEPA and the private intermediaries. It provides almost 80 percent of the oral contraceptives distributed in developing countries.

Finally, because A.I.D. is the development arm of a single government (as opposed to international agencies which must respond to a variety of governmental and NGO groups) A.I.D. is able to forge agreement on a concise and clear direction for population assistance, and to develop programs that adhere to its articulated program goals.

It is this strength or sharpness of focus that is also one of A.I.D.'s liabilities when it comes to responding to LDCs in the area of population. For example, although there is considerable demand in LDCs, A.I.D. will not currently support the provision of abortion services, nor does it distribute Depo-Provera at this time. Legislative requirements to purchase American goods and services also hamper the speed and flexibility of some programs.

A.I.D.'s population program, as any other bilateral assistance program, is much more vulnerable to the vagaries of international politics than are private and international agencies; it also reflects changing U.S. budget realities. There are, as noted above, many countries which do not want an official A.I.D. presence in the population area and some that don't want any

American presence at all. In the first case, the U.S. is able to provide assistance through private intermediary groups. Where even private U.S. voluntary organizations are unwelcome, the best approach is to work through such international agencies as IPPF and UNFPA, and to encourage local private groups and other bilateral donors who may be acceptable to the host government to work in the population area.

The A.I.D. program is also particularly vulnerable to budget and staffing constraints. Except for a few years in the late sixties and early seventies when A.I.D. population budgets were growing rapidly, lack of funds has constrained A.I.D.'s program and inhibited the initiation of a number of new programs. Several missions have called attention to funding problems that may halt some very effective intermediary programs, including the Pathfinder commercial retail sales program in urban areas of Colombia (Bogota 3849). In addition to total budget deficiencies, inadequate operating budgets hamper staffing, travel, and the use of consultants.

Because of tight budgets over the past few years, only a few new centrally-funded projects have been initiated; preference has been given to start-up of bilateral country programs. Inevitably, there has developed a considerable list of needed new projects which would be initiated if funds and staffing were available. These include, for example, testing of integrated family planning projects that stress the impact of other activities such as health and women's programs on fertility; training of auxiliaries, midwives, and community workers; strengthening of operations research to test the most effective way of delivering family planning services; strengthening of

current intermediaries and selection of new intermediaries. The Agency should also enhance its ability to provide technical assistance to the IE&C and management components of family planning services programs, though we recognize that these programs may require significant restructuring as well as additional funds to respond to field needs. As much as \$5 million could profitably go to support contraceptive development research. There are, as well, numerous opportunities to strengthen bilateral programs, particularly in Africa, but also in Latin America, Asia, and the Near East. But more population officers are needed, both in Washington and overseas, both to develop population projects and to make sure that those currently underway are effectively managed.

To summarize, A.I.D.'s population program was developed around strong field and central staffs, a multiplicity of intermediary organizations, closely monitored to assure that their programs are appropriate and cost effective, and a well-developed data and analytical base. It is becoming increasingly clear that this program, although unique and highly successful, cannot meet expanding opportunities if budgets do not also expand.

B. The United Nations Fund for Population Activities

As a multilateral United Nations body, the UNFPA is probably the most broadly politically acceptable organization offering population program assistance in less developed countries. It is able to work in some countries which would not accept funds from any bilateral donor, including the U.S.

Perhaps the most important advantage of the UNFPA is that it provides an organized, internationally accepted program which attracts funds from a

multiplicity of developed country donors and greatly increases the total donor support available for population activities. In the absence of the UNFPA, it is unlikely that anywhere near the present level of donor support would be available for population work from the other developed countries, since many of these countries are neither interested in nor capable of maintaining a bilateral population program of their own.*

Another important advantage of the UNFPA is its ability to provide commodity support (e.g., vehicles, Depo-Provera) which is needed and desired in LDCs and which is difficult for some bilateral donors such as A.I.D. to provide. In Jamaica, for example, UNFPA sponsors a Depo-Provera distribution project which accounts for approximately 25 percent of all family planning acceptors enrolled in the national family planning program (Kingston 2637).

The UNFPA was established as a fund and was expected to utilize other U.N. bodies for technical support and project implementation. Over the years it has developed an increasing technical capacity in New York and overseas. While it continues to look to U.N. specialized agencies as its principal implementing agents, direct funding of government programs and use of NGOs now account for nearly half of UNFPA resource allocations. In Bangladesh, the A.I.D. mission reports that UNFPA has a commendable record with direct implementation of projects and in developing projects that are directly related to the need to strengthen service delivery. The mission feels that UNFPA's success has been largely due to its effective use of in-country technical assistance staffs to plan and monitor projects and to its flexibility in accommodating the bureaucratic requirements of the Government of Bangladesh (Dacca 1950).

At the same time in another setting, our population officer in Guatemala commented that UNFPA

...is essentially a funding organization depending on other UN specialized agencies to provide technical assistance to its projects. This exposes the activities to the same weaknesses of the agencies themselves, i.e. overcentralization of authority and lack of dedicated field staff. Even where UNFPA has field coordinators the person spends most of the time trying to get support, either from the home office in New York or from the other UN agencies who supposedly are assisting in implementation (cited in Guatemala 2332).

Since the UNFPA is responsible to multiple donors and recipient governments, it has developed a broad mandate reflecting the full range of the World Population Plan of Action recommendations. This results in an approach to population program assistance that is considerably broader than A.I.D.'s. For some of these same reasons, the UNFPA is less likely to take a hard-nosed attitude in project design, selection, and monitoring, and does not demand standards of accountability other than those used by the host government itself. Due to UNFPA's broad mandate, it is willing to provide support for a wide range of population activities not directly related to fertility reduction, including attention to and modest assistance for work on population redistribution, problems of the elderly, etc. U.S.A.I.D./ Jamaica, for instance, identified many of UNFPA's programs (research, data collection, family life education, etc.) as "somewhat out of the mainstream," though it noted that A.I.D. and UNFPA work closely together on particular family planning services projects (Kingston 2637). Several other Missions (e.g., Somalia, Mogadischu 1472) have argued that the UNFPA programs have not been particularly effective in encouraging family planning. USAID/Colombia pointed to UNFPA's problems with its own bureaucracy and staffing, its tendency to fund projects partially and to drop them mid-course, and delays in purchasing needed commodities for its programs (Bogota 3849).

It is worth noting that UNFPA has established field posts in some forty countries, and as this number increases some of the problems which have plagued UNFPA to date may be resolved. Nevertheless, as long as it must represent the consensus of a variety of donors and work in a variety of settings, it is not likely to be on the leading edge of fertility reduction program development. Rather, UNFPA will continue to be looked to for funding the vital elements of comprehensive population programs (e.g., official salaries, procurement of commodities and equipment) that A.I.D., the private donors, and other bilateral programs are unable or unwilling to assume.

C. The World Bank

The World Bank has been involved in support for population programs for a number of years, but the conclusion of both the task force and the field missions which responded was that the Bank's projects often have little impact on reducing population growth.

On the one hand, Mr. McNamara has provided strong rhetorical leadership on "population," and the Bank, as the major source of development support for developing countries, is theoretically in a position to insist upon more forthright consideration of population policies on the part of its loan recipients; in fact, however, the Bank has been reluctant to press for meaningful population programs. In Jamaica, for instance, the Bank has provided substantial assistance (\$8.8 million) for two population projects between 1970 and 1980. However, as the Missions notes:

...the word "population" in these projects is largely a euphemism, since the vast majority of the funds were for facilities construction (one hospital ward, 10 rural maternity centers, and 57 health centers). Most of the population elements of this project (training, evaluation,

IV. CONCLUSIONS

The conclusions of the task force concerned four major areas: (1) possible division of labor among population donors; (2) donors' need for and ability to use additional funds; (3) the factors which should be considered in allocating scarce population resources; and (4) ways of improving donor coordination.

A. Division of Labor Among Donors

1. Appropriateness and Opportunities

The task force has reservations about the usefulness of considering a "division of labor" among population donors as a way of increasing efficiency in population assistance programs. Many of the reasons for these reservations have been noted earlier, including: host governments' preferences for which donors will work in their countries and on what types of programs; donors' preferences for working in specific functional and geographic areas; and the need to maintain flexibility to respond to immediate country needs.

Intrinsic strength of the various donor agencies often depends on availability of capable staff, current policies, and leadership to such an extent that it would be unwise to constrain areas where any donor agency might work by artificial or rigid delineations. There appear to be no defensible geographic or functional areas of intrinsic superiority that would outweigh the necessary flexibility that each agency must have to provide a broad based population program in countries in which they may work.

Perhaps the most serious problem with the concept of "comparative advantage" as a mechanism for defining future program strategies is lack of a temporal dimension. The term has been used as if there were a clearly defined functional mix of activities that each country program needs, and that one need only identify the donor best able to satisfy a particular need and "plug him in." The comparative advantage argument as expressed thus far has suggested the possibility of constructing modular population programs.

In fact, timing is a critical issue in any discussion of the comparative advantage of donors. The population program activities that are appropriate to a particular national circumstance depend greatly on where the country stands in the evolution of those variables that determine "social setting" and in its own commitment to fertility control. In many respects, the most important characteristic determining comparative advantage is history. The advantage lies with the donor agency that has been associated with the program for the longest time, knows the country and its circumstances best, is itself trusted and respected, and is best able to respond knowledgeably to changes in the environment.

During the early and most difficult years of program development (i.e. the stage in which most African countries are today), donor emphasis must be on research, demonstration, and policy development activities rather than on large-scale support for the delivery of services. This is an inherently labor-intensive stage and one that requires special sensitivity to the local environment--both the socio-economic and the decision-making setting.

Later, when programs are reasonably well established and accepted, donor inputs can become more mechanical. At that point it matters less who is funding the program than whether or not the funding level is adequate. At the later stages of program development money replaces technical assistance as the most important external input, and the notion of comparative advantage disappears more or less completely (e.g. in Korea, Taiwan).

While it may be that some donors have a slight advantage--comparative or otherwise--in those activities which are relatively more important at the early stages of program development, these pale when compared with the overwhelming absolute advantage that falls to the donor that is there at the outset and that stays with the program the longest.

For instance, A.I.D. has an advantage over the World Bank at the early stages of program development because of (1) its longer experience in population program work, (2) its comparative strengths in those forms of program support that are most appropriate to the early stages of program development (i.e., policy research, operations research, deployment of intermediaries), and (3) its resident missions which are familiar with the social, administrative, and political settings in a way that the Bank staff, with its short-term visiting and appraisal missions cannot be. A.I.D. has basically the same advantages over the UNFPA, although these are considerably less pronounced. And presumably, as the UNFPA gains in program experience and capacity to provide technical expertise to country programs, these advantages will become even less pronounced.

The notion of comparative advantage among population donors, then, only appears useful at the margin. In those rare cases where there are no historical antecedents, no strong government preferences for particular donors or particular programs, and no budgetary, staffing, or other constraints to limit donor initiatives, it is possible to develop programs along the lines of each donor's comparative advantage. Indeed, not to do so would be foolish. But these cases are, unfortunately, rare. In any case, problems and inefficiencies relating to division of labor between donor agencies are minor compared to those imposed by total resource limitations. Lack of fiscal and personnel resources are major problems which keep the donor agencies from doing more in population program assistance. Currently there is only about \$1 billion of the needed \$3 billion available for population programs, and donor assistance makes up about \$450 million of the \$1 billion currently available.

2. Functional Division of Labor

The country statements and Mission cables, attached, indicate that the functional areas in which A.I.D. provides population assistance vary from one country to another. The nature of our support in any country depends, as mentioned above, on a variety of factors, and it is difficult to draw conclusions about a desirable global or regional strategy for A.I.D.'s population assistance. The task force also believes that the country examples support our conclusion that it is desirable for A.I.D. to maintain some capability in each of the functional areas, in order to meet immediate needs and to provide support when it is not available from other

sources.

The present split of A.I.D. population assistance among the functional areas is shown in Table 300 (Attachment C). It is, implicitly, a reflection of A.I.D.'s relative strengths (e.g. in family planning services, training and operations research), and highlights those areas, such as IEC, in which other donors are more active.

IDCA has frequently urged A.I.D. to de-emphasize support to the areas of demographic data collection and IEC, arguing that UNFPA has a comparative advantage in these two areas. The A.I.D. task force has found no evidence to support this argument, though it agrees that significant restructuring of IEC and demographic activities of A.I.D. is necessary.

In the case of demographic data collection, UNFPA does indeed already provide substantial support to census and vital registration activities in a number of countries. These activities complement other UNFPA-funded activities and provide basic information that is much broader than simply that which is needed for family planning programs. It is the impression of the task force, however, that A.I.D.'s record in demographic data collection is at least as strong overall, and much stronger in such innovative areas as contraceptive prevalence surveys and initiation of the World Fertility Survey. The task force believes the Agency should continue to follow the guidelines for these programs set forth in the Agency's population policy paper: moderate expansion of efforts to develop more complete and detailed demographic data to permit more accurate estimates of the demographic impact of various programs; and stable or declining

support for broad, relatively undetailed national censuses. We also note that UNFPA will be curtailing its support for broad census activities as well. The costs associated with these programs will increasingly be borne by the countries themselves. In the case of IEC, the task force views this as an important but difficult element of any family planning program, and one in which no donor has been particularly successful. We believe this area needs further careful study to determine the most useful activities to pursue.

The task force recommends efforts to broaden donor support for policy development. While A.I.D. should continue in the policy area with highly effective and innovative activities such as RAPID, population impact studies, and policy-oriented demonstration programs, we would encourage the UNFPA to increase its role (e.g. the Colombo Conference for Parliamentarians), and urge the Bank to stress population more in its negotiations with LDC governments.

B. Resource Needs in Population

1. Need for Funds and intermediary organizations

The need for additional funds in population is indisputable. Donors currently provide a total of approximately \$450 million each year for family planning information and services in LDCs (excluding China). It is estimated that LDC governments provide roughly \$450 million and \$100 million comes from private sources in LDCs. The total amount spent on population programs worldwide, about \$1 billion, is sufficient to provide family planning information and services to only one-third of the eligible couples

in developing countries. The UNFPA-sponsored international conference of parliamentarians, meeting in Colombo in August 1979, urged donors to increase their population assistance to \$1 billion by the mid-1980s.

The need for more organizations and people to assist in carrying out population activities is also growing. Increasing demands on the large, successful population intermediaries threaten to exceed the capacity of those organizations to respond. Additional intermediary organizations may be required, perhaps with special regional expertise, to continue to provide rapid, flexible responses to countries' calls for assistance. It should be noted, however, that the intermediaries are often most effective when they have adequate support and are carefully monitored by A.I.D. population officers both in Washington and in the Missions. A reduction in A.I.D. staff, as is currently predicted, would substantially lessen the effectiveness of intermediaries in the population field. The more general implications of donor agency staff shortages for expansion of successful population efforts are discussed below.

2. Need for Staff

Adequate staffing has, in the experience of the task force, been essential to the development and implementation of nearly all successful population programs. The lack of staff is likely to constrain the expansion of effective population efforts by all donors.

The presence or absence of staff affects the ability of A.I.D., the Bank, and UNFPA to design and implement effective population programs. Among the weaknesses we have noted in UNFPA and Bank activities has been the absence

or inadequacy of staff stationed in developing countries to assist in developing and monitoring projects. Conversely, one of A.I.D.'s greatest strengths is its ability to place population officers in A.I.D. missions overseas, and to provide them adequate technical and other support staff in A.I.D./Washington. The absence of A.I.D. population staff in the Africa region, for example, contributes in large measure to the bureau's difficulty in spending the population funds allocated to the region and in using centrally-funded intermediaries efficiently, despite opportunities for population program initiatives. In Asia, Latin America, and the Caribbean, on the other hand, where A.I.D. Missions have stronger population staffs, current demands on population resources exceed available funds.*

The use of centrally-funded intermediaries to complement or substitute for bilateral programs does not eliminate the need for A.I.D. population staff, both in Washington and in the field. Some small Missions with no population staff--e.g. Zambia and Sri Lanka--have found themselves too short handed even to monitor the centrally-funded population intermediaries who have opportunities to work in those countries.**

All donors--UNFPA and the World Bank as well as A.I.D.--have tended to make

* The Indonesia population program requires an additional \$5 million in FY 80, and the population officer for Latin America estimates a program shortfall of up to \$10 million this year.

** Discussions at a recent meeting of intermediaries concerning programs in Africa highlighted this point. Many intermediary staff at the meeting described the need for more collaboration and interchange among them in the field, and the important role in these efforts of A.I.D. population personnel within the country.

staffing decisions separately from program development decisions. Clearly, all population donors could do a better job of establishing the links between the financial and the human resources needed to mount effective population programs. In the event of expanded international population assistance in the next few years, one alternative to increasing direct-hire staff in country to develop, monitor, and evaluate population programs may be to recommend or even insist that population intermediaries establish their own resident staffs in LDCs.

The task force believes this possibility should be studied more carefully to determine both the relative effectiveness and the burden on A.I.D. to monitor intermediaries with and without resident staffs. We recognize that the U.S. ambassadors and host governments in some countries might object to resident intermediary staffs because they raise the U.S. profile and increase the visibility of population assistance.

C. Criteria for Establishing Population Programs

The task force drew several conclusions about criteria for determining priority population programs. While some of these criteria were suggested by I.D.C.A. in this assignment, we believe that other factors must also continue to receive consideration.

Among the factors that should enter into any decision about allocation of population assistance are:

- Annual population increase
- Importance of the country to the United States

- Commitment of the host government to reducing population growth and/or supporting family planning programs
- Favorable socioeconomic setting
- Opportunity to develop a strong program that will be useful as a model and, perhaps, a resource for other LDCs
- Comparative advantage--opportunity to provide assistance in a functional area in which the donor is particularly strong.

The importance of the first three criteria in decisions about population assistance is virtually undebatable. The other criteria deserve at least a brief comment, however.

As noted earlier, countries with a favorable socioeconomic setting are those where a sizable latent demand for family planning is likely to exist. These may include countries (e.g. in Latin America and the Caribbean) in which governments may not express strong support for population programs, but in which effective programs may be supported in the private sector. Although many of these countries are small and do not produce a large proportion of the total annual world population increase, a relatively modest investment of donor assistance may have substantial impact on fertility.

The importance of seizing opportunities to develop model programs is seen in countries such as Rwanda and Tunisia which are demographically (and perhaps politically) unimportant, but in which a strong family planning program may have a positive impact on other countries in the region. Tunisia, for example, was for years virtually the only Arab nation with a strong

population policy and liberal laws regarding contraceptives. Officials from a number of LDCs have visited Tunisia to observe its population program, and it is now the site of an IAVS training center for Arab and Francophone African countries. Rwanda is one of very few African countries to request A.I.D. assistance in family planning; its experience in this area may demonstrate to other African governments that such programs are worthwhile and not as politically risky as they now believe.

As for functional comparative advantage, the task force concluded that the opportunity for a donor to provide assistance in the functional area in which it is strongest should carry less weight than the other criteria in donors' practical decisions about which countries should receive population assistance. If the other criteria are satisfied and resources are available, however, we agreed that it would be most useful for donors to coordinate their support for population programs so that each does more of that which it does best in that particular country.

D. Improving Donors' Effectiveness

The task force recommended three ways in which donors can better join forces in population efforts. The first two recommendations in particular are basic and non-controversial. However, the task force feels that both are often ignored in practice, with a resulting loss in efficiency and effectiveness of population efforts.

1. Donors should agree on the most critical needs for population and action in a country, and concentrate resources on those needs.

In the past, attempts to analyze needs--for example, UNFPA Needs Assessments--have sometimes covered a wide range of activities without identifying priorities. Scarce population resources have also gone for activities that are marginal for fertility control.*

As noted above, A.I.D.'s program would be much improved by additional resources and increased numbers of technically qualified population staff, both in Washington and especially overseas; it would also be greatly helped by more serious and sustained attention to population concerns on the part of U.S. Embassy and other top level decision-makers, in addition to the Mission Directors and other A.I.D. staff.

The UNFPA might support A.I.D. interests more satisfactorily if it could focus its assistance on programs which might reasonably be expected to have an impact on fertility rather than its broader approach to population concerns. However, such a shift in focus would require UNDP Governing Council and ECOSOC Endorsement, both of which are unlikely. In any event, the UNFPA could be more conscientious in its efforts to design, monitor, and evaluate the impact of its programs. The World Bank needs to increase its total amount of funds committed to population work and to broaden its support to population programs beyond its present concentration on infrastructure activities. In addition, increased numbers of staff technically qualified in population work, would benefit the World Bank program.

* It is important to note that in the case of UNFPA, this is a reflection of its mandate, which begins with a country's own view of its major population problems. Many countries, for instance, believe that their most serious demographic problem is not population growth but rather population distribution. Hence, UNFPA supports a range of population activities that are marginal to fertility control.

2. Donors should cooperate in encouraging governments to give strong commitment and support to population programs.

It is especially important that the World Bank play a larger role in this, in its negotiations with host governments and in donor consultative groups. Both the Bank and UNFPA have sometimes been more reluctant than the U.S. to urge governments to take effective action in population.

3. Whenever possible, donors should agree with the host government to divide support for population activities so that each donor supports the program components in which it is relative stronger in that country.

As discussed earlier, the task force believes the variations in country settings make it impossible in practice to divide responsibilities for different functional areas of population, worldwide, among the donors. In countries in which a number of donors are involved, however, we agree that it is essential for the donors to coordinate their efforts closely, and where possible to concentrate on the activities they can do best.

Although it is impossible to make global generalizations based on the short program reviews presented above, and although we strongly urge that a complete in-house review of the other major donor programs be undertaken as soon as possible, we conclude that, for the most part, UNFPA and A.I.D. have been able to work well together, and to coordinate their activities with the programs of the private population intermediaries which both support. We are forced to the conclusion that the World Bank's population efforts have been excessively focussed on infrastructure; and coordination with other

donors has been less vigorously pursued. This quick review also highlights the proposition noted at the beginning, namely: program coordination is best handled at the country level, and largely through resident program or project officers who can work together on a regular basis. At the same time, we expect that, as a matter of course, the major population donors will continue to increase headquarters contacts with each other at the working staff levels, thus to facilitate both on-going programs and long-range planning.

UNITED STATES
INTERNATIONAL DEVELOPMENT COOPERATION AGENCY
Washington, D.C. 20523

MEMORANDUM FOR DAA/PPC, CHARLES PAOLILLO
Agency for International Development

February 4, 1980

SUBJECT: IDCA's Population Workplan

As you know, IDCA wants to promote a more efficient division of labor among major donors, in collaboration with the developing countries, as to the types of resources each will offer in different countries. This pursuit of comparative advantage seems to us a vital step in "doing more with less."

One of our first attempts to put this approach into practice is in the field of population. You have seen the memoranda from Tom Ehrlich to Doug Bennet of December 17 and from Bennet to Assistant Administrators of January 4, attached. As part of this effort, we are asking: what are the likely needs for assistance in the next few years and what are the comparative advantages of the U.S. bilateral program vis à vis those of other donors, especially UNFPA and the World Bank, considering the needs and capacities of the LDCs? We would like to look at the major functional areas of population assistance: broad demographic data (e.g. censuses and vital registrations); biomedical research; operations research and other efforts to determine cost-effective ways to deliver services; provision of family planning, considering needs for commodities, training, infrastructure, management, etc.; information/education; policy development; and population/development linkages (Section 104d).

In this effort, we would be helped by having A.I.D.'s own views -- on its strengths and potentials, on those of other donors as A.I.D. sees them, and on better ways to join forces with other donors.

At the same time, we shall request UNFPA's and the World Bank's views of their strengths vis à vis others.

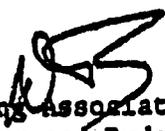
It might also be desirable to ask the opinion of a disinterested expert, though that appears to raise difficult issues with the Bank and UNFPA. In any case, we would not seek such an opinion in lieu of A.I.D.'s own.

Later this spring IDCA will collect the views of A.I.D., the Bank, UNFPA, and any others (e.g. ISTC if possible); sift through them; and reach tentative conclusions on functional and geographic comparative advantage. These we shall share with you for your further suggestions.

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Our particular requests for A.I.D. are attached. We have discussed them extensively with A.I.D. staff and have tried to accommodate their concerns. We do not believe A.I.D.'s input in this effort will be unduly burdensome. We do believe a modest investment of A.I.D.'s time will help make a better case for U.S. assistance and promote the efficient use of the totality of resources available in the population field.

Thank you.



Acting Associate Director
Policy and Budget

Attachments:

1. Ehrlich/Bennet Memo dtd 12/17/79
2. Bennet/Assistant Administrators Memo
dtd 01/04/80

REQUESTS TO A.I.D.

1. **POPULATION OVERVIEW.** We request A.I.D. to:
 - a. Estimate country-specific requirements for population-related assistance and recommend what part could or should come from the donor community;
 - b. provide information on country efforts to deal with population pressures.
2. **COUNTRY ASSESSMENTS.** To complement the global overview, we request that A.I.D. prepare a paper of up to 10 pages on two to three countries in each region which:
 - a. Assesses A.I.D.'s strengths, weaknesses, and potential in the major functional areas of population assistance;
 - b. assesses the strengths, weaknesses, and potential of other donors in these areas;
 - c. recommends a division of labor among population donors.
3. **ADDITIONAL INFORMATION.** If A.I.D. feels it would be helpful to augment the country papers with statements attuned to the region as a whole, we would be delighted to have them. We would also be helped by knowing the views of missions generally on these questions. Similarly, if the Agency feels it would like to comment on the role of the centrally-funded program, we would welcome it.
4. At the same time, we shall ask UNFPA for their views on the same subjects. We shall ask IDCA staff to take the lead in this exercise, but we would appreciate the assistance of the UNFPA project manager in DSB and of other A.I.D. officers.
5. We shall also be asking the World Bank for their views in a similar way; and we welcome A.I.D.'s help in this effort though we are making no specific requests.
6. We request that A.I.D. transmit the material requested in paragraphs 1, 2, and 3 above by April 15, though we welcome the opportunity to see the material in draft beforehand.

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1. BECAUSE OF SEVERITY OF CURRENT DEMOGRAPHIC PRESSURE ON RESOURCES AND LIKELIHOOD THAT THIS SITUATION WILL WORSEN AS DEVELOPMENT PROCEEDS AND POPULATIONS GROW, AID/W CONVINCED THAT ATTENTION TO POPULATION PROBLEMS MUST BE GIVEN GREATER PRIORITY BY THE DONOR COMMUNITY AND LOCS. MORE PARTICULARLY, IN ALLOCATING U.S. DEVELOPMENT ASSISTANCE, WE BELIEVE CAREFUL ATTENTION SHOULD BE PAID TO COUNTRY EFFORTS TO PROMOTE VOLUNTARY FAMILY PLANNING AND TO MISSION EFFORTS TO SUPPORT SAME. (NB: ATTENTION TO POPULATION HAS ALWAYS BEEN PART OF OUR ASSESSMENT OF DEVELOPMENT PERFORMANCE UNDER (FORMER) SECTION 102 (D) OF THE FAA, BUT WE ARE CONSIDERING GIVING IT SOMEWHAT GREATER WEIGHT, IN CONJUNCTION WITH OTHER FACTORS.)

2. WE ALSO MUST DETERMINE WHAT ROLE U.S. ASSISTANCE SHOULD PLAY IN MEETING NEEDS OF LOCS FOR POPULATION ASSISTANCE. WE ARE CURRENTLY UNDERTAKING A STUDY AT THE REQUEST OF IOCA TO ASSESS THE FUTURE NEED FOR POPULATION ASSISTANCE IN DEVELOPING COUNTRIES, THE EFFECTIVENESS OF THE PROGRAMS OF MAJOR POPULATION DONORS AND COMPARATIVE ADVANTAGES AMONG

DONORS, AND WAYS OF IMPROVING DONOR COORDINATION IN POPULATION ACTIVITIES. WE WOULD APPRECIATE YOUR JUDGEMENTS/ COMMENTS ON SUCH ITEMS AS:

(A) THE COUNTRY'S OWN PROGRAM AND PLANS IN THE AREA OF POPULATION/FERTILITY CONTROL;

(B) THE PROGRAM OF OTHER BILATERAL, MULTILATERAL, AND PRIVATE POPULATION AGENCIES, AND THE EXTENT TO WHICH THESE PROGRAMS ARE COMPLEMENTARY; AND,

(C) IN VIEW OF THE PROGRAMS AND COMMITMENTS OF OTHER DONORS, THE APPROPRIATE FUTURE (5-10 YEAR) ROLE FOR USAID IN POPULATION ASSISTANCE IN THE COUNTRY.

WE WOULD ALSO APPRECIATE YOUR VIEWS ON THE COUNTRY'S ABSORPTIVE CAPACITY AND "READINESS" FOR VARIOUS TYPES OF POPULATION PROGRAMS (E.G., POLICY DEVELOPMENT, DEMOGRAPHIC ANALYSIS, DELIVERY OF FAMILY PLANNING SERVICES).

3. WE ARE NOT REQUESTING MAJOR STUDY BUT RATHER YOUR JUDGEMENTS ON THESE QUESTIONS IN FAIRLY BRIEF CABLE. WE HAVE COMPREHENSIVE FISCAL AND DESCRIPTIVE INFO ON AID ACTIVITIES AND SOME ON THE BANK AND UNFPA. ADDITIONAL INFORMATION BY POUCH ON OTHER DONORS WOULD BE ESPECIALLY WELCOME, BUT HOPE CABLE WILL BE JUDGEMENTAL RATHER THAN DESCRIPTIVE.

4. PLEASE CABLE RESPONSE BY APRIL 18, 1980.

5. FOR THE LAC REGION, SINCE MOST OF THE USDS'S POPULATION STRATEGIES AND PROJECT PAPERS REFLECT THE INFORMATION REQUESTED IN NO. 2 ABOVE, WE SUGGEST YOU FOCUS ON THE QUESTION OF COMPARATIVE ADVANTAGE OF AID BILATERAL AND INTERMEDIARY ASSISTANCE AS WELL AS IBRD, IDB AND UNFPA DONOR ASSISTANCE. REFERENCE BROWN LETTER TO MISSION DIRECTORS.

6. FOR ASIAN MISSIONS: SINCE THE POPULATION SECTION OF THE "HEALTH, POPULATION, AND NUTRITION STRATEGY FOR ASIA" (ASIA/TR/NPH, FEB. 80) AND THE ASIA BUREAU'S "REPORT TO THE HOUSE COMMITTEE ON FOREIGN AFFAIRS ON POPULATION AND FAMILY PLANNING PROGRAMS IN ASIA" ALREADY REFLECT IN CONSIDERABLE MEASURE AID'S JUDGEMENT ABOUT AID AND HOST COUNTRY EFFECTIVENESS, WHILE FEELING FREE TO ELABORATE ON THOSE DOCUMENTS, YOU SHOULD GIVE PARTICULAR EMPHASIS TO IBRD AND UNFPA EFFECTIVENESS. VANCE

Benin

Benin has a relatively favorable social setting, a strong government commitment to population programs and a moderate annual increase in population. Estimates of the growth rate range between 2.7 and 3.0%, which indicates a doubling of the population in 20 to 23 years.

Explanation:

The following indicators describe the relatively favorable social setting:

- 33% of girls in the primary school age group are enrolled
- 23% of the population is urban (15% according to PRB)
- there is one paramedic per 3,100 people

However, the adult literacy rate is only 11% and infant mortality is 150/1000.

The GOB's commitment to population programs is evidenced in the inclusion of family planning in its health objectives, the bias towards preventative rather than curative medicine (the government has created a Dept. of preventative medicine and a National Health Education Center) and permission for the IPPF affiliate (CNEPFF) to import, sell and advertise contraceptives. The GOB continues to stress the health benefits of family planning and is also interested in population education.

Policy Options:

AID has no bilateral population program in Benin, but has provided funding for training through the University of California at Santa Cruz, and JHPIEGO (midwives, nurses and doctors). Other AID funding of intermediaries includes UNPFA for census activities, IPPF for family planning services and UNESCO for population education. Future activities could include:

- piggy-backing health services, sanitation education etc. onto the current rural water supply project in order to reduce infant mortality.
- find population education projects (e.g. the CNEPFF project proposal no. 341) since there is demonstrated government interest in this.
- encourage demographic studies, since there is a paucity of reliable data
- continued funding for the provision of services and extension into the rural areas by intermediaries.

memorandum

DATE: April 1, 1980

REPLY TO
ATTN OF: PPC/PDPR/HR, Cindy Steele

SUBJECT: Cameroon

TO: PPC/PDPR/HR, Ms. Ann Van Dusen

Cameroon is placed in the block with more favorable social setting, moderate government commitment to population and moderate annual population increase on the matrix.

Explanation: Cameroon's population growth rate/year has increased from 1.5% in 1950 to 2.3% in 1978, and portends a doubling of the population before 2010.

The following indicators demonstrate the favorable social setting:

- the national literacy rate is 44%
- the enrollment rate for girls in the primary age group is 45%
- the urban population is 28% of the total and is growing about 7.5% annually
- one health worker per 783 people (1:1,890 according to the World Bank)

However, some factors do not indicate a favorable social setting:

- the infant mortality rate is 165/1000
- income distribution is skewed (10% of the population receive 60% of national income)

Previous Government concern about population has focused on geographical distribution rather than on overall growth rates.

An AID financed Future's Group presentation for GURC planners on the relationship between population and development in July 1979 is credited with having stimulated greater awareness of the impact of population on other sectors. President Ahidjo's opening address to the Third National Union Party Congress in 1980 stressed the need to develop a population policy and integrate population planning into the country's development strategy. The official recognition of this indicates an increasingly positive environment for implementing population programs.

Policy Options:

The most appropriate policy for AID would build on the President's own remarks and plans already on stream:



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- to encourage and aid the GURC in setting up a National Population Board which would define a population policy.
- to emphasize MCH since the Futures study indicates that 5 out of 20 women during their childbearing years. Towards this end child-spacing services will be integrated into 36 MCH centers in the new Family Health Project (631-0041).
- to educate the population on family-planning matters (the new AID/C project will set up an information office in Yaounde).
- to assist in developing contraceptive services in urban centers through sponsorship of government and intermediary efforts.
- to supplement family health training currently done through the MEDCAM project for specialized training in the U.S. as well as in-country.
- to continue the support for demographic studies (USAID/C is helping to fund a World Fertility Study) such as the 4-week workshop on census taking conducted by the U.S. Bureau of Census for francophone planners which Cameroon is hosting this month.

memorandum

DATE: April 1, 1980

REPLY TO
ATTN OF: PPC/PDPR/HR, Cindy Steele.

SUBJECT: Ghana

TO: PPC/PDPR/HR, Ms. Ann Van Dusen

Ghana is listed on the population priorities matrix as having a moderate annual increase in population, a favorable socio-economic environment and moderate government commitment to population programs. The annual population growth rate in Ghana is presently 3% which indicates a doubling of the population shortly after 2000.

Explanation: The following indicators describe Ghana's relatively favorable social setting:

- The adult literacy rate is 30%.
- 38% of females in primary age group are enrolled in school (compares to 39% in 1960!)
- There is one paramedic per 860 people (source: World Bank)
- 32% of the population is urbanized
- infant mortality remains high at 115/1000

Despite these indications of a positive socio-economic environment, Ghanaian cultural values are still pro-natalist, with seven as the average desired number of children.

Ghana's population policy, which was issued in 1969, advocates voluntary family planning and overall development methods as appropriate approaches to check population growth. The policy itself is sound but has encountered difficulties in implementation stages: recognition of problems has not led to effective action, the MOH has been reluctant to allocate resources to family planning programs, bureaucratic rivalries between those agencies with responsibilities for population has impeded effective functioning. However, the fact that the President's recent Parliamentary Address highlighted population problems and GOG ministerial interest in a RAPID presentation indicates that official commitment is growing.

Program Options: This is a propitious time for AID involvement in population in Ghana both because the GOG is formulating future development plans and reorganizing existing programs and departments and because a joint USAID/GOG evaluation of program efforts to date will be carried out later this year. The following policies warrant consideration:

- capitalizing on the interest in the RAPID presentation and sponsoring the proposed follow-up studies by the University of Ghana's Population Dynamics Program (PDP);



Buy U.S. Savings Bonds Regularly on the Payroll Savings Plan

- promoting better bureaucratic capabilities and the reduction of ongoing rivalries through a reorganization of responsibility;
- sponsoring population education and IGC efforts to encourage smaller families;
- expanding rural health care delivery with the incorporation of family planning components into MCH. There continues to be an infrastructural and training bias towards curative care; reorientation in curriculum design and resource allocation is needed. Health training projects will include family planning as well;
- continuing to support other donors (UNFPA is assisting in the next census. The ILO is planning a major project relating population to employment) and Ghanaian research in population impact and family planning methods.

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Guinea

On the population priorities matrix, Guinea has a moderate population increase, a less favorable socio-economic environment and a weak government commitment to population programs. The annual population growth rate is estimated to be 2.5% by the Population Reference Bureau and 3.0% by the World Bank.

Explanation:

The weak social setting is described by the following:

- the infant mortality rate is 175/1000
- 16% of the population is urban - based
- there is one paramedic per 2,330 people

The GOG has no official population policy and has a mixed record in its commitment to health overall. Central government health expenditures averaged only 0.75% of the national budget in 1973-8, yet the GOG has made a substantial effort to train health professionals. The GOG does view family spacing as a health measure but does not support the provision of contraceptives at the present time.

Program Options

AID only has a small program in Guinea and has no bilateral activities in population. Because of its limited resources and government intransigence on the population issue, the following steps are recommended:

- a RAPID presentation to alert government officials to effects and implications of population growth.
- encouraging child spacing and the promotion of family planning services within health care systems
- integration of 104(d) concerns and population related components into on-going projects (e.g. health education and the value of child spacing could be included in the WID projects, centres de promotion feminine)
- intermediary activity should be supported since AID/G is not in a position to support bilateral family planning programs at the present time.

memorandum

DATE: April 11, 1980

REPLY TO
ATTN OF: PFC/PDPR/HR, Cindy Steele

SUBJECT: Liberia

TO: PFC/PDPR/HR, Ann Van Dusen

Liberia has a moderate annual increase in population, a relatively favorable socio-economic setting and a weak government commitment to population programs. The annual population growth rate is 3.3%, although population density is low (37 persons/sq. mi.).

Explanation

The following indicators characterize the social setting:

- adult literacy is 21%
- 44% of primary school age females are enrolled
- 30% of the population lives in urban areas
- there is one paramedic/3,150 people (re: World Bank)

Despite this description of a relatively positive climate for population programs, other factors militate against their success:

- infant mortality is 106/1000
- cultural values tend to reinforce the security aspects of large families, the macho preoccupation with fathering many children, and the lack of concern with "illegitimacy," (which increases the number of children born outside of the marriage structure).

The GOL has not developed an official population policy because of the view that the country's favorable population density does not call for reduced growth. As population growth is outstripping GDP, food production is barely able to meet the needs and there is increasing demand for services. There is some evidence that this attitude may change. The Deputy Minister of Economic Planning has drafted a population policy for the next four year development plan which is being written at the present time, and a RAPID presentation has been planned for this month.

Program options

A.I.D. has no bilateral activities in Liberia, although interest is increasing; A.I.D. does fund various intermediaries (Pathfinder, UNFPA). While future A.I.D. involvement will clearly be shaped by the new Liberian development plan, the following areas seem appropriate:



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- continued support for the demographic unit of the University of Liberia (such as A.I.D. funding for a recent conference on fertility and rural development);
- training and assistance to effect greater institutional capacity and coordination of organizations with population responsibilities (there is some confusion and conflict over bailiwicks, particularly between the MOH and the Family Planning Association of Liberia.)
- provision of IEC in local dialects to influence the demand for smaller families;
- buttressing the GOL's rhetorical support for child-spacing and family planning inclusion in general health care through training and improved delivery, especially to rural areas.

Tanzania

On the population priorities grid, Tanzania has a large annual population increase, an unfavorable socio-economic setting and a weak government commitment to population programs. According to the FY 1982 CDSS, the population growth rate has risen from 2.8% in 1973 to 3.3% today (the World Bank and the Population Reference Bureau list 3.0% as the current growth rate). Both figures outstrip the average annual growth in GNP (2.6% between 1960-77).

Explanation:

The relatively unfavorable social setting is indicated by these statistics:

- infant mortality is 125/1000
- there is one paramedic per 3,300 people
- only 9% of the population is urban based
- adult literacy is estimated to be 34%

There is no official population policy in Tanzania; the GOT doesn't advocate reduced growth rates because of the large amounts of unsettled land, the traditional need for children as laborers and providers of security in old age, and the high rates of infertility, miscarriage and still births. The GOT does support child spacing as a health measure and has family planning services and education in the MCH system.

While most of these indicators militate against the successful adoption of a program to reduce fertility rates, there are some encouraging signs in Tanzania. The GOT has emphasized education in the past decade has made strides in increasing female enrollment and has reoriented its curricular focus to provide relevant educational skills. The GOT has also increased its commitment to providing rural preventative health services even at the expense of the urban based hospital system (From 1970 to 78, The proportion of the total health budget allocated to hospital services decreased from 76% to 50%, while funding of rural health centers and preventative services rose from 15% to 34%). Finally, the GOT has taken some measures which may influence family size, although they are only effective in the small urban sector (tax policy, housing regulations and paid government maternity leave only three years have elapsed between births).

Program Options:

USAID/T will soon have a population officer, who should be of enormous help in formulating future bilateral programs.

Nigeria

Nigeria has a less favorable socio-economic setting, a weak government commitment to family planning and a large annual increase in population. The population growth rate is 2.6% per year, which indicates a doubling of the population in just over 20 years.

Explanation:

The weak social setting is demonstrated by the following:

- the infant mortality rate is 157/1000
- there is one paramedic per 3210 people
- only 10% of Nigerian youths are enrolled in secondary school
- adult literacy is 25%
- 18% of the population lives in urban areas

The government has no official population policy, although a National Population Council was established in 1979 to advise officials, and develop and implement plans.

The GON is primarily concerned with spatial redistribution, the health elements of population, and data collection and analysis. It does, however, subsidize the private Family Planning Council of Nigeria (which has 61 clinics) and may integrate family planning into its National Health Service.

Program Options

AID has no bilateral operations in Nigeria and this is unlikely to change, given Nigeria's OPEC status. A large number of donors and private organizations which receive AID finding are involved in Nigeria. UNFPA assists the state operated MCH/FP program and has also supported census activities, expansion of rural health services, IEC, and demographic studies. The Population Council has assisted Nigerian universities in demographic research and training, and is considering establishing a Population Research Center in Lagos. UNESCO, Pathfinder, Johns Hopkins University, IPPF and various other organizations have also been working in Nigeria.

Given Nigeria's large annual population increase, the restrictions on direct AID involvement and the substantial activity of other donors, it would seem appropriate to suggest that donors convene to discuss and coordinate their plans in Nigeria in order to work out the most effective approach possible, through collaborative efforts.

Tanzania

Since AID is perceived as the major donor in the health field, the Mission should seek the incorporation of family planning in all health delivery systems and should promote IEC, sanitation education etc. as part of its effort to inform the citizenry of health matters.

Other appropriate AID actions would be:

- to follow up the fall RAPID presentation with policy guidance for the GOT when possible
- to help develop the research capacity of the GOT (particularly the University) so as to increase the ability to collect, analyze and assimilate demographic data
- to strengthen institutional capacity by sponsoring training for key officials, planners and "trainers of trainers"
- to support intermediary activity in rural outreach programs with family planning components.

Zaire

Zaire's position on the population priorities grid reflects high annual population growth, low government commitment and an unfavorable social setting for population programming. Zaire's population rate has risen from 2.0% in 1960 to 2.7% today, (there are some indications that it may be as high as 3.0%). This portends a doubling of the population - from 26 to 52 million - in 23 years.

Explanation:

The socio-economic environment of Zaire, as described by the following indicators is not conducive to family planning activities:

- the literacy rate of rural women over fifteen years old is 15%
- the infant mortality rate is 168/1000
- employment for women is limited to support services in general.

However, close to 30% of the population lives in urban centers.

The lack of government commitment to demographic concerns is demonstrated by its failure to bring up any population plans in the Mobutu National Development Plan (education, health and nutrition are also ignored or receive little attention in the plan). While the GOZ is not seeking to reduce fertility, it does support childspacing as a health measure.

Program Options

A mix of bilateral and intermediary activity should be used to build on existing resources and programs. A variety of organizations have been providing health services and support for family planning: For example, Pathfinder and FPIA have trained health personnel, provided educational materials and worked to extend family planning in rural areas; UNESCO is funding sex education programs; IPPF funds the National Committee for Desired Births. In addition, church missions provide an estimated 75% of health care in the rural areas.

AID support for these intermediary activities is vital, and future bilateral programs should complement their efforts. Specifically, AID could:

- sponsor a RAPID presentation for officials and government planners (The links between population growth and economic development should be emphasized to them given the deterioration of the economy).
- help build a cadre of trainers for the regional programs to incorporate sex education in the schools, (and sponsor IEC in conjunction with these activities.)

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Zaire

- upgrade existing maternity centers and health facilities;
- train para professional health workers in family planning methods;
- promote the inclusion of MCH/FP into health systems; and
- provide technical assistance (e.g. demographic studies, helping to establish a nurse - midwifery association in Zaire as requested)

Future population programming by AID will be facilitated by the new population officer posted to Zaire. Bilateral action may be possible and desirable in several years, if some initial groundwork has been laid and the GOZ becomes more receptive to it.

BISSAU 0706 (LOU) not included in this appendix

BUJUMBURA 0933 (LOU) not included in this appendix

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ACTION OFFICE POP-04
INFO PPCE-01 PPPB-02 PPEA-01 IA-01 IIA-02 IDCA-01 WID-01
AADS-01 OSHE-01 OLAB-02 CNB-01 ES-01 AAID-01 HEV-09
NUO-02 LAB-05 OMB-02 RELO-01 STA-10 MAST-01 PDPR-01
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UNCLAS SECTION 1 OF 2 ABIDJAN 5181

AIDAC

E.O. 12065: N/A
SUBJ: IVORY COAST POPULATION POLICY

REF: STATE 085558

1. SUMMARY. IVORY COAST POPULATION POLICY IS PRO-NATALIST. THREE OBJECTIVES IN THE AREA OF POPULATION ARE (A) IVORIAN POPULATION GROWTH; (B) ADJUSTMENT OF FOREIGN IMMIGRATION TO MATCH ECONOMIC NEEDS AND LIMITS OF SOCIAL ACCEPTABILITY; AND (C) REORIENTATION OF INTERNAL MIGRATORY FLOWS FOR BALANCED REGIONAL DEVELOPMENT. PROGRAMS FOR ACHIEVING THE FIRST OBJECTIVES ARE: (1) DEVELOPMENT OF HEALTH CARE MEASURES FOR MOTHERS AND CHILDREN; (2) BIRTH SPACING; AND (3) IMPROVING THE STATUS OF CONDITION OF WOMEN AND THE FAMILY. HOWEVER, GOIC HAS YET TO INITIATE EDUCATIONAL, INFORMATION, OR CONTRACEPTION PROGRAMS REGARDING BIRTH SPACING. FEW DONORS ARE INVOLVED IN POPULATION-RELATED ACTIVITIES BECAUSE GOIC FEELS HELP IS NOT NEEDED, THOUGH UNFPA HAS LIMITED PROGRAM. IN ABSENCE OF GOIC DESIRE FOR ADDITIONAL ASSISTANCE IN THE AREA OF POPULATION CONTROL, REDSO HAS ENDEAVORED WITHOUT SUCCESS TO DATE TO DEVELOP A SUB-ACTIVITY UNDER HEALTH CARE FOR MOTHER AND CHILDREN. END SUMMARY.

THE FOLLOWING PARAGRAPHS ARE KEYED TO PARA. 2, A, B, AND C, OF REFTEL.

2. (2A) THE GOIC POPULATION POLICY IS BASED ON SEVERAL DEMOGRAPHIC FACTORS: LOW POPULATION DENSITY (UNDER 30 INHABITANTS/KM2)

; A LARGE FOREIGN POPULATION FUELING A HIGH ECONOMIC GROWTH RATE; SOCIO-CULTURAL VALUE PLACED, AS IN OTHER WEST AFRICAN COUNTRIES, ON HIGH FERTILITY FOR WOMEN AND ACCOMPANYING HIGH STATUS FOR MEN WITH MANY CHILDREN; AND A GENERALLY CONSERVATIVE ATTITUDE TOWARD CONTRACEPTION. THE FOREIGN PRESENCE REPRESENTS 50 PERCENT OF TOTAL IVORY COAST POPULATION OF 7 MILLION PLUS AND CONSTITUTES OVER 40 PERCENT OF THE POPULATION INCREASE OVER THE LAST DECADE. IN ABIDJAN, WHICH HAS A 10 PERCENT POPULATION GROWTH RATE, AT LEAST HALF THE POPULATION IS FOREIGN. FOREIGNERS ARE DEFINED AS TEMPORARY WORKERS, PEOPLE BORN ABROAD, AND FIRST GENERATION DESCENDANTS BORN IN I.C. IVORY COAST IS DIFFERENT FROM OTHER WEST AFRICAN COUNTRIES IN THAT ITS ECONOMY CAN EMPLOY A GROWING LABOR FORCE. ADDITIONAL FOREIGN LABOR HAS BEEN USED BY IVORY COAST TO ACHIEVE THE HIGH REAL ANNUAL GNP GROWTH RATE OF 8 PERCENT (1975-79), LARGELY THROUGH LABOR-INTENSIVE EXPORT AGRICULTURE. GOIC IS FULLY CONSCIOUS, HOWEVER, OF POTENTIAL POLITICAL, ECONOMIC AND SOCIAL PROBLEMS WHICH COULD RESULT FROM TOO MANY FOREIGN WORKERS AND IS ENCOURAGING NATURAL GROWTH OF THE IVORIAN POPULATION TO MINIMIZE THE PERCENTAGE OF FOREIGNERS. ATTITUDE CHANGES OCCUR SLOWLY, ESPECIALLY IN THE ABSENCE OF POLITICAL WILL TO CHANGE. THE PRESIDENT DOES NOT DISCUSS FAMILY PLANNING ISSUES IN THE COUNCIL OF MINISTERS, SAYING THAT IVORY COAST IS NOT YET "RIPE"

3. THE FIVE YEAR PLAN (FYP) LISTS IVORIAN POPULATION GROWTH AS THE FIRST OF THREE POPULATION OBJECTIVES. THIS IS BASED ON A "FUNDAMENTAL" OPTION FAVORING MAINTENANCE OF A HIGH NATURAL BIRTH AND POPULATION GROWTH RATE BETWEEN NOW AND THE END OF THE CENTURY TO INCREASE THE POPULATION NUMERICALLY AND, AT THE SAME TIME, IMPROVE THE HEALTH OF MOTHERS AND CHILDREN, (P. 121). IT IS DESIGNED TO COPE WITH THREE MAJOR PROBLEMS: (A) HIGH INFANT MORTALITY; (B) TOO-CLOSE BIRTH INTERVALS; AND (C) INCREASED FAMILY INSTABILITY AND PROBLEMS RELATED TO A SHIFT TO A MONOGAMOUS FAMILY SYSTEM. PROGRAMS TO HELP SOLVE THESE PROBLEMS ARE (A) DEVELOPMENT OF HEALTH CARE MEASURES FOR MOTHERS AND CHILDREN; (B) IMPROVED BIRTH SPACING; AND (C) IMPROVING THE STATUS AND CONDITIONS OF WOMEN IN THE FAMILY.

4. ACCORDING TO THE FYP, IMPROVED BIRTH SPACING, OF PRIMARY INTEREST TO AID, WOULD ENTAIL INTRODUCING HEALTH, CHILD CARE AND SEX EDUCATION IN SCHOOLS, AND MAKING MODERN CONTRACEPTIVES AVAILABLE TO GIRLS AND WOMEN AS PART OF SCHOOL AND MOTHER/CHILD WELFARE PROGRAMS. THE GOIC HAS YET TO UNDERTAKE ANY BIRTH SPACING ACTIVITIES. NO FAMILY PLANNING INFORMATION IS AVAILABLE AT MCH CENTERS. WOMEN MUST SEEK PRIVATE CONSULTATIONS, AND MUST PAY FOR THE CONTRACTIVES. IN THE CENTRES MEDICO-SCOLAIRES, THE HEALTH CARE UNITS UNDER THE DIRECTION OF NATIONAL EDUCATION WHICH SERVES STUDENTS, NO INFORMATION IS AVAILABLE, NOR CAN GIRLS EASILY OBTAIN GYNECOLOGICAL EXAMINATIONS

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ACTION OFFICE POP-04
 INFO AAAF-01 AFCW-03 AFDR-06 PPCE-01 PPPB-02 PPEA-01 IA-01
 IIA-02 IDCA-01 WID-01 AADS-01 DSHE-01 OLAB-02 CH8-01
 ES-01 AAID-01 HEW-09 HUC-02 LAB-05 OMB-02 RELO-01 STA-10
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AND ADVICE. SEX EDUCATION IS NOT TAUGHT IN SCHOOLS. THE NOTABLE EXCEPTION IS THE TECHNICAL LYCEES, WHERE THE MINISTERS OF TECHNICAL EDUCATION HAS INSTITUTED A SEX EDUCATION COURSE FOR ALL STUDENTS.

5. A RECENT STUDY CONDUCTED IN AN ABIDJAN LYCEE BY THE MINISTRY OF TECHNICAL EDUCATION'S HEALTH LIAISON OFFICER SHOWED THAT AT LEAST 50 PERCENT OF THE 800 FEMALE STUDENTS HAVE HAD AN ABORTION, ALL CLANDESTINE. LESS THAN 10 PERCENT USE MODERN CONTRACEPTIVES. THE STUDY CONCLUDES THAT THERE IS OBVIOUSLY A NEED FOR SEX EDUCATION AND CONTRACEPTIVES, ESPECIALLY IN THE URBAN CENTERS. THIS CONTROVERSIAL REPORT PROBABLY WILL BE DISCUSSED AT THE SUB-MINISTERIAL LEVEL AND MAY BE BROUGHT TO THE ATTENTION OF THE COUNCIL OF MINISTERS NEXT YEAR. HOWEVER, THE GOVERNMENT IS NOT EAGER TO UNDERTAKE SUCH STUDIES IN OTHER AREAS OF THE COUNTRY AND ESPECIALLY NOT WITH FOREIGN DONOR FINANCING.

6. (2B) UNFPA PROVIDES A SENIOR DEMOGRAPHER AT ABIDJAN'S SCHOOL OF STATISTICS, WHO IS TRYING TO LAUNCH A RESEARCH PROGRAM. A FRENCH COOPERANT IS COORDINATING A MAJOR NATIONAL FERTILITY SURVEY IN THE IVORY COAST, THOUGH DATA ON FERTILITY AND MORTALITY ARE STILL INADEQUATE.

7. (2C) REDSO HAS ENDEAVORED WITHOUT SUCCESS TO DATE TO DEVELOP A SUB-ACTIVITY UNDER FAMILY INITIATIVES FOR HEALTH CARE FOR MOTHERS AND CHILDREN. INFANT MORTALITY RATES ARE OFFICIALLY ESTIMATED AT 18.5 PERCENT IN THE RURAL AREAS AND 14 PERCENT IN ABIDJAN. ASSISTANCE TO RURAL MCH CENTERS, INCLUDING NUTRITIONAL INFORMATION, AND THE EPI PROGRAM COULD HAVE SUBSTANTIAL IMPACT ON INFANT MORTALITY RATES. HOWEVER, THE GOIC GIVES A LOW PRIORITY TO PRIMARY HEALTH CARE.

8. PRESENT GOIC POPULATION POLICIES DO NOT SUPPORT A POPULATION PROGRAM. NUMEROUS AID CONTACTS OVER THE LAST TWO YEARS WITH MOH HAVE FAILED TO DEVELOP INTO SERIOUS DISCUSSIONS OF POSSIBLE POPULATION PROGRAMS. WHILE THE MOH IN A JULY 1979 LETTER TO THE AMBASSADOR INVITED FURTHER DISCUSSION OF BIRTH SPACING, SUBSEQUENT APPROACHES TO MOH OFFICIALS RECEIVED NON-COMMITTAL RESPONSES. TO THE EXTENT THAT ANY COLLABORATION IS POSSIBLE BETWEEN GOIC AND USAID, IT MUST BE LIMITED CURRENTLY TO THE FIELD OF MOTHER-CHILD HEALTH.
FRIEDMAN

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PAGE 01 ACCRA 03424 01 OF 02 1507432 5742 A103468
ACTION AID-35

ACTION OFFICE PPPR-01
INFO ARAF-01 AFCH-03 AFDR-06 PPCE-01 PPPB-02 GC-01 GCAF-01
PPFA-01 GCFL-01 HAD3-01 DCHE-01 OSRD-02 ED-01 POP-04
CH8-01 HEV-09 OMB-02 RELO-01 STA-10 MAST-01 AFDA-01
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UNCLAS SECTION 01 OF 02 ACCRA 03424

AIDAC

E.O. 12065: N/A

SUBJECT: ASSESSMENT OF POPULATION ASSISTANCE NEEDS

REF: STATE 85538

1. HIGHLIGHTS OF GHANA'S POPULATION POLICIES AND PROGRAMS ARE DESCRIBED IN FY 82 CDSS, PP. 33-42. OFFICIAL POLICY PUBLISHED IN 1968 REGARDS HIGH POPULATION GROWTH RATE AS DETRIMENTAL TO COUNTRY'S DEVELOPMENT AND SEEKS TO REDUCE IT. VOLUNTARY FAMILY PLANNING IS SEEN AS A MAJOR STRATEGY IN IMPLEMENTING COMPREHENSIVE POLICY. NATIONAL FAMILY PLANNING PROGRAM SECRETARIAT IN MINISTRY OF FINANCE AND ECONOMIC PLANNING COORDINATES FAMILY PLANNING PROGRAMS OF MINISTRY OF HEALTH AND OTHER PARTICIPATING AGENCIES. PRESIDENT LIMANH OF CIVILIAN GOVERNMENT ELECTED LAST SEPTEMBER HAS REAFFIRMED VALIDITY OF 1968 POLICY. HE HAS STATED, QUOTE MY GOVERNMENT WILL TAKE A CRITICAL LOOK AT OUR BROAD POPULATION PROGRAMS, INCLUDING RELEVANT RESEARCH ACTIVITIES IN OUR UNIVERSITIES, AND INTRODUCE APPROPRIATE ORGANIZATIONAL ARRANGEMENTS TO ENSURE THAT DUE COGNIZANCE IS TAKEN OF THE POPULATION ELEMENT IN ALL OUR NATIONAL DEVELOPMENT EFFORTS, END QUOTE. GOG HAS NOT YET ARTICULATED DEFINITIVE PLANS AND PROGRAMS FOR THE NEXT SEVERAL YEARS. USAID HOPES THAT FORTHCOMING INTENSIVE EVALUATION OF AID POPULATION ASSISTANCE, DEVELOPMENT OF MULTI-YEAR POPULATION STRATEGY STATEMENT FOR AID ASSISTANCE, AND PLANNED RAPID PRESENTATION LATER THIS YEAR WILL HELP GOG FOCUS ON POPULATION ISSUE AND DEVELOP CONSENSUS ON FUTURE PROGRAM DIRECTIONS. MISSION CONVINCED THAT WITHOUT GREATER SENSE OF URGENCY AND PRIORITY OF POPULATION POLICY ISSUES BY GOG, PROGRAM IMPACT WILL CONTINUE TO BE DISAPPOINTING.

2. AID HAS BEEN BY FAR THE MAJOR POPULATION DONOR. U.K. AND CANADA HAVE PROVIDED SUPPORT, PARTICULARLY IN EARLY 1970S. UNFPA IS ASSISTING IN CENSUS SUPPORT AND IMPROVEMENT OF VITAL STATISTICS, AND IS INTERESTED IN CONDUCTING A MINIMUM NEEDS ASSESSMENT THIS YEAR. IPPF SUPPORTS THE PLANNED PARENTHOOD ASSOCIATION OF GHANA. WE UNDERSTAND THAT ILO IS PREPARED TO SUPPORT A MAJOR POPULATION AND MANPOWER PROJECT BUT SUCH ACTIVITY IS NOT INCLUDED ON THE JUST NEGOTIATED LIST OF UNOP ACTIVITIES THROUGH 1982. AID FUNDED ORGANIZATIONS SUCH AS WORLD FERTILITY SURVEY, PIEGO, FPIA, AMERICAN HOME ECONOMICS ASSOCIATION AND UNIVERSITY OF CHICAGO ARE ACTIVE. THE GHPPP SECRETARIAT COORDINATES ALL FAMILY PLANNING DONOR ASSISTANCE. USAID CONSIDERS THESE VARIOUS PROGRAMS COMPLEMENTARY.

3. MISSION EXPECTS THAT POPULATION EVALUATION AND

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COLLABORATIVE DEVELOPMENT OF MULTI-YEAR POPULATION ASSISTANCE STRATEGY STATEMENT WILL PROVIDE GUIDANCE FOR AID'S FUTURE ROLE AS WELL AS CLARIFY GOG INTEREST IN DEALING WITH POLICY ISSUES AND ITS CAPACITY TO ABSORB VARIOUS KINDS OF POPULATION PROGRAMS TO IMPLEMENT POLICY. MISSION BELIEVES THAT GOG SATISFIED WITH AID POSITION AS MAJOR DONOR AND WILL CONTINUE TO SEEK SUBSTANTIAL AID ASSISTANCE. THERE HAVE BEEN INDICATIONS, HOWEVER, THAT A BROADER BASE OF DONOR SUPPORT WOULD BE WELCOMED. PRELIMINARY MISSION THINKING ON FUTURE DIRECTION AND DIMENSION OF ASSISTANCE EMPHASIZES ACTIVITIES TO STRENGTHEN AWARENESS OF IMPORTANCE OF POPULATION, CONTINUED EXPANSION OF FAMILY PLANNING SERVICE DELIVERY CAPABILITY INCLUDING MASS INFORMATION AND EDUCATION PROGRAMS, AND RESEARCH AND TRAINING TO ASSIST IN INTEGRATING POPULATION DYNAMICS INTO DEVELOPMENT PLANNING.

4. IMPORTANT DETERMINANT OF USAID ROLE WILL BE MISSION STAFFING TO DESIGN, MONITOR AND IMPLEMENT PROGRAMS. POSSIBILITY OF SUBSTANTIAL REDUCTION IN MISSION POSITIONS HAS LEFT RETENTION OF USOH POPULATION ADVISOR POSITION IN JEOPARDY. WITHOUT FULLTIME POPULATION OFFICER, SCALE OF ACTIVITIES ENVISAGED WOULD HAVE TO BE REDUCED AND INPUTS OF COMPLEMENTARY CENTRALLY FUNDED PROJECTS WOULD HAVE TO BE RESTRICTED.
5. ALMOST ALL TYPES OF POPULATION ACTIVITIES ACCEPTABLE TO GOG INCLUDING, DEMOGRAPHIC ANALYSIS, POLICY DEVELOPMENT, FAMILY PLANNING SERVICES EXCEPT ABORTION, INFORMATION AND EDUCATION OUTREACH, TRAINING, VARIOUS TYPES OF SECTION 104 (D) PROGRAMS. RESOLUTION OF POLICY ISSUES AND ABSORPTIVE CAPACITY ARE LIKELY TO CONTINUE TO BE MAJOR CONSTRAINTS IN UNDERTAKING BIG MEN PROGRAMS. WITH GOG PRIORITY OVER THE NEXT TWO YEARS PLACED ON RENABILITATION OF THE ECONOMY AND RURAL DEVELOPMENT, IT IS IMPORTANT THAT NEW POPULATION/FAMILY PLANNING ACTIVITIES BE DESIGNED TO MINIMIZE FINANCIAL AND

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CHG-01 HEW-09 OMB-02 RELO-01 STA-10 MAST-01 AFDA-01
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TO SECSTATE WASHDC PRIORITY 8138

UNCLAS SECTION 02 OF 02 ACCRA 03424

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MANAGEMENT BURDEN, E. G. THROUGH INTEGRATION WITH OTHER ON-GOING PROGRAMS. EXPANSION OF MOY PRIMARY HEALTH CARE PROGRAM WHICH INCLUDES FAMILY PLANNING REPRESENTS MAJOR OPPORTUNITY FOR AID ASSISTANCE. MOH IS DEFINITELY PLACING GREATER EMPHASIS ON FAMILY PLANNING. UNIVERSITY OF GHANA IS PLANNING TO UNDERTAKE MAJOR RESEARCH EFFORT ON POVERTY AND RURAL DEVELOPMENT. PILOT TESTING OF MINISTRY OF EDUCATION FAMILY LIFE EDUCATION PROGRAM HAS BEEN VERY ENCOURAGING. THERE IS SOME EVIDENCE THAT NEW GOVERNMENT, WITH MANY SENIOR OFFICIALS FROM ACADEMIC BACKGROUNDS, HAS GREATER APPRECIATION FOR RELEVANCE OF POPULATION TO SOUND DEVELOPMENT PLANNING. MANY GHANAIAI PVO'S WOULD BE PREPARED TO ENGAGE IN POPULATION EDUCATION AND FAMILY PLANNING SERVICE DELIVERY IF PROVIDED RESOURCES.

6. GIVEN ELEVEN YEAR EXISTENCE OF GOG POLICY AND TEN YEAR LIFE OF NATIONAL FAMILY PLANNING PROGRAM, THERE IS CONSIDERABLE DISAPPOINTMENT AMONG DONORS AND CONCERNED GHANAIAI LEADERS OVER LACK OF GREATER PROGRESS. YET LAST DECADE HAS SEEN GROWING AWARENESS OF BENEFITS OF FAMILY PLANNING. INITIAL SUCCESS OF RECENTLY ESTABLISHED RETAIL CONTRACEPTIVE SALES PROGRAM IS INDICATION OF SUBSTANTIAL DEMAND. RECENT ECONOMIC HARDSHIPS HAVE RESULTED IN WIDESPREAD PERCEPTION, ESPECIALLY IN URBAN AREAS, THAT TRADITIONAL LARGE FAMILIES CAN NO LONGER BE AFFORDED. MISSION SUGGESTS THAT AID ROLE IS TO PERSIST WITH PROGRAM APPROACHES THAT HAVE RECENTLY PROVEN TO BE EFFECTIVE IN OTHER CONTINENTS SUCH AS WIDESPREAD AVAILABILITY OF FAMILY PLANNING SERVICES, AND TO SEEK WAYS TO ASSIST IN THE INTEGRATION OF POPULATION AND FAMILY PLANNING INTO GHANA'S OTHER HIGH PRIORITY DEVELOPMENT POLICIES AND PROGRAMS. SMITH

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PAGE 01 BAHAKO 03344 301733Z
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FM AMEMBASSY BAHAKO
TO SECSTATE WASHDC 0007

UNCLAS BAHAKO 3344

AIDAC

E.O. 12065: N/A
SUBJ: POPULATION AND FAMILY PLANNING IN MALI

REF: STATE 065550

1. MISSION REGRETS DELAY RESPONSE TO REFTEL.
2. THE GRM HAS THUS FAR REFRAINED FROM OFFICIALLY ARTICULATING A PUBLIC POLICY ON SUBJECT MATTERS. IN PRACTICE, HOWEVER, THE GRM ENCOURAGES A VARIETY OF SUBJECT ACTIVITIES.
3. THE GRM POSITION IS THAT FP ACTIVITIES ARE PART OF MCH SERVICES. THEY ARE NOT TO BE USED AS MEANS TO SOLVE ECONOMIC PROBLEMS. FP SERVICES ARE ACCEPTABLE WHEN INTEGRATED WITH HEALTH SERVICES, BUT ARE UNACCEPTABLE AS FREE-STANDING ACTIVITIES OR WHEN LINKED WITH ECONOMIC DEVELOPMENT SERVICES. PRO-NATALIST BELIEFS ARE WIDESPREAD AND DEEPLY HELD IN MALI. HIGH BIRTH RATES ARE A RATIONAL RESPONSE TO HIGH DEATH RATES. THE GRM BELIEVES THAT AS HEALTH SOCIAL AND ECONOMIC CONDITIONS IMPROVE, DEATH RATES AND BIRTH RATES WILL BOTH DECLINE.
4. THE GRM RECOGNIZES THERE IS AN UNMET DEMAND FOR FP SERVICES PARTICULARLY IN URBAN AREAS AND AMONG SELECTED TARGET GROUPS OF WOMEN IN ALL AREAS. THE MISSION'S POSITION IS TO WORK WITHIN THE EXISTING "POLICY" BY ASSISTING THE GRM PROVIDE FP SERVICES TO THOSE WHO DEMAND THEM. EXAMPLES OF GRM INITIATIVES ON SUBJECT MATTERS ARE:
 - FAMILY PLANNING ACTIVITIES ARE PRESENTLY TAKING PLACE IN 10 CENTERS IN THE BAHAKO AREA AND IN 7 REGIONAL CENTERS.
 - B. THERE ARE TWO LAPAROSCOPES IN OPERATION IN BAHAKO AND IN THE NEXT FEW MONTHS THERE WILL BE TWO MORE.
 - C. THE FUTURES GROUPS HAS BEEN INVITED TO DO A RAPIDS PRESENTATION IN JUNE.
 - D. IFRP IS DEVELOPING A CONTRACEPTIVE USE STUDY AT GRM REQUEST.
 - 5. MISSION BELIEVES THERE IS A FAVORABLE CLIMATE FOR INTEGRATED FP IN MALI. MISSION ALSO BELIEVES THIS CLIMATE IS CHANGING IN FAVOR OF FP AS DEMOGRAPHIC AND ECONOMIC REALITIES BECOME CLEARER.
 - 6. THESE ACTIVITIES AND THOSE OF OTHER DONORS MENTIONED BELOW SPEAK TO THE QUESTION OF GRM READINESS TO ACCEPT PROGRAMS ON SUBJECT MATTERS.
 - A. WHO ASSISTS MCH PERSONNEL CONDUCT SHORT CLINICAL FP COURSES FOR NURSE/MIDWIVES AT REGIONAL HOSPITALS.
 - B. IDRC HAS FINANCED A STUDY ON TRADITIONAL BIRTH CONTROL METHODS.
 - C. IPPF SUPPORTS A FAMILY PLANNING ASSOCIATION AND CLINIC.
 - D. UNFPA ASSISTS THE GRM PROVIDE POPULATION AND FAMILY PLAN-

NING INFORMATION THROUGH SEMINARS, WORKSHOPS, FILMS, VIDEO TAPES, AND EDUCATIONAL MATERIALS. IN THE AREA OF DEMOGRAPHY, UNFPA ASSISTS THE GRM PROCESS AND ANALYZE DATA FROM THE 1976 CENSUS.

7. MISSION PREFERS TO WITHHOLD JUDGEMENT ON THE COMPLEMENTARITY OF THESE PROGRAMS, AS WELL AS ON THE CAPACITY OF THE GRM TO ABSORB THEM. IN VIEW OF GRM POSITION AND CLIMATE FOR CHANGE DESCRIBED ABOVE, MISSION ROLE IN FUTURE POPULATION ASSISTANCE WILL REMAIN LOW KEY (SEE PARA 4 ABOVE AND CDS, PP. 26 AND 31). LIMITED AMOUNTS OF FP COMMODITIES MAY BE PROVIDED IN THE RURAL HEALTH SERVICES DEVELOPMENT PROJECT (080-0208) WHICH TERMINATES IN FY 83; DESIGN OF FOLLOW-ON ACTIVITIES (TO INCLUDE MCH-FP) WILL BE TERMINED SUBSEQUENT TO REVIEW OF AN EVALUATION OF THE PROJECT PRESENTLY IN PROGRESS.
MOLLOVAY

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R 241600Z APR 88
FM AMEMBASSY BANJUL
TO SECSTATE WASHDC 8705
INFO AMEMBASSY ABIDJAN
AMEMBASSY BAHAKO
AMEMBASSY DAKAR

UNCLAS BANJUL 1163

AIDAC

EO 12065: NA
SUBJ: PROMOTION OF VOLUNTARY FAMILY PLANNING

REF: (A) STATE 085558, (B) BANJUL 0923

1. MISSION'S RESPONSES ARE GEARED TO OUTLINED IN PARA. 2 OF REPTEL A.

2. (A) SINCE SENDING REPTEL B, MISSION HAS HAD AN OPPORTUNITY TO DISCUSS FAMILY PLANNING AT SOME LENGTH WITH THE DIRECTOR OF MEDICAL SERVICES (DMS). IT CAME AS SOMEWHAT OF A SURPRISE TO LEARN THAT HIS ATTITUDE WAS MUCH MORE FORTHCOMING THAN WE HAD EXPECTED. UP TO FAIRLY RECENTLY, THE GOVERNMENT HAD APPARENTLY TAKEN A CONSERVATIVE APPROACH TO FAMILY PLANNING. WHILE IT ADVOCATED CHILD SPACING IN ITS HEALTH CARE PROGRAM, IT DID SO IN THE CONTEXT OF BETTER MOTHER-CHILD HEALTH RATHER THAN THE LIMITING OF POPULATION GROWTH, PER SE. FEW FAMILY PLANNING SERVICES WERE PROVIDED. CONTRIBUTING TO THE GOFG'S RELUCTANCE WAS THE OBVIOUS FUTILITY OF TRYING TO ADVOCATE FAMILY PLANNING IN THE FACE OF THE COUNTRY'S HIGH INFANT MORTALITY RATE (17 PERCENT BEFORE THE AGE OF FIVE IN RURAL AREAS). TRADITIONAL RELIGIOUS VALUES REGARDING FAMILY LIFE AND THE IMPORTANCE OF CHILDREN TO THE FAMILY'S FUTURE WELFARE ALSO PLAYED A ROLE. A PARTICULARLY NEGATIVE ELEMENT EVOLVED FROM A BAD EXPERIENCE THE COUNTRY HAD IN THE MID-50S WITH A U.S. FAMILY PLANNING ORGANIZATION THAT APPARENTLY CONDUCTED ITSELF IN AN OFFENSIVE MANNER, THE MEMORY OF WHICH STILL LINGERS.

THE DMS FEELS THAT THE GOFG IS MAKING SOME IN-ROADS ON THE COUNTRY'S POOR HEALTH STATUS AND EXPECTS THIS PROGRESS TO ACCELERATE RAPIDLY OVER THE NEXT FEW YEARS. WITH THE PROGRESS HAS COME THE REALISATION THAT SOMETHING MUST BE DONE ABOUT THE BIRTH RATE AS THE DEATH RATE FALLS OR THE COUNTRY'S DEVELOPMENT WILL SUFFER. AND WHILE THIS YET TO BE TRANSLATED INTO OFFICIAL POLICY, THE DMS WHO IS THE KEY OPERATIVE OFFICIAL WITHIN THE HEALTH SECTOR, HAS NEVERTHELESS BEGUN TO INTEGRATE THE DELIVERY OF FAMILY PLANNING SERVICES IN THE GOFG HEALTH CARE PROGRAM.

(B) THERE ARE NO OTHER-CONDOR FAMILY PLANNING ACTIVITIES IN THE PUBLIC SECTOR THAT WE ARE AWARE OF. THERE IS OTHER-DONOR INVOLVEMENT, HOWEVER, IN THE GAMBIA FAMILY PLANNING ASSOCIATION (GFPA), WHICH IS THE ONLY PRIVATE ORGANIZATION HERE INVOLVED IN FAMILY PLANNING. DONORS INCLUDE: IPPF, PATH-FINDER, UNESCO, UNFPA AND PFIA (FAMILY PLANNING INTERNATIONAL ASSISTANCE). WE DO NOT KNOW THE MAGNITUDE OF THE DONORS' CONTRIBUTION TO THE GFPA.

(C) WITHOUT A MORE SYSTEMATIC EXAMINATION OF THE SITUATION, IT IS DIFFICULT FOR US TO ASSESS WHAT AID'S ROLE MIGHT BE OVER THE NEXT 5 TO 10 YEARS. SUFFICE IT TO SAY THAT BASED ON OUR CONSERVATION WITH THE DMS, THE GOFG WOULD WELCOME ASSISTANCE FROM AID. WHILE THE DMS STRESSED THE NEED FOR CONTRACEPTIVES IN PARTICULAR, WE BELIEVE HE WOULD BE INTERESTED IN OTHER ELEMENTS OF A POPULATION PROGRAM AS WELL (IN-COUNTRY TRAINING, DEMOGRAPHIC STUDIES, ETC.) GIVEN THE SENSITIVITY OF THE SUBJECT AND THE

NEGATIVE EXPERIENCE OF THE PAST, EXPLORATORY EFFORTS SHOULD BE CARRIED OUT ON A LOW KEY BASIS, BUT WE THINK THERE IS A GOOD POSSIBILITY THAT AID COULD BE INFLUENTIAL IN THE DEVELOPMENT OF A COMPREHENSIVE FAMILY PLANNING PROGRAM IN THE BROADER CONTEXT OF OVERALL HEALTH EDUCATION.

3. DR. ISAIAH JACKSON, WHO IS HERE ON TOY FORM REDSO/VA TO ASSIST MISSION IDENTIFY POSSIBLE AREAS FOR AID INVOLVEMENT IN THE HEALTH SECTOR, HAS POINTED OUT THE EXISTENCE OF AN AFRICA REGIONAL PROJECT ENTITLED FAMILY HEALTH INITIATIVES (698-0862) WHICH APPEARS FROM OUR READING OF ITS DESCRIPTION IN THE FY 81 CP TO BE WELL-SUITED TO ADDRESS THE GOFG'S RECEPITIVITY TO AID ASSISTANCE IN THE FAMILY PLANNING AREA. MISSION WOULD APPRECIATE AID/W ADVISE AS TO WHETHER THE GAMBIA IS ELIGIBLE TO PARTICIPATE IN THE PROJECT AND, IF SO, WHAT THE NECESSARY STEPS WOULD BE TO ESTABLISH THE LINKAGE.
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 HEW-09 RELO-01 STA-10 MAST-01 AFDA-01 /041 A4

INFO OCT-01 /038 W -----124735 161152Z /34

R 161010Z APR 80
FM AMEMBASSY CONAKRY
TO SECSTATE WASHDC 6823
INFO AMEMBASSY ABIDJAN

UNCLAS CONAKRY 0867

AIDAC

E. O. 12065: NA
SUBJECT: POPULATION ASSISTANCE

REF: (A) STATE 085558, (B) CONAKRY 0823

1. RE PARAS 2 (A) AND (B) REF A; GUINEA HAS A PRO-NATALIST POLICY BUT IS BECOMING SERIOUSLY INTERESTED IN BIRTH SPACING TO PROMOTE MATERNAL CHILD HEALTH. TO THIS END, GOG HAS REQUESTED UNFPA TO LAY THE FOUNDATIONS THROUGH A TRAINING AND RESEARCH PROJECT PLANNED TO BEGIN EARLY IN 1981. FOR DETAILS SEE REF B AND THE PID FOR AN AID MOTHER CHILD HEALTH AIP POUCHED TO AFR/CWA APRIL 19. UNFPA IS ALSO ASSISTING A NATIONAL CENSUS EXPECTED TO BEGIN WITH 18-24 MONTHS; PREPARATIONS ARE UNDERWAY.

2. RE PARAS 2 (B) REF A; GOG IS AT A VERY INITIAL STAGE IN POPULATION THINKING AND PROGRAMMING. THE PROPOSED MCH PILOT PROJECT MENTIONED ABOVE ALLOWS FOR BUILDING IN A POPULATION ASSISTANCE COMPONENT AS MAY BE DETERMINED BY THE GOG. THE PROJECT TECHNICIAN AND AAO ONCE PROJECT IS UNDERWAY. BASED ON THAT DETERMINATION, A LARGER SCALE PROGRAM CAN BE DEVELOPED OVER THE NEXT TWO YEARS FOR IMPLEMENTATION IN FUTURE YEARS.
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INFO AAAF-01 AFFW-04 AFOR-06 PPCE-01 PPPB-02 PPEA-01 AADS-01
DSAG-02 OSNE-01 POP-03 CNG-01 COM-05 RELO-01 STA-10
MAST-01 AFDA-01 /U43 A1

SECTOR IN GB, WE DO STAND TO RESPOND TO ANY GOGB
REQUESTS FOR ASSISTANCE, BEGINNING WITH DEMOGRAPHIC STUDIES.
HOWEVER, WE CANNOT HOLD OUT ANY PROSPECTS FOR AID INVOLVEMENT
IN THIS AREA IN NEAR FUTURE. MARKS

INFO OCT-81 /036 W

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R 081503Z APR 80
FM AMEMBASSY BISSAU
TO SECSTATE WASHDC 3045

UNCLAS BISSAU 00997

AIDAC

E. O: 12065: N/A
TAGS:
SUBJ: POPULATION AND FP

REF: STATE 085538

1. AS DISCUSSED IN OUR FY 82 SPSS, THE GOGB IS ESSENTIALLY UN-
INTERESTED IN FP PROGRAMS. GUINEA-BISSAU HAS A FAVORABLE POPU-
LATION/LAND RATIO AND GOOD AGRICULTURAL POTENTIAL. IT DOES NOT
REGARD POTENTIAL POPULATION PRESSURE WITH ANY URGENCY AND IS
NOT WILLING TO DIVERT ANY OF ITS SCARCE RESOURCES, NOR THE EF-
FORTS OF ITS FOREIGN DONORS, FROM WHAT IT BELIEVES TO BE MORE
URGENT DEVELOPMENT OBJECTIVES. IT IS HIGHLY UNLIKELY THAT THIS
POLICY WILL CHANGE IN THE FORESEEABLE FUTURE.

2. NEVERTHELESS, FP INFORMATION AND SERVICES ARE AVAILABLE ON
A REQUEST BASIS AT SOME EXISTING CLINICS, ALTHOUGH THE GOVERN-
MENT MAKES NO ATTEMPT TO PROMOTE THEM. THE COUNTRY'S NUMEROUS
DONORS OBVIOUSLY RESPECT THIS POSITION, AND THERE ARE NO PVO'S
OR INTERNATIONAL ORGANIZATIONS CURRENTLY OPERATING IN GUINEA-
BISSAU WHICH COULD SERVE AS INTERMEDIARIES FOR FP SERVICES,
ALTHOUGH SEVERAL COUNTRIES (CANADA, SWEDEN) HAVE VOLUNTEERS
IN-COUNTRY WHICH COULD FULFILL SUCH A ROLE.

3. THE NATIONAL CENSUS TAKEN IN 1979 INDICATED GUINEA-BISSAU'S
POPULATION AT 777,000. THIS DISPELLED PRIOR GUESSTIMATES
WHICH HAD PLACED THE POPULATION AS HIGH AS 900,000. IT SEEMS
THAT THERE WAS SUBSTANTIALLY MORE EMIGRATION AS A RESULT OF
THE WAR FOR INDEPENDENCE THAT HAD BEEN ESTIMATED ORIGINALLY.
WHILE SUBJECT TO REFINEMENT, THE RATE OF NATURAL POPULATION
INCREASE IS ESTIMATED AT 1.2 PERCENT. GUINEA-BISSAU'S RELA-
TIVELY LOW POPULATION GROWTH RATE IS DUE TO ITS EXTREMELY
HIGH INFANT MORTALITY, ONE OF THE HIGHEST IN THE WORLD. THE
OBVIOUS POPULATION PRESSURES OF COUNTRIES LIKE CAPE VERDE ARE
NOT EVIDENT IN GUINEA-BISSAU. NEVERTHELESS, WHILE AN OVER-
POPULATION DILEMMA CURRENTLY DOES NOT EXIST, THERE IS AN OB-
VIOUS POTENTIAL PROBLEM. LIKE MANY DEVELOPING COUNTRIES WITH
A POPULATION SKEWED TOWARD YOUTH, 42 PERCENT OF GUINEA-BISSAU'S
POPULATION IS UNDER THE AGE OF 15. AS THIS GROUP MOVES INTO
PRODUCTIVE AGES, IT WILL SPUR AN INCREASE IN POPULATION GROWTH.
IF AT THE SAME TIME MORTALITY RATES ARE DECREASED (WHICH IS
LIKELY TO OCCUR AS A RESULT OF VACCINATION AND HEALTH CAMPAIGNS
BEING INITIATED BY THE DONOR COMMUNITY) THE PROBLEM WILL IN-
EVITABLY ARISE.

4. WHILE THE DEMOGRAPHIC SITUATION DESCRIBED ABOVE COULD
PROVIDE JUSTIFICATION FOR EMBARKING ON POPULATION/FP PROGRAMS
NOW, GOGB INTEREST JUST IS NOT THERE. WE HAVE RAISED SUBJECT
NUMEROUS TIMES AT VARIOUS LEVELS IN GOGB AND INVARIABLY MET
WITH DISINTEREST. LAST YEAR GOGB (MINECON) DEVELOPMENT AND
PLANNING ARGUED FERVENTLY WITH THE BRITISH (MINECON) OVERSEAS
DEVELOPMENT THAT GB NEEDED MORE, NOT LESS, POPULATION GROWTH.
ALTHOUGH AID/GB DOES NOT INTEND TO VENTURE INTO HEALTH/POPULATION

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INFO ARAF-01 AFEA-03 AFDR-06 PPCE-01 PPPB-02 PPEA-01 AADS-01
OSNE-01 POP-34 CNE-01 NEW-09 ONM-02 RELO-01 STA-10
MAST-01 AFDA-01 /046 A4

INFO OCT-01 /038 W

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P 161240Z APR 80
FM AMEMBASSY DAR ES SALAAM
TO SECSTATE WASHDC PRIORITY 0141

UNCLAS DAR ES SALAAM 2217

AIDAC

E.O. 12958: N/A
SUBJ: POPULATION; LDC ATTENTION TO POPULATION ISSUE

REF: STATE 25358

1. IN ADDITION TO JUDGEMENTS/COMMENTS BELOW, THREE RECENT DOCUMENTS DEAL WITH POPULATION ISSUE IN TANZANIA:

- A. UNFPA REPORT NUMBER 11: NEEDS ASSESSMENT FOR POPULATION ASSISTANCE IN TANZANIA, MAY, 1979;
- B. HERRITT/HEHN MEMO OF NOV. 1979; AND
- C. TANZANIA HEALTH SECTOR STRATEGY, FEB, 1980.

2. MISSION RESPONSES TO SPECIFIC ITEMS OF REFFCL ARE:

A. TANZANIA DOES NOT HAVE A NATIONAL POPULATION POLICY, HOWEVER, FOLLOWING THE RAPID PRESENTATION GREATER NUMBERS OF TAN GOV OFFICIALS SEEM MORE WILLING TO CONSIDER THE NEED TO DIRECTLY ADDRESS THE POPULATION ISSUE IN THE NEXT FIVE YEAR PLAN. THERE IS A MINIMALLY ACTIVE PVO NATIONAL FAMILY PLANNING AGENCY, AND THE GOVERNMENT DEALS WITH FAMILY PLANNING ONLY IN THE CONTEXT OF MCH SERVICES.

B. IPPF, UNFPA AND FPFA ALL HAVE SMALL AND SCATTERED SUPPORT ACTIVITIES IN TANZANIA. USAID, DANIDA, PATHFINDER, AND POP COUNCIL ARE AMONG THE MANY GROUPS EXPLORING ASSISTANCE POSSIBILITIES IN THIS AREA. WFS EXPECTS TO BEGIN A SURVEY IN TANZANIA IN 1980 OR 1981. THESE LEVELS OF ACTIVITY ARE ALL TOO SMALL TO BE CONFLICTING.

C. STRATEGY FOR FUTURE AID INVOLVEMENT IN POPULATION SECTOR IN TANZANIA IS PRESENTED IN BOTH FY 82 COSS AND IN HEALTH SECTOR STRATEGY. TANZANIA'S ABSORPTIVE CAPACITY AND READINESS IS PRESENTLY LIMITED BY LACK OF EXPLICIT GOVERNMENT POLICY. BEST AID ROLE AT PRESENT IS TO CONTINUE ITS EFFORTS TORING POPULATION ISSUE TO THE ATTENTION OF GOVERNMENT LEADERS WHILE GIVING SUPPORT TO AS MANY FAMILY PLANNING AND POPULATION-RELATED ACTIVITIES AS POSSIBLE. MISSION IS ADDING FULL TIME POPULATION OFFICER TO ITS STAFF TO ASSURE THAT FULL ADVANTAGE IS TAKEN OF EVERY OPPORTUNITY TO DEVELOP POPULATION ASSISTANCE IN TANZANIA WHERE THE ANNUAL GROWTH RATE IS ESTIMATED AT 3.31.

3. WITH CONTINUED USE OF THE RAPID PRESENTATION, THE MISSION EXPECTS TANZANIAN OFFICIALS TO BE INCREASINGLY INTERESTED IN DEALING WITH THE PROBLEMS ASSOCIATED WITH UNRESTRAINED POPULATION GROWTH. USAID/T WILL MAKE FULL USE OF CENTRALLY FUNDED PROJECTS TO FURTHER OR SOME OTHER EVENT MAKES A STRONG BILATERAL POPULATION ASSISTANCE PROGRAM POSSIBLE.
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ACTION OFFICE POP-04

INFO AAAF-01 AFEA-03 AFDR-06 AADS-01 DSHE-01 CH8-01 STA-10
MAST-01 AFDA-01 /029 A4

INFO OCT-01 /036 W

-----015507 021321Z /34

R 020751Z APR 80
FM ANEMBASSY DJIBOUTI
TO SECSTATE WASHDC 3139



UNCLAS DJIBOUTI 661

AIDAC

E. O. 12065: N/A
SUBJ: POPULATION

REF: STATE S5558

1. RESPONSE REFTEL PARA TWO:

A). NONE

B). INFORMAL INSTRUCTION THRU MCH PROGRAMS.

C). VERY LITTLE OPPORTUNITY FOR ANY DONORS IN VIEW TRADITIONAL
MOSELEM CONSERVATISM HERE THAT GENERALLY IS OPPOSED TO ANY FORMAL
PROGRAM THIS AREA.

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ACTION
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PAGE 01 CONAKR 00867 161139Z U848 A104585
ACTION AID-35

ACTION OFFICE POPR-01
INFO AAAF-01 APCW-03 AFOP-02 AFDR-06 AADS-01 OSHE-01 POP-04
HEW-04 RELO-01 STA-10 MAST-01 AFDA-01 /041 A4

INFO OCT-01 /038 W -----124739 161152Z /34

R 161010Z APR 80
FM AMEMBASSY CONAKRY
TO SECSTATE WASHDC 8823
INFO AMEMBASSY ABIDJAN

UNCLAS CONAKRY 0867

AIOAC

E.O. 12065: NA
SUBJECT: POPULATION ASSISTANCE

REF: (A) STATE 085550, (B) CONAKRY 0825

1. RE PARAS 2 (A) AND (B) REF A; GUINEA HAS A PRO-NATALIST POLICY BUT IS BECOMING SERIOUSLY INTERESTED IN BIRTH SPACING TO PROMOTE MATERNAL CHILD HEALTH. TO THIS END, GOG HAS REQUESTED UNFPA TO LAY THE FOUNDATIONS THROUGH A TRAINING AND RESEARCH PROJECT PLANNED TO BEGIN EARLY IN 1981. FOR DETAILS SEE REF B AND THE PID FOR AN AID MOTHER CHILD HEALTH AIP POUCHED TO AFR/CWA APRIL 18. UNFPA IS ALSO ASSISTING A NATIONAL CENSUS EXPECTED TO BEGIN WITH 18-24 MONTHS; PREPARATIONS ARE UNDERWAY.

2. RE PARAS 2 (B) REF A; GOG IS AT A VERY INITIAL STAGE IN POPULATION THINKING AND PROGRAMMING. THE PROPOSED MCH PILOT PROJECT MENTIONED ABOVE ALLOWS FOR BUILDING IN A POPULATION ASSISTANCE COMPONENT AS MAY BE DETERMINED BY THE GOG. THE PROJECT TECHNICIAN AND AAO ONCE PROJECT IS UNDERWAY. BASED ON THAT DETERMINATION, A LARGER SCALE PROGRAM CAN BE DEVELOPED OVER THE NEXT TWO YEARS FOR IMPLEMENTATION IN FUTURE YEARS.
CROSBY

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Department of State

INCOMING
TELEGRAM

PAGE 01 FREETO 01295 021419Z
ACTION AID-35

7121 AID09

ACTION OFFICE PDPR-01
INFO AAAF-01 . AFCW-03 AFDR-06 PPCE-01 PPPB-02 AADS-01 DSHE-01
 POP-04 CH8-01 MAST-01 AFDA-01 /023 A4

INFO OCT-01 /036 W

-----016091 021424Z /34

R 021100Z APR 80
FM AMEMBASSY FREETOWN
TO SECSTATE WASHDC 1870

UNCLAS FREETOWN 1295

AIDAC

E. O. 12065: N/A
SUBJECT: POPULATION ASSISTANCE IN SIERRA LEONE

REF: STATE 085558

NEGATIVE RESPONSE. MISSION HAS NO HEALTH/POPULATION PROGRAM
OR STAFF.
LINEHAN

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**INCOMING
TELEGRAM**

Ham D...

PAGE 01 KHARTO 02409 110728Z
ACTION A10-35

0284 A101146

KHARTO 02409 110728Z

0284 A101146

ACTION OFFICE PPPR-01
INFO AFEA-03 AFDP-07 AFDR-06 CRG-01 PPCE-01 PPPB-02 PPEA-01
POG-02 FH-02 AADS-01 OSHE-01 POP-04 CRG-01 PVC-02 NEV-08
CMB-02 RELO-01 STA-10 MAST-01 AFDA-01 /054 A2

INFO OCT-01 /036 V

-----003065 110734Z /34

P 100846Z APR 80
FM AMEMBASSY KHARTOUM
TO SECSTATE WASHDC PRIORITY 4216

UNCLAS KHARTOUM 2409

AIRAC

E.O. 12958: N/A

SUBJECT: POPULATION ACTIVITIES

REF: STATE 085558

PROVIDED BY THE MISSION THROUGH ITS PLANNED FY 1980 FIVE-YEAR HEALTH SECTOR SUPPORT PROJECT WHICH HAS A SIGNIFICANT MCH/FP COMPONENT. APPROXIMATELY DOLS 2.0 MILLION WILL BE REQUESTED FROM POPULATION FUNDS FOR THIS COMPONENT.

8. USAID/SUDAN LOOKS TO THE OS/POP-FUNDED COMMUNITY BASED FAMILY HEALTH PROJECT TO ASSIST IN PROVIDING FIELD-TESTED INFORMATION FROM WHICH POLICY CAN BE DEVELOPED BY GOS AND USAID AS TO THE POSSIBILITY OF INSTITUTIONALIZING THE DELIVERY OF FAMILY HEALTH, NUTRITION AND FAMILY PLANNING SERVICES WITHIN THE GOS PRIMARY HEALTH CARE PROGRAM AND REPLICATING THIS APPROACH COUNTRY WIDE THROUGH FUTURE BILATERAL ASSISTANCE PROJECTS.

9. WE DO NOT SEE AN IMMEDIATE FUTURE FOR AID ASSISTANCE IN THE AREAS OF DEMOGRAPHIC ANALYSIS AND POLICY DEVELOPMENT. WE BELIEVE THAT THE PLANNED 1980 DOLS 12.5 MILLION UNFPA PROJECT WILL EXTEND THE GOS ABSORPTIVE CAPACITY IN THESE AREAS TO ITS LIMITS.
KIRBY

1. ALTHOUGH USAID/SUDAN HAS NO TECHNICAL EXPERTISE IN THE HEALTH/POPULATION FIELD SINCE OUR TWO HEALTH POSITIONS HAVE BEEN VACANT FOR APPROXIMATELY TWO YEARS, WE WILL TRY OUR BEST USING OUR LIMITED STAFF TO PROVIDE THE INFORMATION REQUESTED IN REFTEL.

2. IN RESPONSE TO PARA 2 (A), THERE IS AS YET NO OFFICIAL GOS POLICY ON FAMILY PLANNING. UNOFFICIALLY, THE GOS SUPPORTS FAMILY PLANNING AS A MEANS OF PROMOTING MATERNAL AND CHILD HEALTH THROUGH REDUCTION OF RISKS OF HIGH PARITY AND THE RESULTANT EFFECTS ON THE HEALTH AND WELFARE OF THE MOTHER AND CHILD.

3. THE GOS HAS TAKEN RECENTLY A SIGNIFICANT STEP IN 1) EXPANDING THE INTEGRATION OF FAMILY SPACING INTO MCH SERVICES; 2) CONDUCTING DEMOGRAPHIC ANALYSES AND 3) DEVELOPING POPULATION POLICY. THESE INITIATIVES WILL BE SUPPORTED BY A DOLS 12.5 MILLION UNFPA POPULATION PROJECT WHICH IS EXPECTED TO BEGIN IN JUNE 1980.

4. USAID/SUDAN HAS LONG BEEN INTERESTED IN DEVELOPING PRECISELY THE TYPE OF INFORMATION REQUESTED PARA 2 (B) REFTEL BUT WITHOUT QUALIFIED TECHNICAL STAFF WE HAVE BEEN DEPENDENT ON AID/W STAFF RESOURCES.

5. ONE EVALUATION WAS CONDUCTED IN APRIL 1979 BY LEONARD ROBINSON, OS/POP/AFR. UNFORTUNATELY, HE COULD ONLY SPEND TWO WORK DAYS IN THE SUDAN. AS A RESULT, HIS REPORT WAS INCOMPLETE AND WAS DESCRIPTIVE RATHER THAN ANALYTICAL. MOREOVER, HE DID NOT ADDRESS THE QUESTION OF COMPLEMENTARITY OR IMPACT. RATHER THAN REPEAT REPORT'S CONTENTS HERE, REFER TO HIS TRIP REPORT. USAID HAS PENDING REQUEST IN LETTER TO RICHARD J. METCALFE, OS/POP/PPSD, DATED FEBRUARY 16, 1980 THAT A THOROUGH EVALUATION BE UNDERTAKEN. UPON OS/POP RESPONSE TO THIS REQUEST USAID WOULD WELCOME OPPORTUNITY TO SHARE INFO AS DEVELOPED FROM EVALUATION WHICH WOULD BE RESPONSIVE TO PARA 2 (B) REFTEL.

6. ALTHOUGH IT IS DIFFICULT TO RESPOND TO PARA 2 (C) WITHOUT THE INFORMATION REQUESTED IN PARA 2 (B) WE WILL USE OUR BEST JUDGEMENT BASED ON LIMITED INFORMATION.

7. OUR TWO EXISTING PRIMARY HEALTH CARE PROJECTS - ONE IN THE NORTHERN REGION AND ONE IN THE SOUTHERN REGION - ARE SERVING TO ASSIST IN BUILDING A RURAL HEALTH BASE INTO WHICH POPULATION PROGRAMS WILL EVENTUALLY BE INTEGRATED. MORE DIRECT POPULATION ASSISTANCE WILL BE

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PAGE 01 KIGALI 08071 01 OF 02 150930Z 0808 A103027
ACTION AIG-25

KIGALI 08071 01 OF 02 150930Z

0808 A103027

ACTION OFFICE POPR-01
INFO AAAP-01 AFEA-03 AFDP-02 AFDR-06 AFCA-03 PPCE-01 PPPB-02
PPEA-01 AADS-01 OSNE-01 POP-01 CNE-01 NEW-03 RELO-01
STA-10 MAST-01 AFDA-01 /049 A1

INFO OCT-01 /836 W

-----110400 150930Z /34
R 111324Z APR 80 ZDN CTG RUENR 0900 1050930
FM AMEMBASSY KIGALI
TO SECSTATE WASHDC 9394
INFO AMEMBASSY NAIROBI

UNCLAS SECTION 01 OF 02 KIGALI 08071

AIGAC

NAIROBI FOR REDSO/EA

E.O. 12958: N/A

TAGS: N/A

SUBJECT: RWANDA: FUTURE POPULATION PROGRAM NEEDS

REF: STATE 83358

THE FOLLOWING ASSESSMENT OF RWANDA'S PROGRAM AND PLANS IN THE AREA OF POPULATION/FERTILITY CONTROL IS PROVIDED IN RESPONSE TO, AND IS KEYED TO LETTERED PARAS, REPTEL.

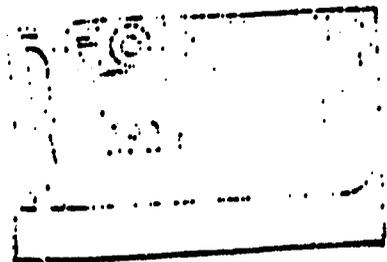
A) SINCE THE VERY FAST POPULATION GROWTH RATE IN RWANDA (CURRENTLY ESTIMATED AT 3.8 PCT) COMBINES WITH AN ALREADY OVERCROWDED AND LIMITED LAND AREA TO HIGHLIGHT THE RESOURCE/POPULATION BALANCE, MANY PEOPLE ARE AWARE OF AND INTERESTED IN THE POPULATION PROBLEM HERE. DIFFERING SOLUTIONS ARE PROPOSED FOR RWANDA'S DEMOGRAPHIC PROBLEMS BUT MOST PEOPLE, INCLUDING MANY WHO REFUSE TO ACCEPT MODERN FP PROGRAMS AS AN ALTERNATIVE, AGREE THAT THERE IS A PROBLEM. THE COUNTRY'S LEADERSHIP HAS RESPONDED TO DIFFERENCES OF OPINION ABOUT SOLUTIONS BY MOVING CAUTIOUSLY TOWARD DEVELOPMENT OF A FAMILY PLANNING INFRASTRUCTURE, BUT IT HAS NOT YET PUBLICLY ENDORSED A FAMILY PLANNING EFFORT. AID, UNFPA AND PATHFINDER'S EFFORTS TO INITIATE ACTIVE HEALTH AND FAMILY PLANNING PROGRAMS HAVE MET WITH VERY LIMITED, BUT POSITIVE ACCEPTANCE WITHIN CERTAIN OFFICES OF THE GOVERNMENT, BUT WITH PASSIVE RESISTANCE IN OTHERS. ALTHOUGH INTERNAL GOVERNMENT CORRESPONDENCE INDICATES THAT THE PRESIDENT SUPPORTS AN ACTIVE FAMILY PLANNING EFFORT INVOLVING AVAILABILITY OF ALL REVERSIBLE CONTRACEPTIVE METHODS, AND THAT HE WILL, AT SOME TIME IN THE FUTURE, ANNOUNCE CREATION OF A NATIONAL POPULATION OFFICE (NPAO) HAVING A MANDATE TO IMPLEMENT A FAMILY PLANNING PROGRAM, POLITICAL CAUTION HAS APPARENTLY DICTATED A VERY SLOW APPROACH TO SUCH DRAMATIC POLICY PRONOUNCEMENTS. WHILE ENCOURAGING AID-FINANCED WORK WHICH CURRENTLY IS PRIMARILY RESPONSIBLE FOR DEVELOPMENT OF SOLUTIONS TO THE POPULATION PROBLEMS, THE SECRETARIAT OF THE CONSEIL SCIENTIFIQUE ET CONSULTATIF POUR LES PROBLEMES SOCIO-DEMOGRAPHIQUES (CSC), IS RELUCTANT TO PROMOTE ACTIVITIES WHICH GO BEYOND TRAINING UNTIL AN EXPANDED MANDATE IS ESTABLISHED BY A PRESIDENTIAL DECREE ANNOUNCING CREATION OF THE NATIONAL POPULATION OFFICE. ALTHOUGH CONCURRED IN BY THE MINISTRIES OF HEALTH AND OF SOCIAL AFFAIRS AND SENT TO THE PRESIDENCY LAST NOVEMBER, THE DRAFT DECREE HAS YET TO BE ACTED UPON. COMPREHENSIVE PROJECT PROPOSALS HAVE BEEN PRESENTED TO THE GOVERNMENT OFFICIALLY BY UNFPA AND INFORMALLY BY AID, BUT NO REAL DELIVERY PROGRAMS (INCLUDING ONE PRESENTED BY PATHFINDER AND AGREED TO BY THE GOVERNMENT IN A 1978 AID-FUNDED PROJECT) ARE LIKELY TO BEGIN BEFORE THE PRESIDENTIAL DECREE IS ISSUED. MEANWHILE AID-SPONSORED TRAINING PROGRAMS CONTINUE.

B) AID/RWANDA HAS WORKED VERY CLOSELY WITH THE PATHFINDER FUND IN ENCOURAGING THE GOV TO ADOPT A FAMILY PROGRAM, AND HAS HAD LENGTHY AND FRANK DISCUSSIONS WITH UNFPA OFFICIALS CONCERNING COORDINATION OF AID/UNFPA ACTIVITIES. AID AND UNFPA HAVE NOW ESTABLISHED FAIRLY CLEAR AREAS OF RESPONSIBILITY FOR A FAMILY PLANNING PROGRAM, AND AID/RWANDA IS REASONABLY SATISFIED WITH THE PROJECT PROPOSAL, PRIMARILY INVOLVING INFORMATION AND COMMUNICATION ACTIVITIES, WHICH UNFPA HAS MOST RECENTLY PRESENTED TO THE GOVERNMENT. NO ORGANIZATIONS, OTHER THAN AID, PATHFINDER AND UNFPA, ARE INVOLVED IN ANY MAJOR WAY IN THE PROMOTION OF FP IN RWANDA.

C) IN PLANNING AND INFORMAL DISCUSSIONS, THE GOVERNMENT'S DE FACTO POPULATION PROGRAM COORDINATOR (CSC) GIVES AID THE MAJOR ROLE IN ALL FAMILY PLANNING ACTIVITIES BEYOND WHAT THE GOVERNMENT TERMS PHASE I OF THE PROGRAM EFFORT, I.E., THE AID-FUNDED PATHFINDER PILOT DELIVERY PROGRAM IN 3 OF THE 18 RWANDAN PREFECTURES. THE RWANDA FAMILY HEALTH INITIATIVES PROJECT (498-0602.01) AGREEMENT, SIGNED ON 3/3/80, PROVIDES THAT THE GOVERNMENT WILL NAME RWANDAN COUNTERPARTS, AS SOON AS POSSIBLE AFTER SIGNING OF THE AGREEMENT, TO WORK WITH EXPERTS TO BE PROVIDED BY AID TO HELP DESIGN A NATIONAL FAMILY PLANNING PLAN FOR RWANDA. IT REMAINS UNCLEAR WHETHER A TEAM WILL BE INVITED TO HELP DRAFT A PLAN BEFORE A PUBLIC POLICY IS ANNOUNCED.

IN RESPONSE TO RATHER GENERAL AND RESTRAINED GOVERNMENT REQUESTS, AID/RWANDA IS NOW DRAFTING A PID WHICH PROPOSES AID SUPPORT OF A COMPREHENSIVE MCM/FP EDUCATION PROGRAM TO COMPLEMENT THE CURRENT AND PERHAPS SOMEWHAT EXPANDED FUTURE CLINICAL DELIVERY ROLE OF PATHFINDER, AS WELL AS THE IN-

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PAGE 01 KIGALI 00871 02 OF 02 120346Z 4181 AID2161
ACTION AID-35

ACTION OFFICE PDPR-01
INFO AFEA-03 AFDP-02 AFDR-06 AFCA-03 CH6-01 PPCE-01 PPPB-02
PPEA-01 FM-02 AADS-01 DSHE-01 CH8-01 HEW-09 OMB-02
RELO-01 STA-10 MAST-01 AFDA-01 /049 A1

INFO OCT-01 /036 W

-----092538 120356Z /34

R 111324Z APR 80
FM AMEMBASSY KIGALI
TO SECSTATE WASHDC 9395
INFO AMEMBASSY NAIROBI

UNCLAS SECTION 02 OF 02 KIGALI 00871

AIDAC

NAIROBI FOR REDSO/EA

FORMATION AND COMMUNICATION ROLE WHICH UNFPA HAS OUTLINED FOR ITSELF. PROPOSED AID ACTIVITIES WOULD FOCUS ON RESEARCH, DEMOGRAPHIC ANALYSIS, POLICY DEVELOPMENT, EDUCATION (PUBLIC SCHOOLS) AND LOCAL-LEVEL, NON-FORMAL TRAINING, AND WOULD BE DESIGNED TO ENCOURAGE AND, AS NECESSARY, SUPPORT SERVICE DELIVERY.

HOWEVER THE PROGRAM DEVELOPS, IT APPEARS CERTAIN THAT AID WILL BE ASKED TO ACCEPT PRIMARY DONOR RESPONSIBILITY FOR ANY COMPREHENSIVE FP ACTIVITY DEVELOPED HERE OVER THE NEXT FEW YEARS. WE ARE ANXIOUS TO ACCEPT THE RESPONSIBILITY AND ARE ACTIVELY ENCOURAGING THE GOVERNMENT TO MOVE ON THE POPULATION FRONT. MELONE

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PAGE 01 LILONG 01231 211553Z 0453 AID0722
ACTION AID-35

LILONG 01231 211553Z

THE DISSEMINATION OF FAMILY SPACING INFORMATION INTER
ALIA.

0453 AID0722

ACTION OFFICE AFDR-06
INFO AAAP-01 AFSA-03 AFDP-02 PPCE-01 PPPB-02 PPEA-01 IA-01
11A-02 IDCA-01 MID-01 AADS-01 CMGT-02 CTR-02 DSNE-01
POP-04 IT-05 OLAB-02 CNB-01 PVC-02 ES-01 NEU-03 NUD-02
LAB-05 OMB-02 RELO-01 STA-10 MAST-01 PDPR-01 AFDA-01
4-00 /075 A1

INFO OCT-01 /036 W
-----124570 211554Z /34

R 211325Z MAY 80
FM AMEMBASSY LILONGWE
TO SECSTATE WASHDC 4753

UNCLAS LILONGWE 1231

AIDAC

SECSTATE FOR AFR/OR/POP AFR/SA DS/POP

E. D. 12065: NA
SUBJECT: POPULATION MALAWI

REF: A) STATE 085558 B) STATE 092460

1. THE NEGATIVE EFFECTS OF INCREASING DEMOGRAPHIC PRESSURES ON MALAWI'S HUMAN AND CAPITAL RESOURCES HAVE BECOME MORE EVIDENT IN RECENT MONTHS THAN EVER BEFORE. ALTHOUGH DEVELOPMENT IN MALAWI HAS PROCEEDED THUS FAR UNDER RELATIVELY FAVORABLE CONDITIONS, RECENT CHANGES IN THE WORLD ECONOMIC SITUATION, THE NEED FOR INCREASING PRODUCTION INPUTS, THE COUNTRY'S LANDLOCKED STATUS AND THE HERETOFORE UNCHECKED POPULATION GROWTH, COLLECTIVELY HAVE PROVIDED CLEARER INSIGHT INTO MALAWI'S ECONOMIC/DEVELOPMENT VULNERABILITY.

2. THE COUNTRY TEAM IS CONCERNED THAT AT THE PRESENT RATE OF FAMILY GROWTH, OURS AND OTHER DONOR INPUTS MAY SOON NOT BE SUFFICIENT TO FURTHER MALAWI'S ADMIRABLE RATE OF REAL GROWTH BUT INSTEAD MAY BE SIMPLY CONSUMED BY UNABATED POPULATION EXPANSION. AN AVOIDABLE CONTRIBUTOR TO ECONOMIC STAGNATION. APPROPRIATE INTERVENTION HOWEVER, SHOULD AVOID CREATING NECESSITY TO INTERVENE NOT ONLY AT THE OBVIOUS POINT BUT ALSO TO MANIPULATE THE VARIABLES WHICH INFLUENCE THE CHOICE TO HAVE CHILDREN. THE TASK CANNOT REST TOTALLY ON THE SHOULDERS OF THE MINISTRY OF HEALTH BUT IS TO BE A SHARED RESPONSIBILITY AMONG ALL CONCERNED WITH GROWTH AND DEVELOPMENT.

3. GIVEN THE ABOVE, WE BELIEVE A POPULATION STRATEGY HERE SHOULD SEEK TO:

A) PROVIDE WOMEN WITH EMPLOYABLE SKILLS SO THAT THEY NO LONGER NEED TO PRODUCE CHILDREN AS A MEANS OF ACQUIRING FINANCIAL SUPPORT FROM THE FATHER OF CHILDREN.

B) EDUCATE THE COUNTRY'S ECONOMISTS AND FINANCIAL PLANNERS SO THAT THEY BEGIN TO LOOK AT THE IMPACT OF UNYIELDING POPULATION GROWTH ON DEVELOPMENT TARGETS.

C) DETERMINE THE MOST ACCEPTABLE MEANS OF ADVANCING THE CONCEPT OF APPROPRIATE FAMILY SPACING.

4. THE PATHFINDER FUND RECENTLY VISITED MALAWI AND CONFERRED WITH A NUMBER OF POLICY MAKERS. WE EXPECT PATHFINDERS TO DEVISE WAYS AND MEANS OF PROVIDING QUIET BUT FUNCTIONAL PROGRAMS FOCUSED ON FAMILY SPACING. LIKEWISE, THE INTERNATIONAL CENTER FOR HEALTH SCIENCES, MERRIY MEDICAL SCHOOL, IS CONCEPTUALIZING AN IN COUNTRY TRAINING PROGRAM IN MATERNAL AND CHILD HEALTH FOR MID LEVEL HEALTH WORKERS WHICH WILL SERVE AS A CONDUIT FOR

5. MALAWI'S STATED APPROACH TO FAMILY PLANNING IS THAT THE GOVERNMENT SHOULD NOT DICTATE THE SIZE OF INDIVIDUAL FAMILIES. WE UNDERSTAND THIS STATEMENT TO INCLUDE DONOR GOVERNMENTS AS WELL; I.E. OTHER GOVERNMENTS SHOULD NOT TRY TO DICTATE THE SIZE OF INDIVIDUAL MALAWIAN FAMILIES. ON THE OTHER HAND, WE PERCEIVE NO FORMIDABLE OBSTRUCTION TO INCORPORATING INFORMATION INTO A VARIETY OF DONOR FUNDED ACTIVITIES WHICH WILL SWELL THE INCREASE OF INDIVIDUAL DEMAND FOR GOODS AND SERVICES (WHICH CONTRARY TO THE BELIEF OF MANY ARE AVAILABLE ON THE MALAWI MARKET) FOR THE ABATEMENT OF PROLIFERATION. MALAWIANS SPEAK OF THE PINCH CAUSED BY HAVING FAMILIES BEYOND THEIR CAPACITY TO PROVIDE SUITABLE CARE. EXTENDED FAMILY RESPONSIBILITIES TEND TO FURTHER EXACERBATE ABILITY TO PROPERLY ATTEND TO THE PRIMARY FAMILY UNIT. THE AVERAGE MALAWIAN FAMILY HAS SEVEN CHILDREN.

6. IN OUR JUDGEMENT IT WOULD BE A MISTAKE TO MARCH IN UP FRONT WITH AN OVERTLY AGGRESSIVE DEMOGRAPHIC PROGRAM. WE SHOULD MOVE SLOWLY, CAREFULLY. WE SHOULD TAKE EVERY OPPORTUNITY TO SENSITIZE THE ENTIRE DEVELOPMENT COMMUNITY OF THE NEGATIVE ECONOMIC IMPACT OF LARGE FAMILIES. WE WILL QUIETLY MAKE AVAILABLE SPECIFIC MEASURES FOR DEMOGRAPHIC CONTROL AS OPPORTUNITY PERMITS AND WE WILL WORK AT CREATING THESE OPPORTUNITIES. MAXIM

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PAGE 01
ACTION AID-35

LOME 01570 081320Z

8764 AID2284

ACTION OFFICE PDPR-01
INFO AAAF-01 APCW-03 AFDR-05 PPCE-01 PPPB-02 PPEA-01 AADS-01
OSHE-01 POP-03 RELO-01 STA-10 MAST-01 AFDA-01 /034 AA

INFO OCT-01 /036 W

-----058465 081320Z /34

R 001140Z APR 88
FM AMEMBASSY LOME
TO SECSTATE WASHDC 8687
INFO AMEMBASSY ABIDJAN
AMEMBASSY COTONOU

UNCLAS LOME 01570

AIDAC

E.O. 12888: N/A
SUBJECT: POPULATION PROGRAMS TOGO/BENIN

REF: STATE 85558

THERE ARE MODEST ACTIVITIES UNDERWAY IN THE AREA OF POPULATION/FERTILITY CONTROL, PARTICULARLY ON THE PART OF PRIVATE POPULATION ORGANIZATIONS, INCLUDING SOME DEGREE OF SUPPORT FROM, AND COORDINATION WITH, GOVERNMENTAL AGENCIES. IN GENERAL, GOVT IS SYMPATHIC TO POPULATION CONCERNS AND THEIR HEALTH PROGRAMS ADDRESS SUCH MATTERS. CHILD SPACING, FOR EXAMPLE, IS AN IMPORTANT ELEMENT INTEGRATED INTO MCH PROGRAMS. AID HEALTH SECTOR ACTIVITIES IN TOGO AND BENIN RECOGNIZE AND INCLUDE POPULATION CONSIDERATIONS. GIVEN, HOWEVER, LIMITED LEVEL OF AID PROGRAMS ANTICIPATED FOR THESE COUNTRIES IN FORESEEABLE FUTURE AND BUDGETARY DEMANDS FROM OTHER PRIORITY SECTORS OFFERING MORE LUCRATIVE AREAS OF CONCENTRATION FOR AID PROGRAMS, IT IS NOT FORESEEN THAT AID WOULD HAVE SIGNIFICANT ROLE IN PROVIDING POPULATION ASSISTANCE IN TOGO OR BENIN BEYOND THE GENERALIZED SUPPORT WITHIN HEALTH SECTOR ACTIVITIES.
JOHNSON

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PAGE 01 MASERU 01035 161624Z 0543 AID0198
ACTION AID-35

ACTION OFFICE DDPR-01
INFO AAAF-01 AFSA-03 AFDP-02 AFDR-06 PPCE-01 PPEM-01 PFPB-02
PPEA-01 PDC-02 AADS-01 DSHE-01 POP-04 IT-06 OLAB-02
CHS-01 PVC-02 RELO-01 STA-10 MAST-01 AFDA-01 ECA-01
/051 A2

INFO OCT-01 /036 W -----I26409 161638Z /34

R 161524Z APR 80
FM AMEMBASSY MASERU
TO SECSTATE WASHDC 2712
INFO AMEMBASSY MBABANE
AMEMBASSY GABORONE

UNCLAS MASERU 01035

AIDAC

E. O. 120657 N/A
SUBJECT: POPULATION LESOTHO

REF: STATE 065558

1. (A) RE REFTEL PARA 2A, LESOTHO IN PROCESS DEVELOPING POPULATION POLICY BASED ON RESOLUTIONS NATIONAL CONFERENCE ON POPULATION MANAGEMENT HELD APRIL, 1979, WHICH SUPPORTED PLANNED POPULATION GROWTH. THIS SEEN AS MAJOR STEP AS LESOTHO HAS LARGE INFLUENTIAL ROMAN CATHOLIC POPULATION. IN CLOSING REMARKS AT LESOTHO DONOR CONFERENCE HELD NOVEMBER 5-9, 1979, PRIME MINISTER STATED THAT, OFFICIAL VIEWS OF PREDOMINANT RELIGIOUS COMMUNITY NOTWITHSTANDING, THE GOV WOULD DISSEMINATE FAMILY PLANNING ADVICE AND ASSISTANCE IN AN EFFORT TO RESOLVE CONFLICT BETWEEN POPULATION GROWTH AND ECONOMIC DEVELOPMENT.

(B) MOH HAS LIMITED FP PROGRAM DELIVERED IN CONTEXT MCH SERVICES. IPPF FUNDED LPPA PROVIDES LARGEST PROGRAM FP SERVICES AND INCLUDES IEC ACTIVITIES THROUGH FIELD WORKERS. THESE SERVICES SUPPLEMENTED BY PROTESTANT MISSION HOSPITALS AND CLINICS IN RURAL AREAS. APPROXIMATELY 10 PCT ALL FERTILE WOMEN ESTIMATED USING CONTRACEPTION.

2. RE REFTEL PARA 2B, IPPF PROVIDES 90 PCT LPPA FUNDING WHILE UNFPA/UNICEF PROVIDE CONTRACEPTIVES MOH PRORAM. UNFPA ALSO PROVIDES OB/GYN PHYSICIAN TO ASSIST DEVELOPMENT NATIONAL MCH/FP PROGRAM. AID FUNDED RURAL HEALTH DEVELOPMENT PROJECT STARTED 1979 PROVIDES FUNDS FOR CONTRACEPTIVES AND TRAINING FOR NURSE PRACTITIONERS AND VILLAGE HEALTH WORKERS. NURSES WILL BE TAUGHT CONTRACEPTIVE TECHNIQUES AND HEALTH WORKERS WILL PROMOTE FP. ALL DONOR PROGRAMS ARE COMPLEMENTARY.

3. RE REFTEL PARA 2C, LESOTHO ABSORPTIVE CAPACITY MINIMAL IN TERMS MANPOWER AND ADMINISTRATIVE CAPABILITY. SEE NO OPPORTUNITY FOR MAJOR USAID POPULATION INITIATIVES IN NEAR FUTURE. MAJOR EFFORT MOH OVER NEXT DECADE WILL BE EXPAND QUANTITY/QUALITY HEALTH SERVICES INCLUDING FP. USAID HEALTH PROJECT ASSISTING MOH INSTITUTIONALIZE TRAINING FOR HEALTH WORKERS OVER NEXT THREE YEARS. NO OTHER MAJOR HEALTH/FP INITIATIVES PLANNED AT THIS TIME. SUGGEST AID THROUGH IPPF CONTINUE SUPPORT AND HELP EXPAND LPPA'S IEC PROGRAM TO STRENGTHEN LPPA AS RESOURCE TO GOV IN DEVELOPING POPULATION EDUCATION PROGRAMS IN ALL SECTORS. CLINGERMAN

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PAGE 01 MABAN 01041 120400Z
ACTION AID-35

4247 A102100

MABAN 01041 120400Z

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ACTION OFFICE PDPR-01
INFO AAAF-01 AFSA-03 AFOR-06 PFCE-01 PPPB-02 PPEA-01 AADS-01
OSNE-01 OSRD-02 POP-04 CMB-01 NEV-09 ONB-02 RELO-01
STA-10 MAST-01 AFDA-01 /048 AA

INFO OCT-01 /038 V

002750 120410Z /34

R 111300Z APR 80
FM AMEMBASSY MABANE
TO SECSTATE WASHDC 1000

UNCLAS MABANE 1041

AIDAC

E.O. 12958: N/A
SUBJECT: SWAZILAND POPULATION PROGRAMS

REF: STATE 003550

1. USAID/S SHARES CONCERNS STATED IN REFTEL REGARDING
SERVENITY OF CURRENT DEMOGRAPHIC PRESSURE AND
ITS EFFECTS ON LOC'S CAPACITY TO MOUNT MEANINGFUL
DEVELOPMENT PROGRAMS TO BENEFIT RURAL POOR POPULATIONS.
OUR COMMENTS BELOW ARE KEYED TO QUESTIONS POSED IN PARA 2.
OF REFTEL.

2. RE PARA A:
A. SWAZILAND NOW PROVIDES CONTRACEPTIVE SERVICES
THROUGH INTEGRATED MCH SERVICES. ORALS ARE AVAILABLE
IN ALL URBAN AND RURAL CLINICS ACCESSIBLE TO
APPROXIMATELY 60 PERCENT OF POPULATION. ONLY A
FEW NURSE/MIDWIVES ARE TRAINED IN CLINICAL CONTRACEPTIVE
METHODS SO THAT IUDS AND INJECTABLES AVAILABLE
ONLY IN URBAN AND PERIURBAN CLINICS. SERVICES
SUPPORTED THROUGH IPPF AFFILIATION WITH MCH. IPPF
SUPPORT ALSO INCLUDES SERVICES OB/GYN EXPATRIATE
PHYSICIAN.

B. MCH PLANS TO INCREASE CAPACITY DELIVER CLINICAL
SERVICES THROUGH TRAINING NURSE/MIDWIVES (N/M) UNDER
SWAZILAND HEALTH MANPOWER DEVELOPMENT PROJECT
(045-0062). BY 1981, 32 RN/M² WILL HAVE BEEN TRAINED
IN CLINICAL CONTRACEPTIVE METHODS AND WORKING IN RURAL
CLINICS AND BY 1983 ALL EXISTING RURAL CLINICS WILL
HAVE TRAINED PERSONNEL.

C. DUE LACK PHYSICIANS, POTENTIAL FOR FEMALE STERILIZATION
LIMITED ALTHOUGH WOMEN IN URBAN AREAS INCREASINGLY
REQUESTING PROCEDURE. IPPF PHYSICIAN ONLY
OB/GYN SPECIALIST IN COUNTRY.

D. PRELIMINARY RESULTS 1976 CENSUS INDICATING 2.8
PERCENT GROWTH RATE NOW RAISING CONCERN IN GOS. AT
REQUEST GOS, USAID/S HAVING POPULATION PROJECTIONS
BASED ON 1976 CENSUS PREPARED BY POPULATION REFERENCE
BUREAU. CENTRALLY FUNDED AID RAPID PRESENTATION ALSO
IN PROCESS AND EXPECTED BE COMPLETED AUGUST 1980.

3. INFORMATION ON POPULATION GROWTH AND FAMILY PLANNING
BEING INTRODUCED BY CONSERVATION AGENTS, DOMESTIC
SCIENCE DEMONSTRATORS, AND PRIMARY HEALTH CARE WORKERS
IN CONTACTS WITH RURAL PEOPLE. GOS ALSO APPROVED
ESTABLISHMENT VOLUNTARY AGENCY FAMILY LIFE ASSOCIATION
WHICH PROVIDES SEX EDUCATION, CONTRACEPTIVE COUNSELING,
AND INFORMATION ON POPULATION GROWTH. USAID/S ALSO
UNDERSTANDS ISSUE RAPID POPULATION GROWTH WILLBE
INTRODUCED IN PARLIAMENT IN JULY 1980.

3. RE PARA B: OTHER DONOR AGENCIES ACTIVE IN
SWAZILAND POPULATION ACTIVITIES INCLUDE UNFPA, FAO
AND IPPF (AS DESCRIBED PARA 2 A ABOVE).

- UNFPA ASSISTS WITH MCH/FP CLINIC CONSTRUCTION,
PRODUCTION POPULATION/FP MATERIALS, AND SPONSORS
UNIVERSITY TRAINING PROGRAMS IN LAW AND POPULATION,
CIVIL REGISTRATION, AND DEMOGRAPHY. UNFPA ALSO
CURRENTLY EXPLORING NEW AREAS FOR INTERVENTION IN
ALL SECTORS.

B: FAO SPONSORS PROGRAMME FOR BETTER FAMILY LIVING
WHICH TRAINS DOMESTIC SCIENCE DEMONSTRATORS (DSD)
TO WORK WITH RURAL FAMILIES TO IMPROVE AGRICULTURE
PRODUCTION, NUTRITION, HYGIENE, CHILD CARE. DSDS
GIVEN TRAINING IN POPULATION/FP METHODS AND COUNSELING.

4. RE PARA C:
A. SWAZILAND LACKS ABSORPTIVE CAPACITY AND
CULTURAL READINESS FOR STARTING VERTICAL POP/FP
PROGRAM AT PRESENT TIME. BASED ON FY 82 COSS SUBMISSION
USAID/S WILL PLAY ROLE IN DEVELOPING AWARENESS
OF PROBLEMS OF RAPID POPULATION GROWTH IN DEVELOPMENT
FROM FY 80-84 THROUGH PROJECTS SUCH AS RAPIO WHICH
HAVE POTENTIAL FOR IMPACT ON POLICY DEVELOPMENT.
COSS STRATEGY PROPOSES MAJOR EFFORT FOR FY 84 IN IEC
ACTIVITIES IN FP/MCH/POP. GIVEN SWAZILAND'S
ABSORPTIVE CAPACITY, POTENTIAL PROGRAM INCREASE FROM
UNFPA, AND AS YET UNKNOWN GOS GENERAL REACTION TO
RAPID AND OTHER AWARENESS PROGRAMS, BELIEVE ANY
OTHER SPECIFIC PLANNING PREMATURE.

B. IN ADDITION, USAID/S ASSISTING MCH EXPAND CAPACITY
FOR DELIVERING CLINICAL FP SERVICES THROUGH PROJECT
0062. OTHER ASSISTANCE INCLUDES IMPROVING INTEGRATION
POPULATION/FP EDUCATION IN PRIMARY CURRICULUM
TRAINING RURAL HEALTH AND AGRICULTURE EXTENSION WORKERS,
AND SUPPORT FOR ACTIVITIES VOLUNTARY FP ASSOCIATION.
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UNCLAS MOGADISHU 1472

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FOR DS/POP

E.O. 12958: NA

SUBJ: POPULATION/FP PROGRAMS

REF: STATE 35558

MISSION'S RESPONSES TO QUESTIONS ARE:

(A) SOMALIA HAS NO POP/FERTILITY CONTROL PROGRAM AND PLANS IN THIS AREA ARE REGIMENTARY.

(B) THERE IS NO BILATERAL OR PRIVATE VOLUNTARY POPULATION AGENCIES IN SOMALIA. UNFPA HAS FUNDED MATERNAL CHILD AND FAMILY HEALTH SERVICES PROJECT (SOM/78/PO1) FOR THREE YEARS. COST DOLS 360,000. FAMILY PLANNING WAS INTRODUCED IN ONE MCH CLINIC IN MOGADISHU IN 3 YEARS. TEN IUDS HAVE BEEN INSERTED TO DATE AND A FEW CLIENTS ARE ON THE PILL. UNFPA HAS SUBMITTED A 5 YEARS PROPOSAL TO EXPAND MCH/CHILD SPACING TO 12 REGIONS (COST DOLS 1.7 MILLION). IN VIEW UNFPA PAST PERFORMANCE IN THE LAST PROJECT, MISSION WOULD QUESTION THE EFFECTIVE USE OF POP/FP FUNDS UNDER SUCH PROJECTS. USAID/SOMALIA HAS COORDINATED ALL ITS HEALTH AND PROPOSED POP/FP ACTIVITIES WITH OTHER DONORS SUCH AS WHO, UNFPA, AND UNICEF, WHO AND ITALIAN GOVERNMENT.

(C) POPULATION CONTROL HAS LOW PRIORITY IN GSDR BECAUSE GOVT. FEELS THAT THE COUNTRY IS UNDER POPULATED AND BECAUSE OF THE BORDER DISPUTE WITH ETHIOPIA. A SUBTLE APPROACH TO SENSITIZE KEY MEMBERS OF THE MO PLANNING AND MCH BY TRAINING IN POP/FP HAS PAID DIVIDENDS. FIVE OB/GYN SPECIALISTS HAVE BEEN TRAINED IN THE JHPIEGO PROGRAM INCLUDING TWO PROFESSORS IN THE MEDICAL SCHOOL. A LAPROSCOPE HAS BEEN INSTALLED IN BAHADIR HOSPITAL (TEACHING HOSPITAL). DIRECTOR OF JHPIEGO PROGRAM VISITED SOMALIA AS GUEST OF DIRECTOR OF BAHADIR HOSPITAL AND MEDICAL SCHOOL. DS/POP CENTRALLY FUNDED CONTRACTS WERE USED TO TRAIN 3 STAFF MEMBERS OF MOP IN MAPPING IN SUDAN, 2 (IN MAURITIUS IN MANAGEMENT/ADMINISTRATION OF CEIUSUS PROGRAM AND 2 MCH STAFF IN SUPERVISION AND MANAGEMENT OF POP/FP PROGRAM IN WASHINGTON, D.C. NORTH CAROLINE UNIVERSITY-CN IS ASSISTING MOP/CSD IN CONDUCTING DEMOGRAPHIC SURVEYS IN BAY AND LOWER SHABELLI REGIONS. UNC-CN ADVISOR WILL BE EXPLORING WAYS WITH THE NATIONAL PLANNING IN UTILIZING DEMOGRAPHIC DATA IN THE DEVELOPMENT PLANNING PROCESSES.

UNC-CN (INTRAM) WILL ASSIST WITH TRAINING OF PARA MEDICAL STAFF. A PID HAS BEEN DEVELOPED TO INTEGRATE FP INTO THE MCH PROGRAM WHICH WILL BE AN INTEGRAL PART OF THE USAID/MCH PRIMARY CARE PROGRAM IN FOUR REGIONS. THIS WAS DONE WITH FULL CONCURRENCE OF THE MCH. IT IS A THREE YEAR DOLS 0.5 MILLION FAMILY INITIATIVE PROJECT. THE PROJECT INVOLVES TRAINING OF MEDICAL AND PARA MEDICAL STAFF, SUPERVISORS OF FAMILY LIFE EDUCATION CENTER, ASSISTING

SOMALI DEMOCRATIC WOMEN'S ASSOCIATION IN SETTING UP A FW/P ASSOCIATION, AND DELIVERY OF FP SERVICES IN THE MCH CENTERS, MCH UNITS AND HEALTH POSTS. THE MOP/CENTRAL STATISTICS DEPARTMENT HAS BEEN DEVELOPING THE CAPABILITY OF CONDUCTING DEMOGRAPHIC SURVEYS WITH ASSISTANCE FROM UNC-CN AND UNFPA. THE COMPUTER CAPABILITY IS ALSO BEING DEVELOPED WITH ASSISTANCE FROM UNFPA. THEY ARE ANALYZING DEMOGRAPHIC DATA TO BE USED FOR DEVELOPMENT PLANNING. ALTHOUGH FAMILY PLANNING IS STILL NOT GIVEN HIGH PRIORITY, GSDR/MCH IS BECOMING AWARE THAT ADDITIONAL EMPHASIS NEEDS TO BE GIVEN TO AN INTEGRATED APPROACH FOR THE DELIVERY MCH/FAMILY PLANNING SERVICES. MCH/FP WILL BE AN INTEGRAL PART OF THE PRIMARY HEALTH CARE PROGRAM THAT WILL BE DEVELOPED SUBSEQUENTLY THROUGHOUT SOMALIA. GSDR'S WEAK INFRASTRUCTURE AND SHORTAGE OF TRAINED MANPOWER COMPOUNDED WITH THE REFUGEE PROBLEM THAT HUNGERS ABOUT HALF MILLION; LIMITS ABSORPTIVE CAPABILITY. HOWEVER USAID/S ASSISTANCE IN THE DIVERSE SECTORS (I.E. HEALTH, AGRICULTURE ETC) IS DESIGNED TO STRENGTHEN THE GSDR INSTITUTIONAL CAPABILITIES WHICH IN-TURN WILL ENLARGE THE ASSORPTIVE CAPACITY. FYI - IN RECENT MEETING WITH SOMALIA WOMEN'S DEMOCRATIC ORGANIZATION WE WERE ADVISED THAT THEY WOULD WELCOME ASSISTANCE IN FAMILY PLANNING EDUCATION FOR SOMALIA WOMEN IN ORGANIZATION'S FAMILY LIFE CENTERS IN RURAL AREAS. IN FY 1. PETERSON

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UNCLAS MONROVIA 03045

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E.O. 12865/N/A
SUBJECT: IMPROVING DONOR COORDINATION IN POPULATION ACTIVITIES -
- REQUESTED COMMENTS TO STATE 085556 LIBERIA

REF: STATE 085556

A. THE LIBERIAN FPAL/FAMILY PLANNING ASSOCIATION RECEIVES FUNDS FROM PATHFINDER, IPPF OTHER DONORS AND OTHER PRIVATE LOCAL RESOURCES. IT IS SUBSIDIZED BY MOHSWAS A FUNCTIONAL VOLUNTARY AGENCY CHARGED WITH IMPLEMENTING NATIONAL PROGRAMS. MOHSW FAVORS CLOSE INTERGRATION WITH MATERNAL CHILD HEALTH AND FAMILY HEALTH PROMOTION PROGRAMS.

B. OTHER POPULATION ACTIVITIES ARE CARRIED OUT WITH CENSUS BUREAU ACTIVITIES AND DATA COLLECTION MIN. OF PLANNING & ECONOMIC AFFAIRS, UNIVERSITY OF LIBERIA, SOCIAL AND DEMOGRAPHIC RESEARCH UNIT. CLOSE TIES WITH POP - GHANA (AID SUPPORTED). AID SUPPORT COMES FROM CENTRALLY FUNDED PROGRAMS AND THROUGH VOLUNTARY AND INTERNATIONAL AGENCIES.

PRESENT ACTIVITIES (AID SUPPORTED)

- 1. FUTURE GROUP RAPID PRESENTATION
- 2. INTEGRATED POP/DEVELOPMENT PLANNING PROJECT
- 3. DEMOGRAPHIC CONFERENCE
- 4. CONTRACEPTION RESEARCH SEMINAR
- 5. SOCIAL DISTRIBUTION OF FPP
- 6. UNC INTERNATIONAL TRAINING IN HEALTH
- 7. HOME ECONOMICS PROJECT

IN ADDITION THE JHP/IEGO PROGRAM HAS BEEN WELL ACCEPTED AND CONTINUES ITS ROLE IN FERTILITY, MANAGEMENT AND MANPOWER DEVELOPMENT. AWARENESS CREATED THROUGH THE TERMINATED LOFA COUNTY HEALTH PROJECT CAUSED FPAL TO START A BRAND OFFICE ON ITS OWN TO BE PLACED AT VOINJAMA. NIMBA COUNTY DEVELOPED ITS OWN INFORMATION AND DISTRIBUTION SERVICES WITH HELP OF PEACE CORPS.

C-1 EXCELLENT ASSESSMENT DONE BY CAROLYN TYSON DURING CDSS PREPARATION. NOW RTI (C PEL HILL) STARTED TO UP-DATE "STATE OF THE ART" IN LIBERIA/POP.

C-2 BELIEVE FOR THE REST 5-10 YEARS LIBERIA'S EFFORT OF SELF-HELP IN POPULATION AWARENESS BEST LEFT TO LIBERIAN ORGANIZATION. SUPPORT THROUGH VOLUNTARY AGENCY SUFFICIENT. PERIODIC ASSESSMENT OF THE STATE OF THE ART TYPE SHOULD CONTINUE, BUT AMERICAN BILATERAL HELP IN FAMILY PLANNING HAS IN THE PAST NOT BEEN SUFFICIENTLY UTILIZED TO WARRANT A BILATERAL SUPPORT PROGRAM. POP ACTIVITIES SHALL CONTINUE TO BE A PRIORITY, ESPECIALLY IN REGARD TO DEMOGRAPHY PERTAINING TO DEVELOPMENT. SMITH

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AIDAC

E.O. 12958: N/A
SUBJ: POPULATION

REF STATE 085558

1. USAID/KENYA NOTES THAT LAC AND ASIA BELIEVE (PARAS 5 AND 6 REFTEL) THAT MUCH OF THE INFORMATION REQUESTED IS ALREADY CONTAINED IN OTHER DOCUMENTS. MUCH DATA FOR KENYA IS ALSO CONTAINED IN THE FY 1982 COSS. IN THAT DOCUMENT POPULATION GROWTH WAS IDENTIFIED AS THE MOST SERIOUS CONSTRAINT TO ECONOMIC AND SOCIAL DEVELOPMENT IN KENYA. THIS MESSAGE WILL THEREFORE REPEAT SOME INFORMATION THAT HAS PREVIOUSLY BEEN REPORTED TO AID/W.

2. KENYA'S PROGRAM: A) KENYA'S ESTIMATED POPULATION OF 16.3 MILLION IS GROWING AT A RATE OF 4 PCT ANNUALLY AND WILL DOUBLE IN 18 YEARS IF PRESENT TRENDS CONTINUE. KENYA WAS THE FIRST AFRICAN COUNTRY TO ADOPT A NATIONAL POPULATION POLICY AND HAS HAD A NATIONAL FAMILY PLANNING PROGRAM FOR 13 YEARS, YET POPULATION GROWTH HAS INCREASED. DEVELOPMENT PLANNERS RECOGNIZE THE CONSEQUENCES OF KENYA'S HIGH RATE OF POPULATION GROWTH. KENYA POSSESSES GOOD DEMOGRAPHIC DATA, AND KENYA INSTITUTIONS HAVE PRODUCED A SERIES OF HIGHLY PROFESSIONAL ANALYSES ON THE EFFECTS OF POPULATION GROWTH ON THE ATTAINMENT OF DEVELOPMENT OBJECTIVES. LEADING KENYAN POLITICIANS ARE AWARE OF THE POPULATION PROBLEM AND HAVE STARTED TO SPEAK OUT ABOUT THE NEED TO REDUCE POPULATION GROWTH AND PRACTICE FAMILY PLANNING. DESPITE GROWING RECOGNITION OF THE POPULATION PROBLEM, KENYA HAS YET TO DEVELOP AN EFFECTIVE RESPONSE IN THE CONTEXT OF KENYA CULTURAL VALUES WHICH STRONGLY SUPPORT LARGE FAMILIES. MOREOVER, THERE HAS BEEN AN ABSENCE OF PROGRAMS OF INFORMATION, EDUCATION AND COMMUNICATION (IEC) THAT MIGHT MOTIVATE RURAL KENYANS TO ADOPT FAMILY PLANNING.

B) ALTHOUGH USAID HAS SUPPORTED HEALTH EDUCATION ACTIVITIES WITH POPULATION FUNDS OVER THE PAST 10 YEARS, WE HAVE BEEN UNSUCCESSFUL IN PERSUADING THE MINISTRY OF HEALTH TO MOUNT VIGOROUS IEC CAMPAIGNS IN SUPPORT OF FP. WE VIEW THIS LACK OF EMPHASIS ON IEC AS A FUNDAMENTAL WEAKNESS OF PAST FP ACTIVITIES. ANOTHER GLARING WEAKNESS HAS BEEN NON EMPHASIS ON STATIC, CLINIC-BASED PROGRAMS WITH A MINIMUM OF COMMUNITY OUT-REACH. THE MOH HAS CONCENTRATED ON THE CREATION OF A MODERN RURAL HEALTH INFRASTRUCTURE AND HAS PLACED LITTLE EMPHASIS ON FAMILY PLANNING. FOR THE PAST FIVE YEARS, CONSIDERABLE DONOR SUPPORT HAS BEEN EXTENDED TO CONSTRUCT AND EQUIP HEALTH FACILITIES AND TO HIRE AND TRAIN ADDITIONAL HEALTH PERSONNEL.

AT THE END OF 1978 THERE WERE 505 OUTLETS (MOH HAS 416, MUNICIPALITIES HAVE 43, AND PRIVATE GROUPS HAVE 46) FOR MCH/FP. THESE FACILITIES WERE SERVING ONLY 100,570 ACTIVE USERS OF FP SERVICES OR 2.7 PCT OF ALL WOMEN AGED 15-49 AT THE END OF 1978. THIS FIGURE REPRESENTS A DECLINE IN NEW ACCEPTORS OF FP FROM 1977, AND PARTIAL DATA FROM THE FIRST THREE QUARTERS OF 1979 SUGGEST A FURTHER DECLINE IN 1979. THIS IS A DISAPPOINTINGLY LOW FIGURE AFTER MANY YEARS OF ORGANIZED FP ACTIVITIES. HOWEVER, IT IS UNDERSTANDABLE WHEN ONE CONSIDERS THE ABSENCE OF POLITICAL SUPPORT FOR FP, THE ABSENCE OF IEC ACTIVITIES, THE LOW PRIORITY ACCORDED BY THE MOH TO FP, THE LACK OF INTEREST OF OTHER GOK MINISTRIES, AND KENYAN CULTURAL SUPPORT OF LARGE FAMILIES.

C) THE FUTURE: (1) USAID BELIEVES THAT THE GOK LEADERSHIP IS FINALLY BECOMING CONCERNED ABOUT KENYA'S POPULATION GROWTH

RATE. VARIOUS SENIOR POLITICIANS HAVE SPOKEN OUT RECENTLY IN FAVOR OF FP AND WE UNDERSTAND THIS SUBJECT WAS DISCUSSED AT THE RECENT MEETING BETWEEN PRESIDENTS MOI AND CARTER. TWO GOK MINISTRIES ARE CURRENTLY FORMULATING PLANS FOR ACTIVITIES TO SLOW POPULATION GROWTH.

(2) THE MINISTRY OF ECONOMIC PLANNING AND DEVELOPMENT (MEPD) IS ATTEMPTING TO CREATE AN INTERMINISTERIAL COORDINATION MECHANISM FOR THE DEVELOPMENT OF IEC ACTIVITIES TO BE IMPLEMENTED BY A NUMBER OF PUBLIC AND PRIVATE INSTITUTIONS. THIS INITIATIVE AROSE OUT OF THE REALIZATION THAT THE MOH HAD FAILED TO MOUNT EFFECTIVE IEC ACTIVITIES AND THAT MULTIDISCIPLINARY IEC ACTIVITIES ARE NECESSARY TO ENHANCE UNDERSTANDING OF POP/FP ISSUES AND TO CREATE DEMAND FOR FAMILY PLANNING. THERE IS CONSIDERABLE INFIGHTING AMONG KENYAN AGENCIES OVER THE LOCATION AND ROLE OF THE PROPOSED COORDINATION UNIT. SOME KENYAN AGENCIES REMAIN RELUCTANT TO INVOLVE THEMSELVES IN THE POPULATION PROBLEM, PREFERING TO LEAVE IT TO THE MOH. USAID IS SUPPORTIVE OF THE MEPD INITIATIVE. WE HAVE INDICATED OUR WILLINGNESS TO SUPPORT A PROGRAM AS SOON AS THE GOK IS READY. WE VIEW COORDINATED IEC AS A POTENTIALLY IMPORTANT AREA FOR USAID ASSISTANCE.

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(1) THE MOH HAS MOBILIZED A NUMBER OF INTERNAL WORKING GROUPS TO PREPARE A PLAN FOR INTEGRATED RURAL HEALTH SERVICES OVER THE NEXT FIVE YEARS. THE PLAN HAS NOT RECEIVED FINAL MOH APPROVAL AND REPORTEDLY HAS MANY GAPS. USAID HAS LEARNED THAT MOH OFFICIALS WORKING ON MCH FP/ACTIVITIES DO NOT FEEL THAT THE PLAN PLACES SUFFICIENT EMPHASIS ON THE PROVISION OF FP INFORMATION AND SERVICES. THE PLAN COVERS THE FULL RANGE OF HEALTH SERVICES TO BE PROVIDED IN RURAL AREAS RANGING FROM IMMUNIZATIONS THROUGH VECTOR BORN DISEASE CONTROL. THE PLAN REPORTEDLY PROPOSES A MAJOR EXPANSION OF RURAL HEALTH INFRASTRUCTURE AND THE CREATION OF A SIZEABLE NEW CADRE OF COMMUNITY HEALTH WORKERS.

(2) ALTHOUGH USAID SUPPORTS THE NEW MOH EMPHASIS ON RURAL HEALTH SERVICES, WE HAVE SERIOUS RESERVATIONS ABOUT THE DIRECTION OF THE RURAL HEALTH PROGRAM. FOR EXAMPLE, IT IS UNCLEAR WHAT FP DUTIES, IF ANY, THE PROPOSED NEW COMMUNITY HEALTH WORKERS WILL HAVE. THE PAST PERFORMANCE OF THE MOH IN IMPLEMENTING THE MCH/FP PROGRAM DOES NOT REASSURE US AS THE PREVIOUS PROGRAM FAILED BADLY IN ACHIEVING ITS FP ACCEPTOR TARGETS. THE MOH SEEMS FAR MORE INTERESTED IN BUILDING ADDITIONAL INFRASTRUCTURE THAN IN EVALUATING AND CORRECTING DEFICIENCIES IN ITS EXISTING SERVICE NETWORK. MANAGERIAL AND ADMINISTRATIVE DEFICIENCIES WITHIN THE MOH MAKE US DOUBT THE WISDOM OF EMBARKING UPON AN AMBITIOUS PROGRAM OF EXPANSION WITHOUT FIRST OVERCOMING THE MAJOR DEFICIENCIES ALREADY EXPERIENCED.

(3) DONOR INVOLVEMENT: (A) IN CONSIDERING THE PROGRAMS OF OTHER BILATERAL, MULTILATERAL, AND PRIVATE AGENCIES, IT SHOULD BE RE-MEMBERED THAT KENYA HAS PROBABLY ATTRACTED MORE DPO/FP ASSISTANCE OVER THE PAST 13 YEARS THAN THE REST OF SUB-SAHARAN AFRICA LUMPED TOGETHER. ALTHOUGH KENYA MAY NOT BE A MATURE COUNTRY IN TERMS OF THE STATUS OF ECONOMIC DEVELOPMENT WHAT HAS BEEN A PRECURSOR TO REDUCED FERTILITY IN CERTAIN COUNTRIES, IT IS MATURE IN TERMS OF RECEIPT OF POP/FP FUNDS. IT HAS ATTRACTED MORE DONOR ATTENTION THAN MANY OF THE COUNTRIES IN OTHER REGIONS WHICH ARE CONSIDERED POP/FP SUCCESS STORIES. HOWEVER, MUCH OF THIS ASSISTANCE HAS NOT BEEN WELL TARGETED AND HAS BEEN IN-EFFECTIVE. IT IS USAID'S VIEW THAT THERE ARE TOO MANY AGENCIES ACTIVE IN KENYA IN POP/FP AND THAT THE NUMBER COULD USEFULLY BE REDUCED, AND PROGRAMS CONSOLIDATED AND OTHERWISE MADE MORE COST-EFFECTIVE. IT IS ALMOST IMPOSSIBLE TO IDENTIFY ALL THE DONOR AGENCIES OPERATING IN THIS FIELD, AS A RECENT DONOR COORDINATION MEETING ORGANIZED BY IPPF REVEALED. IT IS US. O'S ESTIMATE THAT APPROXIMATELY 40 DIFFERENT GROUPS ARE ACTIVE IN KENYA IN POP/FP. THE KENYAN AGENCIES CANNOT COPE WITH ALL OF THEM AND USAID CANNOT COORDINATE WITH ALL OF THEM. FOR EXAMPLE, THE STREAM OF VISITORS TO THE USAID POP OFFICE, ESPECIALLY DURING WINTER MONTHS, HAS TO BE EXPERIENCED TO BE BELIEVED. THE PROLIFERATION OF DONOR GROUPS HAS LED TO DUPLICATION OF EFFORT AND COMPETITION BETWEEN DONORS FOR VIABLE PROGRAMMATIC OPPORTUNITIES. KENYAN AGENCIES CAN GENERALLY FIND DONOR MONEY FOR ALMOST ANY ENTERPRISE, NO MATTER HOW LITTLE MERIT IT MAY APPEAR TO HAVE TO CRITICAL DONORS. THOSE DONORS SUCH AS USAID WHICH HAVE RIGOROUS PERFORMANCE STANDARDS AND CUMBERSOME PROCEDURES ARE AT A DISTINCT DISADVANTAGE. THE ABUNDANCE OF DONOR MONEY FOR EVEN THE MOST MARGINAL POP/FP ACTIVITIES HAS IN OUR VIEW BEEN DECIDEDLY COUNTER-PRODUCTIVE.

(B) THE MAJOR DONORS ARE WORLD BANK, UNFPA, SIDA, DANIDA, NORAD, ODA, WEST GERMANY, AND USAID. ALL PARTICIPATED TO SOME DEGREE IN THE 5-YEAR MULTI-DONOR MCH/FP PROJECT WHICH ENDED LAST YEAR. ALL, INCLUDING USAID ARE INTERESTED IN CONSIDERING MORE ASSISTANCE TO THE MOH, ALTHOUGH EACH IS WELL AWARE OF THE MOH'S

DEFICIENCIES AND MOH HAS BEEN RELATIVELY RELUCTANT TO WORK INDIVIDUALLY WITH THE BILATERAL DONORS. THE WORLD BANK, THE LARGEST DONOR, ORCHESTRATED THE PREVIOUS MULTI-DONOR PROJECT AND IS ATTEMPTING TO DEVELOP NEW MULTI-DONOR PROJECTS IN RURAL HEALTH AND IEC. THE NEXT WORLD BANK TRANSFER OF IOA CREDITS (\$30 MILLION PLUS) CAN BE EXPECTED TO OVARF THE ANTICIPATED ASSISTANCE OF OTHER DONORS.

THE FACT THAT WORLD BANK ASSISTANCE IS ON A LOAN BASIS HAS INFLUENCED THE MOH TO CONCENTRATE ON CONSTRUCTION AND PROCUREMENT OF EQUIPMENT BECAUSE THE GOV HAS NORMALLY BEEN UNWILLING TO ACCEPT LOANS FOR TECHNICAL ASSISTANCE, SALARY SUPPORT, TRAINING, AND OTHER SOFTWARE FORMS OF ASSISTANCE. THIS HAS LED TO AN EMPHASIS - INAPPROPRIATE, IN USAID'S JUDGMENT - ON THE BUILDING OF RURAL HEALTH INFRASTRUCTURE WITH OTHER DONORS PICKING UP TECHNICAL ASSISTANCE PACKAGES IN SUPPORT OF THE 18RD PROGRAM. USAID BELIEVES THAT MUCH GREATER EMPHASIS ON IEC AND FP DELIVERY SHOULD BE THE PRINCIPAL THRUSTS OF A POP/FP STRATEGY.

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C) IN OUR VIEW, UNFPA SHOULD PERHAPS ASSUME DONOR LEADERSHIP IN KENYA. THE INFLUENCE OF UNFPA HAS BEEN RATHER INSIGNIFICANT SINCE THE DEPARTURE OF THE FORMER UNFPA COORDINATOR FOR REASONS OF ILLNESS. HOWEVER, AFTER MANY MONTHS DELAY, A NEW UNFPA COORDINATOR HAS RECENTLY ARRIVED. WHILE WE ARE STILL ENSURE OF UNFPA PRIORITIES IN OPOP/FP ASSISTANCE FOR KENYA, WE BELIEVE THAT UNFPA CAN POTENTIALY PLAY A MAJOR ROLE IN MORE EFFECTIVE DONOR COORDINATION. WE WILL BE EXPLORING THIS POSSIBILITY FURTHER WITH UNFPA. IBND, WHICH HAS, IN THE PAST, ASSUMED LEADERSHIP IN DEALING WITH GOVERNMENT, DOES NOT MAINTAIN RESIDENT PCP/FP STAFF IN NAIROBI. ITS PRACTICE OF SENDING QUARTERLY MISSIONS TO KENYA DOES NOT IN OUR VIEW RESULTS IN THE NECESSARY DEPTH OF KNOWLEDGE AND CONTINUITY IN DEALING WITH GOVERNMENT ON DESIGN AND IMPLEMENTATION.

D) IN USAID'S VIEW, THE MOST EFFECTIVE DONORS IN KENYA HAVE BEEN THE AID GRANTEE/CONTRACTORS SUCH AS POPULATION COUNCIL, PATHFINDER FUND, FAMILY PLANNING INTERNATIONAL ASSISTANCE AND IMPREGO. OUR RECOMMENDATION IN PARAGRAPH 3(A) ON REDUCTION OF NUMBER OF DONORS DOES NOT INCLUDE THE AID GRANTEE/CONTRACTORS. WE RECOMMEND THAT, IN PRINCIPLE, ADDITIONAL AID RESOURCES BE MADE AVAILABLE TO THE AID-FUNDED INTERMEDIARIES PRESENTLY WORKING IN KENYA IN ORDER TO EXPAND THEIR ACTIVITIES. BOTH FPFA AND PATHFINDER HAVE INDICATED TO USAID THAT THEY HVE ADDITIONAL INNOVATIVE PROJECTS IN ENYA TO FUND BUT LACK THE FUNDS TO DO SO. MANY OF THE BILATERAL AND MULTILATERAL AGENCIES LACK THE FLEXIBILITY TO TO OFFER ASSISTANCE TO KENYAN NON-GOVERNMENTAL ORGANIZATIONS. AS THE NGOS ARE DOING MORE INNOVATIVE POP/FP PROJECTS THAN THE GOV, WE WOULD ENCOURAGE AID/W TO PROGRAM MORE RESOURCES TO ENABLE THE AID GRANTEE TO ASSIST ADDITIONAL NGOS.

4. CONCLUSIONS: DESPITE KENYA'S DISAPPOINTING RESPONSE TO ITS POPULATION PROBLEM TO DATE, WE ARE HOPEFUL THAT KENYAN INSTITUTIONS WILL BEGIN TO DEVELOP MORE EFFECTIVE ACTIVITIES AS THE CONSEQUENCES AND DETERMINANTS OF THE COUNTRY'S HIGH FERTILITY BECOME BETTER UNDERSTOOD. WE HOPE THE UPCOMING RAPID PRESENTATION, BEING SPONSORED WITH AID/W ASSISTANCE, WILL BE USEFUL IN PROMOTING UNDERSTANDING OF THE CONSEQUENCES AT LEAST. WE THINK THAT USAID SHOULD PLAY A SIGNIFICANT ROLE OVER THE NEXT 5-10 YEARS. WE WANT TO CONCENTRATE ON INTER-MINISTERIAL IEC PROGRAMS, SOCIAL SCIENCE RESEARCH AND ANALYSIS, POLICY DEVELOPMENT AND DEVELOPMENT OF MORE EFFECTIVE DELIVERY SYSTEMS FOR FP INFORMATION AND SERVICES. IN THIS REGARD, IT HAS BEEN POSSIBLE TO DO SOCIAL SCIENCE RESEARCH AND ANALYSIS E.G., THE AID-FUNDED POPULATION STUDIES AND RESEARCH INSTITUTE HAS IN OUR VIEW BEEN VERY SUCCESSFUL IN DOCUMENTING THE CONSEQUENCES OF POPULATION GROWTH. PSRI IS CURRENTLY PLACING EMPHASIS ON DETERMINANTS OF FERTILITY RESEARCH.

THE PRELIMINARY DATA FROM THE 1977-78 KENYA FERTILITY SURVEY INDICATE THAT ONLY 6 PCT OF KENYAN WOMEN WERE PRACTICING A MODERN OR TRADITIONAL METHOD OF CONTRACEPTION, ALTHOUGH 88 PCT WERE AWARE OF AT LEAST ONE CONTRACEPTIVE METHOD. OF WOMEN WILLING TO STATE A DESIRED NUMBER OF CHILDREN, ONLY 6 PERCT WANTED LESS THAN FOUR CHILDREN. THE OVERALL MEAN DESIRED FAMILY SIZE WAS 6.8 CHILDREN; THE MEAN RISES FROM 5.8 FOR THE YOUNGEST AGE GROUPS TO 8.4 FO THE OOLEST. KENYANS OBVIOUSLY DESIRE LARGE FAMILIES AND THEREIS CULTURAL RESISTANCE TO FAMILY PLANNING. FAMILY PLANNING IS A CONTROVERSIAL SUBJECT IN RURAL KENYA AND THERE IS LITTLE COMMUNICATION OF THE SURJECT. THERE IS NEED TO UNDERSTAND BETTER WHY KENYAS ARE RESISTANT TO FAMILY PLANNING DESPITE GROWING AVAILABILITY OF SERVICES. MUCH NEEDS TO BE DONE IN DETERMINANTS OF FERTILITY RESEARCH. IT IS CURRENTLY

KNOW, FOR EXAMPL, THE POLYGAMY AND BREAST FEEDING INFLUENCE FERTILITY IN KENYA MORE THAN FAMILY PLANNING. WE ARE CURRENTLY WORKING WITH THE MORNARD THE UNIVERSITY OF NORTH CAROLINA TO DEVELOP A SIGNIFICANT MCH/FP TRAINING PROGRAM (FOR CENTRAL FUNDING) HAVE TRAINED KENYANS IN PLACE TO IMPLEMENT GOOD PROGRAMS OR:SE ADOPTED. ALSO, OUR AID GRANTEEES ARE ASSISTING WITH KENYA'S FIRST ATTEMPTS TO DEVELOP COMMUNITY BASED, NON-CLINICAL DISTRIBUTION OF FP SERVICES THROUGH GNO GROUPS. WHEN AND IF THE MCH IS MORE RECEPTIVE, USAID WOULD LIKE TO TEST ALTERNATIVE DELIVERY SYSTEMS WITHIN THE MCH NETWORK. WE WILL ALSO BE ALERT TO THE ISSUE WHETHER OUR ASSISTANCE CAN MOST EFFECTIVELY AND ACCEPTABLY BE CHANNELLED THROUGH A MULTI-DONOR EFFORT OR THRUOH A DISCRETE BILATERAL ACTIVITY. IN CUM, THERE ARE SEVERAL POSSIBILITIES FOR MEANINGFUL AID ASSISTANCE TOWARD A KENYA POPULATION PROGRAM AND WE ARE BY NO MEANS PESSIMISTIC ABOUT MAKING A SIGNIFICANT CONTRIBUTION IN DUE COURSE.

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R 230935Z APR 80
FM AMEMBASSY NIAMEY
TO SECSTATE WASHDC 7449

UNCLAS NIAMEY 01821

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E. O. 120657 N/A

SUBJECT: POPULATION/FERTILITY CONTROL

REF: UNCLAS STATE 085558

1. MISSION, IN ANTICIPATION OF GON PUBLICATION OF NEW FIVE-YEAR PLAN, DELAYED RESPONSE TO REPTEL ABOVE.
2. GON, IN PRIOR PLANNING DOCUMENTS, HAS TREATED SUBJECT OF POPULATION UNDER THE RUBRIC OF FAMILY HEALTH CARE.
3. MINISTRY OF HEALTH HAS PROPOSED THE CONSTRUCTION AND DEVELOPMENT OF A CENTER TO BE LOCATED IN NIAMEY WHICH WILL SERVE AS AN ALL-ENCOMPASSING FAMILY HEALTH CENTER FOR SERVICE AND RESEARCH.
4. RECOMMENDATIONS WOULD EMERGE FROM THIS CENTER TO GON TOWARDS INSTITUTING A NATIONAL POLICY ON FAMILY PLANNING.
5. WHILE RESPECTING GOVERNMENT'S WISHES TO MOVE CAUTIOUSLY ON THE TOPIC OF POPULATION, MISSION HAS NEVERTHELESS ASSISTED IN IDENTIFYING AND PROCESSING KEY PERSONNEL FOR TRAINING IN FERTILITY/POPULATION PROGRAMS IN TUNISIA, DOWN-STATE NEW YORK, CAMEROON AND SENEGAL.
6. IN ADDITION, MISSION HAS SPONSORED AND ACCOMPANIED MOH TEAM ON FAMILY PLANNING SURVEY AND ORIENTATION TRIP TO TUNISIA AND MOROCCO.
7. MISSION HAS ALSO WORKED WITH REPRESENTATIVE WORLD FERTILITY SURVEY, DR. ALPHONSE MCDONALD, TOWARDS DESIGNING GON FERTILITY SURVEY.
8. MISSION WILL CONTINUE TO SUPPORT POPULATION/FERTILITY PROGRAMS AT A PACE COMMENSURATE TO THE WISHES OF THE HOST GOVERNMENT.
9. PLANNING WILL RESUME UPON RETURN OF TWO KEY MINISTRY OF PLAN PERSONNEL WHO ARE PRESENTLY ATTENDING POPULATION WORKSHOP IN CAMEROON.
10. "STATE OF READINESS" WILL NO DOUBT CHANGE GREATLY WITH THE ADVENT OF THE NEW FAMILY HEALTH CARE CENTER.
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PDC-02 AADS-01 DSHE-01 POP-04 CH8-01 PVC-02 STA-10
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INFO AMEMBASSY NAIROBI

UNCLAS LUSAKA 1407

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NAIROBI FOR REDSO/EA

E. O. 120657 N/A
SUBJECT: ZAMBIA: FAMILY PLANNING

REF (A) STATE 065558, (B) STATE 074851

THIS TWO-PERSON POST IS IN NO POSITION TO RESPOND ADEQUATELY TO REF A. IN CONJUNCTION WITH THE ZAMBIA CDSS REVIEW MARCH 17, AID REP MET WITH OFFICIALS OF DS/POP AND AFR/DR/POP TO DISCUSS QUESTIONS RELATED TO AID FAMILY PLANNING STRATEGY IN ZAMBIA AND THE PROBLEMS WE ARE PRESENTLY ENCOUNTERING. AS A RESULT, IT WAS PROPOSED THAT WITHIN THE NEXT TWO MONTHS A TEAM MADE UP OF OFFICIALS FROM AID/W AND REDSO/EA AND AID REP WOULD DEVELOP A FP STRATEGY AS A FOLLOW-ON TO THE CDSS WHICH EMPHASIZES SUPPORT PRIMARILY TO THE AG SECTOR. WE URGE YOU TO REVIEW REF B AND MEET WITH DS/POP AND AFR/DR/POP OFFICIALS CONCERNING THIS MATTER.
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TO SECSTATE WASHDC 4952

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FOR OS/POP, AFR/OR, AFR/SFQE
E.O. 12055: N/A
SUBJECT: NEED FOR POPULATION
ASSISTANCE IN MAURITANIA.

REF: STATE 033558

1. USAID OFFERS THE FOLLOWING VIEWS ON MAURITANIA
AND POPULATION PROGRAMS:

A. MAURITANIA HAS A POPULATION GROWTH RATE OF APPROX.
2.7 PERCENT. IN ADDITION IT HAS A HIGH INFANT AND CHILD
MORTALITY RATE AND RAPIDLY EXPANDING URBAN GROWTH RATE
WITH ITS CONCOMITANT SOCIAL AND ECONOMIC PRESSURES.
THESE PROBLEMS COUPLED WITH THE REALIZATION OF
MAURITANIA'S VERY LIMITED RESOURCES HAVE CAUSED THE
GOVERNMENT OF ISLAMIC REPUBLIC OF MAURITANIA (GIRM) TO
BEGIN LOOKING MORE CLOSELY AT ITS POPULATION PROBLEMS.

B. CURRENTLY THE GIRM HAS NO FAMILY PLANNING POLICY.
HISTORICALLY THE COUNTRY HAS PROHIBITED SUCH ACTIVITIES
JUSTIFYING THIS ON A VERY STRICT INTERPRETATION OF
ISLAMIC LAW. CONTRACEPTIVES, WHEN AVAILABLE, ARE
DISPENSED ONLY BY PRESCRIPTION. TRADITIONAL MEANS OF
CONTRACEPTION ARE INCREASINGLY PRACTICED. POORLY INDUCED
ABORTIONS ARE A SIGNIFICANT PROBLEM.

C. INTEREST IN FAMILY PLANNING HAS BECOME EVIDENT DURING
THE LAST FEW YEARS. WOMEN ARE BEGINNING TO DEMAND
CONTRACEPTIVES AND INFORMATION. MANY WOMEN BRING BACK
CONTRACEPTIVES FROM SENEGAL, MOROCCO OR FRANCE. THIS IS
DONE GENERALLY WITHOUT HUSBAND'S KNOWLEDGE, BUT MEN ARE
BEGINNING TO BE INTERESTED ALSO. THESE MEN AND WOMEN ARE
THE BETTER EDUCATED URBAN RESIDENTS. (ESPECIALLY WORKING
WOMEN). THE DIRECTOR OF THE MCH SERVICES
(A WOMAN) HAS BEEN LAYING THE BASIS FOR FAMILY PLANNING
PROGRAM BY INCLUDING DISCUSSIONS OF FAMILY HEALTH, CHILD
SPACING, ETC. IN MCH CLASSES DIRECTED AT COUPLES. RESPONSE
OF BOTH MEN AND WOMEN HAS BEEN GOOD.

D. THE MINISTRY OF HEALTH AND OTHER HEALTH PERSONNEL
ARE EXPRESSING INCREASING INTEREST IN STARTING SOME TYPE
OF PROGRAM AND POSSIBLY ADVANCING A POLICY. THE INITIAL
CONSTRAINTS THEY HAVE IDENTIFIED ARE LACK OF KNOWLEDGE
ABOUT FAMILY PLANNING (AS WELL AS DYNAMICS OF DEMOGRAPHY
IN GENERAL) AND PROGRAM AND POLICY DEVELOPMENT. THE
DIRECTOR OF PREVENTIVE MEDICINE TOLD USAID HE IS VERY
INTERESTED IN BEGINNING FAMILY PLANNING PROGRAMS BUT
HAS VERY LITTLE UNDERSTANDING OF THE SUBJECT. THE
ESSENTIALLY ALL-MALE MAKE UP OF THE MINISTRY HAS PROBABLY
BEEN RESPONSIBLE FOR THE VERY SLOW EVOLUTION OF
INTEREST.

E. MAURITANIA HAS UNDERWAY A NUMBER OF DEMOGRAPHIC
ACTIVITIES WHICH SHOULD SERVE TO DIRECT THE GIRM TOWARD
A FAMILY PLANNING POLICY IN THE 80'S. GIRM IS ANALYZING
CENSUS DATA (FROM 1977) AND UNFPA IS CONDUCTING A
DETAILED FERTILITY SURVEY WHICH WILL BE FINISHED IN 1981.
THIS SHOULD PROVIDE (FOR THE FIRST TIME) ACCURATE FIGURES
ON FERTILITY.

F. USAID IS IN THE PROCESS OF PREPARING A MORE DETAILED
ANALYSIS OF POPULATION SITUATION AND STRATEGY FOR U.S.
FAMILY PLANNING ASSISTANCE TO MAURITANIA.

G. CURRENT MISSION APPROACH IS AS FOLLOWS:

(1) HOLD REGULAR DISCUSSIONS WITH MCH PERSONNEL, MAKE
LITERATURE AVAILABLE.

(2) SEND REP. TO FAMILY PLANNING COURSE AT ARIANA TRAINING
RESEARCH CENTER IN TUNIS OR JHPIEGO COURSE AT JOHNS
HOPKINS, MAY, 1980. MCH IS SELECTING A PHYSICIAN FOR
ONE OF THESE COURSES.

(3) TAKE ADVANTAGE OF SOME OF THE CENTRALLY FUNDED
POPULATION PROJECTS TO HAVE CONSULTATION AND PROGRAMMING
HELP. USAID DISCUSSING THESE WITH GOVERNMENT.

(4) CONSIDER SENDING MCH DELEGATION TO TUNIS TO SEE
SUCCESSFUL FAMILY PLANNING PROGRAM IN AN ISLAMIC COUNTRY.
MCH HAS EXPRESSED INTEREST IN STUDYING TUNIS PROGRAMS.

(5) TRY TO DEVELOP AN EVENTUAL FAMILY PLANNING COMPONENT
IN THE RURAL MEDICAL ASSISTANCE PROJECT (662-0202).

(6) ENCOURAGE GOVERNMENT TO STOCK CONTRACEPTIVES IN

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PHARMACIES. GOVERNMENT IS CURRENTLY PLANNING A LIBERALIZATION (I. E. PROLIFERATION) OF PHARMACY SYSTEM IN MAURITANIA (NOW ONLY 6 PHARMACIES IN THE COUNTRY).

(7) ENCOURAGE GOVERNMENT TO ESTABLISH A REPRODUCTIVE HEALTH CLINIC IN NOUAKCHOTT. (ON THE ORDER OF SIMILAR CLINICS IN DAKAR, OR BAMAKO) WHICH WOULD INCLUDE CONTRACEPTION AND INFERTILITY CONSULTATION. THE PHYSICIAN RETURNING FROM FAMILY PLANNING COURSE (4. (2) ABOVE) MAY BE INTERESTED.

(8) FIND OUT IF OTHER DONORS (SUCH AS UNFPA) ARE INTERESTED IN FUNDING FAMILY PLANNING PROGRAMS. THE COUNTRY'S ABSORPTIVE CAPACITY FOR SUCH PROGRAMS IS VERY LOW, BUT WITH SUCH CHANGES AS THE AVAILABILITY OF NON-PRESCRIPTION CONTRACEPTIVES, PRESCRIPTION CONTRACEPTIVES (AT URBAN CLINICS), AND EDUCATION AT MCH CENTERS, FAMILY PLANNING SERVICES COULD BECOME WELL ESTABLISHED DURING THE 1980'S.

2. IN SUMMARY IT APPEARS THAT THE CLIMATE MAY BE RIPE TO MOVE FORWARD WITH THE GIRM IN ASSISTING AND ENCOURAGING IT TO FORMULATE A POLICY AND BEGIN TO DESIGN AND IMPLEMENT ACTIVITIES FOR FAMILY PLANNING WITHIN THE CONTEXT OF FAMILY HEALTH. DUNBAR

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E. O. 12065; N/A

SUBJECT: POPULATION/FAMILY PLANNING-UPPER VOLTA

REF STATE 85558

SEE UPPER VOLTA FY82 CISS, PP 7-8, 35-38,
43-45, AND 54-55 FOR RESPONSE TO REFTEL, PARA 2
A AND C. RE PARA 2, B, OTHER DONOR/MULTILATERAL
EFFORTS ARE MINIMAL AND SPORADIC, PRIMARILY
AIMED AT SENSITIZATION TO THE PROBLEM VIA
CONFERENCES AND TRAINING. BOYATT

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E. O. 12065: N/A
SUBJECT: POPULATION ACTIVITIES

REFS: (A) STATE 088558, (B) YAOUNDE 1447

1. RE REPT (A) PARA 2 A, THE GURC IS JUST BEGINNING TO SHOW SERIOUS INTEREST IN DEVELOPING BILATERAL FAMILY PLANNING/POPULATION ACTIVITIES. RE (B) A COPY OF WHICH IS AT THE CAMEROON DESK, IS A SPEECH GIVEN BY PRESIDENT AHIDJO AT THE THIRD CAMEROON NATIONAL UNION PARTY CONGRESS. THIS SPEECH ARTICULATES FOR THE FIRST TIME THE NEED TO DEVELOP A POPULATION POLICY AND TO INTEGRATE POPULATION GROWTH PROBLEMS INTO CAMEROON DEVELOPMENT PLANNING. AS A RESULT OF THIS OFFICIAL RECOGNITION USAID HOPES TO HAVE TWO FAMILY PLANNING PROJECTS READY FOR FUNDING THIS YEAR, ONE WITH THE MINISTRY OF HEALTH (MOH) AND THE OTHER THROUGH A PVO WITH THE MINISTRY OF SOCIAL AFFAIRS.

2. RE REF (A) PARA 2 B, NO OTHER BILATERAL DONOR IS INVOLVED IN FAMILY PLANNING/POPULATION ACTIVITIES. FAMILY PLANNING INTERNATIONAL ASSISTANCE (FPIA) IS CURRENTLY WORKING WITH A PRIVATE PRESBYTERIAN HOSPITAL TO INTEGRATE FAMILY PLANNING SERVICES INTO ITS ACTIVITIES. FPIA IS ALSO WORKING WITH THE MOH TO INCLUDE FAMILY PLANNING SERVICES IN ITS SCHOOL HEALTH PROGRAM. THE UNITED NATIONS FUND FOR POPULATION ACTIVITIES (UNFPA) SPONSORS STUDENTS TO ATTEND SHORT TERM TRAINING IN DEMOGRAPHIC PROBLEMS. UNFPA IS ALSO CURRENTLY FUNDING A LAW AND POPULATION STUDY AT THE UNIVERSITY OF YAOUNDE TO INVESTIGATE THE INTERRELATIONSHIP BETWEEN EXISTING LAWS AND NEW SOCIO-ECONOMIC NEEDS OF CAMEROONIAN. USAID VIEWS ALL THESE ACTIVITIES AS COMPLEMENTARY.

3. RE REF (A) PARA 2 CN REF B EXPLAINS THE GURCS DESIRE AND READINESS TO INCLUDE POPULATION GROWTH PROBLEMS IN ALL ASPECTS OF ITS DEVELOPMENT.
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BANGLADESH

On the population priorities grid, Bangladesh is in the category of having a high annual increase in population, a less favorable socio-economic setting and strong government^{commitment} to fertility control programs.

Explanation: The socio-economic variables for Bangladesh are distressing and present a monumental task for any family planning program.

- The crude birth rate is 47/1000
- Infant mortality rate is 153/1000
- Rate of natural increase is 2.9 percent
- Life expectancy is 46 years
- Per capita GNP is \$90

The country has experienced what appears to be a singularly unsuccessful experiment with family planning. While there are indications that significant numbers of Bangladeshi couples wish to limit their fertility, it is not at all clear that the Government is able to deliver services in an appropriate manner. Furthermore, the Government of Bangladesh (BDG) has set a fertility control target which appears to be utterly unrealizable in the context of voluntarism-- replacement level fertility by 1990 and zero population growth by 2000. Assuming that the death rate falls no lower than 15/1000, the birth rate would have to reach a similar level in order for the goal to be achieved by 2000. Thus, population policy in Bangladesh represents a dilemma: given population densities and the current rate of growth, fertility control is an absolute necessity. Yet, fertility control probably can not be achieved in the short run because of the weaknesses of the administrative system, the inability of political leadership to command adherence to national policies, and a socio-economic and cultural environment that is

somewhat inhospitable to family planning. The three major donors involved in BDG population activities are USAID, the World Bank and UNFPA. Each of the three is about to embark of second phase of their respective population projects.

USAID/Bangladesh has proposed to AID/W a Population/Family Planning project - Phase II (FY 1981-1983) at a funding level of \$37.3 million. The project will include participant training, specifically the training in Indonesia of Thana (county) level Family Planning Officers; provision of contraceptives; logistical and financial support for three national voluntary sterilization campaigns each year; expanded support to the private sector for the provision of family planning services; and a major expansion of the commercial contraceptive ^{distribution} program to rural areas of the country.

In May 1979 the World Bank signed an agreement with the BDG for a second population project, Bangladesh II. The project funding level is set at \$110 million, including \$32 million as an IDA credit, a BDG contribution of \$11 million, and the balance of \$67 million to be financed by other external donors, (Australia, Canada, Germany, Norway, Sweden and the U.K.) This project will concentrate on health care and family planning service delivery; training; IESC; research and evaluation; and innovative and private sector activities.

UNFPA's second population project (1980-1985), with estimated total financing at a level of \$50 million, ^{(with an option to expand to \$100 million),} will include support for the 1981 census; institutional development assistance; advisory services; salary support; food and transportation costs for sterilization clients; extension and expansion of population education; and population research activities.

Program Options: During 1979 the World Bank, UNFPA, and USAID began to work more effectively together with the BDG. A common set of realistic program performance indicators, in the context of a time phased plan of action, and progress made to achieve them will be monitored and reviewed jointly by the BDG and the three major donors. If it becomes apparent that the BDG cannot develop an effective delivery system, program support will be re-evaluated and alternate strategies will be developed.

Until such time, the AID strategy for Bangladesh has the following characteristics: articulation of modest, short-term objectives; a search for innovations, ^{including the use of community and/or individual incentives,} that can be replicated on a broader basis; incorporation of experimentation before nationwide implementation, transference of demographic goals and objectives into national planning ⁱⁿ other development sectors; and the search for approaches that maximize community involvement and peer pressure in population planning activities. This approach will give significantly more attention to private sector institutions than they have received in the past. While such an approach may increase the prevalence of contraceptive use, it is unlikely that the private sector can fully substitute for the public sector in the provision of fertility control services.

BURMA

Burma is listed on the population priorities grid as having a high annual increase in population, a favorable socio-economic setting and weak government commitment to population programs.

Explanation: The Population Reference Bureau data show Burma to have a crude birth rate of 39/1000 and a 2.4 percent rate of natural increase. If such growth continues unchecked, it will take 29 years to double the population, yielding an estimate for the year 2000 of 52.7 million people.

The socio-economic environment in Burma is considered favorable, particularly from a public health perspective. The People's Health Plan, adopted in 1977, stresses Primary Health Care at the village level and is regarded as a model for developing countries. Free public health services have been developed emphasizing preventive, rather than curative medicine; improving maternal and child health services; and controlling major communicable diseases such as tuberculosis, malaria, and filariasis. As of 1971 Burma had one physician for every 9,177 inhabitants. In addition, the Department of Health had twice as many paramedical personnel as physicians among its employees.

Program Options: Burma has maintained a staunch pro-natalist stance for many years. Unless and until this posture changes, there would not appear to be many opportunities for bilateral program activities in Burma. As Burma reestablishes external relationships it is conceivable that the country's view of the relationship between population and national development will change to the point of recognizing that the number of people is less important than many other factors in determining a country's development potential.

AID has centrally-funded resources which could be deployed in the policy and research areas in order to help the Government of Burma to analyze its demographic situation and to evolve revised policies on the relationship between socio-economic development and population growth. Furthermore, since it appears likely that AID will be assisting Burma in the health field, it is conceivable that some family planning could be introduced as a MCH/child-spacing measure at a future date. If a national fertility control effort was to be launched and U.S. bilateral population assistance deemed unacceptable by the Burmese, there would be a potential role for UNFPA.

INDIA

India experiences a high annual population increase, with a relatively unfavorable socio-economic setting for fertility control programs, though a strong government commitment to such activities.

Explanation: India's vastness makes it difficult to characterize the socio-economic setting; there is tremendous variation between and among the many states. The all - India indicators describe a serious situation:

- a crude birth rate of 34/1000.
- a 1.9 percent annual rate of natural population increase.
- an infant mortality rate of 122/1000 live births.
- a ^{per}capita GNP of \$150.

After the elections of 1977, the government reinstated a national family planning effort and enlisted the support of international donors in this effort. The Indian government has determined that its family planning program will be fully integrated with the provision of maternal and child health services. While all forms of contraception are theoretically offered, sterilization remains the program's mainstay. There is a major emphasis on trained staff and construction of facilities in order to expand health and family planning services to underserved rural populations. India also is trying to reduce fertility by enforcing the age-at-marriage laws, and by extending literacy, with special emphasis on women and girls.

Most noteworthy about the new approach to family planning in India is the desire to limit donor efforts to specific geographical subunits of the country. Hence, the World Bank is being asked to concentrate its efforts in Uttar Pradesh and Andhra Pradesh; the UNFPA is being assigned

responsibility for supporting program activities in Rajasthan and the Bihar; DANIDA funding is for Tamil Nadu and Madhya Pradesh, Britain is in Orissa, and so on. ~~When~~ AID becomes involved in bilateral population program activities in India in 1980, support will be limited to the states of Maharashtra, Gujarat, Punjab, Haryana, and Himachal Pradesh.

This division of program ^{support} is designed to eliminate duplication of effort and allow for specific project focus. Coordination of bilateral and multilateral assistance is effected by the

Ministry of Health and Family Welfare.

Program Options: AID does not at present have a bilateral family planning project in India. USAID/India has, however, proposed to AID/W an Integrated Rural Health and Population project (FY 1980-83) at a funding level of \$40 million. The AID funds are envisioned to be used primarily at the village level and will finance basic training programs for village and higher level health and family welfare workers, with emphasis on training that will help to reduce infant and young child mortality; baseline surveys in project districts; development of a management information system to improve rural health systems management; operations research; and the construction and equipping of 300 rural subcenters and about 30 public health centers. AID ~~will~~ encourage the Government of India (GOI) to examine a range of policy measures which extend beyond family planning

Given the GOI's strong interest in limiting donor involvement to financing programs in selected states, ~~each donor's~~ "comparative advantage" ~~is primarily in~~ being the only major donor able to support activities in the ~~states to which it~~ ~~is assigned~~.

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INDONESIA

According to the population priorities grid, Indonesia has a high annual increase in population, a favorable socio-economic setting and strong government commitment to fertility control programs.

Explanation: The Indonesian family planning program, especially the Java-Bali portion, is widely recognized as one of the most successful family planning programs in the world. By March 1979 the program had recruited over 5.5 million users, representing almost 30 percent of the married women of reproductive age. The crude birth rate was reduced 23 percent between 1970 and 1978, from an estimated 43/1000 to 33/1000. This resulted in a net decrease in the population growth rate of 14 percent, down to approximately 1.0 percent per year. On the islands of Java and Bali, the decreases have been even more dramatic--reducing the population growth rate there to 1.8 percent.

These impressive results have been brought about as the result of sustained high-level government commitment to the family planning program and the translation of that commitment into outstanding administrative performance and powerful peer pressure at the local level. One of the critical elements in program success has been the establishment, in 1970, of an autonomous national family planning coordinating Board (BKKBN). The (BKKBN) reports directly to the President and is responsible for all government population activities. In this capacity it examines all donor project proposals to assure maximum family planning program impact and elimination of overlap.

AID's role in the Indonesia family planning story has been important. The Agency has provided strong financial and intellectual support to the program from its outset. Much of what has come to be effective program activity began as small-scale research and development with "risk capital" supplied by AID. The current Family Planning Development and Services grant project focuses on increasing the availability of a variety of contraceptive means; innovating and experimenting with new and improved means of delivering family planning services; institutionalization of village family planning on Java and Bali; and acceleration of development of village family planning in the Outer Islands where much less success has been experienced.

The World Bank has been significantly involved in Indonesia's population program. The Bank's project activities are designed to include the provinces outside Java and Bali, and consist of construction and equipping of administration and training facilities; population education and operational research studies concentrated on community incentive schemes; and studies of the feasibility of using local raw materials for contraceptive sterbids.

The UNFPA has granted funds to support the expansion of family planning services in hospitals, urban facilities, and the Outer Islands. It also provides support for information and education activities, demographic research, and the 1981 census. Despite impressive results and substantial donor involvement in fertility reduction programs there is considerable debate regarding Indonesia's capacity to achieve and sustain a CBR of 20/1000 by the year 2000, without significant improvements in the overall standard of living.

Program Options: AID strategy calls for continued financial support to the Java-Bali program and financial and intellectual support to the expansion of activities in the Outer Islands. The bulk of assistance will be in contraceptive commodities and other sources of support to the family planning program. AID also will fund research efforts aimed at discovering additional policy initiatives which may contribute to fertility reduction, particularly measures appropriate for the Outer Islands.

NEPAL

Nepal, as shown on the population priorities grid, experiences a moderate annual population increase, has a non favorable socio-economic setting for fertility regulation, and fairly weak government commitment to family planning programs.

Explanation: Nepal is unusual in Asia in that its population growth rate, despite a fertility control program, is still on the increase and expected to increase a bit further before it declines. The Government of Nepal's (GON) official policy is to reduce the rate of population growth primarily through socio-economic change and, secondly, through the family planning program. The GON agencies responsible for population/family planning program coordination are the Population Policy Coordination Committee, and the Family Planning/MCH Project of the Ministry of Health. The Committee is an interministerial body which oversees various programs that may affect population growth. The Family Planning/MCH project has been in existence since 1968. Currently the integrated service delivery system is providing minimum services in 48 of Nepal's⁷⁵ districts. The GON has a target of reaching the entire population with an integrated basic health and family planning system by 1985. To expand the delivery system and make it more effective, the government is emphasizing improved management, training, planning and supervisory capabilities at all levels.

Nepal. The UNFPA and USAID are the major donors for population activities in Nepal. The UNFPA is and will continue to be involved in funding program activities such as: data collection; population policy formulation; family planning and maternal and child health services delivery; and information, education and communications. USAID has a five year Population Policy Development project (funded in 1979), designed to develop a population policy support system and to assess determinants of fertility decline and their relationship to and impact on development.

Program Options: As the second part of AID's two-pronged approach to fertility control, (consisting of: 1) support of population policy research and 2) family planning involvement), USAID/Nepal has proposed an Integrated Rural Health and Family Planning Services project for FY 1980-84. In the past, health services in Nepal were delivered through a few disease-specific programs with a separate and parallel family planning system. The new AID project will support a basic change in the delivery system in order to bring about the combined delivery of health and family planning services through integrated program management. The project will finance technical assistance; commodities; and local capital and recurring development costs of selected elements of the expanded rural health and family planning program.

In a context of high death rates and minimal movement toward modern levels of social development in such sectors as health, education or agriculture, AID must regard Nepal as a country ^{to} which we should be prepared to maintain both a development and population planning commitment for many years to come.

PAKISTAN

Pakistan is characterized by a high annual population increase, a less favorable socio-economic setting, and weak government commitment to family planning. It is the only Asian country in which AID recently has had involvement, where both the socio-economic setting and the government commitment are unfavorable.

Explanation: Pakistan faces a bleak demographic future:

- The crude birth rate is 44/1000.
- Rate of natural increase is 3.0 percent.
- Infant mortality rate is 136/1000 live births.
- Life expectancy is 51 years.
- Per capita GNP is \$190.

In addition, no country has failed in family planning program efforts in the past as repeatedly and dramatically as Pakistan has. After numerous setbacks, the ^{population} program collapsed completely in 1976 and 1977 as the result of poor planning, maladministration, and political interference. Thus, there is a crisis of confidence. The country desperately needs a population program success of whatever magnitude in order to reestablish some self-confidence among its managers and fieldworkers.

Until 1976 the Pakistan program had active participation of a number of donors in population activities. Currently the only organization involved in family planning in Pakistan is the UNFPA. They currently fund commodity assistance and have completed a basic needs assessment which outlines possibilities for future project assistance if and when the political climate and administrative capability are conducive to increased population programming.

Program Options: USAID/Pakistan has prepared a Multi-Year-Population Strategy paper (MYPS) which calls for a step-by-step reinvolvement in the program as the Government of Pakistan demonstrates an increasing commitment to and capacity to undertake population planning. There are three components of the proposed strategy: 1) support for small-scale research and development to attempt to discover innovations which show promise for replication on a broader scale; 2) support for research on fertility determinants in order to identify interventions in broader development policy which would be supportive of a lower population growth rate; and 3) experimentation with renewed family planning program activities in sterilization, management information systems, and training in order to get some semblance of family planning services reestablished. In the longer run, however, it will be necessary for the Government of Pakistan to demonstrate renewed commitment by appointing highly competent managers to the population program, allocating internal resources to the program, and enunciating population policies which signal a clear commitment to fertility control.

THE PHILIPPINES

On the population priorities grid, the Philippines is listed as having a high annual increase in population growth, a favorable socio-economic setting and strong government to family planning.

Explanation: Socio-economic factors which are most closely associated with declining fertility are relatively favorable in the Philippines:

- the female literacy rate (for over fifteen years old, as of 1971) was 82.2 percent
- the per capita GNP is listed as (U.S.) \$450
- the infant mortality rate is 80/100 live births

On the other hand, the nonsupportive position of the Catholic Church vis-a-vis family planning services has caused the government to move with considerable caution in the provision of those services. The crude birth rate for the Philippines is 34/1000 and the population growth rate is around 2.4 percent per year. The prevalence of contraceptive use is near 40 percent for women 15-44, but some 40 percent of the rate is accounted for by traditional family planning methods (rhythm, abstinence, withdrawal--and combinations). In recent years there has actually been a decline in the proportion of women using such effective methods as the pill and IUD. Sterilization rates are fairly low but show an encouraging upward trend.

In 1970, the Philippine Government launched a national population program aimed at reducing the population growth rate from its estimated level of over three percent. USAID bilateral assistance is now centered on the community outreach component of the national program. The IBRD provides the majority of its assistance through the Ministry of Health to public, clinic-based health/family planning programs in which AID also participates through the provision of support for the voluntary sterilization component. Meanwhile, the UNFPA centers much of its attention on the introduction of family planning in the non-family planning service sector and on subnational levels of program activity.

Program Options: A study of contraceptive behavior in the early seventies revealed a very strong relationship between a couple's proximity to a source of family planning services and their actual practice of family planning. Accordingly, in 1976 the GOP and the AID Mission agreed on a strategy of "contraceptive outreach." The outreach program is now in its fourth year of field-level implementation. There are some indications that it is succeeding in increasing access to and practice of family planning through ensuring availability of family planning services at the barangay level and encouraging private sector contraceptive distribution and sales activities. AID will continue to support research into the determinants of fertility decline and the factors which explain differential fertility decline in the Philippines. Lastly, AID will support private sector organizations which are actively engaged in fertility control program activities.

SRI LANKA

On the population priorities grid, Sri Lanka is shown to have a moderate annual population increase, a favorable socio-economic setting, and a strong government commitment to population programs.

Explanation: Sri Lanka is a country which has experienced a rapid decline in population growth rates despite the relative absence of a national fertility control program. The crude birth rate is 26/1000, and the population growth rate is 1.8 percent per year--having fallen from 2.5 percent in 1965.

The following indicators reflect the government's commitment to social equity and are evidence of the favorable social setting:

- national literacy rate is 78%
- the infant mortality rate is only 44/1000
- life expectancy at birth is 68 years
- the average age at marriage (1971) is 28 for males, 23.5 for females
- medical care is free and generally there is some health institution available within a five-mile radius of any given location.
- the government Planning Commission has announced a shift in orientation from curative to preventive health services

While there is much in the socio-cultural setting of Sri Lanka to encourage the success of fertility control programs, family planning has been and continues to be a sensitive political issue.

There is a degree of friction between the two main ethnic groups in the country--Sinhalese and Tamils. The Sinhalese, who comprise 72% of the population of the island, have been accused of biasing family planning programs toward the "elimination" of the Tamil population. To ensure harmony, population programs take a distinctly "low profile" and are administered out of the Family Health Bureau which is part of the Colombo Group of Hospitals rather than the central Division of Health Services within the Ministry of Health.

Program Options:

AID has only recently reopened a full mission in Sri Lanka and bilateral program activity is still at a relatively low level. Currently, AID is providing assistance to Sri Lanka solely through centrally-funded intermediaries such as the International Planned Parenthood Federation, Family Planning International Assistance and the Association for Voluntary Sterilization. It may well be that no bilateral program activity is either necessary or desirable at this time. However, the AID Mission will have to make a determination concerning the desirability of providing bilateral population program support after it has completed an evaluation of centrally-funded activities and an assessment of the demographic situation in Sri Lanka. This review is ongoing in FY 1980 and will form the basis for future decisions.

THAILAND

Thailand is found in the category of greatest annual population increase, though encouragingly, there is a strong government commitment to fertility control programs coupled with a favorable socio-economic setting.

Explanation: Recent data suggest that Thailand has one of the most successful population programs in the developing world.—Prevalence of contraceptive use among women 15-44 is over 50 percent, even in the rural areas.—The crude birth rate (CBR) was 32/1000 in 1979 and is rapidly declining.—A significant proportion of the observed decline in fertility is attributed to the family planning program.—It is likely that Thailand will be able to reduce the population growth rate to 2.1% percent or less by 1981 and achieve a CBR of 20/1000 before the end of the century.

The Thai program is noteworthy because family planning is fully integrated with the delivery of health services and is seen as one of several maternal and child health measures. Among the key factors contributing to the success of the program has been the commitment of the Royal Thai Government (RTG), and substantial foreign aid and technical assistance. From its inception in 1970, the National Family Planning Program (NFPP) has received support primarily from the Thai government, USAID, The World Bank, and the UNFPA. Within the broad parameters of the national development objective to reduce the population growth rate, each of the major donors has concentrated its efforts in distinct program areas. USAID has emphasized local cost support of: voluntary sterilization ^{contraception} services and supply; operational research activities; medical ~~equipment and~~ ^{equipment and} vehicles for the voluntary sterilization program; and some local training.

In addition, USAID funds a \$5.3 million loan (FY78-81) -- the Rural Primary Health Care Project -- as a contribution to the World Bank population project. The USAID component of the project assests in the provision of local training, strengthening research & evaluation capabilities, and the development of more efficient management and supervisory pacticies.

The World Bank population project has a funding level of \$68.6 million and operates in 20 of the country's 72 provinces. The funding consists of an IDA credit (\$33.1 million); the AID loan; grants from Canada, Norway and Australia (\$12.4 million); and an RTG contribution of \$17.6 million. The non-AID portion provides funding for infrastructure, including construction and equipping of maternal and child health centers, vehicles, medical equipment and contraceptive supplies, information, education and communication services; technical assistance and operating costs.

UNFPA support of the Thai program has concentrated on the training of paramedical workers and village health workers. The RTG has supported the provision of manpower; active support by key government officials and strong managerial direction; the development of an extensive network of communication and service delivery points; and obtaining cooperation of a large number of health/medical educational institutions. These efforts, as well as those of outside donors and the private sector, have been well coordinated by National Family Planning Committee, which was established to effect inter-donor complementarity.

ogr: Options: The current donor population program activities are funded only through FY 1981. Negotiations have been underway to extend and expand donor involvement, with the understanding that the World Bank would take the lead role in future collaborative multi-donor population project activities. The future role of

World Bank support for the national family planning program is uncertain. Given this uncertainty and the fact that UNFPA involvement has been limited to training, USAID remains as the only major donor with the technical and financial capability of addressing the wide range of support needs crucial to continuation of the program. Given the enormous momentum of the Thai program, it is important that it receive external donor support until responsibility for the program budget can be assumed entirely by the Government. RTG ability to assume program costs is expected to increase gradually. Hence, donor phase-out also should be gradual. The AID strategy will be to work in conjunction with the RTG to support the provision of family planning services, especially voluntary sterilization, and to encourage the continuing move to fully integrate health and family planning service

in Thailand. AID also will support RTG initiatives to incorporate demographic objectives into development activities in other sectors such as education and agriculture.

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FOR OS/POP

EO 12065: NA
SUBJ: POPULATION; OMITTED IN TRANSMISSION RECEIVED

REF STATE 085538

1. PER PARA 6 REFTEL, POPULATION SECTION OF QUOTE HEALTH, POPULATION, AND NUTRITION STRATEGY FOR ASIA UNQUOTE AND ASIA BUREAU'S REPORT TO HOUSE COMMITTEE ON FOREIGN AFFAIRS GIVES DETAILED DESCRIPTION OF ON-GOING POPULATION ACTIVITIES IN THAILAND AND ROLE/COMMITMENT OF RTG IN THIS EFFORT. FURTHER DOCUMENTATION OF POPULATION ACTIVITIES IN THAILAND CAN BE FOUND IN JULY 1979. EVALUATION OF AID-ASSISTED POPULATION PLANNING PROJECT AND THE COSS.

2. UNFPA.

A. UNFPA HAS BEEN AN ACTIVE DONOR IN THAILAND AND HAS CONTRIBUTED WELL OVER 20 MILLION DOLLARS FOR FAMILY PLANNING RELATED PROJECTS SINCE 1971. THE BULK OF THIS SUPPORT HAS BEEN USED TO SUPPORT THE NATIONAL FAMILY PLANNING PROGRAM OF THE MINISTRY OF PUBLIC HEALTH. CURRENTLY, THESE PROJECTS FOCUS ON TRAINING OF VARIOUS CATEGORIES OF MEDICAL AND PARAMEDICAL PERSONNEL, SUPPORT FOR THE RURAL VSC PROGRAM, AND IC&C TO STIMULATE DEMAND FOR FAMILY PLANNING SERVICES. UNFPA IS ALSO SUPPORTING EFFORTS TO PROMOTE/EXPAND POPULATION EDUCATION AND IS ASSISTING WITH THE 1980 CENSUS.

B. RECENTLY, UNFPA ASSISTANCE HAS BEGUN TO SHIFT FROM FAIRLY FOCUSED BUDGETARY SUPPORT FOR THE MFPP TO A BROADER PROGRAM OF ASSISTANCE TO ORGANIZATIONS/INSTITUTIONS ENGAGED IN A WIDE RANGE OF POPULATION-RELATED ACTIVITIES. PROJECTS CURRENTLY UNDER CONSIDERATION INCLUDE POPULATION EDUCATION WITHIN THE MINISTRIES OF EDUCATION AND AGRICULTURE, COMMUNITY-BASED FAMILY PLANNING SERVICES, WOMEN AND RURAL DEVELOPMENT, AND HEALTH/FAMILY PLANNING SERVICES FOR MINORITY GROUPS AND DISPLACED PERSONS. ALTHOUGH PORTFOLIO OF PENDING UNFPA PROJECTS DOES NOT INCLUDE FURTHER ASSISTANCE TO FAMILY HEALTH DIVISION AND CONTRACEPTIVE SUPPLIES, THEY DO NOT RULE OUT SUCH ASSISTANCE IN THE FUTURE IF A CLEAR NEED PRESENTS ITSELF.

C. IF GENERAL, USAID AND UNFPA HAVE COORDINATED CLOSELY IN AN EFFORT TO AVOID OVERLAP AND DUPLICATION. THERE ARE EXAMPLES OF SHARED FUNDING OF SIMILAR ACTIVITIES, PARTICULARLY WITHIN THE MOPH, BUT IN MOST CASES THE

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TOTAL BUDGET SUPPORT NEEDED JUSTIFIED SUPPORT FROM BOTH SOURCES. SEVERAL OF THE NEW UNFPA INITIATIVES, PARTICULARLY IN POPULATION EDUCATION, CLEARLY COMPLEMENT USAID'S ASSISTANCE.

3. IBRD. IBRD SUPPORT FOR POPULATION PROJECT. THIS PROJECT REPRESENTS A GOOD EXAMPLE OF HOW AID AND IBRD RESOURCES CAN BE USED IN COMPLEMENTARY FASHION. AID/V WILL AWARE OF DETAILS OF THIS PROJECT AND UNCERTAINTY RELATED TO CONTINUATION OF THIS ACTIVITY AFTER 1981. SUGGEST CONTACT DAVID RADEL AT IBRD IF FURTHER INFORMATION REQUIRED.

4. USAID NOTE.

A. IN SHORT RUN (2-5 YEARS), USAID ANTICIPATES CONTINUATION OF BUDGETARY SUPPORT FOR VSC, TRAINING, AND CONTRACEPTIVE SUPPLIES. THIS WILL BE AUGMENTED BY SUPPORT TO SPECIAL ACTIVITIES, SUCH AS INTENSIVE IC&C/SERVICE DELIVERY IN LOW PERFORMANCE PROVINCES, INNOVATIVE TRAINING PROGRAMS, AND SUPPORT (GENERALLY THROUGH INTERMEDIARIES) OF COMMUNITY-BASED DELIVERY SYSTEM. WILL ALSO TRY TO ASSIST IN STRENGTHENING/REFINING SELECTED ELEMENTS OF MFPP, SUCH AS LOGISTICS AND SUPPLY, SERVICE STATISTICS, AND BROADENING OF CONTRACEPTIVE SERVICES AVAILABLE BELOW DISTRICT LEVEL.

B. 1. REGARDING LONGER RUN (5-10 YEARS) INVOLVEMENT, USAID PLANS TO BASE THIS STRATEGY ON ASSESSMENT THAT WILL BE CARRIED OUT IN PREPARATION OF FY 82 PID. USAID WILL CONTINUE TO PLACE HIGH PRIORITY ON MAINTENANCE OF A STRONG AND EFFECTIVE FAMILY PLANNING SERVICE PROGRAM. WE HOPE TO BE ABLE, HOWEVER, TO GRADUALLY WITHDRAW FROM ROUTINE BUDGET SUPPORT AND TO FOCUS OUR ASSISTANCE ON SELECTED, INNOVATIVE ELEMENTS OF THE PROGRAM. IN THIS REGARD, THERE EXISTS CONSIDERABLE UNCERTAINTY ABOUT FUTURE CONTRACEPTIVE SUPPLIES. ANTICIPATE ADEQUATE SUPPLIES THROUGH 198, BUT BULK OF ORAL CONTRACEPTIVES AND OMPA BEING FUNDED THROUGH CIOA AND IBRD PROJECT LOANS AND FINAL DELIVERIES ARE SCHEDULED

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AIDAC

E.O. 12865: N/A
SUBJ: POPULATION PLANNING PROGRAM IN PAKISTAN

REF: STATE 083558

1. BACKGROUND: (A) PROGRAM DIRECTION: THE POPULATION PLANNING PROGRAM IN PAKISTAN WAS SUSPENDED DUE TO POLITICAL DISTURBANCES PRECEDING AND FOLLOWING THE GENERAL ELECTIONS OF JAN. 1977. AT THAT TIME, THE PROGRAM WAS BEING IMPLEMENTED AT THE FEDERAL LEVEL THROUGH THE POPULATION DIVISION (PD) UNDER THE DIRECTION OF A FEDERAL SECRETARY. PD WAS A SEPARATE DIVISION OF THE MINISTRY OF HEALTH, POPULATION AND SOCIAL WELFARE (HPSW). IN EARLY 1978, THE GOVERNMENT OF PAKISTAN (GOP) DECIDED TO MERGE THE POPULATION DIVISION INTO HEALTH DIVISION OF THE SAME MINISTRY. CONSEQUENTLY, PD LOST ITS DIVISIONAL STATUS AND WAS PLACED WITH THE HEALTH DIVISION UNDER THE DIRECTION OF HEALTH SECRETARY. THE RANK OF PD SENIOR PERSON WAS REDUCED FROM SECRETARY TO ADDITIONAL SECRETARY. IN EARLY 1980, PD WAS TAKEN OUT OF HPSW AND PLACED WITHIN THE PLANNING AND DEVELOPMENT DIVISION (PAHD) OF THE MINISTRY OF FINANCE, WHERE IT REMAINS.

(B) PROGRAM COMPONENTS: PRIOR TO THE JAN. 1977 SUSPENSION, THE PROGRAM HAD TWO MAJOR COMPONENTS: CONTINUOUS MOTIVATION SYSTEM (CMS) AND CONTRACEPTIVE INNOVATION PLAN (CIP). EVER SINCE 1977, GOP-APPOINTED COMMITTEES AND TASK FORCES HAVE PERFORMED INTENSIVE REVIEWS OF THE PROGRAM SO AS TO REORGANIZE IT AND MAKE IT MORE EFFECTIVE. PENDING FINALIZATION OF THE REORGANIZATION EFFORT, THE PROGRAM WAS PARTIALLY RESUMED IN JULY 1978. SINCE THEN THE PROGRAM HAS CONTINUED ON LOW KEY LEVEL. CMS AND CIP HAVE BEEN ABANDONED, PROGRAM PUBLICITY COMPLETELY BANNED FOR FEAR OF ADVERSE REACTIONS FROM RELIGIOUS LEADERS, AND THE ACTIVITIES LIMITED TO CONTRACEPTIVE DISTRIBUTION, CLINICAL SERVICES AND MINIMAL MOTIVATIONAL EFFORTS.

2. FOLLOWING ARE ANSWERS TO QUESTIONS RAISED IN PARAS 2 AND 6 OF REFTEL:

PARA 2 (A): RECENT ACTIONS: SIGNIFICANT GOP ACTIONS INCLUDE THE FOLLOWING:

(I) PLACEMENT OF PD WITHIN PAHD IS EXPECTED TO RESULT IN BETTER PROGRAM PLANNING AND COORDINATION WITH OTHER MINISTRIES AND DEPARTMENTS BUT ITS TRANSFER FROM THE HEALTH MINISTRY MAY COMPLICATE INTENDED MERGER OF POPULATION AND HEALTH SERVICES AT THE PROVINCIAL AND DISTRICT LEVELS. (GOP HAS NOT RESCINDED ITS PRIOR INSTRUCTIONS MAKING PROVINCIAL HEALTH DEPARTMENTS RESPONSIBLE FOR DELIVERY OF BOTH HEALTH AND POPULATION SERVICES.)

(II) APPOINTMENT OF DR. ATTIYA INAYATULLAH AS ADVISOR TO PRESIDENT ZIA ON POPULATION. THIS APPOINTMENT IS CONSIDERED A POSITIVE STEP. DR. ATTIYA INAYATULLAH HAS BEEN EXECUTIVE VICE PRESIDENT OF FAMILY PLANNING

ASSOCIATION OF PAKISTAN (FPAP) AND IS NOTED NATIONALLY AND INTERNATIONALLY FOR HER DYNAMISM, DEDICATION AND PROGRESSIVE VIEWS ON POPULATION PLANNING. WE EXPECT THAT SHE WILL SPEED UP THE REORGANIZATION EFFORTS AND INFLUENCE THE DIRECTION AND EMPHASIS OF THE PROGRAM. SHE WILL HOLD THE RANK OF A MINISTER OF STATE AND WILL HAVE DIRECT ACCESS TO PRESIDENT ZIA.

(III) DEFEDERALIZATION OF THE PROGRAM EFFECTIVE JULY 1, 1980. OPERATION OF THE POPULATION PROGRAM WILL BECOME THE RESPONSIBILITY OF RESPECTIVE PROVINCES. HOWEVER, GOP HAS NOT FINALIZED OPERATIONAL DETAILS AND SPECIFIC AREAS OF FEDERAL AND PROVINCIAL RESPONSIBILITIES. UNTIL THAT IS DONE, PROVINCES WILL NOT BE ABLE TO ASSUME OPERATIONAL RESPONSIBILITIES OF THE PROGRAM AND THE PROGRAM WILL REMAIN INLIMP. PARA 2 (C) - OTHER DONOR ASSISTANCE: UNTIL THREE YEARS AGO FEDERAL REPUBLIC OF GERMANY, UNITED KINGDOM, JAPAN, AUSTRALIA, SWEDEN, NORWAY, FORD FOUNDATION AND ASIA FOUNDATION DONATED FUNDS FOR THE PAKISTAN POPULATION PLANNING PROGRAM ON AN ANNUAL BASIS. NONE OF THESE DONORS HAVE COMMITTED ANY FUNDS SINCE THEN. IT APPEARS THAT UNFPA WILL BE THE ONLY DONOR WITH \$25 TO \$8 MILLION IN ASSISTANCE OVER A FOUR YEAR PERIOD STARTING IN 1980. PARA 6 - UNFPA EFFECTIVENESS: PRIOR UNFPA FUNDING TO PAKISTAN'S PROGRAM WAS ALMOST HALF OF THE ABOVE LEVEL, I.E. \$14 MILLION OVER A FOUR YEAR PERIOD. PRIOR UNFPA RESIDENT STAFF CONSISTED OF A COORDINATOR, A PROGRAM OFFICER, FINANCIAL ASSISTANT AND A SECRETARY. TO HANDLE THE INCREASED WORKLOAD, UNFPA HAS SO FAR HIRED ONLY TWO MORE EMPLOYEES, A PROGRAM OFFICER AND A SECRETARY. IN OUR OPINION, EXISTING UNFPA STAFF CANNOT EFFECTIVELY PLAN, MANAGE AND/OR MONITOR A \$25 TO \$8 MILLION ASSISTANCE. WE LEARNED THAT UNFPA IS TRYING TO EXPAND ITS STAFF FURTHER.

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UNCLAS KATHMANDU 2123

AIDAC

E. O. NOQWPTY: N/A
SUBJECT: U. S. POPULATION ASSISTANCE

REF: STATE 085558

1. USAID/N (CF 1982 CDSS) CONSIDERS RAPID POPULATION GROWTH TO BE TOP PRIORITY PROBLEM TO BE ADDRESSED IN AID ASSISTANCE TO NEPAL.

2. AT PRESENT TIME, USAID IS ASSISTING GON TO FOCUS ON MORE EFFECTIVE DELIVERY OF FAMILY PLANNING SERVICES AND UPON MEASURES TO STIMULATE DEMAND FOR FAMILY PLANNING. WE SEE A GRADUALLY INCREASING CAPACITY ON PART OF HMG TO ADDRESS THESE ISSUES. THE 6TH 5 YEAR PLAN WILL HAVE A CHAPTER ON POPULATION.

3. THE UNFPA (ON THE BASIS OF ITS 1979 "NEEDS ASSESSMENT REPORT") IS PLANNING A \$16 MILLION PROGRAM OF POPULATION ASSISTANCE OVER THE NEXT 3 YEARS. CLOSE COORDINATION BETWEEN USAID AND UNFPA ENSURES THAT PROJECTS IN FAMILY PLANNING, POPULATION POLICY, POPULATION EDUCATION, STATUS OF WOMEN, ET. AL. ARE COMPLEMENTARY AND MUTUALLY REINFORCING.

4. IBRD IS NOT PROVIDING POPULATION ASSISTANCE AT PRESENT.

5. WITH RESPECT TO REFTEL (2-C), USAID CONCURS WITH THE ASIA BUREAU POPULATION STRATEGY SECTION ON NEPAL. POPULATION STRATEGY MUST BE LONG RANGE IN VIEW OF THE HIGH RATE OF POPULATION GROWTH AT PRESENT AND THE PROSPECT FOR FURTHER DECREASES IN DEATH RATES PRIOR TO ANY WIDESPREAD LIMITATION OF FERTILITY. AID'S COMPARATIVE ADVANTAGE LIES IN THE APPLICATION OF U. S. TECHNOLOGY IN FP/MCH AREA AND APPLICATION OF RIGOROUS QUANTITATIVE EVALUATION TO PROGRAMS WHICH DIRECTLY OR INDIRECTLY IMPACT UPON FERTILITY.
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**INCOMING
TELEGRAM**

PAGE 01
ACTION AID-35

MANILA 07068 120053Z

3731 AID2033

ACTION OFFICE PDPR-01
INFO ASEM-J1 ASPT-01 ASDP-02 PPCE-01 PPPB-02 PPEA-01 PDC-02
ASPO-03 ASTR-01 AADS-01 DSHE-01 POP-04 CH8-01 PVC-02
HEW-04 OMB-02 RELO-01 STA-10 MAST-01 DO-01 /048 A2

INFO OCT-01 /036 W

-----041376 120200Z /34

P 110945Z APR 80
FM AMEMBASSY MANILA
TO SECSTATE WASHDC PRIORITY 8836

UNCLAS MANILA 07068

AIDAC

E. O. 120651N/A
SUBJECT: POPULATION

REFERENCE: STATE 85558

FOLLOWING RESPONSES KEYED TO REFTEL:

1. PARA 2. A&B
- DETAILED AND CURRENT INFORMATION CONTAINED IN MISSION
- MYP5 COMPLETED II/79. REFER PARTICULARLY TO PAGES
- 29 - 32 FOR U. S. STRATEGY, PAGES 19 - 20 FOR DISCUS-
- SION OF OTHER DONORS AND PAGES 13 - 18 FOR STRENGTHS
- AND WEAKNESSES OF CURRENT PROGRAM.
2. PARA 2. (C)
- GOP CURRENT FAMILY PLANNING PROGRAM CONSISTS OF
- EXTENSIVE CLINIC AND COMMUNITY OUTREACH FAMILY PLAN-
- NING DELIVERY AND STRONG DEMOGRAPHIC ANALYSIS THROUGH
- UNIVERSITY OF PHILIPPINES POPULATION INSTITUTE.
- COMMISSION ON POPULATION (POPCOM) DEVELOPING 5-YEAR
- POPULATION PLAN AND IN 1978 PRESIDENT MARCOS APPOINTED
- SPECIAL COMMITTEE TO REVIEW PHILIPPINE POPULATION
- PROGRAM TO RECOMMEND PROGRAM AND POLICY DIRECTIONS FOR
- NEXT FIVE YEARS. THESE DOCUMENTS SHOW CONSIDERABLE
- QUOTE READINESS UNQUOTE TO EXTEND AN ALREADY BROADLY
- CONCEIVED POPULATION PROGRAM. SEE PAGES 21 - 23 OF
- MYP5. GOP ABSORPTIVE CAPACITY LIMITED BY SOME PROB-
- LEMS OF ADMINISTRATION, MANAGEMENT AND LEADERSHIP AT
- POPCOM.
3. PARA 6.
- UNFPA, IBRD AND USAID HAVE CONSCIOUSLY AND CAREFULLY
- COORDINATED THEIR POPULATION PROGRAMS. GOP RELEASES OF
- FUNDS FOR PARTS OF IBRD LOANS I & II HAVE BEEN SLOW.
- IMPLEMENTATION IN SOME AREAS HAVE BEEN DELAYED; HOWEVER,
- PROGRAM HAS NOT BEEN SERIOUSLY AFFECTED. A RESIDENT
- IBRD POPULATION REPRESENTATIVE WOULD BE HELPFUL IN
- SOLVING IMPLEMENTATION PROBLEMS. 1980-84 UNFPA PROGRAM
- HAS BEEN SLOW STARTING DUE TO FAILURE OF GOP AND UNFPA/
- MANILA TO AGREE ON SOME PROCEDURES AND SUBACTIVITY
- ELEMENTS. MISSION FEELS THERE ARE NO MAJOR PROBLEMS
- THAT CANNOT BE WORKED OUT THIS YEAR. MURPHY

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PAGE 01 NEW DE 07189 101220Z
ACTION AID-35

0822 AID0560

ACTION OFFICE POP-03
INFO AAAS-01 ASEM-01 ASBI-01 ASOP-02 PPCE-01 PPPB-02 PPEA-01
ASPD-03 ASTR-01 AADS-01 DSHE-01 CH8-01 HEW-04 OMB-02
RELO-01 STA-10 MAST-01 POPR-01 /044 A4

INFO OCT-01 /036 W -----076422 101220Z /34

R 091156Z APR 80
FM AMEMBASSY NEW DELHI
TO SECSTATE WASHDC 8081

UNCLAS NEW DELHI 07189

AIDAC

E. O. 12065: N/A
SUBJECT: POPULATION

REFERENCE: STATE 085558

1. GOI IS GIVING HIGH PRIORITY TO POPULATION CONTROL. A WELL-ARTICULATED POPULATION POLICY HAS BEEN IN EXISTENCE FOR SEVERAL YEARS NOW. THE LONG TERM GOAL IS TO ACHIEVE AN NRR OF ONE BY THE YEAR 2000. THIS MEANS RAISING THE LEVEL OF CONTRACEPTIVE PREVALENCE FROM 22 PERCENT CURRENTLY TO 60 PERCENT. THE FAMILY PLANNING PROGRAM IS STILL RECOVERING FROM THE SETBACKS SUFFERED DURING THE EMERGENCY. HOWEVER, THE NEW GOVERNMENT IS COMMITTED TO POPULATION CONTROL AND MORE GOVERNMENTAL SUPPORT FOR THE PROGRAM CAN BE EXPECTED.

2. A NUMBER OF BILATERAL AND MULTILATERAL DONORS ARE CURRENTLY SUPPORTING THE PROGRAM. WORLD BANK, UNFPA, SIDA, DANIDA AND THE BRITISH ODM ARE FINANCING MULTIMILLION DOLLAR INTEGRATED POPULATION PROJECTS IN SELECTED DISTRICTS AND STATES UNDER THE GOI'S MODEL PLAN. THESE PROJECTS ARE COMPLEMENTARY AND INTENDED TO REDUCE FERTILITY (AND INFANT MORTALITY) OVER A WIDER GEOGRAPHIC AREA. BESIDES AREA SPECIFIC PROGRAMS, UNFPA IS ALSO FINANCING ACTIVITIES AIMED AT STRENGTHENING INSTITUTIONAL CAPABILITY. BOTH UNFPA AND WORLD BANK ARE LIKELY TO SUPPORT MORE AREA SPECIFIC PROGRAMS IN THE FUTURE. SUCH SUPPORT HAS BEEN EFFECTIVE AND WELCOMED BY THE GOI.

3. UNICEF HAS BEEN SUPPORTING NATIONAL LEVEL MCH PROGRAMS WHICH HAVE ELEMENTS OF POPULATION. NORAD (NORWAY) IS FINANCING FURTHER EXPANSION OF POSTPARTUM FAMILY PLANNING FACILITIES TO DISTRICT AND SUBDISTRICT HOSPITALS.

4. THE LONG TERM POPULATION GOAL OF THE GOI IS AMBITIOUS AND WILL REQUIRE CONTINUOUS EXTERNAL SUPPORT. CONSIDERABLE EXPERTISE EXISTS WITHIN THE COUNTRY IN THE AREAS OF POLICY DEVELOPMENT AND DEMOGRAPHIC ANALYSIS. HOWEVER, SUPPORT FOR EXPANDING AND STRENGTHENING EXISTING DELIVERY SERVICES WILL BE REQUIRED. THE MAJOR QUESTION IS HOW TO REACH THE COUPLES LIVING IN 380,000 VILLAGES OF THE COUNTRY.

5. USAID IS CURRENTLY ENGAGED NEGOTIATING A DOLLAR MILLION FIVE-YEAR INTEGRATED PROJECT COVERING 13 DISTRICTS IN FIVE STATES OF THE COUNTRY, ON THE SAME LINES AS THE WORLD BANK AND UNFPA PROJECTS. WE PERCEIVE NEED FOR FURTHER AREA SPECIFIC SUPPORT AND FOR STRENGTHENING INSTITUTIONAL CAPABILITIES, SUCH AS TRAINING, MANAGEMENT, ETC. FOR USAID/INDIA POPULATION STRATEGY, PLEASE SEE THE RECENT COUNTRY DEVELOPMENT STRATEGY STATEMENT FY 1982-86.
GOMEEN

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COLOMBIA

On the population priorities grid, Colombia is classified as having strong government commitment and a favorable social setting.

Explanation: Over the last 15 years, Colombia's growth rate has dropped dramatically from 3.4% to less than 2% in 1979. Today, contraceptive prevalence is nearly 50% of married women. Nevertheless, there remains approximately 25% of Colombian women of child-bearing age which have yet to be reached by family planning services, mainly in the Atlantic coast and rural areas.

Colombia has a favorable socio-economic environment. In order to achieve the government's goal of a population growth rate of 1% by the year 1985, much work needs to be done to stimulate the public sector and maintain the vigorous private sector program which to date has led the way with respect to the population problem. It appears that the socio-economic context will be favorable to family planning efforts. The Roman Catholic Church has not been vocal of late in its opposition to family planning. High levels of urbanization favor low cost delivery systems, and attitudes towards abortion have been changing as evidenced by a growing debate over legalization of abortion. The National Planning Ministry recognizes and monitors the multi-sectoral financial implications of population growth. With respect to administrative capacity to carry out population programs, there is a strong nucleus of trained personnel in both the public and private sector. The health infrastructure is in place and a strong national private family planning association, now providing nearly 1/3 of all services at the national level, stands ready to carry out innovative program activities. Strong in-country evaluation capabilities, such as the Regional Center for Population Studies and DANE are capable of providing management data for better program administration. Furthermore, a network of commercial outlets, i.e., drugstores and small shops, have already proven their ability to deliver family planning materials, and today are the number one provider of contraceptives in the country, providing 34.7% of the total contraceptive services.

Program options:

1. Train and capacitate the Ministry of Health (MOH) for this non-controversial activity to reach the large unmet demand in the rural areas where it appears the MOH, because of its health infrastructure, has a relative advantage.

2. Support the private sector to in turn train the MOH, set quality standards for all programs, and test innovative mechanisms to deliver family planning services: These innovative mechanisms must be

carefully evaluated because of the worldwide lack of experience in bringing the growth rate from 2% to 1%, a very different challenge from reducing it from 3% to 2%.

3. Challenge the commercial sector to further reduce costs of supplies so that more poor can participate.

In order to carry this program out in the absence of a bilateral A.I.D. program, intermediaries such as IPPF, FPIA and AVS, must be called upon. A.I.D. financed intermediaries with long successful experience in working with Colombian institutions on population problems need to continue their efforts.

On the public sector side, the UNFPA would seem to be the appropriate choice to work with the government except that Colombia is not one of the Funds priority countries and there already is evidence of a cut back in Fund support to high priority programs. The IDB and IBRD have no population activities in Colombia. Here again A.I.D. will have to rely heavily on intermediaries if the program challenge to reach a 1% growth rate by 1985 is not to suffer a setback. In summary, the Colombian program has and will continue to serve as a regional model of success. Our A.I.D. efforts through intermediaries in Mexico and Brazil follow a similar pattern of support through intermediaries. A.I.D.'s role as major donor to population activities in the LAC region is to provide assistance to these three priority countries which comprise about 60% of the region's population, until they reach self sufficiency in dealing with the problem sometime within this decade,

GUATEMALA

On the population priorities grid, Guatemala is classified as having a weak government commitment and a weak but increasingly favorable social setting. The population growth rate in Guatemala remains high, around 3%. Contraceptive prevalence is low at 18%, but has been moving up in recent years.

Various experts have indicated the difficult social context in which family planning operates in Guatemala. Although it is not a very large country, Guatemala's rugged mountain terrain makes transportation and communication difficult, and even impassible during the rainy season. At least half of the country's inhabitants are of Indian heritage, speaking various dialects, and remaining outside the mainstream of Guatemalan economic and social life. A general lack of confidence in government hinders delivery and utilization of services including family planning. Nevertheless, sensitive and effective private sector programs have been successfully mounted. On a national scale, this effort has met only approximately one-fourth of the total demand.

Against this difficult socio-economic background, grass-roots segments of the government are beginning to operate family planning programs effectively - in spite of lack of enthusiastic central government support which did not emerge until early 1980. The major block now appears to be the administrative capacity and financial commitment for the government to carry out a nation-wide program which can take advantage of an infrastructure of over 500 health centers. Meanwhile, APROFAM, the IPPF affiliate, continues to demonstrate its effectiveness to directly deliver information and services and provide assistance to the government and commercial sectors in the delivery of their family planning programs. The commercial and agro-business community have joined together with the help of APROFAM to lobby for provision of family planning services. Nevertheless, delivery of services to rural and indigenous populations will require forthright and forward looking efforts with the private sector leading the way.

Program Options: The future of A.I.D. bilateral population support should show an increase in resources to the government programs to provide core family planning services nation-wide. Currently, only A.I.D. directly supports family planning activities in the country. We expect that starting in 1980 the government will commit increasing levels of resources. At the same time, the private sector must reach out with forward looking programs adept at reaching the rural and indigenous population. Mechanisms developed to reach these harder to reach segments of the population may prove applicable to other sectors, such as education and health. Early efforts by APROFAM to deliver voluntary sterilization and community based projects have been successful, but more needs to be done. Furthermore, APROFAM should take a key role in training a critical mass of competent family planning workers.

A.I.D. and its direct intermediaries have a good track record of working in Guatemala in family planning which must be continued especially since innovative programs are required to reach the hard to reach segments of the population. A.I.D.'s strength in Guatemala is an example of its strength elsewhere in the development of innovative programs, led by population officers who find progressive elements in the society with which to work. On the other hand, UNFPA is negotiating a series of projects, mostly in maternal and child health with the government. But the MOH and the UNFPA both have much broader mandates than A.I.D. in population. Whereas A.I.D. support to the MOH has focussed on family planning and logistic programs, the UNFPA provides broader health care. Some family planning gains are expected from the UNFPA effort, albeit at a high cost. The IDB and IBRD have done nothing in population.

BOGOTA 3848 (LOU) not included in this appendix

TEGUCIGALPA 2273 (LOU) not included in this appendix

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PAGE 01 GEORGE 01655 240240Z
ACTION AID-35

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AN EFFECTIVE WINNING RELATIONSHIP WITH THE UN WE BELIEVE THE
GOG IS MORE LIKELY TO SEEK ANY ADDITIONAL INPUTS IT MAY DESIRE
FROM THE UN RATHER THAN FROM BILATERAL SOURCES.

ACTION OFFICE PDPR-01
INFO LAOP-01 LADR-03 CH6-01 PPCE-01 PPPB-02 GC-01 PPEA-01
GCLA-01 GCFL-01 FH-02 AADS-01 CMGT-02 DCHE-01 ED-01
POP-04 CH6-01 PVC-02 LACA-03 /030 A2

5. THE QUESTION OF COMPARATIVE ADVANTAGES OF AID BILATERAL
AND INTERMEDIARY ASSISTANCE AND THAT THE BANK OR MULTILATERAL
DONORS IS LARGELY ACADEMIC IN LIGHT OF CURRENT GOG POLICY AND
LIMITED NATURE OF EXISTING PROGRAM. THROUGH NO MAJOR POLICY
SHIFT IS ANTICIPATED, THERE SHOULD, AS IN MOST COUNTRIES, BE
SCOPE FOR INPUTS FROM BOTH GROUPS, SHOULD EXISTING CONSTRAINTS
EASE.

INFO OCT-01 /036 V

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ROBERTS

R 221855Z APR 80
FM AMEMBASSY GEORGETOWN
TO SECSTATE WASHDC 2285

UNCLAS GEORGETOWN 1855

AIDAC

E.O. 12065: NA
SUBJ: POPULATION - CURRENT AND FUTURE DONOR ROLE

REF: STATE 85538

1. CURRENT GOG POPULATION/FERTILITY CONTROL POLICY PERMITS
CHILD-SPACING ADVICE AND SERVICES THROUGH PRIVATE AND MINISTRY
OF HEALTH FACILITIES, AND ALSO DEMOGRAPHIC ANALYSIS AS UNDEER-
TAKEN IN THE FERTILITY SURVEY. USAID KNOWS OF NO GOG PLANS
TO UNDERTAKE ADDITIONAL POPULATION-RELATED ACTIVITIES.
2. DONOR SUPPLEMENTATION HAS NOT BEEN SOUGHT BY THE GOG. MODEST
INPUTS HAVE BEEN MADE SINCE 1975 BY BOTH MULTILATERAL
AND BILATERAL AGENCIES. UNFPA/UNDP INPUTS HAVE BEEN LIMITED
TO FINANCIAL SUPPORT OF AN ISI/WFS FERTILITY SURVEY CONDUCTED
IN 1975. IPPF HAS PROVIDED A SMALL ANNUAL GRANT SINCE 1975 IN
SUPPORT OF ITS GUYANA AFFILIATE, THE RESPONSIBLE PARENTHOOD
ASSOCIATION (RPA). RPA ACTIVITIES INCLUDE NO CLINICAL SERVICES
BUT FOCUS PRIMARILY ON INFORMATION, EDUCATION AND COM-
MUNICATION. CURRENT AND FUTURE INITIATIVES ARE DIRECTED
MAINLY TOWARD FAMILY LIFE EDUCATION AND COMMUNITY DEVELOPMENT.
IPPF THIS YEAR INCREASED ITS ANNUAL GRANT SUFFICIENTLY TO
ALLOW RPA TO HIRE A FULL-TIME IEC COORDINATOR. USAID HAS
PROVIDED FUNDS IN SUPPORT OF A SERIES OF NUTRITION
EDUCATION SEMINARS SPONSORED BY RPA, AND HAS ALSO ARRANGED IN-
PUTS OF CONTRACEPTIVES BY FPFA WHICH ARE CURRENTLY BEING MADE
AVAILABLE TO GOVERNMENT HEALTH FACILITIES FOR CHILD SPACING
PURPOSES. AS THE RPA IS A MEMBER OF THE CARIBBEAN PLANNED
PARENTHOOD AFFILIATION, IT IS A POTENTIAL BENEFICIARY OF THE
REGIONAL AID-PVO GRANT NOW UNDER NEGOTIATION THROUGH ROO/C.
USAID KNOWS OF NO COMMITMENTS OR PLANS FOR ESCALATION OF POP-
ULATION-RELATED ASSISTANCE FROM OTHER DONORS.
3. USAID BELIEVES ITS MOST APPROPRIATE ROLE IN POPULATION
ASSISTANCE TO GUYANA NOW AND IN THE FUTURE IS ONE OF CON-
TINUING SUPPORT OF CHILD-SPACING ACTIVITIES AS AN INTEGRAL PART
OF EXISTING BILATERAL PROJECTS. THROUGH THE RURAL HEALTH SYSTEMS
PROJECT, USAID IS SUPPORTING TRAINING OF BOTH MEDICAL AND COMMUNITY
HEALTH WORKERS IN RELEVANT POPULATION DYNAMICS AND METHODOLOGY
OF CHILD SPACING. EFFORTS WILL CONTINUE TO ESTABLISH A RE-
LATIONSHIP BETWEEN THE MCH AND FPFA WHEREBY ESSENTIAL SUPPLIES
AND MATERIALS, BOTH CLINICAL AND EDUCATIONAL, WILL BE AVAILABLE
THROUGH ALL MCH FACILITIES. USAID INTENDS TO REMAIN ALERT TO
OPPORTUNITIES FOR FURTHER SUPPORT OF SELECTED ACTIVITIES OF
RPA CONSIDERED APPROPRIATE, BUT SEES THE PROPOSED REGIONAL
PROJECT REFERRED TO IN 2 ABOVE, AND DEVELOPMENT ASSOCIATES,
INC., AS MORE PROMISING SOURCES OF LARGER SCALE ASSISTANCE IN
THE FUTURE.
4. IT IS OUR JUDGEMENT THAT CURRENT GOG POLICY MAKES INTRO-
DUCTION OF ANY NEW POPULATION-RELATED INITIATIVES UNLIKELY,
A POSSIBLE EXCEPTION MAY BE EXTENSION OF DEMOGRAPHIC ANALYSIS
INITIATED AS PART OF THE FERTILITY SURVEY. HAVING ESTABLISHED

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PAGE 01 KINGST 02637 120408Z 4278 AID2201
ACTION AID-35

ACTION OFFICE LACA-03
INFO LADP-01 LAOR-03 PPCE-01 PPPB-02 GC-01 PPEA-01 GCLA-01
GCFL-01 IA-01 IIA-02 IDCA-01 FM-02 AADS-01 OSNE-01
POP-04 CRB-01 NEW-05 OMB-02 RELO-01 NAST-01 POPR-01
/041 A4

INFO CCT-01 /036 W

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R 111350Z APR 88
FM AMEMBASSY KINGSTON
TO SECSTATE WASHDC 2225

UNCLAS KINGSTON 2637

AIDAC

E.O. 12065: NA
SUBJECT: POPULATION STUDY REQUESTED BY IDCA

REF: STATE 0855538

1. AID/W IS FAMILIAR WITH USAID'S MW7-389, 54-5346 JS 1945H
8, :S -,S 95034 19:7.3.3. THEREFORE, AS SUGGESTED IN REFTEL
PARA. 5, THERE IS LITTLE NEED FOR FURTHER ELABORATION OF
QUESTIONS RAISED IN PARA. 2. WE FEEL USAID MUST CONTINUE TO
PLAY THE LEAD ROLE IN POPULATION ASSISTANCE TO JAMAICA FOR SOME
YEARS TO COME IF THE COUNTRY IS TO ACHIEVE ITS POPULATION OBJEC-
TIVES. THIS IS PRIMARILY BECAUSE THERE ARE NO FEASIBLE SHORT-
TERM SOLUTIONS TO ARRESTING THE STEADY DETERIORATION OF THE
JAMAICAN ECONOMY, WHICH HAS BROUGHT WITH IT A SERIOUS WEAKENING
OF THE NATIONAL FAMILY PLANNING DELIVERY SYSTEM. MOREOVER, THE
ONLY OTHER ESTERNAI DIGNOR OF MAJOR SIGNIFICANCE IN THE POPULA-
TION FIELD, UNFPA, HAS NOW NEW FUNDS FOR POPULATION ASSISTANCE
THIS YEAR AND ITS FUTURE ROLE IS UNCERTAIN.

2. JAMAICA'S ABSORBITIVE CAPACITY AND "READINESS" FOR VARIOUS
TYPES OF POPULATION PROGRAMS IS SOMEWHAT LIMITED BY INADE-
QUATE NUMBERS OF CAPABLE MID-LEVEL MANAGERS AND TECHNICIANS
IN THE HEALTH SECTOR. NEVERTHELESS, JAMAICA HAS BEEN WILLING
TO MOVE FORWARD WITH NEW INITIATIVES IN VITAL NEW AREAS OF
POPULATION PROGRAM DEVELOPMENT SUCH AS ADOLESCENT FERTILITY
AND POPULATION POLICY DEVELOPMENT. THE BASIC OBSTACLE TO
SUCCESS OF THE JAMAICA PROGRAM IS POOR IMPLEMENTATION DUE
TO BUREAUCRATIC INDIFFERENCE AND MISMANAGEMENT FROM BOTH THE
MINISTRY OF HEALTH AND NATIONAL FAMILY PLANNING BOARD.

3. WITH RESPECT TO THE QUESTIONS RAISED IN REFTEL PARA. 5,
MISSION FEELS THAT BOTH BILATERAL AND INTERMEDIARY ASSISTANCE
ARE IMPORTANT TO THE SUCCESS OF THE JAMAICAN FAMILY PLANNING
PROGRAM. THE ADVANTAGE OF BILATERAL FUNDING IS THAT IT PLACES
THE MISSION IN A CLOSE COLLABORATIVE POSITION WITH THE GOJ,
PARTICULARLY WITH RESPECT TO PROJECT PLANNING, MANAGEMENT AND
EVALUATION. IT ALLOWS FOR REASONABLE FLEXIBILITY OF RESPONSE
TO CHANGING NEEDS AS THEY OCCUR, AND IT GIVES THE MISSION
ADDED LEVERAGE TO ENFORCE ADHERENCE TO MUTUALLY AGREED UPON
PROJECT GOALS AND OBJECTIVES, WHEN FOR ONE REASON OR ANOTHER
THEY ARE NOT BEING FULLY ADDRESSED BY THE GOJ. ON THE OTHER
HAND, INTERMEDIARY ASSISTANCE IS MOST USEFUL IN FUNDING ACTI-
VITIES NOT ORIGINALLY ANTICIPATED IN THE PROJECT PAPER, IN
FUNDING PROJECTS CARRIED OUT BY CERTAIN LOCAL PVO'S, IN
FUNDING PROJECTS STILL CONSIDERED SOMEWHAT CONTROVERSIAL OR
PERIPHERAL BY THE HOST GOVERNMENT, AND IN PROVIDING TECHNICAL
ASSISTANCE AND TRAINING NOT AVAILABLE LOCALLY. MISSION HAS
MADE EXTENSIVE USE OF PANA FOR A WIDE RANGE OF TECHNICAL ASSIS-
TANCE, AS WELL AS AVS, PIEGO, DEVELOPMENT ASSOCIATES AND
PATHFINDER FUND.

4. REGARDING QUESTION OF OTHER DONOR ASSISTANCE, THE ONLY

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EXTERNAL SOURCE OF NON-USAID SPONSORED ASSISTANCE OF ANY MAJOR
IMPORTANCE IS UNFPA. UNFPA FUNDS A WIDE RANGE OF POPULATION-
RELATED ACTIVITIES IN JAMAICA ABOUT WHICH AID/W IS FAMILIAR.
MANY OF THESE ACTIVITIES ARE CONCERNED WITH RESEARCH, DATA
COLLECTION, FAMILY LIFE EDUCATION, ETC. WHICH WHILE IMPORTANT ARE
SOMEWHAT OUT OF THE "MAINSTREAM" OF THE FAMILY PLANNING DELIVERY
SYSTEM. UNFPA'S DEPO-PROVERA DISTRIBUTION PROJECT IS, HOWEVER,
DEFINITELY WITHIN THE MAINSTREAM, ACCOUNTING FOR APPROXIMATELY 25
PERCENT OF ALL FAMILY PLANNING ACCEPTORS ENROLLED IN THE NATIONAL
FAMILY PLANNING PROGRAM. MISSION COLLABORATES CLOSELY WITH UNFPA
IN POPULATION PROGRAM DEVELOPMENT. FOR EXAMPLE, USAID BUYS THE
SYRINGES FOR DEPO-PROVERA PROVIDED BY UNFPA. USAID ARRANGED FOR
DUO-LAB CONSULTANTS TO INSTALL A SOFTWARE PACKAGE FOR A DEPT. OF
STATISTICS CENSUS PROGRAM TO BE FUNDED BY UNFPA, AND UNFPA
DEVELOPED A FAMILY LIFE EDUCATION PROJECT WITH THE MINISTRY OF
EDUCATION TO FOLLOW ON AND EXPAND A USAID-INITIATED FLE PROJECT.
MISSION IS CURRENTLY REVIEWING WITH UNFPA POSSIBLE EFFECTS ON OVERALL
JAMAICAN POPULATION PROGRAM OF AFOREMENTIONED UNFPA FUNDING
CUTBACKS.

5. THE IDB DOES NOT PROVIDE SUPPORT TO POPULATION PROGRAMS IN
JAMAICA. PAND, DOES NOT PROVIDE DIRECT SUPPORT TO JAMAICAN POPULA-
TION PROGRAMS, THOUGH PAND DOES PROVIDE VALUABLE SUPPORT (PRIN-
CIPALLY TECHNICAL ASSISTANCE AND TRAINING) TO THE PRIMARY HEALTH CARE
DELIVERY SYSTEM OF THE MOH THROUGH WHICH MOST JAMAICANS RECEIVE
FAMILY PLANNING SERVICES. FINALLY, THE IBRD HAS PROVIDED A
SUBSTANTIAL AMOUNT OF ASSISTANCE (8.8 MILLION DOLLARS) FOR TWO
"POPULATION" PROJECTS BETWEEN 1970 AND 1988. HOWEVER, THE WORD
"POPULATION" IN THESE PROJECTS IS LARGELY A EUPHEMISM, SINCE THE
VAST MAJORITY OF THE FUNDS WERE FOR FACILITIES CONSTRUCTION (ONE
HOSPITAL WING, 18 RURAL MATERNITY CENTERS AND 57 HEALTH CENTERS).
MOST OF THE POPULATION ELEMENTS OF THIS PROJECT (TRAINING,
EVALUATION, HEALTH INFORMATION SYSTEM DEVELOPMENT ETC.) WERE NOT
COMPLETED. IN FACT, USAID HAS AGREED TO FUND MOST OF THE COSTS
OF CERTAIN HIGH PRIORITY ACTIVITIES SUCH AS THE MOH'S POST PARTUM
FAMILY PLANNING SERVICES PROGRAM ORIGINALLY ENCOMPASSED UNDER THE
IBRD PROJECT.
LAWRENCE

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ACTION OFFICE POP-04
INFO LASA-03 LADP-01 LADR-03 CH8-01 PPCE-01 PPPB-02 PPEA-01
FM-02 AADS-01 DSHE-01 CH8-01 HEW-04 RELO-01 MAST-01
POPR-01 /033 AI

INFO OCT-01 OES-09 /045 W
-----I29424 170250Z /01

R 181600Z APR 80
FM AMEMBASSY LIMA
TO SECSTATE WASHDC 603

UNCLAS LIMA 3375

AIDAC

EO 12865: N/A
SUBJ: POPULATION POPULATION STRATEGY

REF: (A) STATE 083558; (B) STATE 080911, (C) LIMA 2549

1. MOST OF INFORMATION REQUESTED IS INCLUDED IN POPULATION STRATEGY POUCHED APRIL 18.

2. MISSION REAFFIRMS SERIOUS DEFICIENCY OF UNFPA PROJECT SUPPORT IN PERU. CLEAR RESPONSE RE: PROGRAM FUNDING WHICH HAS BEEN UNAVAILABLE FOR OVER SIX MONTHS WOULD BE DESIRED. MOH NOW REQUESTING USAID SUPPORT CONSULTANTS FUNDED UNDER PREVIOUS UNFPA PROJECT. UNFPA AND PAHO REP INCOUNTRY BOTH EXPRESS CONFUSION RE: DATE OF INITIATING FUNDING FOR CY 80.

3. RECORD OF UNFPA IN PERU HAS BEEN LIMITED BY MOH VACILLATION RE: POPULATION PROGRAM AND LACK OF DECENTRALIZED REGIONAL PROGRAMMING FOR IMPLEMENTING UNFPA PROJECT.

4. MISSION BELIEVES THAT UNFPA SHOULD FORTIFY ITS TECHNICAL ASSISTANCE IN PERU AND INITIATE PROGRAM SUPPORT FOR FAMILY PLANNING ACTIVITIES.
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**ACTION
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**INCOMING
TELEGRAM**

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INFO LACE-03 LAOP-01 LAOR-03 PPCE-01 PPPB-02 GC-01 PPEA-01
GCLA-01 GCFL-01 AADS-01 OSHE-01 POP-04 CH8-01 HEW-04
OMB-02 RELO-01 STA-10 MAST-01 /045 A4

INFO OCT-01 /036 W -----042987 120446Z /34

R 112218Z APR 80
FM AMEMBASSY PANAMA
TO SECSTATE WASHDC 8329

UNCLAS PANAMA 03236

AIDAC

E. O. 12065: N/A
SUBJECT: POPULATION: COMPARATIVE ADVANTAGE AID ASSISTANCE

REF: (A) STATE 85558, PARA 5

1. NEW FIVE-YEAR BILATERAL POPULATION II PROJECT EMPHASIZES FAMILY PLANNING ASSISTANCE TO MINISTRY OF HEALTH (MOH). AT SAME TIME, UNFPA HAS SIGNED AGREEMENT WITH MOH TO CONTINUE INTEGRATED MCH/FP PROGRAM INITIALLY SUPPORTED BY AID. MISSION BELIEVES PROJECTS ARE COMPLEMENTARY, ALLOWING UNFPA MULTILATERAL SUPPORT IN MCH/FP AND AID SUPPORT IN FP INFORMATION, MOTIVATION AND CONTRACEPTIVE SERVICES. REGULAR WEEKLY COORDINATION MEETINGS ARE HELD WITH AID, UNFPA AND MOH PARTICIPATION IN ORDER TO AVOID DUPLICATION OF EFFORT AND ASSURE MAXIMUM UTILIZATION OF AVAILABLE RESOURCES.
2. BILATERAL AGREEMENT ALSO PROMOTES FP THROUGH PRIVATE FAMILY PLANNING ASSOCIATION, (APLAFAP), COMPLEMENTING ACTIVITIES SUPPORTED BY IPPF AND OTHER AID CENTRALLY FUNDED INSTITUTIONS SUCH AS DEVELOPMENT ASSOCIATES.
3. ADDITIONAL SUPPORT FOR MOH FP CLINICAL ACTIVITIES PROVIDED BY AVS FOR ENDOSCOPIC EQUIPMENT RAM CENTER.
4. NEW INITIATIVES IN FP BEING DEVELOPED WITH LABOR UNIONS THROUGHOUT COUNTRY AND THE SOCIAL SECURITY AGENCY IN METROPOLITAN PANAMA CITY.
5. UNFPA WORKING CLOSELY WITH MINISTRY OF PLANNING TO DEVELOP POPULATION POLICY. MISSION PLANS TO COMPLEMENT THESE ACTIVITIES WITH CENTRALLY-FUNDED RAPID PROJECT.
6. BILATERAL AGREEMENT INCLUDES ACTIVITIES TO DEVELOP AND EXECUTE FAMILY LIFE/SEX EDUCATION THROUGH VARIOUS GOVERNMENT INSTITUTIONS: MINISTRY OF EDUCATION, NATIONAL DIRECTORATE FOR FAMILY AND CHILD MINISTRY OF LABOR, PANAMANIAN INSTITUTE FOR SPECIAL EDUCATION, MOH AND THE FPA ADOLESCENT CENTER.
7. AS EVIDENCED, PANAMA IS RECEPTIVE TO AND IS CURRENTLY USING BILATERAL AND MULTILATERAL ASSISTANCE FOR VARIOUS POPULATION/FAMILY PLANNING ACTIVITIES.
8. AT INSISTENCE OF THE PRESIDENT OF PANAMA, ARISTIDES ROYO, A SPECIAL NATIONAL COMMISSION IS PRESENTLY PREPARING A REPORT ON SITUATION OF FAMILY PLANNING AND RECOMMENDATIONS FOR FUTURE ACTIVITIES AND PROGRAMS. MISSION IS KEEPING ABREAST. MOSS

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INFO LAOP-01 LAOR-03 PPCE-01 PPPB-02 PPEA-01 AADS-01 OSHE-01
ED-01 ENGR-02 CHS-01 PVC-02 RELO-01 STA-18 HAST-01
LACA-03 PDPR-01 /036 A2

INFO OCT-01 /036 V

-----090451 291011Z /34

R 282048Z APR 88
FM AMEMBASSY PORT AU PRINCE
TO SECSTATE WASHDC 5885

UNCLAS PORT AU PRINCE 2881

AIDAC

E.O. 12865: N/A

SUBJECT: POPULATION ASSISTANCE IN HAITI

REF: STATE 88358

1. FOLLOWING ARE RESPONSES TO QUERIES IN REPTEL.

2. GON PROGRAM AND PLANS: HAITIAN DIVISION OF FAMILY HYGIENE (DNF) CURRENTLY PROVIDING MCH/FP SERVICES THROUGH RURAL DISPENSARY NETWORK. UNDER NEW USAID PROJECT 521-0091 SERVICE DELIVERY TO BE TAKEN OVER BY DEPARTMENT PUBLIC HEALTH, (DSPP). DNF PROGRAM WILL THEREFORE TURN TO LESS CLINIC-BASED, MORE INNOVATIVE MEANS FOR EXTENSION OF MCH/FP SERVICES TO RURAL POPULATION, ESPECIALLY THOSE NOT REACHED BY CLINIC/DISPENSARY SYSTEM. CURRENT AND PLANNED INITIATIVES INCLUDE DIRECT WORK WITH COMMUNITY ACTION GROUPS AS WELL AS PIGGYBACKING ON OTHER RURAL GON AND PVC ACTIVITIES. COMMERCIAL VENTURE ALSO PLANNED. DNF STAFF IS STRONG AND WELL MOTIVATED. POLICY HAS IN THE LAST YEAR BECOME MUCH MORE AGGRESSIVE, PARTICULARLY IN INFORMATION, EDUCATION, AND COMMUNICATION (IEC). (COPY OF RECENT DNF POLICY SPEECH POUCHED SEPARATELY TO BRACKETT, LA/DR/POP). DNF FUTURE PLANNING IS REALISTIC WITHOUT BEING TIMID. CAPABILITY TO IMPLEMENT PLANS IS HIGHLY DEPENDENT ON EXTERNAL DONOR SUPPORT FROM UNFPA AND USAID SINCE GON PROVIDES ONLY LIMITED FINANCIAL SUPPORT AT PRESENT. SUPPORT FOR THE IDEA OF FAMILY PLANNING IS NEVERTHELESS STRONG. NEGOTIATIONS CURRENTLY UNDERWAY TO ENCOURAGE GREATER GON FINANCIAL SUPPORT.

3. OTHER DONOR PROGRAMS: (A) UNFPA IS EARLIEST AND LARGEST SUPPORTER OF POPULATION ACTIVITIES IN HAITI. USAID'S CLOSE COORDINATION WITH UNFPA PROGRAM ASSURES COMPLEMENTARITY OF PROGRAMS. THIS COORDINATION HAS RESULTED IN UNFPA SUPPORT BEING PRIMARILY CONCENTRATED AT CENTRAL LEVEL WHILE USAID SUPPORTS RURAL ACTIVITIES. SINCE ARRIVAL OF PERMANENT UNFPA RESIDENT REPRESENTATIVE IN SEPTEMBER 1979, PROGRAM IMPLEMENTATION AND COMMUNICATION HAS IMPROVED. HE IS NOW REVISING NEW UNFPA PROJECT (COPY POUCHED TO BRACKETT, LA/DR/POP) FOLLOWING RECENT DISCUSSIONS IN NEW YORK. WE ARE WORKING CLOSELY WITH HIM IN THIS REVIEW TO ACHIEVE MAXIMUM EFFECT OF OUR JOINT EFFORTS. (B) PAHO WHICH FORMERLY PROVIDED TECHNICAL ASSISTANCE IN MCH/FP AND CURRENTLY PROVIDING SUPPORT IN ADMINISTRATION. THIS ACTIVITY HAS HAD LIMITED SUCCESS SINCE DNF GENERALLY RESENTS FOREIGN ADVISORS WITH BROAD RESPONSIBILITIES WORKING WITHIN THE DNF ITSELF. THIS IS IN PART DUE TO POOR QUALITY OF PAHO ADVISORS IN THE PAST. (C) IPPF WILL BEGIN TESTING COMMERCIAL DISTRIBUTION PROGRAM HERE THIS SUMMER. (D) OTHER ACTIVITIES AT DNF ARE SUPPORTED BY AID-CENTRALLY FUNDED INTERMEDIARIES (SUCH AS DAI, JHP/IGO, IPAYS, ABTELLE, PIA) AND COORDINATED THROUGH USAID POPULATION OFFICER. IN ADDITION, DNF STAFF READILY IDENTIFIED NEEDS FOR OUTSIDE SUPPORT AND IS CAPABLE OF SELECTING AND COORDINATING THEIR ACTIVITIES TO FULFILL THOSE NEEDS.

4. FUTURE USAID ROLE: (A) POPULATION ASSISTANCE SHOULD CONTINUE TO INCLUDE COMMODITIES BUT AT LEVELS THAT ARE REALISTIC AND CONSISTENT WITH ANTICIPATED GROWTH OF OVERALL NEEDS. (B) WE RECOGNIZE THAT NEW DNF PROGRAM OF INNOVATIVE NON-CLINIC BASED SERVICE DELIVERY IS A LABOR-INTENSIVE PROCESS AND ONE WHICH, BECAUSE OF ITS EXPERIMENTAL NATURE, MAY NOT IMMEDIATELY SHOW A DRAMATIC INCREASE IN THE NUMBER ACCEPTORS. HOWEVER, WITH THESE NEW DIRECTIONS DNF IS TRYING TO BUILD WIDE POPULAR SUPPORT FOR FAMILY PLANNING BY CHANGING ATTITUDES AT BOTH THE POLICY AND THE COMMUNITY LEVEL WHILE CONTINUING TO EXPAND ACCESS TO SERVICES. THIS STRATEGY SHOULD BUILD A STRONG BASE FOR ACCEPTANCE IN THE MEDIUM TERM (SEE DNF POLICY SPEECH, P. 11). SOME OF THESE INNOVATIVE APPROACHES MAY APPROPRIATELY BE SUPPORTED AS OPERATIONS RESEARCH. EXTERNAL SUPPORT FOR INNOVATION AND EXPLORATION OF NEW MODES OF SERVICE DELIVERY IS CRITICAL SINCE IT PROVIDES THE NECESSARY SECURITY AGAINST THE RISKS OF INNOVATION. HOWEVER, IN THE HAITIAN SETTING, PATIENCE IS CRUCIAL. (C) TECHNICAL ASSISTANCE MAY BE REQUIRED IN THE FORM OF SHORT-TERM CONSULTANTS TO ADDRESS PARTICULAR PROBLEMS. LONG-TERM TECHNICAL ASSISTANCE IS UNLIKELY TO BE ACCEPTED BY THE DNF, GIVEN PRIOR EXPERIENCE WITH PAHO (SEE PARA 3B), EXCEPT IN AREAS OF SPECIFIC

REQUIREMENTS, E.G. ADVISORY SERVICES UNDER COLUMBIA CONTRACT FOR COMMUNITY BASED DISTRIBUTION. (D) ABSORPTIVE CAPACITY WILL DEPEND IN PART ON INCREASING FINANCIAL SUPPORT TO DNF FROM GON. STAFF AT DNF IS ADEQUATELY TRAINED IN MOST AREAS ALTHOUGH SHORT-TERM TECHNICAL ASSISTANCE IS OCCASIONALLY REQUIRED TO RESOLVE SPECIFIC PROBLEMS. ONE AREA OF WEAKNESS IS DEMOGRAPHIC AND STATISTICAL TECHNIQUES WHERE SOME TRAINING MAY BE NECESSARY TO AUGMENT ABSORPTIVE CAPACITY. IDENTIFICATION OF APPROPRIATE TRAINING IS OFTEN PROBLEMATIC SINCE MOST POTENTIAL TRAINEES SPEAK ONLY FRENCH. (E) POLICY DEVELOPMENT AT DNF LEVEL IS GOOD. DNF CURRENTLY PUTH, 043743 9, 500 -, 5 430 (94 9-938 09) 0:6 - 23) - 443-534 (8, -, :8-) -, 5 -5.8, 854-58; 3 788945. (SEE DNF POLICY SPEECH, P. 13).

5. GENERAL COMMENTS: (A) USAID'S COMPARATIVE ADVANTAGE LIES, FIRST, IN PRESENCE OF USAID STAFF WELL VERSED IN POPULATION MATTERS. SECOND, WE ARE ABLE TO CALL ON A VARIETY OF CENTRALLY-FUNDED INTERMEDIARIES WHO CAN RESPOND QUICKLY TO SPECIFIC NEEDS IDENTIFIED IN THE FIELD. THIS ENHANCES OUR IMPACT AND PROVIDES FLEXIBILITY IN RESPONDING TO DNF REQUESTS. THIRD, BECAUSE USAID IS USUALLY INVOLVED IN ALL SECTORS OF DEVELOPMENT, THE USAID POPULATION OFFICER IS BETTER ABLE TO IDENTIFY POTENTIAL INTERVENTIONS AND OPPORTUNITIES FOR COOPERATION IN OTHER SECTORS, SUCH AS EDUCATION, AGRICULTURE, AND COMMUNITY DEVELOPMENT. (B) DNF STAFF IS BASICALLY A CAPABLE GROUP OF DEDICATED PROFESSIONALS WHO SHOULD BE SUPPORTED IN BOTH POLICY AND PROGRAM AREAS. IMPOSITION OF IDEAS OR STRATEGIES FROM OUTSIDE IS LESS SUCCESSFUL THAN RESPONDING TO DNF PROPOSALS. OBSERVATION VISITS BY DNF STAFF TO OTHER DEVELOPING COUNTRIES HAVE PROVED EXTREMELY USEFUL IN ENCOURAGING INNOVATIVE THINKING AND ADAPTATION OF IDEAS TO HAITIAN SITUATION. (C) MEASURING PROGRAM SUCCESS ONLY IN TERMS OF ACCEPTORS UNDERESTIMATES IMPACT OF PROGRAM ON CHANGING ATTITUDES. (D) CONTINUING CLOSE COORDINATION AMONG MAJOR DONORS WILL ASSURE COMPLEMENTARITY.

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ACTION AIO-35

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INFO LACE-03 LAOP-01 LAOR-03 PPCE-01 PPPB-02 PPEA-01 AADS-01
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RELO-01 STA-10 MAST-01 LACA-03 /049 A3

INFO GCT-01 /036 W

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P 171830Z APR 80
FM AMEMBASSY SAN SALVADOR
TO SECSTATE WASHDC PRIORITY 0898

UNCLAS SECTION 1 OF 2 SAN SALVADOR 2787

AIDAC

E.O. 12065: N/A
SUBJECT: POPULATION: IOGA STUDY

REF: STATE 085558

1. TINY EL SALVADOR IS AN ENigma FROM A DEMOGRAPHIC POINT OF VIEW. UNLIKE OTHER LATIN COUNTRIES WHERE BIRTH RATES ARE FALLING RAPIDLY SUCH AS MEXICO, THE DOMINICAN REPUBLIC, COLOMBIA, AND COSTA RICA THE NATIONAL BIRTH RATE IN EL SALVADOR HAS REMAINED STABLE DURING THE PAST TEN YEARS AT 41 PER THOUSAND POPULATION, ALTHOUGH A MARKED DECLINE IS UNDERWAY IN THE CAPITAL CITY. DENSITY IS THE HIGHEST ON THE CONTINENTAL MAINLAND, FOUR TIMES HIGHER THAN GUATEMALA. THE NEXT MOST DENSELY POPULATED COUNTRY. THIS MOUNTING DEMOGRAPHIC PRESSURE AND THE PIONEER EFFORTS OF CONCERNED CITIZENS STIMULATED THE CREATION OF ORGANIZED FAMILY PLANNING PROGRAMS IN THE LATE 1960'S AND THE ADOPTION OF AN OFFICIAL GOVERNMENT POLICY IN 1974. ONLY COLOMBIA AND THE DOMINICAN REPUBLIC HAD PREVIOUSLY DISCLOSED SUCH POLICIES. ON PAPER THE GOES' POPULATION POLICY IS EXCELLENT SINCE IT CREATES A CABINET-LEVEL POPULATION COMMISSION, ADDRESSES PROBLEMS ASSOCIATED WITH ACCELERATED POPULATION GROWTH, AND STATES THAT THE GOVERNMENT WILL MOVE TO MODIFY SUCH GROWTH, AND STATES THAT THE GOVERNMENT WILL MOVE TO MODIFY SUCH GROWTH. IN ORDER TO STRENGTHEN THE

IMPLEMENTATION OF THE POLICY, THE GOES ISSUED A PRESIDENTIAL DECREE IN LATE 1977 CREATING A TECHNICAL SECRETARIAT TO ADVISE THE COMMISSION

HOWEVER, THE COMMISSION MET ONLY THREE TIMES BETWEEN 1974-1977, AND HAS NOT MET SINCE 1977. FURTHERMORE, DESPITE FREQUENT MEETINGS OF THE TECHNICAL SECRETARIAT WITH REPRESENTATIVES OF OTHER GOVERNMENT MINISTRIES AND THE LOCAL FAMILY PLANNING ASSOCIATION SOME HAVE CHARACTERIZED IT AS MORE OF AN OBSTACLE THAN A FACILITATOR TO EFFECTIVE ACTION IN POPULATION.

2. USAID BELIEVES THAT THERE ARE THREE PRINCIPAL REASONS WHY THE BIRTH

RATE HAS NOT FALLEN IN EL SALVADOR AFTER OVER TWELVE YEARS OF ORGANIZED FAMILY PLANNING PROGRAMS. FIRST, MANY PEOPLE IN GOVERNMENT GIVE ONLY LIP SERVICE TO POPULATION/FAMILY PLANNING MATTERS, AND THE GOES HAS YET TO DEMONSTRATE THE URGENCY AND COMMITMENT TO RESOLVE ITS DEMOGRAPHIC PROBLEM. AT PRESENT THE GOES PAYS THE SALARY OF ONLY ONE PERSON WHO WORKS FULL-TIME IN P/FP AT THE MINISTRY OF PLANNING ALTHOUGH THAT MINISTRY, ACCORDING TO ITS PRO-AG WITH AID, IS OBLIGATED TO ABSORB

SALARIES OF 4 AID FUNDED EMPLOYEES IN P/FP LATER THIS FY. AT THE MINISTRY OF HEALTH, WHICH ADVOCATES INTEGRATION OF FAMILY PLANNING SERVICES WITH THOSE OF MATERNAL-CHILD HEALTH, NO EMPLOYEE IS ASSIGNED FULL-TIME TO P/FP ALONE. AT THE MINISTRIES OF EDUCATION AND AGRICULTURE ALMOST NOTHING IS BEING DONE IN P/FP. THE POPULATION POLICY HAS TURNED OUT TO BE A PAPER TIGER.

A SECOND REASON WHY THE BIRTH RATE CONTINUES HIGH IS BECAUSE FAMILY PLANNING SERVICES HAVE NOT BEEN FULLY AVAILABLE AT LOW OR NO COST

SAN SA 02767 01 OF 02 180744Z 5938 A101410
TO THE RURAL POPULATIONS. SERVICES HAVE BEEN LIMITED TO A CLINIC SETTING (EXCEPT FOR A SMALL PILOT COMMUNITY-BASED DISTRIBUTION PROJECT

WITH THE COTTON GROWER'S ASSOCIATION) IN APPROXIMATELY 250 MINISTRY OF HEALTH CLINICS, 35 SOCIAL SECURITY INSTITUTE CLINICS, AND 3 FAMILY PLANNING ASSOCIATION CLINICS. THE P/FP MASS MEDIA CAMPAIGN HAS REA-

CHED EVERY NOOK AND CRANNY OF THE COUNTRY, BUT CONTRACEPTIVES ARE STILL

NOT READILY AVAILABLE IN RURAL AREAS. (IN THE RECENT CONTRACEPTIVE PREVALENCE SURVEY CARRIED OUT BY CDC AND THE SALVADORAN DEMOGRAPHIC ASSOCIATION, 5.7 PERCENT OF THE RURAL WOMEN SURVEYED CITED LACK OF SERVICES AS THEIR REASON FOR NOT USING CONTRACEPTION.) THE SDA PLANS TO OVERCOME THIS BY PROGRESSIVELY IMPLEMENTING CBO IN OVER 2,000 COMMUNITIES WITH FY 80 AID BILATERAL FUNDING.

A THIRD FACTOR, ESPECIALLY RELATED TO RURAL AREA BIRTH RATES, ARE CONTINUING OBJECTIONS TO ACCEPTANCE OF FAMILY PLANNING. IN THE SAME RANDOM SAMPLE SURVEY MENTIONED ABOVE, 18.3 PERCENT OF RURAL WOMEN NOT USING CONTRACEPTION BUT NOT WANTING ANOTHER CHILD, CITED SPOUSAL OBJECTIONS OR RELIGIOUS REASONS FOR THEIR NON-USE OF SERVICES; 12.3 PERCENT CITED FEAR OF CONTRACEPTION OR OF SIDE EFFECTS AND 12.6 PERCENT STATED THEY QUOTE DID NOT WANT TO USE CONTRACEPTION OR DID NOT LIKE IT UNQUOTE WITHOUT BEING MORE SPECIFIC. THE NEED TO OVERCOME SUCH OBJECTIONS LIES AT THE ROOT OF EFFORTS OF PARTS OF THE GOES TO INVOLVE A WIDE SPECTRUM OF GOES MINISTRIES IN A MOTIVATIONAL CAMPAIGN IN SUPPLEMENT TO FAMILY PLANNING AS A PART OF OUTREACH WORKERS TASKS IN RURAL AREAS.

3. THE POLICY OF EXTERNAL DONORS, SPECIALLY THE UNFPA, IN POPULATION IN EL SALVADOR IS CONTROVERSIAL, EVEN WITHIN THE USAID. THE UNFPA HAS FOR SEVERAL YEARS SUPPORTED THE NOW INTEGRATED MCH/FP PROGRAM AND HAS JUST APPROVED A NEW FOUR-YEAR \$3 MILLION GRANT TO THE MINISTRY OF HEALTH. A MAJORITY OF THESE RESOURCES AS WELL WILL SUPPORT INTEGRATED MCH/FAMILY PLANNING ACTIVITIES. ALTHOUGH THIS PERMITS THE MINISTRY

TO EXPAND ITS TOTAL COVERAGE OF THE MCH/FP TARGET GROUP, THIS LIBERAL POLICY HAS THE COUNTER-PRODUCTIVE IMPACT OF DIVERTING BOTH ATTENTION AND POPULATION RESOURCES FROM THE COUNTRY'S POPULATION PROBLEM.

4. CURRENTLY, THERE IS A NEW FIVE-MAN CIVILIAN-MILITARY GOVERNMENT. THE

MISSION HAS BEEN INFORMED BY THE PRESIDENT AND EXECUTIVE DIRECTOR OF THE FAMILY PLANNING ASSOCIATION, WHO HAVE MET WITH FOUR OF THE FIVE MEMBERS OF THE JUNTA, THAT THEY PLAN TO GIVE P/FP MATTERS PRIORITY. THE MINISTER OF HEALTH HAS CALLED FOR AN EVALUATION OF THE FP PROGRAM, AND HAS SAID HE WILL SET UP A SPECIALIZED OFFICE IN THE MINISTRY TO DEAL WITH FAMILY PLANNING. THERE IS ALSO DISCUSSION OF RESTRUCTURING THE POPULATION TECHNICAL SECRETARIAT AT THE MINISTRY OF PLANNING. A RECENT WORLD BANK STUDY OF P/FP IN EL SALVADOR STATED QUOTE A KEY OBSERVATION OF THE REPORT IS THAT THE FERTILITY DECLINE, ALREADY OBSERVED IN RECENT DEMOGRAPHIC INDICATORS CAN BE ENCOURAGED INTO A MORE RAPID DESCENT BY THE ACTIVE COMMITMENT AND INTERVENTION OF THE GOEV. CHIEF AMONG THE INTERVENTIONS THAT THE PUBLIC SECTOR MAY MORE ACTIVELY PURSUE IS A WELL-CONCEIVED, DIRECTEDLY PROPERLY IMPLEMENTED FAMILY PLANNING PROGRAM. UNQUOTE, TIME WILL TELL IF THE CURRENT GOVERNMENT WILL PROVIDE SUFFICIENT POLITICAL SUPPORT AND COMMITMENT TO AMOUNT AN EFFECTIVE NATIONWIDE P/FP PROGRAM. IN ANY CASE, IN VIEW OF THE INSTABILITY AND SENSITIVITIES OF GOVERNMENT CONFRONTING A DIFFICULT POLITICAL SITUATION, THE MISSION PLANS TO PROVIDE INCREASED FUNDING TO THE PRIVATE FAMILY PLANNING ASSOCIATION FOR COMMUNITY-BASED DISTRIBUTION OF CONTRACEPTIVES, MASS MEDIA, AND PERSON-TO-PERSON COMMUNICATION.

5. THE MAJOR EXTERNAL DONORS FOR P/FP IN EL SALVADOR ARE USAID, THE UNFPA, THE INTERNATIONAL PLANNED PARENTHOOD FEDERATION, AND THE ASSOCIATION FOR VOLUNTARY STERILIZATION. PROVIDING SMALLER AMOUNTS OF FUNDING, BUT CRITICALLY IMPORTANT TECHNICAL ASSISTANCE ARE THE CENTER FOR DISEASE CONTROL, THE UNIVERSITIES OF CHICAGO AND JOHNS HOPKINGS, DEVELOPMENT ASSOCIATES, AND THE INTERNATIONAL FERTILITY RESEARCH PROGRAM. IN LATE 1978 THE WORLD BANK SENT AN ASSESSMENT TEAM TO EL

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SALVADOR, WHICH PRODUCED A SPECIAL REPORT TITLED DEMOGRAPHIC ISSUES
AND PROSPECTS OF EL SALVADOR.,

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INFO AAAF-01 AFEA-03 AFSA-03 AFRA-03 AFFW-04 AFCW-03 AFDR-06
 AFCA-03 AAAS-01 ASEM-01 ASPT-01 ASBI-01 ASPN-01 ASDP-02
 AALA-01 LACE-03 LASA-03 LADP-01 PPCE-01 PPEM-01 PPPB-02
 PPEA-01 ASPD-03 CH8-01 MAST-01 ASSP-02 LACA-03 DO-01
 AFDA-01 /059 A3

INFO OCT-01 /036 W

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R 032018Z APR 80
FM ANEMBASSY SANTIAGO
TO SECSTATE WASHDC 6671

UNCLAS SANTIAGO 2088

AIDAC

E. O. 12065: N/A

TAGS:

SUBJ: POPULATION ASSISTANCE FOR LDGS

REF: STATE 085558

USAID/CHILE HAS NOT FUNDED POPULATION ACTIVITIES SINCE FY 1972.
IN VIEW OF MISSION PHASE OUT AND THE FACT THAT CHILE'S BIRTH
RATE CONTINUES TO BE ONE OF THE LOWEST IN LATIN AMERICA WE DO
NOT FORESEE ANY ACTIVE ROLE FOR USAID IN THE POPULATION FIELD.
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INFO AALA-01 LADP-01 LADR-03 PPCE-01 PPPB-02 GC-01 PPEA-01
GCLA-01 GCFI-01 IA-01 IIA-02 POC-02 AADS-01 OSNE-01
POP-04 IT-06 CWB-01 PYC-02 ES-01 CIA-05 NEW-09 NUO-02
NSC-05 OHW-02 RELO-01 MAST-01 LACA-03 /062 A

INFO OCT-01 /038 W

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O 101700Z APR 80
FM AMEMBASSY SANTO DOMINGO
TO SECSTATE WASHDC IMMEDIATE 3771

UNCLAS SANTO DOMINGO 2476

AIDAG

E.O. 12865: N/A
SUBJECT: POPULATION PROGRAMS

REF STATE 85558

1. FOLLOWING IS OUR RESPONSE TO REFTEL. BROWNLETTER TO MISSION DIRECTOR HAS NOT ARRIVED AT POST. HOPEFULLY, FOLLOWING INFORMATION WILL MEET YOUR NEEDS.

2. THE QUESTION OF A BILATERAL POPULATION PROGRAM IN THE DOMINICAN REPUBLIC HAS BEEN ADDRESSED IN OUR CDSS REVIEW. IN SHORT, THE GOOR HAS SPECIFICALLY STATED THAT THEY DO NOT DESIRE, NOR SEE THE NEED FOR A BILATERAL POPULATION PROGRAM. THE GOOR CREATED THE NATIONAL COUNCIL ON POPULATION AND FAMILY (CONAPOFA) IN 1962, TO DESIGN A NATIONAL POPULATION PROGRAM AND COORDINATE ALL EFFORTS IN THIS FIELD. OVER THE LAST 12 YEARS CONAPOFA, AND ITS MEMBER INSTITUTIONS, HAS PUT TOGETHER A NATIONAL FAMILY PLANNING PROGRAM WHICH PROVIDES SERVICES THROUGHOUT MOST OF THE DOMINICAN REPUBLIC. KNOWLEDGE OF FAMILY PLANNING APPEARS TO BE INCREASING AND THE DEMAND FOR SERVICES IS HIGH.

3. TO DATE MOST OF THE OTHER DONOR ASSISTANCE HAS COME FROM THE UNFPA PROJECT WORKING THROUGH CONAPOFA, THESE FUNDS HAVE BEEN WELL USED FOR THE PURCHASE OF EQUIPMENT FOR FAMILY PLANNING CLINICS, TRAINING AND AUDIO VISUAL MATERIALS AND, MOST IMPORTANT, TO COVER THE COST OF FEMALE STERILIZATIONS AT PUBLIC AND PRIVATE CLINICS (PATHFINDER HAS ALSO PROVIDED FUNDS FOR FEMALE STERILIZATIONS). THIS PROGRAM HAS BEEN FAIRLY SUCCESSFUL AND HAS DEMONSTRATED THE DEMAND FOR PERMANENT METHODS IN THIS COUNTRY. WE BELIEVE THAT AN INCREASE IN FUNDING FOR THIS PROGRAM WILL EVENTUALLY HAVE AN IMPORTANT EFFECT ON THE BIRTH RATE.

4. THE WORLD BANK IS CURRENTLY IMPLEMENTING A \$5 MILLION LOAN SIGNED IN SEPT 76. THE LOAN IS ALLEGEDLY A POPULATION AND FAMILY HEALTH PROJECT BUT IN REALITY LESS THAN \$300,000 WAS BUDGETED FOR DIRECT FAMILY PLANNING PURPOSES. OUR IMPRESSION IS THAT THIS PROJECT HAS NOT BEEN TERRIBLY SUCCESSFUL IN THE AREA OF FAMILY PLANNING.

5. IFRE IS ACTIVE IN THE DOMINICAN REPUBLIC THROUGH ITS PROJECT WITH A PRIVATE FOUNDATION, DOMINICAN ASSOCIATION FOR FAMILY WELFARE (ADPF). THIS PROJECT HAS HAD INCREASING SUCCESS IN ITS EDUCATIONAL AND MOTIVATIONAL CAMPAIGNS, AS WELL AS INITIATING A COMMUNITY BASED DISTRIBUTION SYSTEM FOR CONTRACEPTIVES. THESE PROGRAMS SHOULD BE CONTINUED AT HIGHER FUNDING LEVELS. 11

6. AS DISCUSSED IN OUR CDSS REVIEW THE PRESENT DOMINICAN FAMILY PLANNING PROGRAM IS WORKING WELL AND EXPANDING. HOWEVER, MUCH OF THIS EXPANSION IS BEING FINANCED BY THE UNFPA, IPPF AND OTHER INTERMEDIARIES. WHAT APPEARS TO BE LACKING IS A NATIONAL LONG TERM PLAN WHICH SETS ATTAINABLE GOALS AND TARGETS FOR THE VARIOUS

DOMINICAN PUBLIC AND PRIVATE INSTITUTIONS WORKING IN THIS FIELD. IN RECENT DISCUSSIONS WITH CONAPOFA AND SESPAS PERSONNEL, THE NEED TO DEVELOP LONG TERM PLANS WAS DISCUSSED AND CONAPOFA IS ATTEMPTING TO SET UP A MEETING OF THE NATIONAL COUNCIL TO DEVELOP A FIRST DRAFT OF A FIVE-YEAR PLAN. SESPAS PERSONNEL INFORMED THE MISSION THAT IBRD HAS JUST THIS WEEK SUGGESTED THIS SAME COURSE OF ACTION.

7. OUR BEST JUDGEMENT, CONCURRED IN, WE BELIEVE, IN OUR CDSS REVIEW, IS THAT AID SHOULD CONTINUE TO SUPPORT GOOR POPULATION ACTIVITIES THROUGH UNFPA AND AID FUNDED INTERMEDIARIES SUCH AS POP COUNCIL, IPPF, PATHFINDER, ETC., ALBIET AT HIGHER LEVELS.

THE MISSION PLANS TO FOLLOW-UP ON THE NEED TO DEVELOP A LONG TERM NATIONAL PLAN, HOPEFULLY INVOLVING PUBLIC AS WELL AS PRIVATE INSTITUTIONS. CONAPOFA STATED THAT ONCE THE FIRST DRAFT IS FINISHED, THEY WOULD APPRECIATE ASSISTANCE FROM AID IN REVIEWING THE PLAN BEFORE FURTHER WORK IS DONE. THUS, WHILE THE GOOR IS CLEARLY INTERESTED IN IMPROVING ITS OWN PROGRAMS AND IN BETTER UTILIZING THE USE OF INTERMEDIARY INSTITUTIONS, AID RETAINS READY ACCESS TO POLICY AND PROGRAM ISSUES.
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POPULATION/FAMILY PLANNING: NEAR EAST STRATEGY STATEMENT

Some 240 million persons comprising around 6% of the world's population live in 18 countries which we call the Near East region. Strategic locations and energy resources make the region much more important than its size alone would imply

The region has a crude birth rate of 40, a crude death rate of 13 and a population growth rate of 2.7% per year. The region is growing by over 6 million persons a year with 3 countries (i.e., Iran, Egypt and Turkey) contributing over 50% of this growth.

AID population assistance via intermediaries has flowed to 11 countries of the region and AID has ongoing bilateral projects with 3 of these countries, (Egypt, Tunisia and Morocco).

The primary objectives of AID population assistance is to improve the health and well being of the region's people by bringing population growth into balance with present and future country resources. The nations of the region vary widely in their will and capacity to deal with their population growth problems as categorized below.

Category I - Countries with a successful program where AID bilateral assistance can probably be reduced in 3 to 5 years: Tunisia.

Category II - Countries with somewhat mature but not yet effective programs or nascent programs into which continuing AID bilateral assistance should be channeled: Egypt, (ESF Funds) and Morocco.

Category III - Countries with embryonic programs or emerging government policies which could be supportive of programs in which AID bilateral and intermediary assistance should be more thoroughly explored: Jordan, Syria, Turkey, North Yemen (Sana). (A bilateral program in Jordan is planned for FY 1981.)

Category IV - Countries in which program development may be possible and desirable although expanded bilateral assistance possibilities are not immediately foreseen: Algeria, Iraq, Iran, Portugal, Cyprus, Lebanon.

Category V - Countries of the region which have generally pro-natalist policies for a variety of reasons: Libya, Saudi Arabia, Kuwait, Oman, United Arab Emirates.

Regional strategy calls for focusing attention on the first three categories of countries which together account for 59% of the region's population growth. The thrust for Categories I and II will be aimed at extending and improving the effectiveness and delivery efficiency of all forms of family planning services to all elements of those societies. The thrust for Category III countries will be new population policy initiatives aimed at creating an awareness of the implications of population growth. To the extent possible, targets of opportunity in all countries which show promise for eventual improvement of family planning services will be pursued, but primary focus will be on the Category I, II and III countries.

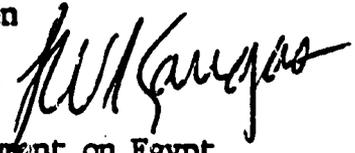
William H. Johnson, DS/POP, L.W. Kangas, NE/TECH/HPN
Revised January 8, 1980

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MEMORANDUM

DATE : May 30, 1980

TO : PPC/PDPR/HR, Ms. Ann VanDusen

FROM : NE/TECH/HPN, Lemmi W. Kangas 

SUBJECT: Population Task Force - Statement on Egypt

The socio-economic setting confronting Egypt is on the less favorable side with a moderate commitment to fertility control.

Explanation: In view of most observers Egypt is not headed toward a demographic crisis; it is in the midst of one. Despite an official Family Planning effort dating to 1965, Egypt's bureaucracy has yet to be energized to promote fertility control. With a population growing by about 1 million persons every ten months, Egypt's population will pass the 42 million mark before mid-1980. Other indicators:

- a crude birth rate which has actually increased from 34/1000 in 1976 to 38/1000 now (partly as a consequence of peace and stability and some demobilization of the armed forces).
- a labor force of 13 million which will reach 21 million in the next 20 years, placing a formidable burden on the economy to accumulate savings and generate enough jobs.
- a high density of 745 persons per square kilometer of inhabited area.
- a density in urban areas such as Cairo which has increased from 7,000 people per square kilometer in 1927 to an incredible 25,000 persons per square kilometer in 1979. Some areas in Cairo have densities over 100,000 per square kilometer
- 62% of primary school aged children in school, with the percentage perhaps declining.
- an infant mortality rate, imperfectly measured, but estimated at 85/1000.
- an average completed family size of 5.5.
- a contraceptive prevalence rate estimated at 20% nationally, but only 10-12% in rural areas where half of all Egyptians live.

Status of Family Planning Activities: Egypt enjoys important advantages over other developing countries in that it is a relatively homogenous population which is nearly 100% Arabic speaking, 90% Muslim, not divided by mountains, and with its population limited to a relatively small geographic area. In addition, the health infrastructure by almost any standard is excellent, with over 2,800 clinics in rural areas, fully staffed and facilities within 3-5 kilometers distance from almost all of its people. In urban areas of 50,000 population and above, contraceptive prevalence rates often exceed 40%; these are not limited to Cairo and Alexandria. The economy is beginning to move and the populace shares a general expectation of improvement and rapid modernization.

The delivery of family planning services is largely the responsibility of the Ministry of Health, but during the last four years has been supplemented with a program managed by the Population and Family Planning Board with UNFPA's support, tying community development actions to family planning acceptance and services. Some confusion about coverage has resulted, with the Board's program working only partially in 12 of the 26 governorates, a proposed World Bank project which will operate in six governorates, 5 of which are already serviced by the Board with UNFPA support, and a proposed expansion of the USAID-assisted Menoufia project into four additional governorates this year.

Population Policy: In December of 1979, for the first time, the Five Year Plan statement presented to the IBRD Consultative Group placed population issues front-and-center. While this has yet to be widely internalized within the government leadership and acted upon, it nevertheless signifies a growing awareness of the critical importance of rapid population growth on Egypt's development prospects. Two presentations of the AID-funded "RAPID" program in December, 1979 and January, 1980 reached senior policy makers including the Prime Minister, the Cabinet Ministers for Economy, Planning, and Health, and the Supreme Council for Family Planning. At that time, decisions were made to popularize this kind of information activity, and at the moment it seems reasonable to expect a continuing evolution of policy support.

Still missing however, is an action plan that translates generalized and accepted goals of reducing fertility by 1/10 of 1 percent annually into program implementation. Other issues concern the need to better coordinating the activities of various donors (AID: \$17,000,000; IBRD: \$33,000,000; UNFPA: \$10,000,000) and agreement on a better division of labor among their support activities. The GOE has agreed to call such a working coordination meeting late in the Summer, 1980.

Donor Roles: Egypt's situation may be unique in development history in that there is an abundance of external support confronting a poor and slow pace of implementation. Of the \$17 million obligated by USAID since 1977, for example, the GOE has spent only \$3.5 million; the World Bank project (second population loan) consisting of a \$25 million loan from the Bank, supplemented by an \$8 million grant from the UK/ODM, was signed in 1978, but no action plan has yet been agreed upon. Of the three major donors only UNFPA support of \$10 million obligated in 1975 for a five year period has been nearly spent on schedule. The population development project supported by the Board—linking community development activities with Family Planning and which received its initial support from the UNFPA—provides a viable vehicle for increasing contraceptive prevalence. It will reflect great credit upon the UN for supporting and sticking with a risk venture that has been the subject of considerable criticism. However it turns out, it clearly has been a worthwhile attempt and all the signs now point to institutionalizing a genuinely unique approach to family planning services.

USAID in early 1980 agreed to support its replication in two additional governorates with the prospect of further expansion in the near term. The World Bank project, however, still lacks an agreed upon implementation plan with serious defects centering on the question of whether paramedical and nurse workers will actually dispense contraceptives and, secondly how "turf" problems can be resolved with the Board's PDP efforts. These and similar issues might be resolved in the Donor meeting scheduled for Summer 1980 which is to be convened by the GOE.

MEMORANDUM

DATE : May 30, 1980

TO : PPC/PDPR/HR, Ms. Ann VanDusen

FROM : NE/TECH/HPN, Lemmi W. Kangas

SUBJECT: Population Task Force - Statement on Jordan

Jordan continues to occupy a borderline position on the socio-economic setting grid, with an annual population increase pegged variously between 3.3% (Population Reference Bureau, 1979) and an estimated 4.2%; the latter would mean its population would double in only 17 years. Even if the rate of natural increase (RNI) were 3.4% (a widely held estimate) population would double in 20 years. The November 1977 Jordan census reports a crude birth rate of 50/1000 and a sharp drop death rate to 12/1000, with a resulting RNI of 3.8%, highest in the Near East Region. There is, in addition, a 1.0% increase from immigration bringing the annual population growth rate to an astounding 4.8%.

The 3.8% figure connotes doubling in 18 years; the 4.8% rate projects doubling in 14 years.

Explanation: The low priority officially given to population problems stems from the government's obvious preoccupation, over the past three decades, with political and military instability. To these constraints must be added the various religious and ethnic biases which typify the slow progress on the population front of most of the Muslim nations of the areas compared to that of the developing countries of Asia. The Jordanian leadership can point, of course, to the country's very low unemployment, and the remittances of its expatriate workers, the largest source of foreign exchange. Its population (60%-70% urban) has per capita incomes of \$619 on average (1977 figure) which is twice those of Egypt or the Sudan, but a fraction of the Persian Gulf States, and even less than Syria's.

There have been stirrings of official recognition of the population problem particularly of the demographic consequences on water resources, on public health (particularly mothers and children), and the nation's educational system which is already burdened with upward of 605,000 students at various levels—more than 400,000 in primary grades alone, i.e., 20% of the East Bank's population total!

Thanks to the findings of the AID-funded World Fertility Survey report (1976) and Jordan's first census since 1961, which took place in November of 1979, some recognition of the country's population dynamics is being raised among the decision makers. A RAPID presentation by the Futures Group had noticeable impact last year and is being rescheduled for

high-level showing. While a National Population Commission was formed in 1976 its accomplishments have been modest, and the task of furthering population initiatives has fallen upon the Jordan Family Planning Protective Association (JFPPA); the University of Jordan (with a strengthened Department of Community Medicine and active units devoted to fertility control and study of sexuality within its Department of Obstetrics and Gynecology); the Amman Urban Region Planning Group; the Royal Scientific Society, and other government or non-government entities. Aside from these indigenous efforts there has been considerable activity through AID intermediaries, such as JHPIEGO, IPAUS and others, and by other donors such as UNFPA.

Program Options: It is not likely that the Government of Jordan in the near future will embrace a population policy resembling those of Egypt, Tunisia, Morocco, or even neighboring Lebanon (which in recent weeks has reversed itself and mandated the provision of family planning services Ministry of Health and Ministry of Social Welfare facilities). A likelier course will be GOJ's tacit approval—as in the recent past but perhaps broader in scope—of intermediary activities which could be developed quietly without roiling conservative religious groups like the Muslim Brotherhood or heightening tensions between East and West Bank activists concerned with the population numbers game. At this time several courses are being jointly explored by AID/W and the Jordan Mission. They range along the lines:

- An operations research project in MCH to test different modes of contraceptive service delivery and key health interventions, along the lines of the Tunisia and Egypt operations research projects which have resulted in marked increased of contraceptive use.
- Support for the Jordan Family Planning Protective Association to expand its clinical and outreach activity by funding staff and clinics now open only part-time.
- Establishment of a full range of post partum contraceptive counselling and services in several of the largest Jordanian maternity hospitals, with supporting outreach/followup to increase case load and sustain initial contraceptive acceptors.
- Organization of conferences and seminars which could trigger dialogues between Jordanian professionals, press, academicians, and government representatives.

These activities should be undertaken against the background of Jordan's network of MCH centers which, since 1979, have received UNFPA support. Family planning services are obtainable at these 59 facilities which are administered by the Ministry of Health, but with little publicity. Moreover any program options of the type described should take into account the need for institution building and enhanced population problem

awareness among such existing institution as the National Planning Council, the MOH's MCH and Health Education Division, the Department of Statistics, the University of Jordan, the Adult Education/Literacy Division of the Ministry of Education, the Workers' Education Division of the Ministry of Labor, etc.

Donor Roles:

UNFPA can probably be expected to carry on its program of about \$3 million (in 1979) of family planning services as a measure of its "special interest" in Jordan.

Pathfinder Fund or Family Planning International Assistance may be drawn into assistance programs but probably not until after October 1, 1980, except for some commodities.

The centrally funded DS/POP Research Division and the Johns Hopkins University Contractor group are interested in the operations research activity proposed.

Battelle and Research Triangle Institute might well serve as organizers of seminars and conferences to focus on the ways and means of alerting Jordan's leadership.

IPPF's increasingly widespread and burdened program budget may permit more support for the JFFPA.

The principal problem appears to be orchestrating these various notions and proposals within the Mission's and the GOJ's perceived constraints and in such fashion that they can bridge the gap between drawing board/conference table and the realities of deploying a meaningful program in highly charged atmosphere.

MEMORANDUM

DATE : May 30, 1980

TO : PPC/PDPR/HR, Ms. Ann VanDusen

FROM : NE/TECH/HPN, Lemni W. Kangas *LW Kangas*

SUBJECT: Population Task Force - Statement on Morocco

Morocco's position on the grid straddles the line between a more or less favorable socio-economic setting. In the more modernized sector, which is principally urban, the receptivity to family limitation is greater than in more traditional rural areas. Government support for fertility control can be characterized as "overtly ambivalent, covertly supportive." Morocco's population size will pass 20,000,000 in mid-1980, with crude birth and death rates of 46/1000 and 14/1000 respectively, and an annual growth rate of 3.2 percent.

Explanation: Although some government ministries such as Health, Youth and Social Affairs have sufficient mandate to encourage modest family planning efforts, no national policy has been articulated and acted upon to fully support the broad range of activities needed to lower birth rates, or for that matter to bring growth rates into line with anticipated rates of economic development. A number of influential leaders hold the view that "size means strength" and that more people, not less, are needed to fully exploit the Kingdom's economic potential. Additional indicators:

- an infant mortality rate estimated at 133/1000
- 30% of female children enrolled in primary schools
- a labor force estimated at 5.4 million which will reach 10 million plus in the year 2000 with only slight increases in female participation rates.

Program Options: Given the unlikelihood of major policy changes in the near term, i.e., 2-3 years, the most promising course is to simultaneously demonstrate the acceptability of family planning while extending services and expect policy formulation to move in tandem with such service extension. The USAID assisted household distribution project launched in Marrakech is presently being expanded to three more provinces by the Ministry of Health and shows promise. AID-supported intermediaries, namely JHPIEGO and IPAVS, are actively advancing voluntary surgical contraceptive training, services, and technical assistance for the 1981 census is being provided by the U.S. Bureau of Census.

Donor Roles: UNFPA support to Morocco began in 1975-76, with a \$3 million grant project to the Ministry of Health for training, and to the Ministry of Youth and Sports for IE&C. The program was largely inherited from UNICEF and cannot be regarded as a genuine population program. Some \$2.7 million of the \$3 million initial grant was earmarked for equipment of various kinds including audio-visual vans which are still to be delivered. This project was officially terminated in December 1979.

A UNFPA Basic Needs Mission was conducted in the Fall of 1979, but its final report will not be ready in time for review by the UNFPA governing council in June 1980. UNFPA, however, has agreed to provide "pre-project financing" for \$21,000 worth of vehicles for the expansion in three provinces of the household distribution project which is of significant value. Since it is unlikely that any specific project development will take place before June 1980, it must be concluded that the UNFPA will not contribute in any material way to fertility reduction in Morocco until at least 1982. The needs assessment does recommend that the UN engage in: a) population education; b) vital registration improvement; c) Ministry of Health training; and d) some activity in the IE&C area. This is a reasonable division of labor amongst the two leading donors, AID and UNFPA.

Recommended Policy Actions: Morocco presents a clear case where donors should act in concert to nudge the GOM toward a more straight-forward policy on the need for fertility control. AID, with an annual assistance level of \$18-20 million, is a minor actor on the scene compared to the World Bank which in 1979 obligated \$400 million to the GOM and France whose contributions amount to \$100 million per year. Clearly, the Bank is the only donor in a position to advance the cause of population policy with any influence. One of the persistent frustrations many of us have in regard to the Bank's population activity is that it continues to fail to incorporate Mr. McNamara's forthright exhortations on population matters in its own bi-lateral negotiations. It would be timely and entirely appropriate for IDCA, AID and UNFPA to confer with the Bank on this issue with the early objective of advancing population policy actions with the GOM this calendar year.

AID should continue to be the leading contributor to supporting family planning services and discrete actions such as the Futures Group "RAPID" presentation (scheduled soon) and selective participant training in and out of country.

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PAGE 01 BEIRUT 02370 190320Z

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ACTION AID-35

ACTION OFFICE OPPR-01

INFO NEOP-01 NETC-04 NEJL-03 PFCB-01 PPPB-02 PPEA-01 FM-02

AADS-01 OSHE-01 POP-04 CHB-01 HEW-09 OMB-02 RELO-01

STA-10 MAST-01 DO-01 /038 A4

INFO OCT-01 /038 W

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R 181325Z APR 80
FM AMEMBASSY BEIRUT
TO SECSTATE WASHDC 0810

UNCLAS BEIRUT 2370

AIDAC

E. O. 12065: N/A
SUBJECT: FAMILY PLANNING ASSOCIATION

REF: (A) BEIRUT 1517; (B) STATE 085558.

1. THE GOL HAS NOT HAD ANY PROGRAMS IN THE FIELD THOUGH THERE HAS BEEN ACTIVITY AMONG PRIVATE INSTITUTIONS. AS REPORTED IN BEIRUT 1517 THE GOL HAS RECENTLY REVERSED ITS PRO-NATAL ATTITUDE AND ENDORSED THE PROVISION OF FP SERVICES AS A FAMILY HEALTH MEASURE WITHIN THE HEALTH-CLINICS THEY OPERATE. THE LOCAL IPPF ASSOCIATION (LPPA) IS CONTRACTING WITH THE GOL TO ASSIST IN THE TRAINING REQUIREMENTS NECESSARY TO PROVIDE THESE SERVICES.

2. THE OTHER BILATERAL AND MULTILATERAL AGENCIES HAVE NOT FP PROGRAM IN LEBANON. SOME ACTIVITIES ARE CARRIED OUT BY PRIVATE AGENCIES SUCH AS SAVE THE CHILDREN FOUNDATION AND PERHAPS OTHERS. THE EXTENT OF THESE EFFORT IS TO DATE QUITE LIMITED.

3. THE LPPA HAS MADE A PROPOSAL FOR AID ASSISTANCE IN ITS TRAINING PROGRAM WHICH IS BEING POUCHED. WE WOULD WELCOME AID/W REVIEW AND RECOMMENDATION. IN PLANNING OUR FY 1981 AND SUBSEQUENT YEAR PROGRAMS WE HAVE PROVIDED FOR ASSISTANCE IN BASIC HEALTH CARE. WE ANTICIPATE FP COULD BE INCLUDED WITH THIS PROGRAM.
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ACTION AID-33

ACTION OFFICE POPR-01
INFO NEPD-03 NEDP-01 NETA-04 NEEI-03 PPCE-01 PPPB-02 FM-02
AADS-01 OSNE-01 POP-04 IT-06 CHB-01 NEM-09 OHB-02 NELD-01
STA-10 MAST-01 PPEB-01 /054 A1

INFO OCT-01 /036 V
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R 091326Z APR 68
FM AMEMBASSY CAIRO
TO SECSTATE WASHDC 6706

UNCLAS SECTION 01 OF 02 CAIRO 07850

AIDAC

E.O. 12065: N/A
SUBJECT: POPULATION

REF: STATE 085558

1. USAID PLEASED AID/V CONSIDERING EMPHASIZING POPULATION IN DEVELOPMENT EFFORTS, AS WELL AS ASSESSING EFFECTIVENESS OF POPULATION PROGRAMS AND WAYS OF IMPROVING DONOR COORDINATION. OUR RESPONSE TO REFTEL KEVED TO YOUR QUESTIONS.

- A. EGYPT INCREASINGLY AWARE THAT CURRENT ANNUAL POPULATION GROWTH RATE OF 2.8 PERCENT IS AN IMPEDIMENT TO DEVELOPMENT AND INCREASES PRESSURES ON SCARCE RESOURCES. DR. GABR, MINISTER OF HEALTH AND CHAIRMAN OF THE SUPREME COUNCIL FOR POPULATION AND FAMILY PLANNING, NOTED IN HIS DECEMBER 1979 STATEMENT TO THE CONSULTATIVE GROUP IN PARIS THAT EGYPT HAS A "SERIOUS POPULATION PROBLEM." DR. GABR CALLED FOR REDUCING THE POPULATION GROWTH RATE .1 PERCENT A YEAR WHICH, IF THE 1.8 PERCENT BY 1990, AND .8 PERCENT BY 2000. TO ACHIEVE THIS GOAL, THE MINISTER CALLED FOR A THREE-PRONGED APPROACH: (1) IMMEDIATE UPGRADING OF FAMILY PLANNING SERVICES; (2) EXTENSION OF COMMUNITY-BASED POPULATION PROGRAMS NATIONWIDE OVER A TWO-YEAR TIME PERIOD; (3) INTENSIFICATION OF POPULATION INFORMATION, EDUCATION AND COMMUNICATION ACTIVITIES TO SUPPORT THE FAMILY PLANNING SERVICE AND COMMUNITY BASED ACTIVITIES. USAID CAUTIOUSLY OPTIMISTIC THE MINISTER'S OUTLINE HAS THE POTENTIAL FOR BECOMING A VIABLE POPULATION FAMILY PLANNING PROGRAM STRATEGY FOR THE 80'S.

- USAID NOTES MOH HAS RECENTLY TAKEN THE INITIATIVE IN PROPOSING FAMILY PLANNING SERVICE TRAINING FOR GOE PHYSICIANS TO INCLUDE IUD INSERTION AND DIAPHRAGM FITTING. THE EGYPTIAN FERTILITY CARE SOCIETY IS CURRENTLY DEVELOPING AN ADVANCED FERTILITY MANAGEMENT PROGRAM FOR 6 MEDICAL SCHOOLS COUNTRYWIDE. AT THE COMMUNITY LEVEL, THE MENOUIA PROJECT HAS DEMONSTRATED HOUSE-TO-HOUSE DISTRIBUTION OF CONTRACEPTIVES IS FEASIBLE AND EFFECTIVE. THE POPULATION AND FAMILY PLANNING BOARD (PPFB) POPULATION AND DEVELOPMENT PROJECT'S PRELIMINARY DATA SHOW A DOUBLING OF MODERN CONTRACEPTIVE USE IN RURAL PROJECT AREAS FROM 3 PERCENT TO 7 PERCENT AFTER ONE AND A HALF YEARS. THE URBAN BASED PILOT COMMUNITY BASED FAMILY PLANNING SERVICES PROJECT (CBFPO), WHICH DISTRIBUTES FOAM TABLETS, COPPER IUD'S AND CONDOMS THROUGH PRIVATE PHYSICIANS AND PHARMACIES HAS QUICKLY SOLD OUT OF CONTRACEPTIVES. THE USAID SUPPORTED STATE INFORMATION SERVICE (SIS) POPULATION AWARENESS CAMPAIGN HAS BEEN WELL RECEIVED, SIS IS CURRENTLY PLANNING AN INTENSIVE NATIONWIDE FAMILY PLANNING SERVICE CAMPAIGN TO BEGIN JULY 1, 1980.

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- B. CURRENTLY THERE IS QUITE GOOD DONOR COOPERATION IN THE POPULATION SECTOR. USAID AND WEST AFRICAN ARE SUPPORTING PILOT PROJECTS TO IMPROVE RURAL HEALTH AND FAMILY PLANNING SERVICE. UNFPA AND USAID ARE COOPERATING IN SUPPORTING THE PPFB'S COMMUNITY BASED POPULATION AND DEVELOPMENT PROJECT, USAID AND IPPF ARE COOPERATING IN CONTINUING THE MOMENTUM OF THE IPPF INITIATED COPS PROJECT. THESE ASSISTANCE ACTIVITIES REQUIRE CLOSE COORDINATION, BUT TO DATE WE BELIEVE THE EFFORTS HAVE BEEN COMPLEMENTARY. THE 1980'S FIVE YEAR \$60.0 MILLION SECOND POPULATION PROJECT IS PLANNED FOR SEVEN GOVERNORATES AND SOMETIMES AN ENGINA BECAUSE THERE IS NO IN-187,345 7-, 1 430433, 3-569, . WHEN BANK MISSIONS ARE IN TOWN, THEY ARE CANDID ABOUT IBRD PROJECT, AND WE HAVE FRANK EXCHANGES ABOUT NEW DEVELOPMENTS AND PROBLEMS. IF THE GOE DOES SERIOUSLY ENBAK ON THE ABOVE NATIONWIDE STRATEGY, IT WOULD FACILITATE POPULATION COORDINATION IF THE BANK HAD A POPULATION REPRESENTATIVE IN EGYPT.

- C. IN CONCERT WITH THE GOE, USAID HAS IN THE PAST FEW YEARS ASSISTED THE GOE IN TESTING WAYS OF IMPROVING RURAL HEALTH SERVICES, AS WELL AS A MORE EFFECTIVE COMMUNITY FAMILY PLANNING EFFORT IN MENOUIA GOVERNORATE. THESE PROJECTS NEED TO BE CONTINUED IN ORDER TO MORE PRELIMINARY FINDINGS, BUT IT IS CLEAR THAT USAID CAN ASSIST WITH A SOMEWHAT MORE ACCELERATED EXPANSION OF FAMILY PLANNING SERVICES IF THE GOE DOES ENBAK ON PURSUING THE ABOVE STRATEGY.

LOOKING TOWARD THE FUTURE, USAID EXPECTS TO ADD \$7.0 MILLION IN FY 1980 AND \$10 - \$15 MILLION IN FY 1981 TO ITS CURRENT FAMILY PLANNING PROJECT. BEGINNING IN EARLY FY 1981, USAID WOULD HOPE TO BEGIN DEVELOPMENT OF A NEW 3 YEAR, \$8 - \$75 MILLION POPULATION PROJECT. THIS WOULD INCLUDE CONTRACEPTIVE ASSISTANCE, TRAINING, STRENGTHENING OF FAMILY PLANNING SERVICES, SUPPORT FOR COMMUNITY BASED RURAL AND URBAN POPULATION/FAMILY PLANNING ACTIVITIES EVALUATION AND DEVELOPMENT AND POSSIBLY MODEST CLINIC AND TRAINING CENTER CONSTRUCTION.

2. WHILE THE ABOVE PROGRAM DEVELOPMENTS ARE ENCOURAGING, WE MUST EMPHASIZE THAT AN EFFECTIVE, VIABLE GOE POPULATION

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6712 AID0501

ACTION OFFICE PDPR-01
INFO NEPD-03 NEDP-01 CH6-01 NETC-04 NEEI-03 PPCE-01 PPPB-02
PPEA-01 FM-02 AADS-01 DSHE-01 POP-04 IT-06 CH8-01 HEW-09
OMB-02 RELO-01 STA-10 MAST-01 /055 A1

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R 091326Z APR 80
FM AMEMBASSY CAIRO
TO SECSTATE WASHDC 6707

UNCLAS SECTION 02 OF 02 CAIRO 07850

AIDAC.

PROGRAM STRATEGY FOR THE 80'S WILL REQUIRE SERIOUS,
SUSTAINED GOE COMMITMENT AS WELL AS INCREASING GOE FINAN-
CIAL RESOURCES IN SOLVING EGYPT'S POPULATION PROBLEM.
IT ALSO REQUIRED CONTINUED STABILITY, A FAVORABLE POLITICAL
CLIMATE, AND A CONTINUATION OF THE WILLINGNESS OF
EGYPTIAN PRINCIPALS AND THE GENERAL PUBLIC TO DISCUSS
POPULATION MATTERS OPENLY.

3. FOR ADDITIONAL BACKGROUND, WE SUGGEST YOU REVIEW
DR. GABR'S DECEMBER 1979 STATEMENT; EGYPT'S
POPULATION PERSPECTIVE, AS WELL AS USAID'S MARCH 1978
MULTI-YEAR POPULATION STRATEGY PAPER. ATHERTON

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PAGE 01 RABAT 02640 151035Z
ACTION AID-35

7720 AID4019

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ACTION OFFICE POP-04

INFO NETC-04 NEMA-03 PPCE-01 PPPB-02 PPEA-01 1A-01 11A-02
AADS-01 OSNE-01 CH8-01 NEV-00 EAST-01 PPR-01 /032 AI

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R 151035Z APR 80
FM AMEMBASSY RABAT
TO SECSTATE WASHDC 3791

UNCLAS RABAT 2640

AIDAC

E.O. 12865 N/A
SUBJECT : POPULATION; MOROCCO'S PROGRESS AND NEEDS

REF: STATE 083358

1. FOLLOWING IS GEARED TO REFTEL PARAGRAPH 2.
- 2A. PROGRAM AND PLANS. MOROCCO PRESENTLY IN THROES OF PREPARING NEW ECONOMIC DEVELOPMENT PLAN FOR 1981-85. MOM CARRIES PRIMARY BURDEN FOR POPULATION ACTIVITIES, AND APPARENTLY WILL CONTINUE TO DO SO WELL INTO NEXT PLAN PERIOD. MOM PROJECTS EXPANDED AND INTENSIFIED FAMILY PLANNING EFFORT, PARTICULARLY IN RURAL AREAS, BUILDING UPON MARRAKECH VOMS EXPERIENCE. ANTICIPATED RESULTS INCLUDE LOWERING CRUDE BIRTHRATE BY A MINIMUM OF 16-20 PERCENT AS RESULT OF GOVERNMENT EFFORT ALONE (PLU WHATEVER EFFECT MIGHT COME FROM PRIVATE SECTOR ACTIVITIES). PROGRESS OVER PAST THREE YEARS HAS BEEN QUITE POSITIVE, BOTH IN TERMS OF ATTENTION FOCUSED ON POPULATION PROBLEMS AND IN TERMS OF RESULTS IN RECRUITING OF NEW ACCEPTORS AND IN DEVELOPING AND LAUNCHING NEW AND SIGNIFICANT PROGRAMS IN THE FIELD. PRIMARY CONSTRAINT IS ABSORPTIVE CAPACITY, SINCE BASE OF COMPETENT OFFICIALS DEALING WITH POPULATION PROGRAMS IS EXTREMELY NARROW. DESPITE THIS CONSTRAINT, PROGRESS HAS BEEN GOOD AND IS EXPECTED TO ACCELERATE IN NEXT PLAN PERIOD.
- 2B. OTHER DONORS. UNFPA IS NEARING END OF OOL'S \$3 MILLION, 3-YEAR PROJECT WHICH HAS PROVIDED ASSISTANCE TO OTHER MOM MINISTRIES AS WELL AS THE MOM. IMPLEMENTATION OF THIS PROJECT HAS AT TIMES BEEN DIFFICULT, BUT ON WHOLE UNFPA ACTIVITIES ARE JUDGED AS POSITIVE AND COMPLIMENTARY TO THOSE OF USAID. COORDINATION IS EXCELLENT. UNFORTUNATELY, INTERNAL UNFPA CONSTRAINTS PRECLUDE FULL DEVELOPMENT OF CONTINUING ASSISTANCE PACKAGE IN TIME FOR JUNE 1980 MEETING OF INTERNATIONAL ADVISORY COMMITTEE, BEST THAT CAN BE HOPED FOR IS A TEMPORARY PLAN OF LIMITED ACTIVITIES PENDING PRESENTATION OF FULLY DEVELOPED PLANS TO COMMITTEE IN JUNE OF 1981. THIS IS DISAPPOINTING BOTH TO US AND TO MOM.
- IBRD HAS ATTEMPTED DEVELOP PROJECT IN AREA OF FAMILY HEALTH FOR PAST TWO YEARS. OUR JUDGMENT IS THAT IT HIGHLY UNLIKELY TO MATERIALIZE IN FORESEEABLE FUTURE. UNICEF HAS BEEN MAKING POSITIVE CONTRIBUTION TO POPULATION SCENE, BOTH AS IMPLEMENTING AGENCY FOR UNFPA AND UNDER OWN AEGIS AS CONCERNS ORS AND OTHER INPUTS TIED INTO EXPANDED VOMS PROGRAM. THERE ARE NO OTHER SIGNIFICANT DONORS IN POPULATION ARENA IN MOROCCO, OTHER THAN IPPF WHICH SUPPORTS MSHALL BUT IMPORTANT EFFORT ON PART OF PRIVATE MOROCCAN FAMILY PLANNING ASSOCIATION.
- 2C. USAID ROLE. IN OUR JUDGMENT, USAID REMAINS AND WILL REMAIN FOR NEXT 5-10 YEARS THE BEST-PLACED DONOR TO CONTRIBUTE TO THE DEVELOPMENT OF POPULATION POLICY AND PROGRAMS IN MOROCCO. THIS IS DUE BOTH TO THE PRESENT CONTEXT AND RELATIONSHIPS IN WHICH BUSINESS TAKES PLACE IN MOROCCO, AND TO EXPERIENCE AND RANGE OF

COMPETENCY WHICH USAID COMMANDS BOTH FROM INTERNAL AND FROM EXTERNAL RESOURCES. OVER THE NEXT 10 YEARS THE MOROCCAN PROGRAM WILL BE GROWING RAPIDLY AND WILL BE EXPERIMENTING WITH VARIOUS MODES OF SERVICE DELIVERY. THE POTENTIAL ACCEPTOR POOL IS HUGE AND IS INCREASINGLY BEING TAPPED, RESULTING IN RAPIDLY GROWING DEMANDS ON THE SERVICE INFRASTRUCTURE TO PROVIDE HIGH QUALITY INFORMATION AND SERVICES. AN AWAKENING IS TAKING PLACE WITH RESPECT TO THE NEED FOR INVOLVEMENT OF OTHER MOM ENTITIES IN THE POPULATION AREA. THIS AWARENESS CANNOT BUT INTENSIFY AND THE FLEGLING PROGRAMS OF THE MINISTRIES OF EDUCATION, YOUTH AND SPORTS, SOCIAL AFFAIRS, INFORMATION, ETC. CONTINUE TO DEVELOP. USAID, TOGETHER WITH UNFPA IPPF, AND ASSISTED BY SPECIALIZED INSTITUTIONS SUCH AS THE ISI, CDC, ETC. WILL PLAY A CRITICAL ROLE IN ASSISTING THE MOM TO MAXIMIZE THE IMPACT OF ITS POPULATION ACTIVITIES, AND TO DEVELOP POLICIES AND PROGRAMS WHICH HAVE THE POTENTIAL TO CURB RAPID POPULATION GROWTH.

2. WE LOOK FOR, AND FULLY EXPECT TO WITNESS, A DRAMATIC INCREASE IN CONTRACEPTIVE PREVALENCE IN MOROCCO IN THE NEXT 5-10 YEARS, WITH A RESULTANT DROP IN MARITAL FERTILITY RATES. NEVERTHELESS, AND DESPITE ANY CONCEIVABLE EFFORTS ON THE PART OF THE MOROCCAN GOVERNMENT, A REASONABLE EXPECTATION WOULD BE THE CONTINUED GROWTH OF THE TOTAL POPULATION TO REACH A LEVEL OF AT LEAST 40 MILLION BY THE YEAR 2040.
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**ACTION
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Department of State

**INCOMING
TELEGRAM**

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ACTION AID-35

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ACTION OFFICE PPPR-01
INFO NEPD-03 NECP-01 NEHA-03 PPCE-01 PPPB-02 PPEA-01 AADB-01
DSNE-01 POP-04 CNE-01 NEV-00 OMB-02 SLO-03 STA-10
MAST-01 /042 A4

INFO OCT-01 /036 W

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E.O. 12065: N/A
SUBJECT TUNISIAN POPULATION/FAMILY PLANNING PROGRAM

REF: STATE 085558

1. MISSION CONCURS WITH VIEWPOINT EXPRESSED PARA 1 REFTEL, PARTICULARLY IN REGARD TO THE CONTINUING NEED FOR AID/W, OTHER DONORS AND LOGS TO ASSIGN HIGH PRIORITY TO POPULATION PROBLEMS.

2. RE INFORMATION REQUESTED PARA 2 REFTEL - DURING PAST FIFTEEN YEARS, TUNISIAN FAMILY PLANNING PROGRAM HAS DEVELOPED INTO ONE OF THE LARGEST AND MOST COMPREHENSIVE PROGRAMS IN AFRICA AND THE MIDDLE EAST, EVIDENCE OF PROGRAM IMPACT INCLUDES REDUCTION OF CRUDE BIRTH RATE FOR 48 PER THOUSAND IN 1965 TO CURRENT RATE OF 33.9, THE LOWEST IN ARAB WORLD. AN ESTIMATED 47 PERCENT OF THE MWRA HAVE USED OR CURRENT USE A MODERN METHOD OF CONTRACEPTION. THE GOV PLANS TO CONTINUE CURRENT PROGRAM WITH INCREASED EMPHASIS ON PROVIDING SERVICES IN THE RURAL AREAS.

3. THE GO FAMILY PLANNING PROGRAM HAS RECEIVED SIGNIFICANT LEVELS OF DONOR SUPPORT WHICH HAS BEEN AND IS CURRENTLY COORDINATED THROUGH THE TUNISIAN NATIONAL FAMILY PLANNING OFFICE (GNPPP). IN ADDITION TO AID, OTHER DONORS INCLUDE THE WORLD BANK, WHO AND BILATERAL ASSISTANCE FROM OTHER COUNTRIES - SUCH AS BELGIUM AND LUXEMBOURG. MISSION FEELS THAT DONOR ACTIVITIES ARE COMPLEMENTARY AND HAVE BEEN WELL COORDINATED BY THE GNPPP.

4. AID HAS PROVIDED ASSISTANCE (APPROXIMATELY \$26 MILLION) TO THE GOV FAMILY PLANNING PROGRAM FOR PAST FIFTEEN YEARS. EARLY ASSISTANCE EFFORTS FOCUSED ON INFRASTRUCTURE DEVELOPMENT AND LATER EMPHASIS WAS PLACED ON SERVICE DEVELOPMENT. CURRENT PROGRAM OBJECTIVE IS TO MAKE SERVICES MORE READILY AVAILABLE TO RURAL POPULATION. RESULTS OF RECENTLY COMPLETED MID-PROJECT EVALUATION INDICATE THAT ADDITIONAL ASSISTANCE WILL BE REQUIRED TO ENABLE THE GOV TO ACHIEVE OVERALL DEMOGRAPHIC GOALS PARTICULARLY IN THE AREA OF INCREASING THE AVAILABILITY OF SERVICES IN THE RURAL AREAS.

5. TUNISIA HAS SHOWN EXCELLENT ABSORPTIVE CAPACITY AND READINESS FOR VARIOUS TYPES OF POPULATION PROGRAMS. THE GOV HAS PROVIDED LEADERSHIP TO OTHER COUNTRIES IN AFRICA AND THE MIDDLE EAST IN TERMS OF POLICY DEVELOPMENT, DEMOGRAPHIC ANALYSIS AND THE DELIVERY OF FAMILY PLANNING SERVICES. ALTHOUGH MORE WORK REMAINS TO BE DONE IN AREA OF POLICY DEVELOPMENT, TUNISIA HAS ALREADY DEVELOPED LEGISLATION INCREASING THE LEGAL

AGE OF MARRIAGE, INSTITUTED FAMILY SIZE LIMITATIONS FOR RECEIPT OF CERTAIN SOCIAL WELFARE BENEFITS, LEGALIZED ABORTION AND DEVELOPED REFORMS WHICH UPGRADE THE STATUS OF WOMEN FOR DEMOGRAPHIC ANALYSIS. TUNISIA NOW HAS ONE OF THE MOST SOPHISTICATED DATA COLLECTION AND ANALYSIS SYSTEMS OF THE DEVELOPING WORLD. ITS FAMILY PLANNING SERVICE DELIVERY SYSTEM IS EFFECTIVE BUT NEEDS STRENGTHENING IN THE RURAL AREAS, AS INDICATED IN PARA 4.
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TABLE 300
A.I.D. Population Program Assistance, By Major Functions

SUMMARY

PROGRAM GOALS	TOTAL		FY1965-FY1969		FY1970-FY1974		FY1975-FY1979		FY 1980-FY 1981	
	x\$000	(%)	x\$000	(%)	x\$000	(%)	x\$000	(%)	x\$000	(%)
<u>Goal #1</u> Development of Adequate Demographic Data	149,229	(8)	7,614	(8)	42,700	(8)	67,239	(9)	31,676	(7)
<u>Goal #2</u> Development of Adequate Population Policies										
a. Policy Development	49,680	(3)	2,544	(3)	8,012	(2)	19,200	(3)	19,924	(5)
b. Social Science Research	60,651	(3)	2,566	(3)	19,295	(4)	23,231	(3)	15,509	(4)
<u>Goal #3</u> Development of Adequate Means of Fertility Control										
a. Biomedical Research	84,828	(5)	6,340	(7)	35,409	(7)	30,806	(4)	12,273	(3)
b. Operational Research	62,116	(4)	3,001	(3)	16,386	(3)	27,117	(4)	15,612	(4)
<u>Goal #4</u> Development of Adequate Family Planning Services										
a. Contraceptives, Equipment	352,659	(20)	5,189	(6)	72,789	(13)	181,761	(25)	92,920	(21)
b. Service Programs	524,503	(29)	38,641	(43)	163,606	(30)	195,250	(27)	127,006	(29)
<u>Goal #5</u> Development of Adequate Information Programs	164,981	(9)	6,100	(7)	62,581	(12)	67,747	(9)	28,553	(7)
<u>Goal #6</u> Development of Adequate Manpower and Institutions										
a. Training	213,204	(12)	5,656	(6)	58,747	(11)	86,059	(12)	67,742	(14)
b. Institutional Development	90,645	(5)	10,971	(12)	30,174	(6)	22,700	(3)	26,800	(6)
AID Operational Expenses	34,048	(2)	2,043	(2)	22,005	(4)	10,000	(1)		
TOTAL	1,786,544	(100)	90,665	(100)	531,704	(100)	731,160	(100)	433,015	(100)

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TABLE 300
A.I.D. Population Program Assistance, By Major Functions

FY 1965 - FY 1969

PROGRAM GOALS	FY 1965-FY 1967		FY 1968		FY 1969	
	x\$000	(Z)	x\$000	(Z)	x\$000	(Z)
<u>Goal #1</u> Development of Adequate Demographic Data	900	(9)	2,632	(7)	4,082	(9)
<u>Goal #2</u> Development of Adequate Population Policies						
a. Policy Development	665	(6)	620	(2)	1,259	(3)
b. Social Science Research	679	(7)	932	(3)	955	(2)
<u>Goal #3</u> Development of Adequate Means of Fertility Control						
a. Biomedical Research	204	(2)	173	(1)	3,963	(13)
b. Operational Research	651	(6)	1,262	(4)	1,088	(2)
<u>Goal #4</u> Development of Adequate Family Planning Services						
a. Contraceptives, Equipment	-	-	1,059	(3)	4,130	(9)
b. Service Programs	4,258	(41)	17,028	(51)	16,555	(37)
<u>Goal #5</u> Development of Adequate Information Programs	225	(2)	2,002	(6)	3,873	(9)
<u>Goal #6</u> Development of Adequate Manpower and Institutions						
a. Training	888	(8)	2,102	(6)	2,666	(6)
b. Institutional Development	1,477	(14)	5,705	(16)	3,789	(8)
AID Operational Expenses	524	(5)	435	(1)	1,084	(2)
TOTAL	10,471	(100)	34,750	(100)	45,444	(100)

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A.I.D. Population Program Assistance, By Major Functions

FY 1970 - . . 1974

PROGRAM GOALS	FY 1970		FY 1971		FY 1972		FY 1973		FY 1974	
	x\$000	(Z)	x\$000	(Z)	x\$000	(Z)	x\$000	(Z)	x\$000	(Z)
<u>Goal #1</u> Development of Adequate Demographic Data	4,480	(6)	7,720	(8)	9,778	(8)	9,121	(7)	11,601	(10)
<u>Goal #2</u> Development of Adequate Population Policies										
a. Policy Development	2,844	(4)	950	(1)	2,134	(2)	1,430	(1)	654	(1)
b. Social Science Research	1,527	(2)	4,424	(5)	7,698	(6)	3,480	(3)	2,166	(2)
<u>Goal #3</u> Development of Adequate Means of Fertility Control										
a. Biomedical Research	8,163	(11)	6,820	(7)	11,520	(9)	5,550	(4)	3,356	(3)
b. Operational Research	7,787	(10)	3,231	(3)	1,639	(1)	2,025	(2)	1,704	(2)
<u>Goal #4</u> Development of Adequate Family Planning Services										
a. Contraceptives, Equipment	4,103	(5)	3,686	(4)	7,049	(6)	36,092	(29)	21,857	(19)
b. Service Programs	30,307	(41)	33,031	(35)	45,368	(37)	25,771	(21)	29,129	(26)
<u>Goal #5</u> Development of Adequate Information Programs	4,204	(6)	10,766	(11)	17,277	(14)	16,335	(17)	13,999	(12)
<u>Goal #6</u> Development of Adequate Manpower and Institutions										
a. Training	7,195	(10)	13,840	(14)	9,954	(8)	15,283	(12)	12,475	(11)
b. Institutional Development	2,491	(3)	9,507		8,434	(7)	6,538	(5)	3,204	(3)
AID Operational Expenses	1,469	(2)	1,893	(2)	2,414	(2)	3,929	(3)	12,300	(11)
TOTAL	74,572	(100)	95,868	(100)	123,265	(100)	125,554	(100)	112,445	(100)

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TABLE JCS
A.I.D. Population Program Assistance, By Major Functions

1975 - FY 1979

PROGRAM GOALS	FY 1975		FY 1976		TJ		FY 1977		FY 1978		FY 1979	
	x\$000	(Z)	x\$000	(Z)	x\$000	(Z)	x\$000	(Z)	x\$000	(Z)	x\$000	(Z)
Goal #1 Development of Adequate Demographic Data	11,906	(11)	9,150	(9)	3,647	(11)	8,544	(6)	16,379	(10)	17,617	(10)
Goal #2 Development of Adequate Population Policies												
a. Policy Development	999	(1)	1,876	(2)	259	(1)	2,973	(2)	4,189	(3)	8,844	(5)
b. Social Science Research	3,771	(3)	2,348	(2)	847	(3)	5,007	(4)	4,906	(3)	6,402	(3)
Goal #3 Development of Adequate Means of Fertility Control												
a. Biomedical Research	4,227	(4)	5,832	(6)	971	(3)	6,980	(5)	6,055	(4)	6,741	(4)
b. Operational Research	1,377	(1)	2,754	(3)	504	(1)	7,645	(5)	7,485	(5)	7,352	(4)
Goal #4 Development of Adequate Family Planning Services												
a. Contraceptives, Equipment	26,609	(24)	31,281	(30)	15,199	(47)	29,335	(21)	29,088	(18)	50,049	(27)
b. Service Programs	26,966	(23)	25,227	(24)	5,349	(16)	38,604	(27)	49,721	(31)	49,383	(27)
Goal #5 Development of Adequate Information Programs	12,976	(12)	12,021	(12)	2,822	(9)	15,367	(11)	13,049	(8)	11,517	(6)
Goal #6 Development of Adequate Manpower and Institutions												
a. Training	8,199	(7)	9,942	(10)	2,486	(8)	21,076	(16)	23,871	(15)	19,685	(10)
b. Institutional Development	2,945	(3)	2,601	(2)	284	(1)	3,719	(3)	5,797	(3)	7,354	(4)
AID Operational Expenses	10,000	(9)	-	-	-	-	-	-	-	-	-	-
TOTAL	109,975	(100)	102,992	(100)	32,468	(100)	140,250	(100)	160,540	(100)	184,935	(100)

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TABLE 300
A.I.D. Population Program Assistance, By Major Functions

FY 1980 - FY 1984

PROGRAM GOALS	FY 1980		FY 1981		FY 1982		FY 1983		FY 1984	
	x\$000	(Z)	x\$000	(Z)	x\$000	(Z)	x\$000	(Z)	x\$000	(Z)
<u>Goal #1</u> Development of Adequate Demographic Data	15,337	(8)	16,319	(7)						
<u>Goal #2</u> Development of Adequate Population Policies										
a. Policy Development	9,397	(5)	10,327	(4)						
b. Social Science Research	7,968	(4)	7,541	(3)						
<u>Goal #3</u> Development of Adequate Means of Fertility Control										
a. Biomedical Research	5,790	(3)	6,483	(3)						
b. Operational Research	7,360	(4)	8,237	(3)						
<u>Goal #4</u> Development of Adequate Family Planning Services										
a. Contraceptives, Equipment	34,484	(18)	38,436	(25)						
b. Service Programs	58,729	(30)	68,277	(29)						
<u>Goal #5</u> Development of Adequate Information Programs	12,781	(6)	15,772	(7)						
<u>Goal #6</u> Development of Adequate Manpower and Institutions										
a. Training	28,630	(15)	34,117	(14)						
b. Institutional Development	14,304	(7)	12,496	(5)						
AID Operational Expenses										
TOTAL	195,000	(100)	238,015	(100)						

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PRIMARY¹ SOURCES OF GRANT FUNDS² FOR INTERNATIONAL POPULATION ASSISTANCE
(in \$ millions³)

Sources / Funding Period ⁴	1965-74	1975	1976	1977	1978	1979	Cumulative Thru 79
Major Donors (excl U.S.)							
Australia	1.019	.545	.403	.500	.990	2.818	6.275
Belgium	.914	.424	.934	1.431	1.024	2.089	6.816
Canada	20.346	12.500	5.050	10.745	13.826	9.625	72.352
Denmark	11.938	3.961	5.032	6.550	8.050	8.549	44.090
Fed'l Rep'c of Germany	16.018	7.494	6.962	7.722	12.094	12.700	62.990
Japan	14.163	7.900	9.000	12.197	16.250	19.100	78.610
Netherlands	18.212	7.159	8.119	8.819	12.023	14.844	69.136
Norway	35.893	13.636	18.556	26.283	29.213	21.060	154.646
Sweden	73.154	27.381	30.581	32.000	27.927	28.300	219.343
United Kingdom	17.657	6.030	8.400	10.393	13.278	17.972	78.826
OPEC Countries							
Iraq	.022	.014	.025	-	1.000	-	1.061
Libya	.010	.010	1.000	.020	.022	.020	1.080
Catar	.010	-	-	1.000	-	-	1.010
Kuwait	.045	-	2.525	-	-	-	2.570
Saudi Arabia	.030	.030	2.030	-	-	-	2.090
United Arab Emirates	-	-	1.500	-	-	-	1.500
Other OPEC	.789	.158	.576	.260	.193	.092	2.064
All Other Donors	7.026	3.368	4.700	2.197	1.135	2.336	21.062
ALL COUNTRIES (excl U.S.)	217.342	90.610	105.393	120.117	142.484	149.965	823.511
Non-Governmental							
Ford Foundation	156.557	10.700	10.800	8.561	7.800	6.451	200.269
Rockefeller Foundation	57.769	6.198	5.500	4.500	4.090	5.600	63.357
TOTAL NON-GOVERNMENTAL	214.326	16.898	16.300	13.161	11.890	12.051	283.626
TOTAL: NON-U.S. GOV'T	431.668	107.508	121.693	133.278	154.374	162.016	1,109.137
U.S. GOV'T (A.I.D.)	622.359	109.975	135.460	140.350	160.540	124.925	1,353.529
GRANT TOTAL	1,054.027	217.483	257.153	273.478	314.914	346.551	2,463.606

Notes: (1) Includes all significant governmental and private sources but excludes resources available to the World Bank group.

(2) Represents bilateral and multilateral assistance, excluding funding by the World Bank group.

(3) Exchange rates employed were those in effect when the assistance was reported.

(4) The period reported is the funding period employed by the funding body—i.e. each year represents a variety of fiscal years. Amounts shown represent commitments/obligations or expenditures/disbursements, depending on the reporting practice of each funding source.

MULTILATERAL SOURCES OF POPULATION ASSISTANCE¹
(in \$ millions)

Sources / Funding Period	1965-74	1975	1976	1977	1978	1979	Cumulative Thru 79
U. N. F. P. A.	175.600	64.300	73.500	81.500	102.900	111.800	618.600
World Bank Group	66.200	40.000	11.600	29.500	72.000	102.000	321.300
I. F. P. F.	112.300	33.700	33.500	38.300	45.700	46.622	310.159

Notes: (1) U.N.F.P.A. and I.F.P.F. are accounted for in the data on primary sources of assistance; the World Bank Group represents loans rather than grants and is additive to the primary sources.

PRIMARY SOURCES OF GRANT FUNDS
FOR INTERNATIONAL POPULATION ASSISTANCE

Percentage Shares

Sources / Funding Period	1965-74	1975	1976	1977	1978	1979	Cumulative Thru 79
Major Donors (excl U.S.)							
Australia	*	*	*	*	*	.8	*
Belgium	*	*	*	.5	*	.6	*
Canada	1.9	5.7	2.0	3.9	4.4	2.8	2.9
Denmark	1.1	1.8	2.0	2.4	2.6	2.5	1.8
Fed'l Rep'c of Germany	1.5	3.4	2.7	2.8	3.8	3.7	2.6
Japan	1.3	3.6	3.5	4.5	5.2	5.5	3.2
Netherlands	1.7	3.3	3.2	3.2	3.8	4.3	2.8
Norway	3.4	6.3	7.2	9.6	9.3	9.0	6.3
Sweden	6.9	12.6	11.9	11.7	8.9	8.2	8.9
United Kingdom	1.7	2.8	3.3	3.8	5.8	5.2	3.2
<u>OPEC Countries</u>							
Iraq	*	*	*	-	*	-	*
Libya	*	*	*	*	*	*	*
Qatar	*	-	1.0	*	-	-	*
Kuwait	*	-	.8	-	-	-	*
Saudi Arabia	*	*	.6	-	-	-	*
United Arab Emirates	-	-	*	-	-	-	*
Other OPEC	*	*	*	*	*	*	*
<u>All Other Donors</u>	.7	1.5	1.8	.8	.5	.7	.9
ALL COUNTRIES (excl U.S.)	20.6	41.6	41.0	43.9	45.2	43.1	33.5
<u>Non-Governmental</u>							
Ford Foundation	14.9	4.9	4.2	3.1	2.5	1.9	8.1
Rockefeller Foundation	5.5	2.9	2.1	1.7	1.3	1.6	3.4
TOTAL NON-GOVERNMENTAL	20.4	7.8	6.3	4.8	3.8	3.5	11.5
TOTAL: NON-U.S. GOV'T	41.0	49.4	47.3	48.7	49.0	46.6	45.0
U.S. GOV'T (A.I.D.)	59.0	50.6	52.7	51.3	51.0	53.4	55.0
GRAND TOTAL	100.0						

Note: * signifies less than .5%